2019

Retiree Benefits Overview

Your Benefits, Your Choice

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices for more details.

Introduction to your 2019 Benefit Guide

Welcome to the 2019 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 http://hr.smcgov.org/employee-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 http://hr.smcgov.org/retiree-health-benefits-current-retirees if you have any questions about retiree health benefits.

Thank you.

Benefits Staff

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 http://hr.smcgov.org/employee-and-labor-relations or at page 14 (Summary of Health Benefits).

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, continued

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, Blue Shield HMO, Blue Shield Trio, Blue Shield PPO, Blue Shield High Deductible Health Plan, Kaiser High Deductible Health Plan.

If you are over 65 years old, your plan options are the following Medicare plans: Kaiser Senior Advantage, Blue Shield PPO, UnitedHealthcare Secure Horizons HMO. **(High Deductible plans are not available once you are on Medicare.)** **See Medicare plan information on page**

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 page 50.

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, continued

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 Mass Mutual 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 Mass Mutual 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, continued

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, continued

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 retiree's monthly County contribution is deposited in your bank account. This amount becomes taxable to the retiree.

Does the County's contribution cover my dependents?

Retirees can apply the County's contribution toward coverage for retiree, spouse/domestic partner, or children up to age 26.

Retiree Health FAQs, continued

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

Unfortunately IRS rules prohibit the County from allowing employees to cash 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 page 33 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, continued

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

You must complete and submit the Retiree Change Form 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 http://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 455 County Center Redwood City, CA 94063. 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, continued

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 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.

As a retiree, you have the option of terminating your 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.

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, United Healthcare-Secure Horizons or the Blue Shield Medicare PPO Plan). 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 at 455 County Center 5th Floor, Redwood City CA 94063 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.

What is a supplement to Medicare plan?

In a supplement to Medicare plan, the benefits and care you receive are coordinated with Medicare. This means that claims will first be submitted to Medicare for payment and then Blue Shield will pay as a secondary insurance, based on plan benefits.

About Medicare, continued

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 United Healthcare-Secure Horizons). This means that when you choose to enroll in Kaiser Senior Advantage or United Healthcare Group-Secure Horizons, you assign your Medicare to the insurance plan. This means that Kaiser and/or United Healthcare-Secure Horizons provides your Medicare Parts A and B coverage.

Do I need both my Medicare Card and my Kaiser, United HealthCare and Blue Shield Medicare PPO when I see medical services?

For Kaiser and United Health Care, your Medicare card is not needed.

For Blue Shield Medicare PPO, both cards are needed. Your Medicare card is required since this coverage pays as primary and your Blue Shield card is needed since this coverage pays as secondary after Medicare pays.

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, continued

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 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. **If you elect the Blue Shield Retiree PPO plan**, your non-Medicare dependents would go on either the Active Blue Shield PPO plan, or the Active HMO plan.
- You may only go the United Healthcare Group Medicare Advantage HMO plan if your dependents are Medicare-eligible or if you have no dependents.

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

- **If you are on the Active Kaiser plan,** your Medicare-eligible dependents would go on the Kaiser Senior Advantage plan.
- **If you are on the Active Blue Shield HMO plans**, your Medicare–eligible dependents would go on the Blue Shield Retiree PPO 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
San Mateo County Council of Engineers (SMCCE) Building Construction Trades Council (BCTC)	If the employee has less than 20 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. There is an annual inflation factor for those who retire with at least 15 years of service. 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 is an inflation factor of 2% for employees with 15-19 yrs of service and 4% for employees with 20+ years.
American Federation of State, County and Municipal Employees (AFSCME) Service Employees International Union SEIU) Probation and Detention Association (PDA) Law Enforcement Unit (LEU) – Deputy Sheriff's (Non-Safety)	If hired prior to January 1, 2011 (July 10, 2011 for LEU) If the employee has less than 20 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. There is an annual inflation factor for those who retire with at least 15 years of service. 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 is an inflation factor of 2% for employees with 15-19 yrs of service and 4% for employees with 20+ years. If hired on/after January 1, 2011 (July 10, 2011 for 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.

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) 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 January 1, 2011 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.
Deputy Sheriff's Association (Safety)	Employees hired prior to April 1, 2011- Tier 1 Employees If employees agreed to a continued salary deduction into the retirement Tier 1 benefit, for each eight (8) hours of unused sick leave at time of retirement, the County shall pay for one month's premium for health, dental, and/or vision coverage for the employee and eligible dependents (if such dependents are enrolled in the plan at the time of retirement) provided that the County shall not be obligated to contribute in excess of $675 per month. Employees may increase the number of hours per month to be converted up to a maximum of fifty (50) hours of sick leave per month. Employees hired after June 30, 2011 and those employees in Tier 2 For each 8 hours of unused sick leave at time of retirement, the County shall pay for one month's premium for health, dental, and/or vision coverage for the employee and eligible dependents (if such dependents are enrolled in the plan at the time of retirement) provided that the County shall not be obligated to contribute in excess of $400 per month. Employees may increase the number of hours per month to be converted up to a maximum of fifty (50) hours of sick leave per month.
Organization of Sheriff's Sergeants	The County pays $675 toward the monthly premium for health, dental and vision plans for every 8 hours of sick leave remaining upon retirement. The employee can use up to 50 hours of sick leave to pay for the monthly premium, and can keep all three County plans in retirement.

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 Kaiser Permanente and Blue Shield.

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. More information about Kaiser's health plan benefits is available at http://hr.smcgov.org/employee-benefits; click on Medical Plans.

Kaiser Permanente High Deductible Health Plan - This is a plan that works in conjunction with a Health Savings Account (please see page 42). 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 the rest of the year.

Medical Benefits for Retirees Under 65

blue of california

Blue Shield HMO – a Health Maintenance Organization (HMO) in which patients seek medical care from a doctor participating in the plan's network. If you join Blue Shield, you select a PCP within Blue Shield's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated through your PCP and will require a referral or authorization. More information about Blue Shield's health plan benefits is available at http://hr.smcgov.org/employee-benefits ; click on Medical Plans.

Blue Shield Trio ACO HMO – Trio is powered by a new innovation in healthcare: the accountable care organization (ACO). An ACO is a network of doctors and hospitals that share responsibility in providing high-quality coordinated care when needed while lowering the cost of delivering care more efficiently.

Trio works similar to a traditional HMO plan.

Blue Shield PPO – a Preferred Provider (PPO) plan allows members the flexibility to receive medical services from a PPO network doctor or out-of-network doctor.

- In Network (PPO): Medical services are provided through the Blue Shield PPO network. You are responsible for paying an annual deductible and a percentage of the cost of the services (generally 20% of Blue Shield'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 Blue Shield's allowable amount).

*Note: The Blue Shield Medical PPO Out of Area is closed to new enrollees. Please contact the Benefits Division for more information.

Blue Shield High Deductible Health Plan - This is a plan that works in conjunction with a Health Savings Account (please see page 41). You use the same PPO Network that you would under the standard PPO 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 Over 65

KAISER PERMANENTE

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. More information about Kaiser's health plan benefits is available at http://hr.smcgov.org/employee-benefits ; click on Medical Plans. Early Retirees can remain on the Kaiser plan; once you reach age 65, you will need to enroll in the Kaiser Senior Advantage plan.

UnitedHealthcare Secure Horizons HMO – a Health Maintenance Organization (HMO) in which patients seek medical care from a doctor participating in the plan's network. If you join United Healthcare, you select a PCP within Secure Horizon's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated through your PCP and will require a referral or authorization. More information about Secure Horizon's health plan benefits is available at http://hr.smcgov.org/employee-benefits ; click on Medical Plans.

blue of california

Blue Shield PPO – a Preferred Provider (PPO) plan allows members the flexibility to receive medical services from a PPO network doctor or out-of-network doctor.

- In Network (PPO): Medical services are provided through the Blue Shield PPO network. You are responsible for paying an annual deductible and a percentage of the cost of the services (generally 20% of Blue Shield'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 Blue Shield's allowable amount).

*Note: The Blue Shield Medical PPO Out of Area is available to retirees who are living out of state. Please contact the Benefits Division for more information.

Comparison of Health Plans for Retirees

UNDER 65

	BLUE SHIELD TRADITIONAL HMO & TRIO	KAISER HMO	BLUE SHIELD PPO In-Network	BLUE SHIELD PPO Out Of Network
Deductible	None.	None.	$200 per person/$600 per family.	$500 per person/ $1000 per family.
Maximum Annual Out of Pocket	$1,000 per person/up to $3,000 per family	$1,500 per person/$3,000 per family	$2,000 per person/ $4,000 per family.	$4,000 per person/ $8,000 per family.
Service Area	Limited to a 30 mile radius in Blue Shield HMO service area. Emergency care Worldwide.	Limited to Kaiser Permanente HMO service areas. (See Kaiser's zip code listing.) Worldwide in cases of emergency only.	Limited to Blue Shield preferred provider service area. Over 47,000 providers in California. Emergency Care Worldwide.	Nationwide. Emergency Care Worldwide.
Choice of doctors and hospitals	Limited to plan doctors and hospitals as chosen by primary physicians except in emergency.	Limited to Kaiser Permanente facilities and plan physicians except in emergency.	Limited to Blue Shield preferred providers.	Complete choice of covered providers.
Physician /Professional Service				
Preventive Health Care, including physical exams, pediatric and adult immunizations, mammograms, and well baby care	Covered in full.	Covered in full.	Covered in full.	Not Covered.
Physician Office Visit	$15 per visit. $30 per visit Access+ Specialist benefit (self-referred office visits and consultations only).	$15 per visit.	Paid at 80%. Not subject to the calendar year deductible.	Paid at 60%.
Physician Hospital Visit/Consultation	Covered in full.	Covered in full.	Paid at 80%.	Paid at 60%.
Surgical Procedures, In-Patient Surgery	Inpatient: After $100 hospital copay, covered in full.	Inpatient: After $100 Copay, covered in full	Paid at 80%.	Paid at 60% (up to $600 per day)
Out-Patient Surgery or Surgery in Office	Outpatient: $50 per visit	Outpatient: $50 per visit.	Paid at 80%.	Paid at 60%. (max of $350 per day.)
Maternity Care. Hospital and Delivery - Normal Delivery (up to 48 hour stay) - Caesarian Section (up to 96 hour stay)	$100 per admission.	$100 per admission. No limit on length of stay (determined by your physician).	Paid at 80%.	Paid at 60% (up to $600 per day)
Obstetrician Visits (pre and post natal)	Covered in full.	Covered in full.	Paid at 80%.	Paid at 60%.
Out-Patient Services				
Lab and X-Ray Diagnostic	Covered in full.	$5 per visit.	Paid at 80%.	Paid at 60%.
Allergy Injection	$15 per visit.	$5 per visit.	Paid at 80%.	Paid at 60%.
Allergy Testing	$15 per visit.	Covered in full.	Paid at 80%.	Paid at 60%.
Physical Therapy, Short-Term	$15 per visit.	$15 per visit. (60-days per evaluation)	Paid at 80%.	Paid at 50%.

Comparison of Health Plans for Retirees

UNDER 65

	BLUE SHIELD TRADITIONAL HMO & TRIO	KAISER TRADITIONAL HMO	BLUE SHIELD PPO In-Network	BLUE SHIELD PPO Out Of Network
Hospital Benefits				
In-Patient Physician Benefit	Covered in full.	Covered in full.	Requires prior authorization except for emergency. Paid at 80%	Requires prior authorization except for emergency. Paid at 60%.
Second Surgical Opinion	Inpatient: Covered in full. Outpatient: $15 per visit	Inpatient: Covered in full. Outpatient: $15 per visit.	Paid at 80%	Paid at 60%
Room and Board	$100 co-pay per admission.	$100 co-pay per admission.	Covered at 80% for semi-private room.	Covered at 60% for semi-private room (up to $600 per day)
Emergency Room Treatment	$100 per visit co-payment. Waived if admitted to hospital.	$100 per visit. Waived if admitted.	$100 per admission for emergency (not subject to the calendar year medical deductible)	
Urgent Care	$50 for Urgent service outside service area.	$15 for Urgent Care		
Ambulance (emergency)	$100 per trip	$50 per trip	Paid at 80% of billed rate.	Paid at 60% of billed rate.
Special Care Units	Covered in full.	Covered in full.	Paid at 80%	Paid at 60%
Hospital Lab and Ancillary Charges	Covered in full.	Covered in full.	Paid at 80%	Paid at 60% (up to $600 per day)
Skilled Nursing Facility Care	Covered in full (100-day max per year).	Up to 100 days per benefit period. Covered in full as prescribed. (Must reside in a Kaiser Permanente service area.	Paid at 80%	Freestanding: 80% Hospital: 60%
Hospice Care	Covered in full in service area.	Covered in full in service area.	Not Covered	Not Covered
Home Health Care, medically necessary	Covered in full in service area (100 visits per year)	Covered in full in service area (100-d). Must reside in a Kaiser service area.	Paid at 80%	Not Covered.
Prescription Drugs				
Prescription Drugs	$15 generic, $25 brand, $40 non-formulary per prescription or refill at retail up to a 30 day supply. $30 generic, $50 brand, $80 non-formulary per prescription or refill for mail order for 31-90 day supply.	$10 generic, $20 Brand, per 100-day supply for maintenance drugs. Must be filled at Kaiser Permanente pharmacy. 50% of member rate for all drugs associated with covered infertility services. Mail order available for refill only.	$15 generic, $30 formulary brand, $45 non-formulary brand are retail per 30 day supply	Non-Participating Pharmacy: $15/$30/$45 + 25%
			Mail Order: $30/$60/$90 for 90-day supply	Mail Order: Not covered.
Nicotine Replacement Therapy (PATCH)	Not Covered.	Provided at drug copay. Must attend Smoking Cessation Class.	Not Covered	

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail.

Comparison of Health Plans for Retirees

UNDER 65

	BLUE SHIELD TRADITIONAL HMO & TRIO	KAISER HMO	BLUE SHIELD PPO	
			In-Network	Out Of Network
Mental Health Services				
Inpatient Hospital	$100 per admission. Medically necessary only. Pre auth required except emergency.	$100 per admission	Paid at 80%.	Paid at 60% (up to $600/day)
Outpatient	$15 copay	$15 copay; $7 group	Paid at 80% (not subject to calendar year deductible)	Paid at 60%.
Substance Abuse Services				
Inpatient Hospital	$100 per admission.	$100 per Admission	Paid at 80%.	Paid at 60% (up to $600/day)
Residential care	$100 per admission	$100 per Admission (detox only)	Paid at 80%.	Paid at 60% (up to $600/day)
Outpatient	$15 per visit	$15 copay; $5 per group visit	Paid at 80% (not subject to calendar year deductible)	Paid at 60%.
Family Planning				
Physicians Family Planning Services	Covered in full.	Covered in full.	Covered in full.	Paid at 60%.
Vasectomy	$75 co-pay	$50 per procedure.	Paid at 80%.	Not covered.
Tubal Ligation	Covered in full.	$50 per procedure.	Covered in full.	Paid at 60%.
Elective Abortion	$100 co-pay.	$50 per procedure.	Paid at 80%.	Paid at 60%.
Infertility				
Infertility Testing and Treatment	Pays 50% of allowable charges.	Pays 50% of allowable charges.	Not covered.	Not covered.
Assisted Reproductive Technology (ART): Gamete Intrafallopian Transfer GIFT), Zygote Intrafallopian Transfer (ZIFT), In-Vitro Fertilization (IVF), or cryopreserved embryo transfer	Not Covered.	Pays 50% of allowable charges.	Not covered.	Not covered.
Artificial Insemination	Not Covered.	Pays 50% of allowable charges.	Not covered.	Not covered.
Procurement and storage of semen and eggs	Not Covered.	Not Covered.	Not Covered.	Not Covered.
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	Covered in full	20% of non-member rates (must reside in a Kaiser Permanente service area).	Paid at 80%.	Paid at 60%.
Orthotic and Prosthetic Devices	Covered in full. Subject to limitations & exclusions.	Covered in full. Subject to limitations and exclusions.	Paid at 80%.	Paid at 60%.
Acupuncture and Chiropractic	$10/30 combined visits	$15/20 combined visits	Paid at 80%. (Combined 30 visits per calendar year)	Paid at 60%.

Comparison of Health Plans for Retirees

UNDER 65

	BLUE SHIELD OF CALIFORNIA HDHP		KAISER PERMANENTE HDHP
	In-Network	Out of Network	
Benefits			
Calendar Year Deductible Single / Family	$1,500/$3,000		$1,500 / $3,000
Annual Out-of-Pocket Maximum			
Single / Family	$3,000/$6,000	$6,000/$12,000	$3,000 / $6,000
Lifetime Maximum	Unlimited		Unlimited
Physician Office Visit	10%	40%	10%
Specialist Copay	10%	40%	10%
Preventive Care	No Charge (deductible waived)	Not Covered	No Charge (deductible waived)
Physical and Occupational Therapy	10%	50%	10%
Speech Therapy	10%	40%	10%
Lab and X-Ray	10%	40%	10%
Chiropractic	10%	50%	Not Covered
Acupuncture	Not Covered	Not Covered	Not Covered
Hospitalization			
Inpatient Hospitalization	$100 per admit + 10%	40%	10%
Outpatient Surgery	10%	40%	10%
Other Benefits			
Ambulance	10%	10%	10%
Emergency Room	$100 + 10%	$100 + 10%	10%
Durable Medical Equipment	20%	40%	20% Coinsurance
Skilled Nursing Facility	No Charge	30%	No Charge
Hospice	No Charge	Not Covered	No Charge
Transgender	Covered		Covered
Mental Health			
Inpatient	20%	40%	$100 per admission
Outpatient	20%	40%	$15 (individual); $7 (group)
Substance Abuse			
Inpatient	20%	40%	$100 per admission
Outpatient	20%	40%	$15 (individual); $5 (group)
Prescription Drugs			
Retail (100 day supply)	$10/$25/$40	$10/$25/$40 + $25%	$10 / $30 (30 day supply)
Mail Order (90 day supply)	$20/$50/$80	Not Covered	$20 / $60
Specialty Drugs	30% (up to $200 copay max/drug)	Not Covered	

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 Health Plans for Retirees

OVER 65

MEDICAL BENEFITS	KAISER SENIOR ADVANTAGE	UNITEDHEALTHCARE SECURE HORIZONS HMO	BLUE SHIELD PPO
Deductible	None.	None.	$300 per person/ $900 per family.
Maximum Annual Out of Pocket Maximum	$1,500 per person/$3,000 per family	$6,700 per person.	In Network: $2,000 per person/ $4,000 per family Out of Network: $3,000 per person/$6,000 per family
Service Area	Limited to Kaiser Permanente medical facilities service areas. Worldwide in emergency only.	Limited to a 30-mile radius for Non-emergency Care. Emergency Care Worldwide.	Nationwide. Emergency Care Worldwide.
Choice of Doctors and Hospitals	Limited to Kaiser-Permanente doctors and hospitals except in emergency.	Limited to Provider Contracts	Preferred Providers and Non Preferred Providers
HOSPITAL BENEFITS			
Inpatient/Room & Board Out Patient Surgery Emergency Room	Covered in full. $10 per procedure. $20 (waived if admitted)	$250 copay. $125 copay. $50 (waived if admitted)	Medicare pays as primary. BSC pays as secondary (deductible waived if Medicare pays as primary).
Hospice Care	Provided by licensed hospice approved by the medical group and certified by Medicare.	Provided by licensed hospice approved by the medical group and certified by Medicare.	100% preferred; 100% if pre authorized for non-preferred.
Skilled Nursing Facility	Covered in full up to 100 days per benefit period.	Days 1-20: Covered in full Days 21-100: $50 copay up to 100 days per benefits period.	Medicare pays as primary. BSC pays as secondary (deductible waived if Medicare pays as primary).

Comparison of Health Plans for Retirees

OVER 65

MEDICAL BENEFITS	KAISER SENIOR ADVANTAGE	UNITEDHEALTHCARE SECURE HORIZONS HMO	BLUE SHIELD PPO
Physician Care	$10 per office visit	$10 copay Primary Physician $20 copay Specialists	Medicare assigned providers: 100%. Blue Shield covers 80% for preferred providers; 60% for non-preferred providers, less Medicare payments. Subject to the $300 per person/$900 per family deductible.
Preventive Care (including annual gynecological exams and mammograms)	Covered in full.	Covered in full.	Medicare assigned providers: 100% Covered in full for preferred providers; non-preferred at 60% after deductible
Vision (Optical)	$10 per exam $150 combined allowance for lenses & frames every 24 months	Covered in full annual exam every 12 months $20 copay for specialists.	Not covered.
Dental Care	Not covered	Basic Dental Benefit (See Fee Schedule)	Not covered.
Hearing Services	Routine Exam: $10 co-pay Hearing Aids: Not covered	Covered in full. Routine hearing exam. $20 Specialist Hearing Aids: $500 every 36 months.	Not covered.
Acupuncture/Chiropractic Services	$15/20 combined visits	Covered under Medicare-50% coinsurance.	Acupuncture and chiropractic are limited to a combined 20 visits per calendar. After the calendar year deductible has been met, plan pays at 80% preferred provider; 60% non-preferred provider. (chiropractic reduced by Medicare payment) *Acupuncture for non preferred providers is not covered
Prescriptions	Retail: $10 per prescription 100 day supply for most maintenance medications. Unlimited Annual Maximum	Retail: 30 day supply. $10 generic, $20 brand Mail order: 90 day supply $20 generic, $40 brand Unlimited Annual Maximum	Retail: $10.00 generic, $20.00 brand, $35.00 non-formulary. 30 day supply. Mail order: 90 day supply $20 generic, $40 brand, $60 non-formulary Unlimited Annual Maximum

Enhanced Services

FREE VIDEO CONSULTATIONS

KAISER PERMANENTE MOBILE APP

Getting the right care at the right time just got easier with the KP 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

Enhanced Services

Kaiser Permanente gives you choices on how you can have access to care for non-emergency issues.

See your doctor in person.

Opt for a free telephone appointment with your PCP.

Call Kaiser's advice nurses, 24/7 at (866) 454-8855

Schedule a free video visit with your PCP (if available). Visit www.kp.org/mydoctor/videovisits for more information.

Email your doctor's office.

If you reasonably believe you have an emergency medical condition, which is a medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health, call 911 or go to the nearest emergency department.

Enhanced Services

INTRODUCING BLUE SHIELD'S OPEN ENROLLMENT APP!

Open enrollment is in the palm of your hands, literally.

Apps let you do almost anything on your mobile devices – and now you can use them to select a plan during Open Enrollment (OE) this fall.

Downloading the app is easy. Just go to the App Store SM or Google Play SM and search for "Blue Shield Open Enrollment." Download the app and enter the access code: **smc**

With Blue Shield of California's OE App, you can:

- **View details** such as plan copayments, out of pocket expenses and health and wellness programs and services
- **Search for doctors and hospitals** near your home or work
- **Download** helpful **Open Enrollment documents** to get more details
- Contact your dedicated Member Services team seven days a week
- **Learn about** the many programs and services available to you

For more detailed download instructions please visit blueshieldca.com/oeapp

TELADOC

Blue Shield of California is excited to offer Teladoc™ –

A new and convenient way to access quality care. Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many of your non-emergency medical issues through phone or video consults. When you need care, a Teladoc doctor is just a call or click away. For a $5 copay, you can use Teladoc for treatment of many medical conditions including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

Visit Teladoc.com/bsc to learn more and to set up your account.

Enhanced Services

Introducing Virtual Doctor Visits for UnitedHealthcare® Group retirees. Talk to a doctor whenever, wherever.

Starting January 1, 2017, you will be able to see a doctor any time, any day, from wherever you can access a strong internet connection. Experience a live video chat* with a doctor using your computer, tablet or smartphone. Ask questions, get a diagnosis, even get medication prescribed** and have it sent to your pharmacy. Doctor on Demand and American Well (AmWell) have joined the UnitedHealthcare provider network to bring you this innovative service.[1]

Here are answers to some common questions.

How much does it cost?

A virtual doctor visit with Doctor on Demand or AmWell has a $0 co-pay.

How quickly can I talk to someone and how long does a visit last?

Once a request for a visit has been submitted, the average wait time is about 5–10 minutes. A typical visit lasts 10 minutes.

Who will I be talking to?

You can find a list of participating virtual doctor visit providers by logging in online at www.UHCRetiree.com.

Can I use it for any medical situation?

Virtual visits may be best for situations like a cold, flu, skin rash or eye issue. You will be advised by the virtual provider if an in-person visit is appropriate. Virtual Visits are not appropriate for serious or emergency medical situations.[2]

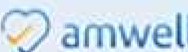
Get started.

On your computer:

1. Go to **www.UHCRetiree.com.**
2. Sign in with your user name and password.
3. Click on the Virtual Visits toolbox to view your virtual provider group choices, access their websites and set up an appointment.

On your tablet or smartphone:

Download the Doctor on Demand app



Or, download the American Well app

* The device you use must be webcam-enabled.

**Doctors cannot prescribe medications in all states.

[1] Providers listed may not be available in every area. Other providers are available in our network. Contact the Customer service number on the back of your Member ID card for more information.

[2] This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

Dental Benefits

The County offers two voluntary dental plans for retirees: **DeltaCare Dental HMO and Cigna PPO**.

DeltaCare® USA

DeltaCare –Under this plan, you select a DeltaCare USA network dentist to provide your dental care. With DeltaCare USA, you must visit your selected primary care dentist to receive benefits. When you need specialty care, your primary care dentist can obtain a referral. Advantages of the DeltaCare USA plan include low or no copayments for services, no deductibles and no maximums on services provided by primary care dentists. You will receive a schedule of copayments, which lets you know your copayment responsibility for each service, as well as which services are covered.

Cigna – a Preferred Provider Organization (PPO) plan in which dental services are provided through the Blue Shield 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.

More information about the dental plans are available online at http://hr.smcgov.org/employee-benefits; click on Retiree Plans.

Voluntary Dental Plans

Dental Benefits	ADA code	DeltaCare (DHMO)	Cigna (Core)		Cigna (Management)	
Diagnostic and Preventive		Member Pays:	In Network	Out of Network[1]	In Network	Out of Network[1]
Office Visit Teeth Cleaning X-Rays Sealants - *per tooth*	0999 1110 0210 1351	No Charge No Charge No Charge No Charge	No Charge	Plan Pays 80% (no deductible)	Plan Pays 100%	Plan Pays 100%
Restorative						
Amalgam Filling - *1-3 surfaces* Composite Filling - *1-3 surfaces*	2140-60 2330-32	No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)	Plan Pays 100%	Plan Pays 100%
Periodontics						
Scaling and Root Planning - per quad Gingivectomy (Per Quadrant) Osseous Surgery	4341 4210 4260	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)	Plan Pays 100%	Plan Pays 100%
Endodontics (Root Canal Therapy)						
Pulp Cap Therapeutic Pulpotomy Root Canal Therapy - (anterior, bicuspid, molar)	3110 3220 3310-30	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)	Plan Pays 100%	Plan Pays 100%
Prosthodontics						
Immediate - Upper or Lower Complete - Upper or Lower Partial Denture - Upper or Lower	5130-40 5110-20 5213	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 50% (after deductible)	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	2510-44 2740 2750 2790	No Charge No Charge No Charge No Charge	Plan Pays 50% (after deductible)	Plan Pays 50% (after deductible)	Plan Pays 100%	Plan Pays 100%
Oral Surgery (Extractions)						
Impacted tooth: soft tissue Impacted tooth: partial bony Impacted tooth: full bony	7220 7230 7240	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)	Plan Pays 100%	Plan Pays 100%
Implants						
Implants	6010-6013	Not Covered	Plan Pays 50% Up to $1,500	Plan Pays 50% Up to $1,500	Plan Pays 100%	Plan Pays 100%
Orthodontics - comprehensive						
Child Adult	8070 8090	$1,000 $1,000	Not Covered		Not Covered	
Calendar Year Maximum						
Individual		N/A	$1,500	$1,500	None	
Calendar Year Deductible						
Individual / Family		N/A	$50 / $150		None	

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

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.

Vision Benefits	In Network	Out-of-Network Reimbursement
Exam Copay	$10	Up to $50
Prescription Glasses Copay	$10	Up to $70
Annual Eye Exam	Covered in Full	Up to $50
Single Lenses	Covered in Full	Up to $50
Bifocal Lenses*	Covered in Full	Up to $75
Trifocal Lenses*	Covered in Full	Up to $100
Contacts Fit & Follow Up Exams	15% Discount	No Benefit
Contact Lenses**		
Elective	Up to $150; 15% off over $150	Up to $105
Medically Necessary	Covered in Full	Up to $210
Frames	$130 Allowance; 20% off over $130	Up to $70
Benefit Frequency		
Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	

* Progressive bifocals may be purchased for the difference in cost
** Contact lenses are in lieu of spectacle lenses and frames

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.

2019 Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES UNDER 65

CARRIER	MONTHLY PREMIUM
KAISER HMO	
Employee Only	685.22
Employee +1	1,370.44
Employee + Family	1,939.20
KAISER HDHP	
Employee Only	537.94
Employee +1	1,075.88
Employee + Family	1,522.38
BLUE SHIELD HMO	
Employee Only	1,144.32
Employee +1	2,288.64
Employee + Family	3,238.44
BLUE SHIELD TRIO HMO	
Employee Only	979.20
Employee +1	1,958.40
Employee + Family	2,771.14
BLUE SHIELD HDHP	
Employee Only	882.90
Employee +1	1,765.80
Employee + Family	2,498.62
BLUE SHIELD PPO	
Employee Only	1,362.04
Employee +1	2,828.90
Employee + Family	4,116.40
BLUE SHIELD PPO (Out-Of-Area)[1]	
Employee Only	1,165.56
Employee +1	2,425.94
Employee + Family	3,581.10

[1] Closed to new enrollees.

2019 Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES 65 AND OVER

HMO PLANS

KAISER SENIOR ADVANTAGE

Single - Subscriber with Medicare	383.86
Two-Party - Subscriber with Medicare & Spouse with Medicare	767.72
Two-Party - Subscriber with Medicare & Dependent without Medicare	1,069.08
Two-Party - Subscriber without Medicare & Spouse with Medicare	1,069.08
Family - Subscriber with Medicare & Children without Medicare	1,637.84
Family - Subscriber with Medicare, Spouse without Medicare, & Child without Medicare	1,637.84
Family - Subscriber without Medicare, Spouse with Medicare, and Child without Medicare	1,637.84
Family - Subscriber with Medicare, Spouse with Medicare, and Children without Medicare	1,336.48
Family - Subscriber with Medicare, Spouse without Medicare, and Children without Medicare	1,637.84
Family - Subscriber without Medicare, Spouse with Medicare, and Children without Medicare	1,637.84
Family - Subscriber without Medicare, Spouse with Medicare, and Children with Medicare	1,452.56
Family - Subscriber with Medicare, Spouse with Medicare, and Children with Medicare	1,151.20

UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE

Single - Retiree with Medicare	394.86
Two-Party - Both with Medicare	789.72

BLUE SHIELD ACCESS+ HMO and PPO (Medicare)

Two-Party - Ret with Medicare (PPO), Spouse w/o (HMO)	1,764.74
Two-Party - Ret w/o Medicare (HMO), Spouse with Medicare (PPO)	1,764.74
Family - Ret with Med (PPO) + Spouse and Child without (HMO)	2,714.54
Family - Ret & Spouse with Med (PPO) & Child without Medicare (HMO)	2,385.16

BLUE SHIELD HMO TRIO and PPO (Medicare)

Two-Party - Ret with Medicare (PPO), Spouse w/o (TRIO HMO)	1,599.62
Two-Party - Ret w/o Medicare (TRIO HMO), Spouse with Medicare (PPO)	1,599.62
Family - Ret with Med (PPO) + Spouse and Child without (TRIO HMO)	2,412.36
Family - Ret & Spouse with (PPO) & Child without Medicare (TRIO HMO)	2,220.04

2019 Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES 65 AND OVER

PPO PLANS

BLUE SHIELD PPO (COB Plan)

Single - Retiree with Medicare	620.42
Two-Party - Both with Medicare	1,240.84
Two-Party - Ret w/o Medicare (PPO), Spouse with Medicare (PPO)	1,982.46
Two-Party - Ret with Medicare (PPO), Spouse w/o (PPO)	2,087.28
Family - Ret with Med (PPO) + Spouse and Child without (PPO)	3,374.78
Family - Ret with Med, Spouse with Medicare & Child(ren) with Medicare	1,861.26

BLUE SHIELD PPO (Out of Area)[1]

Two-Party - Ret with Medicare (PPO), Spouse w/o (OOA PPO)	1,880.80
Two-Party - Ret (OOA PPO) + Spouse with Medicare (PPO)	1,785.98
Family - Ret (OOA PPO) + Spouse with Medicare (PPO) + Child (OOA PPO)	3,046.36

[1] Closed to new enrollees.

2019 Monthly Cost of Voluntary Dental & Vision Benefits

VOLUNTARY CIGNA DENTAL PPO

Single	41.18
Two-Party	79.28
Family	142.21

VOLUNTARY DELTA DENTAL DHMO

Single	27.63
Two-Party	46.97
Family	71.84

VOLUNTARY VISION SERVICE PLAN (VSP)

Single	9.29
Two-Party	18.58
Family	29.91

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.

CIGNA DENTAL PPO

Management	141.35
Represented	114.08

DELTA DENTAL DHMO

Management	44.97
Represented	44.97

VISION SERVICE PLAN (VSP)

Management (Composite Rate)	16.05

2019 Monthly Cost of Health Benefit

OPERATING ENGINEERS

UNDER 65

PPO, DENTAL AND VISION

Employee Only	770.00
Employee +1	1,540.00
Employee + Family	2,079.00

KAISER, DENTAL AND VISION

Employee Only	854.00
Employee +1	1,708.00
Employee + Family	2,228.00

OVER 65

KAISER (MEDICARE)

Single - Subscriber with Medicare	466.00
Two-Party - Subscriber with Medicare & Spouse with Medicare	931.00
Family - Subscriber with Medicare, Spouse with Medicare, and Children with Medicare	1,375.00

PPO (MEDICARE)

Single - Subscriber with Medicare	770.00
Two-Party - Subscriber with Medicare & Spouse with Medicare	1,540.00
Family - Subscriber with Medicare, Spouse with Medicare, and Children with Medicare	2,079.00

Retiree Billing Process with BCC

Thirty (30) to ninety (90) 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).**

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 can be provided to BCC Customer Service at 800-685-6100 or to the Benefits Division at (650) 363-1919.

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

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

blue of california

Health and Wellness

- Flexible gym membership programs
- Weight management programs (under Wellvolution Diabetes Prevention Program)

Alternative Care (via American Specialty Health Group network)

- 25% off usual & customary fees on acupuncture, chiropractic & massage therapy services

Discount Hearing Program

- 30% to 60% off manufacturers' SRP on major brands through EPIC Hearing Healthcare. To learn more, call EPIC at (866) 956-5400 or visit **epichearing.com**

Vision Discounts

- Discounts on LASIK surgery. To find out if you are a potential candidate, call (877) 437-6110 or visit qualsight.com/-lasikca
- Get a 15% discount for services from NVISION Laser Eye Centers. To learn more, call NVISION at (877) 91-NVISION or (877) 916-8474, or visit NVISIONcenters.com to find a provider.

Learn more

See all the ways you can save money and take better care of yourself at
www.blueshieldca.com/wellnessdiscounts

KAISER PERMANENTE

Wellness Resources

- Nurseline

On-line Resources

- 10,000 Steps Program
- Stop Smoking Program
- Weight Management Program
- Healthy Discounts
- Fitness Discounts
- Weight Watchers Discounts
- Tools and Calculators
- Wellness Library

Kaiser Facility Programs

- Managing Chronic Conditions
- Losing Weight
- Eating Healthy
- Managing Diabetes
- Quitting Smoking
- Reducing Stress
- Managing Depression & Anxiety
- Getting a Good night's Sleep
- Managing Back Pain

1-800-464-4000
www.kp.org/healthylifestyles

Wellness Resources

AARP MedicareComplete® Program

EverCare Solutions for Caregivers
1-866-896-1895

- Optum Programs
- Nurseline services
- Wellness Advising Program
- Discounts on Vision, cosmetic dental, alternative care, wellness products, and long-term care services

1-866-832-8671
AARP Secure Horizons
1-888-422-6000 | TTY: 1-866-832-8671

Health Savings Account

ADMINISTERED BY OPTUM (formerly Wells Fargo)

A Health Savings Account (HSA) is a special "tax advantaged" account owned by an individual that is used in conjunction with a High Deductible Health Plan (HDHP).

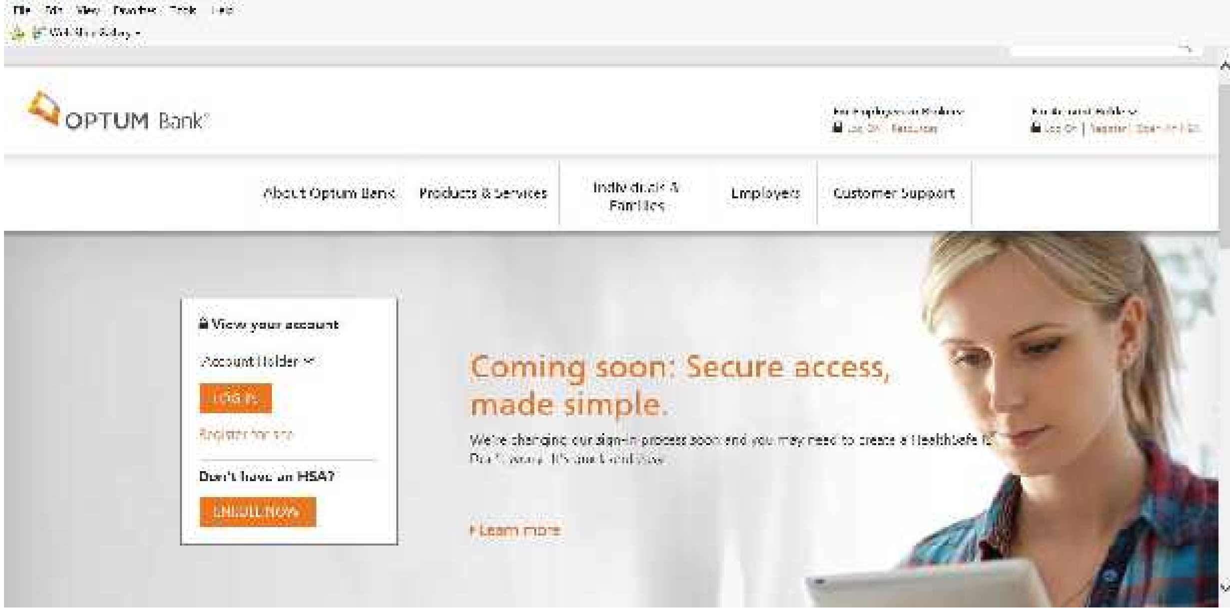
- This account comes with a debit card that you can use to pay for qualified medical expenses. For a detailed list of qualified medical expenses and further information, please refer to the plan documents. You will also be able to access your account online at www.optumbank.com
- In 2019, you can contribute a maximum of **$3,500** for employee only or **$7,000** for employee + one or more.
- Since your medical expenses may change within the year, you may change (increase or decrease) your contributions at any time.
- As an early retiree (under age 65), you are eligible to enroll in an HSA. You must contact Optum Bank directly to enroll as this enrollment is not handled through the County Benefits Division. Optum Bank can be reached at 800-234-8913 or www.optumbank.com

This money to help pay for qualified medical expenses.

- If you have remaining funds at the end of the year, they will roll over into next year, there is no "use it or lose it" rule.
- These funds can also earn interest or you can choose to invest the funds using the online investment tool. (Plan minimums apply)
- If you decide you do not want to be enrolled in the HDHP plan, this account stays with you.
- You may only contribute to the account if you are enrolled in a HDHP plan.

You may not continue to contribute to an HSA account once you are enrolled in Medicare. When you turn 65,

- You can use any unused funds in the account for any purpose, penalty free, but you will be subject to ordinary income tax.



Key Carrier Contacts At-A-Glance

BLUE SHIELD TRIO CONCIERGE		
Group #W0014027	www.blueshieldca.com	(855) 829-3566
BLUE SHIELD HMO (Under 65) BLUE SHIELD PPO (65+)		
Group # W0014027	www.blueshieldca.com	(855) 256-9404
KAISER PERMANENTE SENIOR ADVANTAGE (65+) TRADITIONAL HMO (UNDER 65)		
Group #7056-0005	www.kp.org	(800) 464-4000
UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE HMO (65+)		
Group #515318	www.uhcretiree.com	(877) 714-0178
DELTACARE® USA (DENTAL—DHMO)		
71444-0003 (Retiree) 71444-0005 (Ret-Voluntary)	www.deltadentalins.com	(800) 422-4234
CIGNA (DENTAL — DPPO)		
Group # 3340005	www.cigna.com	(800) 244-6224
VSP (VISION)		
Group #25600	www.vsp.com	(800) 877-7195
OPTUM (Health Savings Account)		
County of San Mateo	www.optumbank.com	(844) 326-7967
THE STANDARD (Life)		
Group #649107	www.standard.com	(800) 628-8600
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
BENEFIT COORDINATORS CORPORATION (BCC) COBRA		
County of San Mateo	www.benxcel.com	(800) 685-6100

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

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

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

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

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. Call your health plan's Member Services for more information.

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 carrier directly at the number at the back of your medical card.

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 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 rights, you may add the dependent to your current coverage or change to another health plan.

NOTICE OF CHOICE OF PROVIDERS

Health Maintenance Organization (HMO) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, your carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your carrier directly. For children, you may designate a pediatrician as the primary care provider.

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

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, Blue Shield 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, 2019

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

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
☐ Reduction in hours of employment
☐ Death of employee
☐ Divorce or legal separation
☐ Entitlement to Medicare
☐ 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 http://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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid

Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 Benefits Division.

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 value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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 received 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

RETIREE HEALTH ENROLLMENT FORM

San Mateo County Human Resources Department ~ Employee Benefits Division
455 County Center, 5th Floor, Redwood City, CA 94063 Phone: (650) 363-1919 | Fax: (650) 599-1573 benefits@smcgov.org

Name (First and Last – M.I. If applicable)				SSN
DOB	DOH	Term Date	Eff Date of Retiree Health	Employee Group

☐ I have received a copy of the County's Retiree Benefits Guide and understand the retiree health benefits afforded to me under the Memorandum of Understanding (MOU) or Resolution for my employee group.

☐ I understand that my active benefits terminate on last day of the month of my termination date, and that my retiree health benefits commence on first day of the month following termination date.

☐ I understand that the County will only contribute to the cost of my retiree health premiums if I have unused sick leave at retirement (or additional sick leave credits are provided to me per MOU or Resolution). If I have no sick leave at the time of retirement or if I exhaust all of my sick leave credits, I can remain on the County's retiree health plan and pay the full premium cost.

☐ I understand that I can change my retiree health elections or the amount of sick leave credits I use per month (up to 14 hours per month) during Open Enrollment in October every year. Changing the sick leave credit amount increases or decreases the County's monthly contribution to my premium cost.

☐ I understand that I must notify the Benefits office in the event of a divorce, marriage, death of spouse – or any other life event that impacts your benefit elections, and that changes to benefits must be made within 30 days of the life event.

☐ I understand that if I move out an existing HMO coverage area, I have the option of enrolling the County's Alternate Health Plan. If I elect the Alternate Health Plan, I am required to show proof of alternate coverage and cost of coverage on a annual basis.

☐ I understand that if I drop my retiree health coverage, I waive all my rights to use any remaining sick leave credits, and I will only be allowed to enroll in the Voluntary Dental and Voluntary Vision Plans. I will not be able to re -enroll in the County's Health Plans at a later date.

☐ I understand that I have 30 days from the date of termination to elect to continue my life insurance in retirement. Contact Standard Life Insurance at 800-378-4668 ext. 6785 for more information. (Group # 649107)

☐ I understand that survivor benefits extend to my spouse and family, provided they are currently enrolled on my plan and a designated beneficiary with SamCERA.

☐ I understand that I am responsible for paying any premium cost not covered by the County's contribution. I have submitted the Electronic Fund Transfer (EFT) form to the County of San Mateo and the cost will be deducted through EFT. I understand that I will be billed for any amount that was not deducted from my account.

☐ I understand and agree that BCC will deduct from my account any insurance premium rate changes, or at the expiration of my sick-leave credits.

☐ I understand that I will receive a letter 3 months prior to my sick leave running out. At which time I may request any or all of my coverage be termed in writing. Otherwise, my coverage will continue and I will be responsible for the premiums.

☐ I understand that I am required to enroll in Medicare Parts A & B when I turn 65 years old. If I do not enroll in Medicare at that time, I (and any family members) will be dropped from coverage.

Sick Leave Credits

I elect to use ______ sick leave credits per month toward the cost of my retiree health benefits. Based on this election, my sick leave credits is estimated to expire on _______________, after which I will be responsible for paying the entire of cost of the insurance.

For computation of estimated sick leave credits, see worksheet.

_______________________________________ _______________________________

Retiree Signature Date HR Benefits Partner Date

COUNTY OF SAN MATEO RETIREE PARTICIPANT DATA

Name (First and Last – M.I. If applicable)						Participant ID (CSM + 9-digit EID)
Gender	Date of Birth	Marital Status	SSN	Hire Date	Termination Date	Eff Date of Retiree Health
Street Address			City		State	Zip
Email address		Home Phone Number	Cell Phone Number		Preferred communication ☐Mail ☐email ☐phone	
Sick Leave Hours at Retirement	Disability Adjustment		Other Adjustment		Total Sick Leave Hours	
Sick Leave Hrs. /mo.	Contribution Amount	Years of Service	Is the participant a Retiree Judge?	Annuitant Code	Pay Cycle Monthly	
Refer to CSM / BCC codes for the information below:						
Division (R Code)	Payroll Clock #	Employment Class	Occupation	Credits/Contributions	Payroll ID	

COVERAGE ELECTION

MEDICAL ☐ WAIVED ☐ COBRA	**DENTAL** ☐ WAIVED ☐ COBRA	**VISION** ☐ WAIVED ☐ COBRA
☐ ALT Credit	☐ Delta DHMO	☐ VSP ☐ VSP Buy-Up
Under 65 Plans: ☐ KP HMO ☐ KP HDHP ☐ BSC HMO ☐ BSC TRIO ☐ BSC HDHP ☐ BSC PPO ☐ Op Eng KP ☐ Op Eng PPO	☐ Cigna DPPO - Rep ☐ Buy Up 1/2/3	☐ Voluntary VSP
Over 65 Plans: ☐ KP Sr. Advantage ☐ BSC PPO ☐ Secure Horizons	☐ Cigna DPPO - Mgt ☐ Buy Up 1 ☐ Vol Cigna DPPO ☐ Vol Delta DHMO	
Coverage Election: ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family	Coverage Election: ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family	Coverage Election: ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family

DEPENDENT INFORMATION FOR RETIREE COVERAGE (if applicable)

Name (First and Last – M.I. If applicable)					SSN
Gender	Date of Birth	Relationship	Coverage ☐ Vis ☐ Den ☐ Med	Medicare Eligible	Medical Plan
Name (First and Last – M.I. If applicable)					SSN
Gender	Date of Birth	Relationship	Coverage ☐ Vis ☐ Den ☐ Med	Medicare Eligible	Medical Plan
Name (First and Last – M.I. If applicable)					SSN
Gender	Date of Birth	Relationship	Coverage ☐ Vis ☐ Den ☐ Med	Medicare Eligible	Medical Plan
Name (First and Last – M.I. If applicable)					SSN
Gender	Date of Birth	Relationship	Coverage ☐ Vis ☐ Den ☐ Med	Medicare Eligible	Medical Plan

Retiree Signature Date

HR Benefits Partner Date

Date / Initial:
☐ BCC
☐ SHARET

INDIVIDUAL ELECTRONIC FUNDS TRANSFER (EFT)

Group Name: County of San Mateo **Customer Number:** CSM

Customer Name: ____________ **Social Security Number:** ____________

Address: ____________

City: ____________ **State:** ____________ **Zip:** ____________

☐ Select this box to authorize an ***Invoice/Premium EFT Payment***

Name of Financial Institution: ____________

Bank Routing Number: ____________ Account Number: ____________

Account Name: ____________ ☐ Checking Account ☐ Savings Account

If Electronic Debit Authorization (EDA) is required, instruct financial institution to set the authorization as:

Bank Filter *Submitting Bank (ODFI):* **Dollar Bank**

Company Name (Acct Name): **Benefit Coordinators Corp.**

Contract Number: **2251453488**

--- Attach Check Here ---

Please attach a voided check and return this form to:
San Mateo County, Benefits Department
455 County Center, 5th Floor
Redwood City, CA 94063

TERMS: This authority is to remain in full force and effect in conjunction with the Agreement until BCC and the financial institution have received written notification of its termination in such time and in such manner as to afford BCC and the financial institution a reasonable time to act accordingly. In the event that my electronic debit or transfer is returned, I agree that a $25 returned-item fee will be charged automatically to my account.

Signature ____________ Date ____________

Print Name ____________ Phone Number ____________

Rev 10.2016

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