2019
Employee Benefits Overview

Your Benefits, Your Choice

COUNTY OF SAN MATEO
CALIFORNIA

Human Resources Department
TABLE OF CONTENTS

Welcome to the County of San Mateo! ................................................................. 3
Who You Can Cover ........................................................................................... 4
Dependent Eligibility Verification ..................................................................... 5
When You Can Make Changes to Your Benefits ........................................... 6
When Your Benefits Terminate ......................................................................... 7
What's New in 2019? ....................................................................................... 8
Medical Benefits .............................................................................................. 11
Cost of Health and Dental Benefits ................................................................. 14
2019 Semi-Monthly Cost of Medical Benefits ............................................... 15
Making the Most of Your Benefits Program .................................................. 17
Comparison of HMO Plans ............................................................................ 18
Comparison of PPO Plans ............................................................................... 20
Dental Benefits ................................................................................................ 22
Vision ............................................................................................................... 25
Getting Care When You Need It Now .............................................................. 26
Enhanced Services .......................................................................................... 27
Employee Assistance Program ........................................................................ 30
Health and Wellness ........................................................................................ 32
Life Insurance .................................................................................................. 35
Supplemental (Additional) Life Insurance ....................................................... 37
Short Term Disability Insurance ..................................................................... 38
Travel Assistance .............................................................................................. 40
Health Savings Account ................................................................................... 41
Flexible Spending Account .............................................................................. 42
Additional Benefits ........................................................................................ 47
Meet Ben-IQ ...................................................................................................... 51
Contact Numbers ............................................................................................ 52
Key Terms ........................................................................................................ 53
Important Plan Notices and Documents .......................................................... 55
Welcome to the County of San Mateo!

Welcome to the 2019 Employee Benefits Guide, your single source document for the information you need to make informed decisions about your benefits for yourself and your family.

The 2019 Employee Benefits Guide is intended to be a summary of some of the benefits offered to you and your family including:

- health insurance
- dental insurance
- vision insurance
- life and disability insurance
- flexible spending accounts

Health and wellness resources are also featured in this guide to help you create and achieve a more balanced, healthier, and productive well-being.

Additional information and forms about these employee benefits and others are available online at http://hr.smcgov.org/employee-benefits.

The benefits described herein are offered to eligible employees of the County of San Mateo. All benefits are subject to change and there is no guarantee that these benefits will be continued indefinitely. The descriptions are very general and are not intended to provide complete details about any or all plans. Exact specifications for all plans are provided in the official Plan Documents, copies of which are available at http://hr.smcgov.org/employee-benefits.

For an overview of benefits by Bargaining Unit, go to the Employee Benefits website and click on Benefits at a Glance.

Thank you,

The Benefits Team
Who You Can Cover

WHO IS ELIGIBLE?

All regular and probationary employees working 20 or more hours a week are eligible to enroll in the County’s Health, Dental and Vision programs.

You can enroll the following family members in our medical, dental and vision plans.

- 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 19 or older.
- A tax-qualified dependent

County employees who are married or a dependent of another County employee must maintain dental and vision coverage through the County but may elect to waive this coverage and enroll under the spouse/domestic partner’s during Open Enrollment. Please contact Benefits Division during the open enrollment period if you have questions.

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.

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of County of San Mateo cannot also be covered as a dependent.
- Employees who work less than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

WHEN CAN I ENROLL?

Coverage for new hire begins on the 1st of Month Following Date of Hire. New employees who do not make an election within 31 days of becoming eligible will automatically be enrolled for single coverage under the Kaiser Traditional HMO.

Open enrollment for next plan year is generally held in October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to submit a Workday event within 31 days if you have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31 days to make your change in Workday.

ADDING OR REMOVING DEPENDENTS?

You are responsible for updating your dependent status via Workday during the plan year (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 notification 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.
# Dependent Eligibility Verification

All employees adding dependents will be asked to upload documentation in Workday verifying eligibility of their covered dependents. The following chart is an easy guide to which form and documents must be submitted. Failure to submit appropriate documentation will result in dependent’s ineligibility for coverage.

<table>
<thead>
<tr>
<th>Dependent Type</th>
<th>Eligibility Definition</th>
<th>Documents Required for Verifying Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Person to whom you are legally married</td>
<td>Marriage Certificate</td>
</tr>
<tr>
<td>Domestic Partners At least 18 years old</td>
<td>Meet County Domestic Partner Eligibility Requirements</td>
<td>County of San Mateo Affidavit of Domestic Partnership -or- Declaration of Partnership filed with the California Secretary of State</td>
</tr>
<tr>
<td>Natural Child(ren) Under Age 26</td>
<td>Minor or Adult Child(ren) of Employee who is under age 26yrs</td>
<td>Birth Certificate</td>
</tr>
<tr>
<td>Step Child(ren) Under Age 26</td>
<td>Minor or Adult Child(ren) of Employee Spouse who is under age 26yrs</td>
<td>Birth Certificate –and- Marriage Certificate showing Spouse as Parent</td>
</tr>
<tr>
<td>Children Legally Adopted/Wards</td>
<td>Minor or Adult Child(ren) legally adopted by Employee who is married or unmarried under age 26yrs</td>
<td>Court documentation (Must include presiding Judge Signature &amp; Court Seal)</td>
</tr>
<tr>
<td>Children of Domestic Partners Under Age 26</td>
<td>Minor or Adult Child(ren) of Employee Domestic Partner who is under age 26yrs</td>
<td>County of San Mateo Affidavit of Domestic Partnership –and- Birth Certificate</td>
</tr>
<tr>
<td>Disabled Children No age limit</td>
<td>Natural Child, Step Child or Adopted Child of Employee who is over age 26yrs and incapable of self-care due to physical or mental illness.</td>
<td>Birth Certificate –and- Certification of Disability from Social Security –or- Document of Disability from Physician if not SSA Certified</td>
</tr>
<tr>
<td>Other Qualifying Relatives Under Age 26</td>
<td>Meets Requirements of IRS Code. Sec. 105(b) under age 26yrs</td>
<td>Birth Certificate Showing Individual to be an Eligible Relative –and- County of San Mateo Affidavit of Tax Qualifying Dependent</td>
</tr>
</tbody>
</table>

Both the Affidavit of Tax Qualifying Dependent and the Affidavit for Domestic Partnership are available online at [http://hr.smcgov.org/employee-benefits](http://hr.smcgov.org/employee-benefits), click on Benefits Forms.
When You Can Make Changes to Your Benefits

Other than during the annual “open enrollment” period, you may not change your coverage unless you experience a qualifying event. Qualifying events include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, registration or dissolution of domestic partnership, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status**, including the start or termination of employment by you, your spouse, or your dependent child
- **Permanent change in work schedule**, including a significant increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child
- **An event that is a special enrollment event under HIPAA** (the Health Insurance Portability and Accountability Act), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
  - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
  - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage

Removing Dependents

- Dependents who gain other coverage elsewhere must be dropped within 31 days. Proof of other group coverage will need to be uploaded in the Workday Event

**Important—Three rules apply to making changes to your benefits during the year:**

- Any changes you make must be consistent with the change in status,
- You must make the changes within 31 days of the date the event (marriage, birth, etc.) occurs
- With the exception of births, life events take effect the first of the following month in which they are entered into the Workday Event.

**Question:** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
When Your Benefits Terminate

Your medical, dental and vision plan coverage ends on the last day of the month following your date of termination or loss of eligibility. For example: if termination date is March 14, benefits will end on March 31. If termination date is March 31, benefits will end on March 31.

You may continue benefits during a family leave of absence according to federal guidelines and in conjunction with the County's policy for a limited period of time after termination, or under your federal and state COBRA rights. Your coverage ends on the date of your termination for your Flexible Spending Accounts (FSA), Group Life/AD&D, Long Term Disability (LTD), and Employee Assistance Program (EAP).

Upon termination of loss of eligibility, employees can port or convert their Life Insurance coverage. For more information, please refer to page 36.

For more information on COBRA, please refer to page 60.

BENEFITS DURING FAMILY AND MEDICAL LEAVE AND CALIFORNIA FAMILY RIGHTS ACT

An employee taking family/medical leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave (for a maximum of 12 work-weeks) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The County will continue to make the same premium contributions as if the employee had continued working. The continued participation in health benefits begins on the date leave first begins under the Family and Medical Leave Act (e.g. for pregnancy disability leaves) or under the Family and Medical Leave Act/CFRA (e.g. for all other family care and medical leaves).

In some instances, the County may recover premiums it paid to maintain health coverage for you if you fail to return to work following pregnancy disability leave.

Employees on family/medical leave who are not eligible for continued paid coverage may continue their group health insurance coverage at their own expense in conjunction with the federal COBRA guidelines. Employees should contact the Human Resources department for further information. Under most circumstances, upon return from family/medical leave, an employee will be reinstated to his or her original job or to an equivalent pay, benefits, and other employment terms and conditions. However, an employee has no greater right to reinstatement than if he or she had been continuously employed rather than on leave. For example, if an employee on family/medical leave would have been laid off or terminated had he or she not gone on leave, or if the employee’s job is eliminated during the leave and no equivalent or comparable job is available, then the employee would not be entitled to reinstatement.

An employee’s use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.
What’s New in 2019?

VOLUNTARY BENEFITS VIA ALLIANTCHOICE+

WHO CAN ENROLL AND WHEN CAN YOU ENROLL?

All permanent, fixed term, provisional, temporary and regular employees can enroll in Voluntary Benefits during Open Enrollment only and make changes to their existing Voluntary plans within 30 days of a Qualified Life event.

HOW MUCH DOES IT COST?

Rates vary depending on your elections and your status as a tobacco smoker/non-smoker. Your rates will be available on the AlliantChoice+ website on October 9, 2018. Some sample rates are provided in the descriptions below.

Your semi-monthly premium will be deducted from your paycheck. Summary of your monthly cost will be provided to you during your enrollment on the AlliantChoice+ external enrollment site. These plans will not be seen in your benefits summary in Workday but can be found at the external site.

ACCIDENT:

Accident Insurance through Unum can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events. This coverage can help you with out-of-pocket costs that your medical plan doesn’t cover, like co-pays and deductibles.

For example, if you experience a covered accident and have any of the following treatments or services, eligible benefits would be paid as follows:

- Ambulance - $200
- Emergency room treatment - $100
- Surgical repair of knee cartilage - $500
- Medical Imaging testing - $100
- Outpatient surgery facility service - $150
- TOTAL EXAMPLE BENEFIT: $1050

This plan also provides a one-time $50 benefit once per year if you have one of 26 covered wellness tests per covered individual (such as employee and spouse or domestic partner). Examples of covered wellness tests include: Colonoscopy, mammography, pap smear, serum cholesterol test and skin cancer biopsy.

Per Paycheck Rates:

<table>
<thead>
<tr>
<th>Employee + Spouse/DP</th>
<th>Employee + Dependent Child(ren)</th>
<th>Employee + SP/DP + Dependent Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3.19</td>
<td>$5.93</td>
<td>$8.23</td>
</tr>
</tbody>
</table>

Please access AlliantCHOICE Plus through the Workday link to see a full schedule of benefits.
What’s New in 2019?

VOLUNTARY BENEFITS VIA ALLIANTCHOICE+

CRITICAL ILLNESS:

Critical Illness insurance through the Aflac Group can help with the treatment costs of covered critical illnesses, such as a heart attack, cancer or stroke.

With the Critical Illness plan, if you elect a coverage level of $10,000 and you are diagnosed with a covered Critical Illness such as cancer while on the plan, this policy will pay you a benefit of 100% of your $10,000 elected policy.

Employees can choose their level of coverage – either $10,000, $20,000 or $30,000. Spouses/Domestic Partners and dependent children are eligible for up to 50% of the employee’s amount.

Examples of coverage payment options are listed below:

<table>
<thead>
<tr>
<th>Covered Critical Illnesses</th>
<th>Percentage of Face Amount / Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>100% of elected policy amount</td>
</tr>
<tr>
<td>Limited Benefit Major Organ Transplant</td>
<td>100% of elected policy amount</td>
</tr>
<tr>
<td>Kidney Failure (End-Stage Renal Failure)</td>
<td>100% of elected policy amount</td>
</tr>
<tr>
<td>Stroke</td>
<td>100% of elected policy amount</td>
</tr>
<tr>
<td>Bone Marrow Transplant (Stem Cell Transplant)</td>
<td>100% of elected policy amount</td>
</tr>
<tr>
<td>Sudden Cardiac Arrest</td>
<td>100% of elected policy amount</td>
</tr>
<tr>
<td>Non-Invasive Cancer</td>
<td>25% of elected policy amount</td>
</tr>
<tr>
<td>Coronary Artery Bypass Surgery</td>
<td>25% of elected policy amount</td>
</tr>
<tr>
<td>Skin Cancer</td>
<td>$250</td>
</tr>
<tr>
<td>Wellness Benefit</td>
<td>$50/insured/calendar year</td>
</tr>
</tbody>
</table>

This plan also provides a one-time $50 benefit once per year if you have one of 19+ covered health screening tests per covered individual (such as employee and spouse or domestic partner). Examples of covered wellness tests include: Colonoscopy, pap smear, serum cholesterol test, fasting blood glucose test or any other medically accepted cancer screening test.

Mammography tests performed while an insured’s coverage is in force are eligible for a $200 benefit once per calendar year based on the insured’s age (please see brochure for further details).

Coverage is affordable, because you choose how much you buy. For instance, a 45 year old non-smoker will pay about $7.50 per paycheck for $10,000 in coverage.

Please access AlliantCHOICE Plus through the Workday link to see the rates that would apply for you and your family members.
What's New in 2019?

VOLUNTARY BENEFITS VIA ALLIANTCHOICE+

HOSPITAL INDEMNITY:

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. Hospital Indemnity Insurance can provide financial assistance to enhance your current medical coverage.

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital Admission Benefit – $500
- Hospital Confinement Benefit – $100
- Hospital Intensive Care Benefit – $100
- Intermediate Intensive Care Step-Down Unit – $50

Please note the Hospital Intensive Care Benefit and the Intermediate Intensive Care Step-Down Unit Benefits are payable in addition to the Hospital Confinement Benefit.

Please see product brochure/certificate for a full explanation of benefits.

PER PAYCHECK RATES:

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee + Spouse/DP</th>
<th>Employee + Dependent Child(ren)</th>
<th>Employee + SP/DP + Dep Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$5.25</td>
<td>$10.53</td>
<td>$8.48</td>
<td>$13.76</td>
</tr>
</tbody>
</table>

Mammography tests performed while an insured’s coverage is in force are eligible for a $100 benefit once per calendar year based on the insured’s age (please see brochure for further details).

Please access AlliantCHOICE Plus through the Workday link to learn more about hospital indemnity insurance and elect coverage.

Need more information?

PLEASE CONTACT ALLIANTCHOICE+ DIRECTLY.

Call 833-634-7132 or email choiceplus@alliant.com
Medical Benefits

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. The County offers a choice of medical plans through Kaiser Permanente and Blue Shield.

- **Kaiser Permanente** – 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](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 41). 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.

- **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](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).

**Question:** Contact Benefits Division: 650-363-1919 or [benefits@smcgov.org](mailto:benefits@smcgov.org)
Medical Benefits, continued

Blue Shield of California

- **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.

**Building and Construction Trades Council Option**

Eligible employees who are members of the Building and Construction Trades Council also have the option of choosing the Operating Engineer’s plan which includes health (either a PPO or a Kaiser HMO plan), dental and vision benefits.

For more information about the Operating Engineers Plan, contact Benefits Division at 650-363-1919 or email benefits@smcgov.org.
Dental Benefits

The County offers two dental plans for employees: Cigna PPO and DeltaCare DHMO. Employees are required to enroll in one of these two plans.

**Cigna** – a Preferred Provider Organization (PPO) plan in which dental services are provided through Cigna’s PPO network. However, 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 $250 or more. Orthodontic treatment is not a covered service. More information about the Cigna plan is available online at [http://hr.smcgov.org/employee-benefits](http://hr.smcgov.org/employee-benefits); click on Dental Plans.

These 3 buy-up options are still available to represented employees with more than 1 year of service:

- Core Dental Plan Plus Option #1 with $4,000 Maximum
- Core Dental Plan Plus Option #2 with $4,000 Orthodontia Coverage
- Core Dental Plan Plus Option #3 with $4,000 Max and Ortho Coverage

The dental buy-up option with $4,000 orthodontia coverage is still available to Management, Confidential, District Attorney/County Counsel, and Sheriff Sergeant.

**DeltaCare** – a Dental Health Maintenance Organization (DHMO) plan that is affiliated with Delta Dental. Under this plan, you must select a DeltaCare USA dentist and you must visit your selected dentist for all of your dental care. There are no claim forms to complete, no deductibles, and no co-pays for most services. More information about the DeltaCare plan is available online at [http://hr.smcgov.org/employee-benefits](http://hr.smcgov.org/employee-benefits); click on Dental Plans.

**Reminder**

Employees who are enrolled in any of the buy-up plans are required to stay in the plans for a minimum of two (2) years.

**Question:** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Cost of Health and Dental Benefits

WHAT IS THE COST TO ENROLL IN THE COUNTY’S HEALTH AND DENTAL PLANS?

Both employees and the County share in the cost of your health coverage. The amount of the premium you are responsible for depends on your employment status (full-time, 3/4 time or 1/2 time), the number of your dependents (if any) covered, and the specific plan you choose. For purposes of determining health premium costs, a full time employee works 40 hours per week, a half-time employee works 20-29 hours per week, and a ¾ time employee works 30-39 hours per week.

The employee portion of the premiums is automatically deducted from your paycheck on a semi-monthly pre-tax basis. The tables on the next page list each health plan’s monthly premium cost for both the employee and County.
# 2019 Semi-Monthly Cost of Medical Benefits

## ALL EMPLOYEES

<table>
<thead>
<tr>
<th></th>
<th>Full Time Employees</th>
<th>3/4 Time Employees</th>
<th>1/2 Time Employees</th>
<th>Total Semi-Monthly Premium</th>
<th>Total Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser HMO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$51.39</td>
<td>$292.22</td>
<td>$124.20</td>
<td>$219.41</td>
<td>$146.61</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$102.78</td>
<td>$583.44</td>
<td>$248.39</td>
<td>$437.83</td>
<td>$292.22</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$145.44</td>
<td>$825.16</td>
<td>$351.48</td>
<td>$619.12</td>
<td>$413.08</td>
</tr>
<tr>
<td><strong>Kaiser HDHP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$40.35</td>
<td>$229.62</td>
<td>$154.66</td>
<td>$269.97</td>
<td>$115.31</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$80.69</td>
<td>$458.25</td>
<td>$309.32</td>
<td>$538.94</td>
<td>$229.62</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$114.18</td>
<td>$648.01</td>
<td>$437.83</td>
<td>$762.19</td>
<td>$324.51</td>
</tr>
<tr>
<td><strong>Blue Shield HMO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$85.82</td>
<td>$486.34</td>
<td>$40.35</td>
<td>$572.16</td>
<td>$229.62</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$171.65</td>
<td>$972.67</td>
<td>$195.00</td>
<td>$1144.32</td>
<td>$486.34</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$242.88</td>
<td>$1376.34</td>
<td>$275.93</td>
<td>$1619.22</td>
<td>$688.17</td>
</tr>
<tr>
<td><strong>Blue Shield TRIO HMO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$73.44</td>
<td>$416.16</td>
<td>$207.41</td>
<td>$489.60</td>
<td>$312.12</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$146.88</td>
<td>$832.32</td>
<td>$586.97</td>
<td>$1385.57</td>
<td>$416.16</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$207.84</td>
<td>$1177.73</td>
<td>$796.70</td>
<td>$1958.40</td>
<td>$588.17</td>
</tr>
<tr>
<td><strong>Blue Shield HDHP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$107.25</td>
<td>$510.77</td>
<td>$297.94</td>
<td>$681.02</td>
<td>$383.08</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$353.61</td>
<td>$1080.84</td>
<td>$618.62</td>
<td>$1414.45</td>
<td>$785.63</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$514.55</td>
<td>$1543.86</td>
<td>$900.48</td>
<td>$2058.20</td>
<td>$1157.74</td>
</tr>
<tr>
<td><strong>Blue Shield PPO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$66.22</td>
<td>$375.23</td>
<td>$160.03</td>
<td>$441.45</td>
<td>$281.42</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$132.43</td>
<td>$750.47</td>
<td>$320.05</td>
<td>$882.90</td>
<td>$562.85</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$187.40</td>
<td>$1101.91</td>
<td>$452.87</td>
<td>$1249.31</td>
<td>$735.44</td>
</tr>
<tr>
<td><strong>Kaiser, Dental &amp; Vision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$38.50</td>
<td>$346.50</td>
<td>$125.12</td>
<td>$425.64</td>
<td>$281.42</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$77.00</td>
<td>$683.00</td>
<td>$250.25</td>
<td>$854.00</td>
<td>$519.75</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$103.95</td>
<td>$935.55</td>
<td>$337.84</td>
<td>$1039.50</td>
<td>$701.66</td>
</tr>
</tbody>
</table>

## OPERATING ENGINEERS

<table>
<thead>
<tr>
<th></th>
<th>Full Time Employees</th>
<th>3/4 Time Employees</th>
<th>1/2 Time Employees</th>
<th>Total Semi-Monthly Premium</th>
<th>Total Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PPO, Dental &amp; Vision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$42.70</td>
<td>$384.30</td>
<td>$138.77</td>
<td>$234.85</td>
<td>$192.15</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$85.40</td>
<td>$768.60</td>
<td>$277.55</td>
<td>$469.70</td>
<td>$384.30</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$111.40</td>
<td>$1002.60</td>
<td>$362.05</td>
<td>$612.70</td>
<td>$501.30</td>
</tr>
<tr>
<td><strong>Kaiser, Dental &amp; Vision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$42.70</td>
<td>$384.30</td>
<td>$138.77</td>
<td>$234.85</td>
<td>$192.15</td>
</tr>
<tr>
<td>Employee +1</td>
<td>$85.40</td>
<td>$768.60</td>
<td>$277.55</td>
<td>$469.70</td>
<td>$384.30</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$111.40</td>
<td>$1002.60</td>
<td>$362.05</td>
<td>$612.70</td>
<td>$501.30</td>
</tr>
</tbody>
</table>

*Question: Contact Benefits Division: 650-363-1919 or benefits@smcgov.org*
## 2019 Semi-Monthly Cost of Medical Benefits

### DENTAL AND VISION CONTRIBUTIONS

<table>
<thead>
<tr>
<th>Management, Confidential, District Attorney/County Counsel, Sheriff Sergeant</th>
<th>Cigna Dental PPO</th>
<th>VSP Vision Care Buy-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Dental Plan (No max, no ortho coverage)</strong></td>
<td>Employee Cost</td>
<td>County Cost (^1)</td>
</tr>
<tr>
<td>Employee Only</td>
<td>2.25</td>
<td>20.24</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>4.78</td>
<td>8.03</td>
</tr>
<tr>
<td>Employee + 2 or more</td>
<td>6.83</td>
<td></td>
</tr>
<tr>
<td><strong>Management Buy-up - Core plus Buy-Up (4k Ortho Coverage)</strong></td>
<td>Employee Cost</td>
<td>County Cost (^1)</td>
</tr>
<tr>
<td>Employee Only</td>
<td>22.54</td>
<td>63.61</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>39.56</td>
<td>51.93</td>
</tr>
<tr>
<td>Employee + 2 or more</td>
<td>51.93</td>
<td></td>
</tr>
</tbody>
</table>

### Delta Care DHMO

<table>
<thead>
<tr>
<th>Employee cost</th>
<th>County cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management, Confidential, District Attorney/County Counsel, Sheriff Sergeant</td>
<td>2.25</td>
</tr>
<tr>
<td>All other represented employee groups</td>
<td>2.25</td>
</tr>
</tbody>
</table>

### VSP Vision Care

<table>
<thead>
<tr>
<th>Employee cost</th>
<th>County cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2+ Actives - Core plus Buy-Up 1 (4k Max)</td>
<td>0.00</td>
</tr>
</tbody>
</table>

---

**Question:** Contact Benefits Division: 650-363-1919 or [benefits@smcgov.org](mailto:benefits@smcgov.org)
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.
Comparison of HMO Plans

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

<table>
<thead>
<tr>
<th></th>
<th>Kaiser Permanente Traditional HMO</th>
<th>Kaiser Permanente HDHP</th>
<th>Blue Shield HMO</th>
<th>Blue Shield TRIO HMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$0 per individual $0 family limit</td>
<td>$1,500 per individual $3,000 family limit</td>
<td>$0 per individual $0 family limit</td>
<td>$0 per individual $0 family limit</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual EE + 1 Family</td>
<td>$1,500 $3,000</td>
<td>$3,000 $6,000</td>
<td>$1,000 $2,000 3,000</td>
<td>$1,000 $2,000 3,000</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician &amp; Specialist</td>
<td>$15 copay Plan pays 90% after deductible</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Access+ Specialist</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Telemedicine</strong></td>
<td>No Charge</td>
<td>No Charge</td>
<td>$5 per consultation</td>
<td>$5 per consultation</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Chiropractic and Acupuncture Care</strong></td>
<td>$15 copay (up to 20 visits per year)</td>
<td>Not covered</td>
<td>$10 copay (up to 30 visits per year)</td>
<td>$10 copay (up to 30 visits per year)</td>
</tr>
<tr>
<td><strong>Lab and X-ray</strong></td>
<td>$5 copay then plan pays 100% Plan pays 90% after deductible</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td><strong>Infertility Testing and Treatment</strong></td>
<td>50% of allowable Charge 50% of allowable Charge</td>
<td>50% of allowable Charge 50% of allowable Charge</td>
<td>50% of allowable Charge Not Covered</td>
<td>50% of allowable Charge Not Covered</td>
</tr>
<tr>
<td>Assisted Reproductive Technology (ART) Services</td>
<td>GIFT, In Vitro Fertilization (IVF), ZIFT, Transfer of cryopreserved embryos</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>$100 admission copay Plan pays 90% after deductible</td>
<td>$100 admission copay</td>
<td>$100 admission copay</td>
<td>$100 admission copay</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>$50 copay Plan pays 90% after deductible</td>
<td>$50 copay</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$15 copay Plan pays 90% after deductible</td>
<td>$15 copay</td>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$100 copay (waived if admitted) Plan pays 90% after deductible</td>
<td>$100 copay (waived if admitted)</td>
<td>$100 copay (waived if admitted)</td>
<td>$100 copay (waived if admitted)</td>
</tr>
</tbody>
</table>

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Prescription Drugs

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

<table>
<thead>
<tr>
<th>Prescription Drug Benefits</th>
<th>Kaiser Permanente Traditional HMO</th>
<th>Kaiser Permanente HDHP</th>
<th>Blue Shield of CA HMO</th>
<th>Blue Shield of CA TRIO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 per prescription</td>
<td>$10 per prescription</td>
<td>$15 per prescription</td>
<td>$15 per prescription</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$20 per prescription</td>
<td>$30 per prescription</td>
<td>$25 per prescription</td>
<td>$25 per prescription</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$20 per prescription</td>
<td>$30 per prescription</td>
<td>$40 per prescription</td>
<td>$40 per prescription</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$20 per prescription</td>
<td>$30 per prescription</td>
<td>20% up to $100 max per prescription</td>
<td></td>
</tr>
<tr>
<td>Supply Limit</td>
<td>100 days</td>
<td>30 days</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 per prescription</td>
<td>$20 per prescription</td>
<td>$30 per prescription</td>
<td>$30 per prescription</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$20 per prescription</td>
<td>$60 per prescription</td>
<td>$50 per prescription</td>
<td>$50 per prescription</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$20 per prescription</td>
<td>$60 per prescription</td>
<td>$80 per prescription</td>
<td>$80 per prescription</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$20 per prescription</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>100 days</td>
<td>100 days</td>
<td>90 days</td>
<td>90 days</td>
</tr>
</tbody>
</table>

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

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
# Comparison of PPO Plans

<table>
<thead>
<tr>
<th></th>
<th>Blue Shield PPO Plan</th>
<th>Blue Shield of CA HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$200</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$600</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Max</strong></td>
<td>$2,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Individual</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$8,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Lifetime Max</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP &amp; Specialist</td>
<td>Plan pays 80%</td>
<td>Plan pays 90% after deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>$5 per consultation</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>$5 per consultation</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Plan pays 100%</td>
<td>Plan pays 100%</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Chiropractic and Acupuncture Care</td>
<td>Plan pays 80% after deductible (up to 30 visits per year)</td>
<td>Plan pays 90% after deductible (up to 20 visits per year)</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible (in-network limitations apply)</td>
<td>Plan pays 50% after deductible (in-network limitations apply)</td>
</tr>
<tr>
<td>Lab and X-ray</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 90% after deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible (up to $350 per day)</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>Plan pays 80% after deductible</td>
<td>$100 copay then plan pays 90% after deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible (up to $600 per day)</td>
<td>Plan pays 60% after deductible (up to $600 per day)</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 90% after deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible (up to $350 per day)</td>
<td>Plan pays 60% after deductible (up to $350 per day)</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Plan pays 80%</td>
<td>Plan pays 90% after deductible</td>
</tr>
<tr>
<td></td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 60% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 copay (waived if admitted)</td>
<td>$100 copay then plan pays 90% after deductible (copay waived if admitted)</td>
</tr>
</tbody>
</table>

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

**Questions?** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
## Prescription Drugs

### Blue Shield of CA

<table>
<thead>
<tr>
<th></th>
<th>PPO Plan</th>
<th>HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$15 per prescription</td>
<td>$10 per prescription</td>
</tr>
<tr>
<td></td>
<td>25% + $15 per prescription</td>
<td>25% + $10 per prescription</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30 per prescription</td>
<td>$25 per prescription</td>
</tr>
<tr>
<td></td>
<td>25% + $30 per prescription</td>
<td>25% + $25 per prescription</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$45 per prescription</td>
<td>$40 per prescription</td>
</tr>
<tr>
<td></td>
<td>25% + $45 per prescription</td>
<td>25% + $40 per prescription</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>20% up to $100 per prescription</td>
<td>30% up to $200 per prescription</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>30 days</td>
<td>30 days</td>
</tr>
</tbody>
</table>

### Mail Order

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$30 per prescription</td>
<td>$20 per prescription</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$60 per prescription</td>
<td>$50 per prescription</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Non-preferred Brand</td>
<td>$90 per prescription</td>
<td>$80 per prescription</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Supply Limit</td>
<td>90 days</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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

**FOR REPRESENTED ACTIVES WITH LESS THAN 1 YEAR OF SERVICE**

<table>
<thead>
<tr>
<th></th>
<th>DeltaCare DHMO</th>
<th>Cigna Dental PPO Represented - Actives Less Than 1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PPO</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>$2,500</td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td>No Charge</td>
<td></td>
</tr>
<tr>
<td>Oral Exams</td>
<td></td>
<td>Plan Pays 60%</td>
</tr>
<tr>
<td>Routine Cleanings</td>
<td></td>
<td>After deductible</td>
</tr>
<tr>
<td>Full Mouth X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td></td>
<td>Plan Pays 60%</td>
</tr>
<tr>
<td>Panoramic X-ray</td>
<td></td>
<td>After deductible</td>
</tr>
<tr>
<td>Fluoride Application</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td>Plan Pays 60%</td>
</tr>
<tr>
<td>Amalgam/Composite Fillings</td>
<td>No Charge</td>
<td>After deductible</td>
</tr>
<tr>
<td>Periodontics (Gum disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics (Root Canal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions &amp; Other Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
<td>Plan Pays 60%</td>
</tr>
<tr>
<td>Crown Repair</td>
<td>No Charge</td>
<td>After deductible</td>
</tr>
<tr>
<td>Restorative - Inlays and Crowns</td>
<td>No Charge</td>
<td>After deductible</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td></td>
<td>Plan Pays 60%</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>None</td>
<td>After deductible up to $1,000</td>
</tr>
<tr>
<td>Orthodontics</td>
<td></td>
<td>$1,000 copay</td>
</tr>
<tr>
<td>Child to Age 19 and Adult</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Based on maximum allowable charge (In-Network fee level)

---

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
## Dental Plans

**FOR REPRESENTED ACTIVES WITH MORE THAN 1 YEAR OF SERVICE**

<table>
<thead>
<tr>
<th>Dental Benefits</th>
<th>DeltaCare DHMO</th>
<th>Cigna Dental PPO Core Dental Plan - Represented Actives</th>
<th>Cigna Dental PPO Year 2+ Actives - Core plus Buy Up Option #1 with $4K Max</th>
<th>Cigna Dental PPO Year 2+ Actives - Core plus Buy Up Option #2 with $4K Ortho Coverage</th>
<th>Cigna Dental PPO Year 2+ Actives - Core plus Buy Up Option #3 with $4K Max &amp; $4K Ortho Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum</td>
<td>PPO</td>
<td>OON¹</td>
<td>PPO</td>
<td>OON¹</td>
<td>PPO</td>
</tr>
<tr>
<td>None</td>
<td>$2,500</td>
<td>$2,500</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$2,500</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>Individual</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventive</td>
<td>Oral Exams</td>
<td>Routine Cleanings</td>
<td>Full Mouth X-rays</td>
<td>No Charge</td>
<td>Plan pays 85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>Amalgam/Composite Fillings</td>
<td>Periodontics (Gum disease)</td>
<td>Endodontics (Root Canal)</td>
<td>No Charge</td>
<td>Plan pays 85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>Crown Repair</td>
<td>Restorative - Inlays and Crowns</td>
<td>Prosthodontics</td>
<td>No Charge</td>
<td>Plan pays 85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>Complex Oral Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>None</td>
<td>Plan pays 85% up to $1,000</td>
<td>Plan pays 85% up to $1,000</td>
<td>Plan pays 85% up to $1,000</td>
<td>Plan pays 85% up to $1,000</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>Lifetime Maximum</td>
<td>Child/Adult</td>
<td>$1,000</td>
<td>copay</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

¹Out Of Network Coinsurance Based on Maximum Allowable Charge (In Network Fee Level).

**Questions?** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
# Dental Plans

**FOR MANAGEMENT, CONFIDENTIAL, DISTRICT ATTORNEY/COUNTY COUNSEL, SHERIFF SERGEANT**

## Dental Benefits

<table>
<thead>
<tr>
<th>Calendar Year Maximum</th>
<th>DeltaCare DHMO</th>
<th>Cigna Dental PPO Core Dental Plan - Management</th>
<th>Cigna Dental PPO Management Buy Up - Core plus Buy Up Option with $4K Ortho Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
<td>PPO</td>
<td>OON¹</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventive</td>
<td>Oral Exam</td>
<td>No Charge</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td>X-Rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth Cleaning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitewings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam/Composite Fillings</td>
<td>No Charge</td>
<td>Plan Pays 100%</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td>Periodontics (Gum disease)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics (Root Canal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extractions &amp; Other Oral Surgery</td>
<td>No Charge</td>
<td>Plan Pays 100%</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown Repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative - Inlays and Crowns Prosthodontics</td>
<td>No Charge</td>
<td>Plan Pays 100%</td>
<td>Plan Pays 100%</td>
</tr>
<tr>
<td>Complex Oral Surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for Benefit</td>
<td>Child/Adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$1,000 copay</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Out Of Network payment based on maximum allowable amount (In-Network level).

**Questions? Contact Benefits Division: 650-363-1919 or benefits@smcmgov.org**
## Vision

All regular employees working full-time or part-time (over 20 hours per week) must enroll in the County’s vision insurance plan. This benefit is fully paid for by the County. More information about the VSP plan is available online at [http://hr.smcgov.org/employee-benefits](http://hr.smcgov.org/employee-benefits); click on Vision Plan.

### CORE PLAN
(Premium Paid for by the County)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Every 12 months</td>
<td>Every 24 months</td>
</tr>
<tr>
<td>Exam</td>
<td>$10 / $10</td>
<td>Subject to out of network allowance</td>
</tr>
<tr>
<td>Lenses/Contacts</td>
<td>15% off contact fitting and evaluation exam, not to exceed $60</td>
<td></td>
</tr>
<tr>
<td>Frames**</td>
<td>$130 allowance for frames</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$150 allowance for featured frame brands</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$70 Costco frame allowance</td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td>$150 Allowance; in lieu of lens and frame*</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>$105**</td>
<td></td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Covered in full</td>
<td>$210</td>
</tr>
</tbody>
</table>

### BUY-UP PLAN
(Employee Paid)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>In-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Every 12 months</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>Exam</td>
<td>$10 / $10</td>
<td>Subject to out of network allowance</td>
</tr>
<tr>
<td>Lenses/Contacts</td>
<td>15% off contact fitting and evaluation exam, not to exceed $60</td>
<td></td>
</tr>
<tr>
<td>Frames**</td>
<td>$200 allowance for frames</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$220 allowance for featured frame brands</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$110 Costco frame allowance</td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td>$200 Allowance; in lieu of lens and frame*</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>$105**</td>
<td></td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Covered in full</td>
<td>$210</td>
</tr>
</tbody>
</table>

* Progressive bifocals may be purchased for the difference in cost
** Contact lenses are in lieu of spectacle lenses and frames
Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Kaiser Permanente Members
- Call Kaiser's 24/7 NurseLine at 800-464-4000
- Find an urgent care center by visiting kp.org

Blue Shield of CA Members
- Call NurseHelp 24/7 at (877) 304-0504
- Call Teladoc at (800) 835-2362
- Find an urgent care at blueshieldca.com

GET A VIDEO HOUSE CALL

Blue Shield and Kaiser members can video chat with a doctor from the comfort of their own homes, without an appointment. Blue Shield's Teladoc provides 24/7 access to U.S. board-certified physicians, for just $5 copay. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit www.teladoc.com/bsc

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.
Enhanced Services

FREE VIDEO CONSULTATIONS

Video Visits

a picture is worth a thousand words

The next time you schedule an appointment at Kaiser Permanente, you may be offered a video visit with your doctor.

- Convenient access from your home or office
- Secure and easy way to visit your doctor
- Saves travel time and expense

All you need is a computer with a high-speed internet connection and a webcam or a smartphone mobile device (iOS iPhone or iPad or Android mobile device) using the latest version of the KP Preventive Care App.

Visit kp.org/mydoctor/videovisits for more information.

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

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
**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℠ or Google Play℠ 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.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Employee Assistance Program

ADMINISTERED BY CONCERN

You and your family members are covered by an Employee Assistance Program (EAP) provided by the County. This program, called CONCERN, is entirely voluntary and confidential.

CONCERN is a full service EAP provider based locally in Mountain View and has earned a reputation for quick and easy access to licensed clinical providers, specialized training, and comprehensive work/life resources and referrals.

OVERVIEW OF THE EMPLOYEE ASSISTANCE PROGRAM
The County's EAP Program is an essential component of the County's work-life benefit, offering work-life assistance to our employees and family members. Personalized consultations, resources and referrals are available at no cost for a wide range of needs that include:

Confidential individual counseling around stress management, grief and loss as well as family, couple and relationship counseling
  - 5 face to face sessions per person per incident per year
  - 10 substance abuse consultations per year

Concierge services—resources and referrals for home repair and construction, housecleaners, apartments and moving services, etc.
  - Financial and legal assistance
  - Eldercare resources
  - Parenting and Childcare resources

LifeAdviser (Concern’s online resource center) - provides 24/7 immediate access to a wealth of information, education and skill building tools, including streaming videos and short 30-minute courses on Personal and Professional Development.

Resiliency Hub - an environment for building resilience through toolkits, articles, and apps, not to merely recover from stress, but to harness it for personal growth.

CONCERN services are accessible 24-hours a day, 365 days-a-year nationwide
(800) 344-4222

www.concern-eap.com
Company code: smcgov

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
# Employee Assistance Program

<table>
<thead>
<tr>
<th><strong>SELF-REFERRAL</strong></th>
<th><strong>SUPERVISOR REFERRAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Overview</strong></td>
<td>Free, short-term counseling to employees and members of their families who wish to address personal or work issues</td>
</tr>
</tbody>
</table>
| **Referral Source** | • Self-referral  
• Available for immediate family members including:  
  o Your spouse/domestic partner  
  o Your children  
  o Spouse/domestic partner’s children  
  o Young adult dependents up to age 26 | • Initiated by supervisor, manager or Human Resources Department  
• Not a mandatory referral  
• Offered as part of a performance improvement plan |
| **Available Sessions** | Up to 5 face-to-face counseling sessions | Up to 10 face-to-face counseling sessions |
| **How to Get Started** | Two Options:  
• Call 800-344-4222  
• Visit the CONCERN website at employees.concern-eap.com  
• Sponsor Code: smcgov  
• Complete a Counseling Service Request Form | 1. Manager/Supervisor/HR calls 800-344-4222 for a clinical consultation  
2. Supervisor Referral Form is completed, shared with CONCERN & with the employee  
3. The employee can:  
  • Call 800-344-4222 or  
  • Complete a Counseling Service Request Form on the CONCERN website at employees.concern-eap.com (Sponsor Code: smcgov) |
| **Eligibility** | All San Mateo County & Court employees are eligible, except seasonal temporary and extra help workers |

*Representatives are available 24 hours a day, 365 days a year.*
Health and Wellness

The Employee 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 employees with health education and lifestyle skills, the Employee Wellness Program plays a pivotal role in fostering a healthy work environment, high employee engagement and a productive workforce.

As a County employee, you are encouraged to be proactive and take good care of your health. You can attend most employee health programs and classes on County time at little or no cost to you. A sampling of the Employee Wellness Program services are listed below.

Preventive Health Services
✓ Flu Clinics
✓ Wellness Screenings
✓ Online Health Assessment
✓ Smoking Cessation Program
✓ Disease Management Program
✓ Weight Management Program

‘Culture of Health’ Organizational Initiatives
✓ County Wellness Policy (includes healthy vending and catering guidelines)
✓ Designated Walking Routes
✓ County Wellness Committee
✓ Wellness Leadership Recognition Program
✓ Take Your Work Break Initiative
✓ Gifts of Gratitude Initiative
✓ Wellness Grants Program
✓ Wellness Dividends Program

Special Events/Community Outreach
✓ Blood Drives
✓ Farmers Market
✓ Health Club Information and Discounts
✓ Recreation tournaments: Basketball, Bowling, Soccer, Softball, Volleyball

Work-Life Education Programs
✓ Babies & You Prenatal Health Program – what to expect when you’re expecting and what to expect in the first year
✓ Worksite Lactation Program – breast pump loaner program and consultations

Wellness Classes & Services
✓ Well-Being Team Challenges
✓ Classes & Workshops (physical, mental/emotional, nutrition, and health improvement)
✓ Lifestyle Coaching
✓ Onsite Massage Therapy
✓ Health Club Discounts

For more information about the Employee Wellness Program, visit http://hr.smcgov.org/employee-wellness-program-work-life-services

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Health and Wellness

SMOKING CESSATION

KAISER

www.kp.org
Click “Health & Wellness” tab

· Nicotine Patches at regular drug co-payment for up to six months when registered for smoking cessation class.

· Variety of medications covered at generic ($5) and formulary ($15) copays

· Stop smoking classes offered at no fee to Members.

· Members can meet with a Clinical Health Educator for one-on-one counseling at regular office visit co-pay.

· A free online personalized Stop Smoking Program is also offered at: http://www.kp.org/healthylifestyles

BLUE SHIELD

www.blueshieldca.com/hlr

· Coverage of prescription smoking cessation medication limited to one 12-week course per lifetime

· Quit for Life® Web-based and telephone coaching

· Acupuncture offered at a 25% discount through Blue Shield’s Alternative Health Provider Network.

· Medications prescribed by physician: Bupropion (generic copay) Chantix and Nicotrol products (brand copay)

· Healthy Lifestyle Rewards – 6-week smoking cessation module available, plus articles

WEIGHT MANAGEMENT & NUTRITION COUNSELING

KAISER

· Nutrition Counseling available upon MD referral. $15 visit co-pay applies, no limits.

· Lifestyle Weight Management Course plus other health education programs

· A free online personalized Weight Management Program is offered at: http://www.kp.org/healthylifestyles.

· Weight Watchers discounts
  " Online Program (3 & 12 months)
  " Local Meeting Vouchers
  " At Home Kit

· Bariatric Surgery referral to a specialist for weight loss surgery; extensive preoperative evaluation by multidisciplinary team; post-operative care; specialized support groups. Cosmetic surgery not covered

BLUE SHIELD

· Nutrition counseling covered only for Diabetics or if recommended by a Bariatric provider after surgery, subject to medical necessity.

· Diabetic Care self-management training, HMO (if authorized): $15 copay
  No limits

· Healthy Lifestyle Rewards – 6-week nutrition & weight management modules available, plus articles

· Weight Watchers discounts
  " Online Program (3 & 12 months)
  " Local Meeting Vouchers
  " At Home Kit

· Bariatric Surgery. For POS, requires prior authorization by Blue Shield’s Medical Management. For HMO, referral from the PCP to the specialist, then Medical Group authorization.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Health and Wellness

KAISER

Wellness Resources

- Online Resources
  - Total Health Assessment
  - Wellness Coaching: Learn how to make healthy behavior changes to help manage your weight, quit tobacco, reduce stress, be more active or make healthier food choices
  - Extensive Online Health Video Library
  - Online Fitness Trainer (Fitness Coach.com)
  - “Choose Healthy” Network for discounts on healthy products, acupuncture, chiropractor, and massage therapy

- Online Programs
  - Breathe™
  - Balance™
  - Relax™
  - Nourish™
  - Care™ for your Health
  - Care™ for Pain
  - Care™ for Diabetes
  - Overcoming™ Depression
  - Overcoming™ Insomnia
  - Care™ for your Back

- Kaiser Classes
  - 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

- Fitness Center Discounts
  - Available through “Choose healthy Network
  - Online Fitness Trainer (Fitness Coach.com)

BLUE SHIELD

A 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

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Life Insurance

ADMINISTERED BY THE STANDARD

To be eligible for the County's life insurance benefit, an employee must be a regular full-time or part-time employee (working 20 or more hours per week).

The County offers three kinds of life insurance benefits administered by Standard Life Insurance: Basic Life Insurance, Accidental Death and Dismemberment (AD&D) and Additional Life Insurance. Basic Life and AD&D are benefits paid for by the County in an amount specified in employee's Memorandum of Understanding (MOU) or, for non-represented employees, Board Resolutions.

Employees also have the option of buying Additional Life Insurance coverage between $50,000 to $500,000 for themselves and $25,000 to $250,000 for a spouse/domestic partner. Employees pay the premiums for additional life insurance through semi-monthly post-tax payroll deductions.

More information about The County of San Mateo's life insurance benefits is available online at http://hr.smcgov.org/employee-benefits; click on Life Insurance.

<table>
<thead>
<tr>
<th>Employee benefit amount</th>
<th>BASIC LIFE INSURANCE</th>
<th>SUPPLEMENTAL (Additional) LIFE INSURANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spousal benefit amount</td>
<td>$2,000</td>
<td>Up to $250,000</td>
</tr>
<tr>
<td>Cost for spousal benefit</td>
<td>None – County paid</td>
<td>Cost based on age (see rate sheet on page 34)</td>
</tr>
<tr>
<td>Dependent child benefit amount (birth to age 24)</td>
<td>$2,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Cost of dependent child benefit</td>
<td>None – County paid</td>
<td>$0.882 per $1,000</td>
</tr>
</tbody>
</table>
Life Insurance

SPECIAL FEATURES INCLUDED IN YOUR LIFE INSURANCE:

Your County paid and additional life policies come with the following features:

- **Waiver of Premium** – If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment until age 70 provided you give The Standard satisfactory proof that you remain totally disabled.

- **Accelerated Benefit** – If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

- **Portability** – If your insurance ends because your employment terminates, you may continue to your life insurance coverage by obtaining the cost directly from The Standard.

- **Conversion** – If your insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health. **Premiums for the converted policy will be substantially higher compared to the County sponsored term plan.**

If you need more information on these options, please reach out to Benefits Division or visit [http://hr.smcgov.org/employee-benefits](http://hr.smcgov.org/employee-benefits); click on Life Insurance.
# Supplemental (Additional) Life Insurance

## RATE CALCULATION WORKSHEET

### Active Employee Rates

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate Per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Age 25</td>
<td>$0.04</td>
</tr>
<tr>
<td>Age 25-29</td>
<td>$0.04</td>
</tr>
<tr>
<td>Age 30-34</td>
<td>$0.05</td>
</tr>
<tr>
<td>Age 35-39</td>
<td>$0.06</td>
</tr>
<tr>
<td>Age 40-44</td>
<td>$0.06</td>
</tr>
<tr>
<td>Age 45-49</td>
<td>$0.10</td>
</tr>
<tr>
<td>Age 50-54</td>
<td>$0.16</td>
</tr>
<tr>
<td>Age 55-59</td>
<td>$0.30</td>
</tr>
<tr>
<td>Age 60-64</td>
<td>$0.45</td>
</tr>
<tr>
<td>Age 65-69</td>
<td>$0.89</td>
</tr>
<tr>
<td>Age 70 or over</td>
<td>$1.39</td>
</tr>
</tbody>
</table>

**To calculate your monthly premium:**

1. Amount Elected: Write the amount of units you want. (1 unit = $1,000) Line 1: __________
2. Write your age-based rate from the table to the left. Line 2: __________
3. Multiple Line 1 by Line 2. This is your monthly premium amount. Line 3: __________

*Example:*

40 year old employee requesting $250,000 = 250 x $0.06 = $15.00/monthly premium

### Spouse Rates

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate Per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Age 25</td>
<td>$0.04</td>
</tr>
<tr>
<td>Age 25-29</td>
<td>$0.04</td>
</tr>
<tr>
<td>Age 30-34</td>
<td>$0.05</td>
</tr>
<tr>
<td>Age 35-39</td>
<td>$0.06</td>
</tr>
<tr>
<td>Age 40-44</td>
<td>$0.06</td>
</tr>
<tr>
<td>Age 45-49</td>
<td>$0.10</td>
</tr>
<tr>
<td>Age 50-54</td>
<td>$0.16</td>
</tr>
<tr>
<td>Age 55-59</td>
<td>$0.30</td>
</tr>
<tr>
<td>Age 60-64</td>
<td>$0.45</td>
</tr>
<tr>
<td>Age 65-69</td>
<td>$0.89</td>
</tr>
<tr>
<td>Age 70 or over</td>
<td>$1.39</td>
</tr>
</tbody>
</table>

**To calculate your monthly premium:**

1. Amount Elected: Write the amount of units you want. (1 unit = $1,000) Line 1: __________
2. Write your age-based rate from the table to the left. Line 2: __________
3. Multiple Line 1 by Line 2. This is your monthly premium amount. Line 3: __________

*Example:*

28 year old spouse requesting $25,000 = 5 x $0.04 = $1.00/monthly premium

---

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
# Short Term Disability Insurance

**ADMINISTERED BY THE STANDARD**

The County offers short-term disability (STD) insurance for those employees working 20 or more hours per week and who are NOT enrolled in State Disability Insurance (SDI). New employees enrolled in SDI may also enroll in the basic short term disability program for their first seven months on the job. After seven months, when SDI benefits become payable, the basic STD benefits will be cancelled.

STD insurance, administered by Standard Life Insurance, is designed to pay a weekly benefit in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, which can help you meet your financial commitments in a time of need.

The County offers two STD plans: Basic and Expanded. The Basic STD plan offers a lower weekly benefit amount and is available to any employee not enrolled in SDI. The Expanded STD plan offers a greater weekly benefit amount (at a higher cost) and is available only to certain employee groups based on terms of MOU / Resolution (generally Management, confidential employees, SMCCC, and attorneys). More information about STD benefits is available online at [http://hr.smcgov.org/employee-benefits](http://hr.smcgov.org/employee-benefits); click on Disability Benefits.

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>BASIC STD</th>
<th>EXPANDED STD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees who are not enrolled in SDI</td>
<td>Employees in certain bargaining groups (generally Management, Attorneys, SMCCC &amp; Confidential employees who are not enrolled in CA SDI)</td>
<td></td>
</tr>
<tr>
<td>Benefit Amount</td>
<td>$95/week (not to exceed 70% of pre-disability earnings)</td>
<td>60% of the first $2,115 of pre-disability earnings</td>
</tr>
<tr>
<td>Maximum Benefit Amount</td>
<td>$95/week</td>
<td>$1,269/week</td>
</tr>
<tr>
<td>Minimum Benefit Amount</td>
<td>$15</td>
<td>$15</td>
</tr>
<tr>
<td>Benefit cost</td>
<td>$2.35 semi-monthly cost</td>
<td>Based on age of employee</td>
</tr>
<tr>
<td>Benefit duration</td>
<td>18 weeks</td>
<td>52 weeks</td>
</tr>
<tr>
<td>Benefit waiting period</td>
<td>14 days</td>
<td>14 days(^1)</td>
</tr>
</tbody>
</table>

\(^1\)If you enroll outside of your initial hire, you would be subject to a 60-day waiting period for all claims that are submitted in the first 12 months. After the initial 12 months, the waiting period for claim payment will revert to 14 days.

---

**Questions?** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
## Short Term Disability Insurance

### RATE CALCULATION WORKSHEET

<table>
<thead>
<tr>
<th>BASIC STD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All ages</td>
<td>2.347</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPANDED STD</th>
<th>Age</th>
<th>Rate (Per $100 of Monthly Benefit)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 25</td>
<td>$0.24</td>
</tr>
<tr>
<td></td>
<td>Under 30</td>
<td>$0.24</td>
</tr>
<tr>
<td></td>
<td>30-34</td>
<td>$0.28</td>
</tr>
<tr>
<td></td>
<td>35-39</td>
<td>$0.32</td>
</tr>
<tr>
<td></td>
<td>40-44</td>
<td>$0.39</td>
</tr>
<tr>
<td></td>
<td>45-49</td>
<td>$0.55</td>
</tr>
<tr>
<td></td>
<td>50-54</td>
<td>$0.62</td>
</tr>
<tr>
<td></td>
<td>55-59</td>
<td>$0.88</td>
</tr>
<tr>
<td></td>
<td>60 &amp; over</td>
<td>$1.21</td>
</tr>
</tbody>
</table>

- The cost of **Basic** STD is $2.347 semi-monthly.
- The cost of **Expanded** STD is based on your age. To calculate your semi-monthly premium for Expanded STD:

  1. Monthly benefit: Annual income divided by 12 and multiply by 60% (Round up on $100)  
  2. Write your age-based rate from the table to the left.  
  3. Multiply Line 1 by Line 2 and divide by 100. This is your semi-monthly premium amount:

Example:

36 year old employee earning $65,000 annually

- $65,000 / 12 x 60% = $3,250.00; $3,300 ($3,250 rounded up to nearest $100)  
- $3,300 x $0.320 / 100 = **$10.56 semi-monthly premium**
Travel Assistance
ADMINISTERED BY THE STANDARD

Travel Assistance\(^1\) helps you cope with emergencies when you travel more than 100 miles from home or internationally for trips of up to 180 days. It can also help you with non-emergencies, such as planning your trip. You do not have to enroll. As a participant in the County’s group insurance from The Standard, you are automatically covered – and so is your family. All services are available 24 hours a day, every day.

This program, provided by **Generali Global Assistance**, offers aid before and during your trip, including:

- Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- Help replacing prescription medication or lost corrective lenses and advancing funds for emergency medical payment
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee’s home, including repatriation of remains\(^2\)
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization\(^2\)
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of a natural disaster, political unrest and social instability

Travel Assistance is available if you travel more than 100 miles from home or in a foreign country.

**Contact**
866.455.9188: United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda
+1.240.330.1380: Everywhere else
ops@gga-usa.com

In all cases, the medical professionals, medical facilities or legal counsel suggested by Generali Global Assistance (GGA) to provide services to Participants are not employees or agents of The Standard or GGA, and the final decision to utilize any such medical professional, medical facility, or legal counsel is the Participant’s choice alone. The Standard and GGA are not responsible and shall not be liable for any wrongful act or omission of any transportation provider, healthcare professional or legal counsel who is not an employee of The Standard or GGA, as applicable. Generali Global Assistance is the marketing name for GMMI, Inc.

---

1 Travel Assistance is provided by Generali Global Assistance. Generali Global Assistance (GGA) is the marketing name used by GMMI, Inc. for their services, which is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. GGA is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard’s group policy.

2 Must be arranged by Generali Global Assistance. The Combined Single Limit (CSL) for these services is $1 million. One service or combination of the services may exceed the CSL. The insured is responsible for payment of any expenses that exceed the CSL.
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.
- If you elect to enroll in one of the HDHP plans offered through Kaiser or Blue Shield, the County will fund 50% of the deductible for 2019.
- In 2019, you can contribute a maximum of $3,500 for employee only or $7,000 for employee + one or more. This maximum includes both employer and employee contributions.
- Since your medical expenses may change within the year, you may change (increase or decrease) your contributions at any time.

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.
Flexible Spending Account
ADMINISTERED BY BENEFITS COORDINATION CORPORATION (BCC)

Participating in a Flexible Spending Account (FSA) is a great way to save money over the course of a year. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your medical plan, as well as reimbursement for dependent care expenses.

Since your medical expenses may change within the year, you may change (increase or decrease) your contributions ONLY if you have an IRS qualifying event (got married, have a baby etc.)

There are two accounts to choose from: You may use the Healthcare Spending Account, the Dependent Day Care Spending Account, or both. When you enroll, you decide how much money to contribute to your personal accounts for the coming year. These contributions are gradually deducted from your paychecks through the year and deposited into your account(s).

Healthcare Spending Account
This account will reimburse you with pre-tax dollars for eligible healthcare expenses not reimbursed under your family’s healthcare plans. Due to Health Care Reform, the maximum amount you may contribute to a Healthcare Spending Account for the 2019 Plan Year is $2,700. You may choose to set aside, as a pre-tax payroll deduction, a spending account for medical-related expenses. These include money for co-pays, deductibles, and many other qualified medical expenses.

Please note that you may not be enrolled in the medical portion of the FSA account if you are enrolled in the Health Savings Account (HSA). However, you may still enroll in the “limited purpose” FSA for your vision and dental expenses.

Healthcare FSA Rollover Feature:
You make the election for deduction annually, and should estimate the amount you need for qualified-medical expenses. Keep in mind that any unused funds from your Healthcare FSA by December 31, 2019 (minimum of $5 up to $500) will automatically be rolled over for use in the next plan year.

(Note: Participants will have until March 31st to submit claims for expenses incurred during 1/1/2019-12/31/2019.)

~ Over the Counter Drugs ~
Your over-the-counter drugs and medicines may need a doctor’s prescription in order to get reimbursed. See below for more details.

The following items will require a doctor’s Rx:
- Acid Controllers, Allergy & Sinus
- Antibiotic Products
- Anti-Diarrheal, Anti-Gas
- Anti-Itch & Insect Bite
- Anti-parasitic treatments
- Baby Rash Ointments, Cold Sore Remedies
- Cough, Cold, & Flu, Digestive Aids
- Feminine Anti-Fungal/Anti-itch
- Hemorrhoid Preps, Laxatives
- Motion Sickness, Pain Relief
- Respiratory Treatments
- Sleep Aids & Sedatives, Stomach Remedies

The following items remain eligible WITHOUT an Rx:
- Band Aids
- Birth Control
- Braces & Supports
- Catheters
- Contact Lens Supplies & Solutions
- Denture Adhesives
- Diagnostic Tests & Monitors
- Elastic Bandages & Wraps
- Insulin & Diabetic Supplies
- Ostomy Products
- Reading Glasses
- Wheelchairs, Walkers, Canes

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Advantages of an FSA

What’s the Advantage of Pre-Tax?

Pre-tax means the dollars you use for eligible expenses are not subject to social security tax, federal income tax and, in most cases, state and local taxes. Money you would have paid in taxes can be used to pay qualified expenses. Depending on your tax bracket, you can save 23% to 46% on every expense you pay through the flex accounts and increase your take home pay by up to $20 to $40 on every $100 you set aside. It’s a tax break you cannot afford to ignore!

Here is an example of an FSA savings potential:

<table>
<thead>
<tr>
<th>Earnings Illustration: Tax Savings Using an FSA</th>
<th>Without an FSA</th>
<th>With an FSA</th>
<th>Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Pay</td>
<td>$40,000</td>
<td>$40,000</td>
<td></td>
</tr>
<tr>
<td>Contribution to FSA Before Tax</td>
<td>$0</td>
<td>-$3,000</td>
<td>Contribution is Pre-Tax</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$40,000</td>
<td>$37,000</td>
<td>Less Taxable Income</td>
</tr>
<tr>
<td>Estimated Taxes</td>
<td>-$6,233</td>
<td>-$5,387</td>
<td>Less Paid in Taxes</td>
</tr>
<tr>
<td>Income After Taxes</td>
<td>$33,767</td>
<td>$31,613</td>
<td></td>
</tr>
<tr>
<td>Dependent Day Care/Health Care Expenses</td>
<td>-$3,000</td>
<td>-$3,000</td>
<td></td>
</tr>
<tr>
<td>Tax Free Plan Reimbursement</td>
<td>$0</td>
<td>$3,000</td>
<td>Tax Free</td>
</tr>
<tr>
<td>Net Income After Taxes &amp; Expenses</td>
<td>$30,767</td>
<td>$31,613</td>
<td>More Money in Your Paycheck!</td>
</tr>
</tbody>
</table>

How do I Enroll?
First figure out the amount of expenses you’re sure you will incur during the course of the upcoming plan year for both the Health Care and Dependent Care Flexible Spending Accounts. You must enroll through Workday during open enrollment or within 31 days of a qualifying event.

How do I get reimbursed? (2019 Funds)
There are two ways to get reimbursed from your FSA accounts:

1. BCC offers employees the option to use a debit card for your healthcare expenses. The money you set aside in your FSA account(s) for medical expenses is available on your card. When you pay for these expenses, you do not need to pay out-of-pocket and wait for reimbursement from BCC – expenses are automatically deducted from your account on the card. Typically, when you pay with your debit card at a pharmacy or doctor’s office, receipts will not be required by BCC, but you must still obtain and keep a receipt for the purchase.

2. You can also submit receipts to BCC and they will reimburse you via direct deposit.

For more information on the Flexible Spending Accounts offered through BCC including a list of Qualified Expenses, please visit the County website at:

http://hr.smcgov.org/employee-benefits;
click on Flexible Spending Account.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Flexible Spending Accounts (FSA)
ADMINISTERED BY BENEFIT COORDINATORS CORPORATION (BCC)

DEPENDENT DAY CARE SPENDING ACCOUNT
This account will reimburse you with pre-tax dollars for daycare expenses for your child(ren) and other qualifying dependents. The maximum amount you may contribute to a Dependent Day Care Spending Account is $5,000 a year, or $2,500 a year if you are married but file separate tax returns. You may choose to set aside, as a pre-tax payroll deduction, a spending account for dependent care expenses. These include expenses for child care or dependent adult care for a member of your household.

Eligible Dependents Include:
• Children under the age of 13 who qualify as dependents on your federal tax return; and
• Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return.

You may use the federal childcare tax credit and the Dependent Care Spending Account; however, your federal credit will be offset by any amount deferred into dependent care plan.

After you set the money aside by pre-tax payroll deduction, you can use the money to pay for these items. You make the election for deduction annually, and should estimate the amount you need carefully. There is a “use it or lose it” provision: Taking into account the 2 1/2 month Grace Period, if you don’t use the money in your account by March 15 the following year you make your contribution, you lose the unexpended portion. (Note: Participants will have until March 31st to submit claims for expenses incurred during said plan year).
Flexible Spending Accounts – BCC

DEBIT CARD

Aside from using your BCC debit card, there are two ways you can manually submit claims for reimbursement:

MY SMARTCARE MOBILE APP:

The My SmartCare mobile app and online portal allow you to freely and securely access your BCC Reimbursement Accounts 24/7. Participants use the same user name and password to log into both the app and the online portal. Here’s how it all works:

**Download**

1. Open the app store from your iOS or Android powered device.
2. Search “BCCSmartCare”.
3. Install the free app to your device.

**Launch**

1. Open the app on your device.
2. Sign in using your existing My SmartCare login and password OR click “Register” if you are a new user.
3. You have the option to save your User ID to your mobile device by choosing ‘ON’ next to “Save this Online ID”. This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial login.

**New Users**

- When registering as a new user, MySmartCare will walk you through a series of registration questions followed by a secure authentication process to validate you as a user.
- Each time you log in with a new device, you will complete the secure authentication process.
- Be sure to use your Social Security Number as your Employee ID and your FSA debit card number as your Registration ID when registering.
- By registering your e-mail address, you will receive important push notifications regarding your account balance, grace period or year-end reminders, notice of debit card mailed, etc.

**Questions?** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Flexible Spending Accounts – BCC

MY SMARTCARE ONLINE PORTAL

- Log on to https://www.mywealthcareonline.com/bccsmartcare/
- Sign in using your existing MySmartCare log in and password OR click “Register” if you are a new user.
- You have the option to save your User ID to your mobile device by choosing ‘ON’ next to “Save this Online ID”. This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial login.

Once logged in to My SmartCare Portal, click on ‘Reimbursement Request’ in the left Navigation menu.

In the ‘New Claims’ box, click ‘Add New’ and a new screen will appear.

- Fill out all required fields (marked with *).
- Upload a receipt file by clicking ‘Browse’ and choosing the pdf or the image of your claim substantiation. You can upload one receipt file per claim.
- Click ‘OK’ when form is complete.

When finished adding new claims, read the Certification message and click the acknowledgement box that you agree with the statement.

- Click the ‘Submit’ button to submit all claims.

A ‘Thank You’ screen will appear once the claim has been successfully submitted to BCC.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Additional Benefits

DEFERRED COMPENSATION

Deferred Compensation permits full-time and permanent part-time employees (working 20 or more hours per week), on a voluntary basis, to authorize a portion of salary to be withheld and invested for payment at a later date upon termination or retirement. You have two enrollment options, the Traditional 457 Plan and the Roth 457 Plan.

Under the Traditional 457 Plan neither the deferred amount nor earnings on the investments are subject to current federal or state income taxes. Taxes become payable when deferred income plus earnings are distributed, presumably during retirement when you are in a lower income tax bracket.

The Roth 457 Plan option provides an alternative to pre-tax investing. Roth contributions are considered “after-tax,” which means taxes are withheld when you contribute. However, qualified distributions on your contributions plus any earnings are completely tax-free. For example, if you contribute $100, the entire $100 comes out of your net pay, but when you make eligible withdrawals from your account, the entire amount plus any earnings are entirely tax-free.

The normal contribution limit for the 457 Plan is $19,000. Employees age 50 or older may contribute up to an additional $6,000 for a total of $25,000.

Pre-Retirement Catch

Employees taking advantage of the special pre-retirement catch-up may be eligible to contribute up to double the normal limit, for a total of $36,000, if you are within three years of normal retirement age (62 years old for non-safety members and 50 years old for qualified safety employees).

To elect the additional pre-retirement catch-up, please contact your Mass Mutual Retirement Specialist at 1-888-593-0259 and complete the pre-retirement catch-up form and send it to Controller’s office (Pony CTL135)

Please note that you may not contribute to the additional Age 50+ catch-up ($6,000) and pre-retirement catch-up (supplemental $18,000) simultaneously.

Employees may enroll at any time during the year.

For more information, visit www.viewmyretirement.com/sanmateocounty.
Additional Benefits

COMMUTE ALTERNATIVES PROGRAM (CAP)

The County of San Mateo offers employees incentives that support the use of public transportation, carpool, vanpool, and walking/biking to work. Through the Commute Alternatives Program, employees can pay for transit on a pre-tax basis and receive a monthly subsidy for transit and other alternative modes. The Commute Alternatives Program also provides the SMC Commuter, a private shuttle for employees coming from the East Bay and Daly City areas. From real financial savings, to a healthier environment, to a less stressful commute that results in more productive work time, CAP can get your workday off to a better start and free you from the cost and stress of driving alone. For more information, visit the new SharePoint site at https://smcgov.sharepoint.com/sites/commutealternatives.

COLLEGE COACH

College Coach delivers unbiased, impartial expertise from former college admissions officers and college financial aid officers. Our goals are to reduce your stress, improve your well-being, provide correct guidance, and help you and your children get a better outcome from the college process.

The College Coach consists of live events, online support, and personalized, one-on-one assistance. It is available at no cost to San Mateo County employees and family members.

- **On site / Webinar Presentations.** 60-minute presentations highlight important college admissions and college finance topics for parents.

- **Learning Center.** An online learning environment where employees can access interactive videos as well as a broad range of resources, FAQs, and other information. Access to the Learning Center is free and available 24/7 through the College Coach portal.

- **Personalized Assistance.** College Coach experts provide personalized assistance that is customized to the needs and grade of your child. It can include but is not limited to phone counseling, college essay critique, customized college list development, and use of “Quick Questions.”

For more information and to register for the College Coach Program:

Visit the Portal:

https://passport.getintocollege.com/Account/Login

Passcode: smcgov (first time only)

Call: 866-468-3129

Email: smcgov@getintocollege.com

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
Additional Benefits

TUITION REIMBURSEMENT
The County’s Tuition Reimbursement Program provides financial assistance for regular employees who are participating in job-related degree or certificate programs, skill enhancement workshops, or programs for Continuing Education Units.

The current level of reimbursement is $263 for college courses under 3 units (and workshops less than 30 hours in length) and $438 for courses of 3 units or more (or workshops over 30 hours in length). Funds do not cover equipment, parking passes, etc. Effective July 1, 2007, $25 per course for books will be reimbursed for community college, undergraduate level and graduate level courses. For more information about Tuition Reimbursement, visit www.smcgov.org/hr click on Training and Development.

VOLUNTARY TIME OFF (VTO) PROGRAM
The Voluntary Time Off (VTO) Policy is designed to provide flexible working hours for County employees. This policy allows employees to reduce their time at work by 1%, 2%, 3%, 4%, 5%, 10%, 15% or 20% without losing many of the benefits available to them. The policy also permits employees to use this time to reduce their work day, work week or schedule blocks of time off. For more information, please visit http://hr.smcgov.org/employee-benefits.

CATASTROPHIC LEAVE PROGRAM
This program allows an employee who has exhausted all vacation, sick, compensatory and holiday time due to a serious illness, injury or condition to receive donations of paid time off from other employees so that he/she can remain in paid status longer. Participating in this program requires Department Head approval. For more information about the Catastrophic Leave Program, visit http://hr.smcgov.org/employee-benefits.

EMPLOYEE REFERRAL PROGRAM (ERP)
Employees are eligible to receive up to $500 when successfully referring candidates to hard-to-fill positions. $250 will be awarded on initial hire of referred employee and an additional $250 will be awarded if the referred employee successfully completes probation. For hard-to-fill classifications, there will be a supplemental question requesting applicants to indicate if they were referred to the position by a County employee and if so, by whom. Every six months, the Human Resources Department will use the following criteria to determine which classifications are hard-to-fill:

1. Over 10% vacancy rate for a sustained period of time.
2. Length of time of the ongoing recruitment for the classification.
3. Number of appointable candidates on the eligible list.

For more information on the Employee Referral Program, please visit http://hr.smcgov.org/employee-referral-program

Questions? Contact Benefits Division: 650-363-1919 or benefits@smgov.org
Additional Benefits

WORKER’S COMPENSATION

All County employees are covered by the County’s Worker’s Compensation Policy for any job-related injury, including first-aid type injuries and work-related illnesses. To read more about the types of injuries qualify as “job-related,” please visit the County's Worker’s Compensation page: [http://hr.smcgov.org/workers-compensation](http://hr.smcgov.org/workers-compensation)

TELEWORK

The County of San Mateo’s commitment to providing a flexible working environment includes the ability to telework. Telework allows County employees to work offsite, often from home, with supervisor approval. Learn more about the County’s telework options, please visit: [http://www.commute.org/files/programs/SMC_Telework_Toolkit.pdf](http://www.commute.org/files/programs/SMC_Telework_Toolkit.pdf)
Meet Ben-IQ

Ben-IQ is a free app that includes much of the information that's included in this overview, but in a place that's always at your fingertips — your smartphone. Ben-IQ is available for Android and iPhone.

GETTING STARTED WITH BEN-IQ

1. Download and launch the app.

2. Enter your assigned Employer Key: smc.gov

3. Read and agree to the Terms and Conditions.

TAKE ADVANTAGE OF:

- **BENEFIT INFO**
  Access to health plan highlights

- **FIND CONTACTS**
  Find nurse line and other important contact numbers

- **ACCESS ID CARDS**
  Store and organize plan ID cards

- **WELLNESS TIPS**
  Wellness program information and tips

- **COST OF CARE**
  Find out how much care should cost

- **MESSAGES**
  Receive important messages from your HR/benefits team

- **VIDEOS**
  Learn more about plan benefits with access to online videos

- **FAQ**
  Access answers to frequently asked benefits questions

Take a tour of Ben-IQ and review plan summaries, and important contacts such as your plans' member services numbers. Store and organize ID cards using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members too.
## Contact Numbers

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Group Number</th>
<th>Website</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser Permanente (HMO and HDHP)</td>
<td>Group #7056</td>
<td><a href="http://www.kp.org">www.kp.org</a></td>
<td>800-464-4000</td>
</tr>
<tr>
<td>Blue Shield TRIO Concierge</td>
<td>Group #W0014027</td>
<td><a href="http://www.blueshieldca.com">www.blueshieldca.com</a></td>
<td>855-829-3566</td>
</tr>
<tr>
<td>Blue Shield of CA (HMO, PPO &amp; HDHP)</td>
<td>Group #W0014027</td>
<td><a href="http://www.blueshieldca.com">www.blueshieldca.com</a></td>
<td>855-256-9404</td>
</tr>
<tr>
<td>Cigna (Dental — PPO)</td>
<td>Group # 3340005</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
<td>800-244-6224</td>
</tr>
<tr>
<td>Delta Dental of California (Dental—HMO)</td>
<td>Group #71444-0001</td>
<td><a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
<td>888-335-8227</td>
</tr>
<tr>
<td>Vision Service Plan (VSP)</td>
<td>Group #00256000</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
<td>800-877-7195</td>
</tr>
<tr>
<td>The Standard (Life)</td>
<td>Group #649107</td>
<td><a href="http://www.standard.com">www.standard.com</a></td>
<td>(t) 800-628-8600</td>
</tr>
<tr>
<td>The Standard (Disability)</td>
<td>Group #645866</td>
<td><a href="http://www.standard.com">www.standard.com</a></td>
<td>(f) 800-368-2859</td>
</tr>
<tr>
<td>Generali Global Assistance (Travel Assistance)</td>
<td>Group #D2STD</td>
<td><a href="http://www.standard.com/travel">www.standard.com/travel</a></td>
<td>866-455-9188</td>
</tr>
<tr>
<td>CONCERN (EAP)</td>
<td></td>
<td></td>
<td>(US, Canada, PR, US VI &amp; Bermuda) 1+240-330-1380</td>
</tr>
<tr>
<td>Mass Mutual (Deferred Compensation)</td>
<td></td>
<td><a href="http://www.concern-eap.com">www.concern-eap.com</a></td>
<td>800-344-4222</td>
</tr>
<tr>
<td>Optum (Health Savings Account)</td>
<td></td>
<td><a href="http://www.massmutual.com/serve">www.massmutual.com/serve</a></td>
<td>800-743-5274</td>
</tr>
<tr>
<td>Benefit Coordinators Corporation (FSA)</td>
<td></td>
<td><a href="http://www.optumbank.com">www.optumbank.com</a></td>
<td>844-326-7967</td>
</tr>
<tr>
<td>SAN MATEO COUNTY EMPLOYEES’ RETIREMENT ASSOCIATION (SamCERA – Pension)</td>
<td></td>
<td><a href="http://www.samcera.org">www.samcera.org</a></td>
<td>(650) 599-1234</td>
</tr>
</tbody>
</table>

**Questions?** Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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.

NON DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

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

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

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


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
MEDICARE PART D NOTICE

Important Notice from County of San Mateo About Your Prescription Drug Coverage and Medicare

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

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

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

2. County of San Mateo has determined that the prescription drug coverage offered by Kaiser Permanente, 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.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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](http://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.

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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 –

<table>
<thead>
<tr>
<th>State</th>
<th>Program Name</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>FLORIDA – Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Website: <a href="http://flmedicaidtiprecovery.com/hipp/">http://flmedicaidtiprecovery.com/hipp/</a></td>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALASKA – Medicaid</td>
<td>GEORGIA – Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a></td>
<td>Phone: 1-866-251-4861</td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>- Click on Health Insurance Premium Payment (HIPP)</td>
<td>Medicaid Eligibility:</td>
<td></td>
</tr>
<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARKANSAS – Medicaid</td>
<td>INDIANA – Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a></td>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td>Phone 1-800-403-0864</td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
| COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) | IOWA – Medicaid |
| Health First Colorado Website: [https://www.healthfirstcolorado.com/](https://www.healthfirstcolorado.com/) | Website: [http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp](http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp) |
| Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 | Phone: 1-888-346-9562 |
| CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus | |

| KANSAS – Medicaid | NEW HAMPSHIRE – Medicaid |
| Phone: 1-785-296-3512 | Phone: 603-271-5218 |

| KENTUCKY – Medicaid | NEW JERSEY – Medicaid |
| Website: [http://chfs.ky.gov/dms/default.htm](http://chfs.ky.gov/dms/default.htm) | Medicaid Website: [http://www.state.nj.us/humanservices/dmahs/clients/medicaid/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/) |
| Phone: 1-800-635-2570 | Medicaid Phone: 609-631-2392 |
| | CHIP Website: [http://www.njfamilycare.org/index.html](http://www.njfamilycare.org/index.html) |
| | CHIP Phone: 1-800-701-0710 |

| LOUISIANA – Medicaid | NEW YORK – Medicaid |
| Website: [http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331](http://dhhs.louisiana.gov/index.cfm/subhome/1/n/331) | Website: [https://www.health.ny.gov/health_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/) |
| Phone: 1-888-695-2447 | Phone: 1-800-541-2831 |

| MAINE – Medicaid | NORTH CAROLINA – Medicaid |
| Phone: 1-800-442-6003 | Phone: 919-855-4100 |
| TTY: Maine relay 711 | |

| MASSACHUSETTS – Medicaid and CHIP | NORTH DAKOTA – Medicaid |
| Phone: 1-800-862-4840 | Phone: 1-844-854-4825 |

| MINNESOTA – Medicaid | OKLAHOMA – Medicaid and CHIP |
| Phone: 1-800-657-3739 | Phone: 1-888-365-3742 |

| MISSOURI – Medicaid | OREGON – Medicaid |
| Website: [http://dss.mo.gov/mhd/participants/pages/hipp.htm](http://dss.mo.gov/mhd/participants/pages/hipp.htm) | Website: [http://healthcare.oregon.gov/Pages/index.aspx](http://healthcare.oregon.gov/Pages/index.aspx) |
| Phone: 1-800-699-9075 | |

| MONTANA – Medicaid | PENNSYLVANIA – Medicaid |
| Phone: 1-800-694-3084 | Phone: 1-800-692-7462 |

| NEBRASKA – Medicaid | RHODE ISLAND – Medicaid |
| Website: [http://www.ACCESSNebraska.ne.gov](http://www.ACCESSNebraska.ne.gov) | Website: [http://www.eohhs.ri.gov/](http://www.eohhs.ri.gov/) |
| Phone: (855) 632-7633 | Phone: 855-697-4347 |
| Lincoln: (402) 473-7000 | |
| Omaha: (402) 595-1178 | |

| NEVADA – Medicaid | SOUTH CAROLINA – Medicaid |

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
<table>
<thead>
<tr>
<th>State/Region</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOUTH DAKOTA - Medicaid</td>
<td><a href="https://dwss.nv.gov/">https://dwss.nv.gov/</a></td>
<td>1-800-992-0900</td>
<td><a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
<td>1-888-549-0820</td>
</tr>
<tr>
<td>WASHINGTON – Medicaid</td>
<td><a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a></td>
<td>1-800-562-3022 ext. 15473</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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](http://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](http://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](mailto: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

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
COUNTY OF SAN MATEO

4. Employer Identification Number (EIN)
94-6000532

5. Employer address
455 COUNTY CENTER

6. Employer phone number
(650) 363-1919

7. City
REDWOOD CITY

8. State
CA

9. ZIP Code
94063

10. Who can we contact about employee health coverage at this job?
BENEFITS DIVISION

11. Phone number (if different from above)
(650) 363-1919

12. Email address
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:

- 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...

Questions? Contact Benefits Division: 650-363-1919 or benefits@smcgov.org
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