2023

EMPLOYEE BENEFITS OVERVIEW




Your Benefits, Your Choice.

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Welcome to the County of San Mateo!

Welcome to the 2023 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 2023 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 https://www.smcgov.org/hr/health-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 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** https://www.smcgov.org/hr/health-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 may 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 26 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 the month following date of hire. New employees who do not make an election within 31 days of becoming eligible will automatically be enrolled for employee only 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 from the qualifying life event 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.

Dependent Type	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse	• Person to whom you are legally married	• Marriage Certificate
Domestic Partners At least 18 years old	• Meet County Domestic Partner Eligibility Requirements • Must be at least 6 months between any domestic partnerships	• County of San Mateo Affidavit of Domestic Partnership **-or-** • Declaration of Partnership filed with the California Secretary of State
Natural Child(ren) Under Age 26	• Minor or Adult Child(ren) of Employee who is under age 26yrs	• Birth Certificate
Step Child(ren) Under Age 26	• Minor or Adult Child(ren) of Employee Spouse who is under age 26yrs	• Birth Certificate **–and-** • Marriage Certificate showing Spouse as Parent
Children Legally Adopted/Wards	• Minor or Adult Child(ren) legally adopted by Employee who is married or unmarried under age 26yrs	• Court documentation (Must include presiding Judge Signature & Court Seal)
Children of Domestic Partners Under Age 26	• Minor or Adult Child(ren) of Employee Domestic Partner who is under age 26yrs	• County of San Mateo Affidavit of Domestic Partnership **–and-** • Birth Certificate
Disabled Children No age limit	• 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.	• Birth Certificate **–and-** • Certification of Disability from Social Security **-or-** • Document of Disability from Physician if not SSA Certified
Other Qualifying Relatives Under Age 26	• Meets Requirements of IRS Code. Sec. 105(b) • under age 26yrs	• Birth Certificate Showing Individual to be an Eligible Relative –**and-** • County of San Mateo Affidavit of Tax Qualifying Dependent

PLEASE NOTE: The deduction for a domestic partner **is not** a pre-tax qualified deduction. Since this is not a pre-tax qualified deduction, County employees will be assessed imputed taxable income on their W2 tax statement at the end of the year that needs to be reported when filing taxes. It is recommended that the employee consults with a qualified tax specialist or accountant for any additional questions.

Both the Affidavit of Tax Qualifying Dependent and the Affidavit for Domestic Partnership are available online at https://www.smcgov.org/hr/rules-coverage-eligibility; 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:

1. Any changes you make must be consistent with the change in status,
2. You must make the changes within 31 days of the date the *event* (marriage, birth, etc.) occurs,
3. With the exception of births, life events take effect the first of the following month after the life event effective date.

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 the Life Insurance section of this guide.

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

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.

For more information on Leave of Absence, visit https://www.smcgov.org/hr/leave-absence.

What's New in 2023?

MEDICAL – NEW CARRIER!

- Effective January 1, 2023, Aetna will replace Blue Shield HMO & PPO plans

  Aetna offers the following advantages:

  - Lower premiums which equate to lower out-of-pocket costs for employees
  - Lower cost value network which includes the Sutter/Mills-Peninsula Medical Group
  - Additional options for early retirees who move out of state
  - Benefit enhancements
  - Significate premiums saving for Medicare retirees
  - A 24/7 peer support program for first responders
  - Questions? Call (833) 576-2494 weekdays between 8 AM and 6 PM (PST)

VISION – BENEFIT UPGRADE

- Benefits upgrade to the VSP Core Vision plan
  - Upgrade to the In-Network Frame allowance from $130 in 2022 to $150 in 2023

EMPLOYEE ASSISTANCE PROGRAM – BENEFIT UPGRADE

- Benefits upgrade increasing from 5 to 8 sessions per incident, per year

Medical Benefits

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

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

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

Medical Benefits

KAISER PERMANENTE®

- **Health Maintenance Organization (HMO)** - a plan 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 https://www.smcgov.org/hr/health-benefits; click on Health Benefits.

- **High Deductible Health Plan** - This is a plan that works in conjunction with a Health Savings Account (please see Health Savings Account section). 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. More information about Kaiser's health plan benefits is available at https://www.smcgov.org/hr/health-benefits; click on Health Benefits.

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.

Medical Benefits

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (Health Maintenance Organization) if:	
• You want lower, predictable out-of-pocket costs • You like having one doctor manage your care • You are happy with the selection of network providers • You don't see any doctors that are out-of-network	Plans To Consider • Aetna HMO • Aetna AVN • Kaiser Traditional HMO

Consider the OAMC PPO (Preferred Provider Organization) if:	
• You want to be able to see any provider, even a specialist, without a referral • You want access to one of the largest national networks in the Country, with the ability to see any licensed provider in the nation, regardless of whether or not the provider is in the network	Plan To Consider • Aetna OAMC

Consider a High Deductible Health Plan (HDHP) if:	
• You want to be able to see any provider, even a specialist, without a referral • You are willing to pay more to see out-of-network providers • You want tax-free savings on your healthcare costs • You want to build a savings account for future healthcare costs for you and your eligible family members • You want an extra way to add to your retirement savings	Plans To Consider • Aetna High Deductible Health Plan OAMC • Kaiser High Deductible Plan (HMO)

More information about our health plan benefits is available at https://www.smcgov.org/hr/health-benefits; click on Health Benefits.

Dental Benefits

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

DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO)

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

PREFERRED PROVIDER ORGANIZATION (PPO)

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.

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.

More information about the Cigna plan is available online at https://www.smcgov.org/hr/health-benefits; click on Dental Plans.

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

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

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.

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.

2023 Semi-Monthly Cost of Medical Benefits

County Employees

2023 Health Insurance Plans (Effective January 1, 2023)

Aetna Full HMO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	County Cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	93.94	532.31	227.02	399.23	360.09	266.16	626.25	1252.50
Employee +1	187.87	1064.63	454.03	798.47	720.18	532.32	1252.50	2505.00
Employee + Family	265.84	1506.45	642.45	1129.84	1019.06	753.23	1772.29	3544.58

Aetna AVN HMO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	County Cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	72.77	412.34	175.85	309.26	278.94	206.17	485.11	970.22
Employee +1	145.53	824.68	351.70	618.51	557.87	412.34	970.21	1940.42
Employee + Family	205.93	1166.92	497.66	875.19	789.39	583.46	1372.85	2745.70

Aetna OAMC PPO ($200 Deductible)	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	County Cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	199.71	599.15	349.50	449.36	499.28	299.58	798.86	1597.72
Employee +1	414.80	1244.40	725.90	933.30	1037.00	622.20	1659.20	3318.40
Employee + Family	603.58	1810.73	1056.26	1358.05	1508.94	905.37	2414.31	4828.62

Aetna HDHP OAMC PPO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	County Cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	77.67	440.16	187.71	330.12	297.75	220.08	517.83	1035.66
Employee +1	155.35	880.31	375.43	660.23	595.50	440.16	1035.66	2071.32
Employee + Family	219.82	1245.65	531.23	934.24	842.64	622.83	1465.47	2930.94

Kaiser HMO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium[2]	Total Monthly Premium[2]
	Employee Cost	County Cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	59.08	335.76	59.08	335.76	226.46	168.38	394.84	789.68
Employee +1	118.15	670.53	285.53	503.15	452.92	335.76	788.68	1577.36
Employee + Family	167.19	948.38	404.03	711.54	640.88	474.69	1115.57	2231.14

Kaiser HDHP	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium[2]	Total Monthly Premium[2]
	Employee Cost	County Cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	46.40	263.92	46.40	263.92	177.86	132.46	310.32	620.64
Employee +1	92.80	526.84	224.26	395.38	355.72	263.92	619.64	1239.28
Employee + Family	131.31	745.06	317.32	559.05	503.34	373.03	876.37	1752.74

Operating Engineers PPO, Dental & Vision	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee cost	County cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	51.45	463.05	167.21	347.29	282.97	231.53	514.50	1029.00
Employee +1	102.85	925.65	334.26	694.24	565.67	462.83	1028.50	2057.00
Employee + Family	138.85	1249.65	451.26	937.24	763.67	624.83	1388.50	2777.00

Operating Engineers Kaiser, Dental & Vision	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee cost	County cost	Employee cost	County cost	Employee cost	County cost		
Employee Only	47.35	426.15	153.89	319.61	260.42	213.08	473.50	947.00
Employee +1	94.70	852.30	307.77	639.23	520.85	426.15	947.00	1894.00
Employee + Family	123.50	1111.50	401.37	833.63	679.25	555.75	1235.00	2470.00

2023 Semi-Monthly Cost of Medical Benefits

Courts Employees

2023 Health Insurance Plans (Effective July 1, 2023)

Aetna Full HMO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	Courts Cost	Employee cost	Courts cost	Employee cost	Courts cost		
Employee Only	0.00	626.25	0.00	626.25	0.00	626.25	626.25	1252.50
Employee +1	0.00	1252.50	0.00	1252.50	0.00	1252.50	1252.50	2505.00
Employee + Family	0.00	1772.29	0.00	1772.29	0.00	1772.29	1772.29	3544.58

Aetna AVN HMO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	Courts Cost	Employee cost	Courts cost	Employee cost	Courts cost		
Employee Only	0.00	485.11	0.00	485.11	0.00	485.11	485.11	970.22
Employee +1	0.00	970.21	0.00	970.21	0.00	970.21	970.21	1940.42
Employee + Family	0.00	1372.85	0.00	1372.85	0.00	1372.85	1372.85	2745.70

Aetna OAMC PPO ($200 Deductible)	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	Courts Cost	Employee cost	Courts cost	Employee cost	Courts cost		
Employee Only	79.89	718.97	259.63	539.23	439.37	359.49	798.86	1597.72
Employee +1	165.92	1493.28	539.24	1119.96	912.56	746.64	1659.20	3318.40
Employee + Family	241.43	2172.88	784.65	1629.66	1327.87	1086.44	2414.31	4828.62

Aetna HDHP OAMC PPO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium	Total Monthly Premium
	Employee Cost	Courts Cost	Employee cost	Courts cost	Employee cost	Courts cost		
Employee Only	0.00	517.83	0.00	517.83	0.00	517.83	517.83	1035.66
Employee +1	0.00	1035.66	0.00	1035.66	0.00	1035.66	1035.66	2071.32
Employee + Family	0.00	1465.47	0.00	1465.47	0.00	1465.47	1465.47	2930.94

Kaiser HMO	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium[2]	Total Monthly Premium[2]
	Employee Cost	Courts Cost	Employee cost	Courts cost	Employee cost	Courts cost		
Employee Only	0.00	394.84	0.00	394.84	0.00	394.84	394.84	789.68
Employee +1	0.00	788.68	0.00	788.68	0.00	788.68	788.68	1577.36
Employee + Family	0.00	1115.57	0.00	1115.57	0.00	1115.57	1115.57	2231.14

Kaiser HDHP	Full Time Employees		3/4 Time Employees		1/2 Time Employees		Total Semi-Monthly Premium[2]	Total Monthly Premium[2]
	Employee Cost	Courts Cost	Employee cost	Courts cost	Employee cost	Courts cost		
Employee Only	0.00	310.32	0.00	310.32	0.00	310.32	310.32	620.64
Employee +1	0.00	619.64	0.00	619.64	0.00	619.64	619.64	1239.28
Employee + Family	0.00	876.37	0.00	876.37	0.00	876.37	876.37	1752.74

2023 Semi-Monthly Cost of Dental and Vision Benefits

Dental

	Cigna Dental PPO			
Management, Confidential, District Attorney/County Counsel, Sheriff Sergeant	*Core Dental Plan (No max, no ortho coverage)*		*Management Buy up- Core plus Buy-Up (4k Ortho Coverage)*	
	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]
Employee Only	6.76	60.88	22.71	60.88
Employee + 1			39.85	
Employee + 2 ore more			52.32	

	Cigna Dental PPO							
All other represented employee groups	*Core Dental Plan (2.5k Max)*		*Year 2+ Actives - Core plus Buy-Up 1 (4k Max)*		*Year 2+ Actives - Core plus Buy-Up 2 (4k Ortho Coverage)*		*Year 2+ Actives - Core plus Buy-Up 3 (4k Max & 4k Ortho Coverage)*	
	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]
Employee Only	5.46	49.13	11.98	49.13	17.18	49.13	23.42	49.13
Employee + 1			18.86		29.77		42.88	
Employee + 2 ore more			23.87		38.93		57.03	

	Cigna DHMO		VSP Vision Care	
	Employee cost	County cost	Employee cost	County cost
Management, Confidential, District Attorney/County Counsel, Sheriff Sergeant	2.15	19.34	0.00	8.26
All other represented employee groups	2.15	19.34		

Vision

	VSP Vision Care Buy-Up	
	Employee cost	County cost
Employee Only	2.66	8.26
Employee + 1	5.59	
Employee + 2 ore more	7.99	

Preventive Care Screening Benefits

YOU TAKE YOUR CAR IN FOR MAINTENANCE. WHY NOT DO THE SAME FOR YOURSELF?

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

WHAT IS PREVENTIVE CARE?

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

NOT ALL EXAMS AND TESTS ARE CONSIDERED PREVENTIVE

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

TYPICAL SCREENINGS FOR ADULTS

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

Preventive care for women should include breast and gynecological exams

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

Should I skip my checkup due to COVID-19?

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

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

Medical

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.

	Aetna		Kaiser Permanente	
	HMO	AVN	Traditional HMO	HDHP
	In-Network	**In-Network**	**In-Network**	**In-Network**
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit	$0 per individual $0 family limit	$1,500 per individual $2,800 (per member in a family of two or more) $3,000 family limit
Annual Out-of-Pocket Max Individual Family	$1,000 $3,000	$1,000 $3,000	$1,500 $3,000	$3,000 per individual $3,000 (per member in a family of two or more) $6,000 family limit
Physician/Professional Services				
Office Visits Physician & Specialist	$15 copay	$15 copay	$15 copay	Plan pays 90% after deductible
Designated Walk-in Clinic Visit (e.g., CVS HealthHUB or CVS MinuteClinic)	$0 copay	$0 copay	Not applicable	Not applicable
Telemedicine	$15 copay	$15 copay	No charge	No charge
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic and Acupuncture Care	$10 copay (up to 30 visits per year)	$10 copay (up to 30 visits per year)	$15 copay (up to 20 visits per year)	Not covered
Lab and X-ray	Plan pays 100%	Plan pays 100%	$5 copay then plan pays 100%	Plan pays 90% after deductible
Infertility (Please refer to the EOC for additional details)				
Diagnosis and treatment of infertility	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	50% coinsurance	50% coinsurance after deductible
Assisted reproductive technology (“ART”) Services	Not Covered	Not Covered	50% coinsurance (one treatment cycle lifetime maximum)	50% coinsurance (one treatment cycle lifetime maximum)
Family Planning				
Physicians Family Planning Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Vasectomy	Cost shared based on where performed	Cost shared based on where performed	$50 per procedure	Plan pays 90% after deductible
Tubal Ligation	Plan pays 100%	Plan pays 100%	$50 per procedure	Plan pays 90% after deductible

New employees hired between December 2022 through November 2023 can receive a $900 incentive by enrolling in the Aetna Value Network (AVN) HMO during new hire benefits election.

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

Medical

HMO PLANS

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

[1] New employees hired between December 2022 through November 2023 can receive a $900 incentive by enrolling in the Aetna Value Network (AVN) HMO during new hire benefits election.

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

Medical

PRESCRIPTION COVERAGE

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

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

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

Medical

PPO PLANS

Aetna OAMC PPO Plan ($200 Deductible)

Aetna OAMC PPO HDHP Plan

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

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible Individual Family	$200 (individual) $600 (family)	$500 (individual) $1,000 (family)	$1,500 (individual) $3,000 (individual w/in family) $3,000 (family)	$3,000 (individual) $3,000 (individual w/in family) $6,000 (family))
Annual Out-of-Pocket Max Individual	$2,000	$4,000	$3,000 (individual) $3,000 (individual w/in family)	$6,000 (individual) $6,000 (individual w/in family)
Family	$4,000 (family)	$8,000 (family)	$6,000 (family)	$12,000 (family)
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Physician/Professional Services				
Office Visits PCP & Specialist	Plan pays 80%	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Telemedicine	Plan pays 80%	Not Covered	Plan pays 90% after deductible	Not Covered
Preventive Services	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Not covered
Chiropractic and Acupuncture Care (visit limits apply)	Chiro = Plan pays 80% after deductible Acupuncture = Plan pays 80%	Chiro = Plan pays 80% after deductible Acupuncture = Plan pays 80%	Chiro = Plan pays 90% after deductible Acupuncture = Plan pays 90% after deductible	Chiro = Plan pays 50% after deductible Acupuncture = Plan pays 60%
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Infertility (Please refer to the EOC for additional details)				
Diagnosis and treatment of infertility	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)
Assisted reproductive technology ("ART") Services (such as outpatient procedures or laboratory tests)	Not Covered	Not Covered	Not Covered	Not Covered

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

Medical

PPO PLANS

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

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

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Family Planning				
Physicians Family Planning Services	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Not covered
Vasectomy	Cost shared based on where performed	Not Covered	Plan pays 90% after deductible	Not covered
Tubal Ligation	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible
Hospital Services				
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 100%	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Emergency Room	$100 copay (waived if admitted)		Plan pays 90% after deductible	
Mental Health Services				
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Outpatient	Plan pays 80%	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Substance Abuse Services				
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Residential Care	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Outpatient	Plan pays 80%	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible

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

Medical

PPO PLANS

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

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

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Other Services				
Transgender	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Orthotic and Prosthetic Devices	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility Up to 100 days per Member, per Benefit Period	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible

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

Medical

PPO PRESCRIPTION COVERAGE

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

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

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Pharmacy				
Plan Deductible Applies?	No	No	Yes	Yes
$0 Chronic Drug List	Plan pays 100%	25% to $250 max. copay per prescription	Plan pays 100%	25% to $250 max. copay per prescription
Preferred Generic	$15 per prescription	25% + $15 to $250 max. copay per prescription	$10 per prescription	25% + $10 to $250 max. copay per prescription
Preferred Brand	$30 per prescription	25% + $30 to $250 max. copay per prescription	$25 per prescription	25% + $25 to $250 max. copay per prescription
Non-Preferred Generic and Brand	$45 per prescription	25% + $45 to $250 max. copay per prescription	$40 per prescription	25% + $40 to $250 max. copay per prescription
Specialty (must use Aetna's Specialty Rx network)	20% to $100 max. copay per prescription	Not Covered	30% up to $200 max. copay per prescription	Not Covered
Supply Limit	30 days	30 days	30 days	30 days
Mail Order				
Plan Deductible Applies?	No	No	Yes	Yes
Value Drugs (chronic)	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Preferred Generic	$30 per prescription	Not Covered	$20 per prescription	Not covered
Preferred Brand	$60 per prescription	Not Covered	$50 per prescription	Not covered
Non-Preferred Generic and Brand	$90 per prescription	Not covered	$80 per prescription	Not covered
Specialty	20% to $100 max. copay/prescription	Not covered	20% to $100 max. copay/prescription	Not covered
Supply Limit	90 days	Not applicable	90 days	Not applicable

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

Dental

FOR REPRESENTED ACTIVES WITH LESS THAN 1 YEAR OF SERVICE

Dental Benefits	Cigna Dental HMO	Cigna Dental PPO Represented – Actives Less Than 1 Year	
		PPO	OON[1]
Calendar Year Maximum			
	None	$2,500	$2,500
Calendar Year Deductible			
Individual	None	$100	$100
Diagnostic and Preventive			
Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-ray Fluoride Application	No Charge	Plan Pays 60% No deductible	Plan Pays 60% No deductible
Basic Services			
Amalgam/Composite Fillings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Oral Surgery	No Charge	Plan Pays 60% After deductible	Plan Pays 60% After deductible
Major Services			
Crown Repair Restorative - Inlays and Crowns Prosthodontics Complex Oral Surgery	No Charge	Plan Pays 60% After deductible	Plan Pays 60% After deductible
Implants			
Calendar Year Maximum	None	Plan Pays 60% After deductible up to $1,000	Plan Pays 60%
Orthodontics			
Child to Age 19 and Adult	**No Charge**	**Not Covered**	

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

Dental

FOR REPRESENTED ACTIVES WITH MORE THAN 1 YEAR OF SERVICE

Dental Benefits	Cigna Dental HMO	Cigna Dental PPO Core Dental Plan - Represented Actives		Cigna Dental PPO Year 2+ Actives - Core plus Buy Up Option #1 with $4K Max		Cigna Dental PPO Year 2+ Actives - Core plus Buy Up Option #2 with $4K Ortho Coverage		Cigna Dental PPO Year 2+ Actives - Core plus Buy Up Option #3 with $4K Max & $4K Ortho Coverage	
Calendar Year Maximum		**PPO**	**OON[1]**	**PPO**	**OON[1]**	**PPO**	**OON[1]**	**PPO**	**OON[1]**
	None	$2,500	$2,500	**$4,000**	**$4,000**	$2,500	$2,500	**$4,000**	**$4,000**
Calendar Year Deductible									
Individual	None	None	None	None	None	None	None	None	None
Diagnostic and Preventive									
Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-ray Fluoride Application	No Charge	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%
Basic Services									
Amalgam/Composite Fillings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Oral Surgery	No Charge	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%
Major Services									
Crown Repair Restorative - Inlays and Crowns Prosthodontics Complex Oral Surgery	No Charge	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%	Plan pays 85%
Implants									
Calendar Year Maximum	None	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000	Plan pays 85% up to $1,000
Orthodontics									
Lifetime Maximum	Child/Adult: **No Charge**	**Not covered**		**Not covered**		**Child/Adult $4,000**		**Child/Adult $4,000**	

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

Dental

FOR MANAGEMENT, CONFIDENTIAL, DISTRICT ATTORNEY/COUNTY COUNSEL, SHERRIFF SERGEANT

Dental Benefits	Cigna Dental HMO	Cigna Dental PPO Core Dental Plan - Management		Cigna Dental PPO Management Buy Up - Core plus Buy Up Option with $4K Ortho Coverage	
		PPO	OON[1]	PPO	OON[1]
Calendar Year Maximum					
	None	None	None	None	None
Calendar Year Deductible					
Individual	None	None	None	None	None
Diagnostic and Preventive					
Oral Exam X-Rays Teeth Cleaning Fluoride Treatment Space Maintainers Bitewings Sealants	No Charge	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Basic Services					
Amalgam/Composite Fillings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Oral Surgery	No Charge	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Major Services					
Crown Repair Restorative - Inlays and Crowns Prosthodontics Complex Oral Surgery	No Charge	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Implants					
Calendar Year Maximum		None		None	
Orthodontics					
Eligible for Benefit Lifetime Maximum	Child/Adult: **No Charge**	Not Covered		**Child/Adult $4,000**	

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

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 https://www.smcgov.org/hr/health-benefits, Click Vision Care Plan

	CORE PLAN		BUY-UP PLAN (with KidsCare)	
Benefits	**In-Network**	**Non-Network**	**In-Network**	**Non-Network**
Frequency				
Exam	Every 12 months		Every 12 months[1]	
Lenses/Contacts	Every 12 months		Every 12 months	
Frames	Every 24 months		Every 12months	
Copayment				
Exam/Prescription Glasses	$10 / $10	Subject to out of network allowance	$10 / $10	Subject to out of network allowance
Contacts	15% off contact fitting and evaluation exam, not to exceed $60		15% off contact fitting and evaluation exam, not to exceed $60	
Exam	**Copay**	**Plan Pays up to:**	**Copay**	**Plan Pays up to:**
Exam	Covered in full	$50	Covered in full	$50
Lenses				
Anti-reflective coating	Not covered		$35 copay	
Single Lenses	Covered in full	$50	Covered in full	$50
Bifocal Lenses	Covered in full	$75	Covered in full	$75
Trifocal Lenses	Covered in full	$100	Covered in full	$100
Lenticular Lenses	Covered in full	$125	Covered in full	$125
Ultraviolet (UV) Coating	Not Covered		Covered in full	Not covered
Frames				
Frame Allowance	$150 Allowance; 20% off over $150 $70 Costco/Walmart/ Sam's Club frames	$70	$200 $220 for featured frame brands $110 Costco/ Walmart/ Sam's Club frames	$70
Suncare Option	Not Covered		Covered in full	Not covered
Contacts				
Elective	$150 Allowance; in lieu of lens and frame[2]	$105[2]	$200 Allowance; in lieu of lens and frame[2]	$105[2]
Medically Necessary	Covered in full	$210	Covered in full	$210

[1]KidsCare: Two WellVision exams for children for children under 18 years old

[2]Contact lenses are in lieu of spectacle lenses and frames

Looking for the Perfect Pair? Visit eyeconic.com!

VSP's online store lets you use apply your benefits directly to your purchase.

Know Where To Go

TYPE	APPROPRIATE FOR	EXAMPLES	ACCESS & CONTACT INFO
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7 **Kaiser:** (800) 464-4000 **Aetna:** (800) 556-1555
Online visit 	Minor illnesses and conditions	• Common cold, flu, fever • Headache, migraine • Skin conditions • Allergies	24/7 **Kaiser:** www.kp.org **Aetna:** www.teladoc.com/Aetna
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours **To locate a provider:** • Kaiser Permanente • Aetna
Urgent care, Walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Vary, up to 24/7 **To locate a facility:** • Kaiser Permanente • Aetna
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7 **To locate a facility:** • Kaiser Permanente • Aetna

Enhanced Services

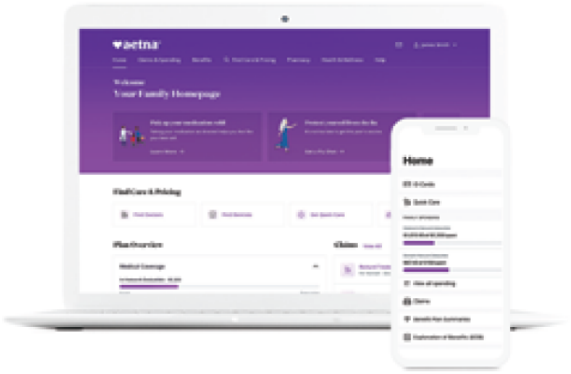
MOBILE APP

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

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

As a member, you can:

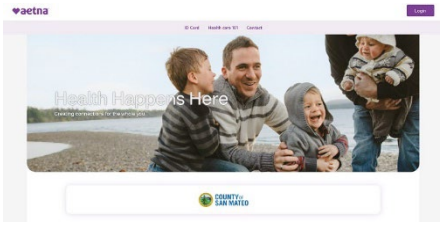
- View your health plan summary and get information about what's covered
- Track spending and progress toward your deductible or maximums for you and your family
- View and pay claims, and even see the breakdown of your costs, like what's covered by your plan and what you're responsible for



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

MICROSITE

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



NO COST/LOW COST MINUTECLINIC®

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

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

CONDITION MANAGEMENT PROGRAMS

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

Enhanced Services

AETNA BACK & JOINT CARE PROGRAM

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

Teladoc®

24/7 access to quality care

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

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

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

AETNA ENHANCED MATERNITY PROGRAM

Going through a maternity journey is different for everyone. That's why this program supports all women throughout their entire experience, whether they have risk factors or not.

Special program features include:

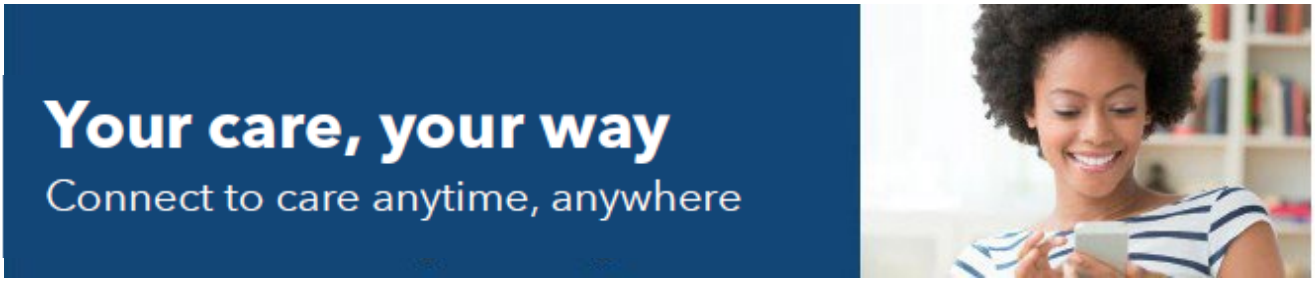
- A fertility advocate* to be your care manager and provide support if you're facing infertility
- Predictive data to help us identify pregnancies early on so we can provide timely, more responsive outreach to you
- Preeclampsia prevention by providing education and resources, if needed
- Guided genetic counseling and screening services, backed by medical expertise
- Education and resources to help close racial gaps in health care and support women of color

You can count on us for support — wherever you are in the maternity journey.

**While only your doctor can diagnose, prescribe or give medical advice, our fertility advocates/care managers can provide information on a variety of maternity-related topics.*

Enhanced Services

KAISER PERMANENTE®



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

24/7 care advice
Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

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

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

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

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

E-visit
Get quick online care for common health problems.
Fill out a short questionnaire about your symptoms, and a physician will get back to you with a care plan and prescriptions (if appropriate) – usually within 2 hours.

Need care now? Know before you go.

Urgent care
An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition.
This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

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

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

1If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your Evidence of Coverage or other coverage documents.
2 These features are available when you receive care at Kaiser Permanente facilities.
3 When appropriate and available.

Employee Assistance Program

ADMINISTERED BY CLAREMONT, POWERED BY UPRISE HEALTH

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

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:

Counseling visits - The EAP offers 8 free counseling visits per incident, per rolling 12 months for almost any personal issue. Claremont EAP will work with you to find the most appropriate counselor to meet your needs.

- Marital/Relationship issues
- Parenting/Family issues
- Work concerns
- Depression
- Anxiety

Work/Life referrals - consultants can provide you with referrals and information for services such as: child care, elder care, pet care, adoption assistance, school/College assistance, health and wellness, convenience referrals, stress, substance abuse, and other issues impacting your quality of life.

Legal consultation - EAP offers up to 30 minutes of free consultation with an attorney per issue to answer your legal questions, either in-person or over the phone. On-going services, if required, are offered at a 25% discount. EAP can assist with legal issues such as: divorce, child custody, real estate, personal injury, criminal law, and free simple will kits.

Financial consultation - Financial professionals and licensed CPAs will provide up to 30 minutes of telephonic coaching per issue on a range of financial issues such as: budgeting, debt management, tax planning, retirement planning, home buying strategies, college planning, and credit repot coaching.

Call toll-free, 24 hours a day, seven days a week: 800-834-3773

Or you can visit www.claremonteap.com and enter **County of San Mateo** as the organization name

Employee Assistance Program

	SELF-REFERRAL	SUPERVISOR REFERRAL
Service Overview	Free, short-term counseling to employees and members of their families who wish to address personal or work issues	Provides an employee with support and assistance in solving their work performance problem
Referral Source	• Available for immediate family members including: • Your spouse/domestic partner • Your children • Spouse/domestic partner's children • 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	Call 800-834-3773 Group/Employer: County of San Mateo Representatives are available 24 hours a day, 7 days a week	Manager/Supervisor/HR calls 800-834-3773 for a clinical consultation. Supervisor Referral Form is completed, shared with Claremont and with the employee the employee calls 800-834-3773 Representatives are available 24 hours a day, 7 days a week
Eligibility	All San Mateo County & Court employees are eligible.	

Health and Wellness

The Employee Wellness Program is designed to help you improve or maintain your health and wellbeing through a variety of classes, services, challenges, surveys, recreation events, and activities. Employees are empowered with health education, social support, and strategies to achieve long-term health and wellness goals. The Employee Wellness Program plays a pivotal role in fostering a healthy and safe work environment, high employee engagement, a productive workforce, and a sense of care and wellbeing.

As a County employee, you are strongly encouraged to regularly participate in the Employee Wellness Program. You can attend most activities and classes on County time at no cost to you. The County uses a Whole Person Wellbeing model and organizes offerings into 3 areas of wellness: Physical, Emotional, and Social.

Physical Wellness

- ✓ Flu Clinics
- ✓ Wellness Screenings
- ✓ Online Health Assessment
- ✓ Smoking Cessation Program
- ✓ Weight Loss Challenges
- ✓ Nutrition Counseling
- ✓ Health Coaching
- ✓ Gym Discounts
- ✓ Physical Activity Challenges

Emotional Wellness

- ✓ Stress Management Classes
- ✓ Mindfulness Classes
- ✓ Massage Therapy Program
- ✓ Emotional Wellbeing Videos
- ✓ Yoga in the Park
- ✓ Take-a-Hike Program
- ✓ Art & Music Therapy Classes
- ✓ EAP Workshops
- ✓ Mental Health Apps from Aetna and Kaiser

Social & Family Wellness

- ✓ Bright Horizons College Coaching
- ✓ Childcare Discounts & Tuition Assistance Program
- ✓ Recreation Events & Socials
- ✓ Employee Wellness Yammer Page with Collaborative Videos, Photo Collages, and Recipes
- ✓ Employee Interest Groups
- ✓ Babies & You Program
- ✓ Blood Drives
- ✓ Peer Support Groups

For more information about the Employee Wellness Program, visit https://smcgov.sharepoint.com/sites/wellness

PREVENTIONCLOUD WELLNESS PORTAL QUICK START GUIDE

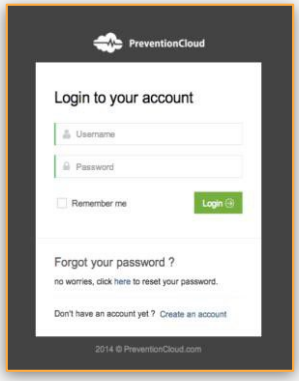
WELLNESS PORTAL REGISTRATION

Okta Access

Using your computer or mobile device, go to
https://preventioncloud.com/oauth/okta (Okta access)

Library & Courts Employees:
Using your computer or mobile device, go to https://www.preventioncloud.com

- **Employee Username**
  County email address (Jdoe@smcgov.org)
- **Password**
  Birthdate (MMDDYYYY) - ***Once logged in, you will be prompted to change your password***



Library & Courts Employees

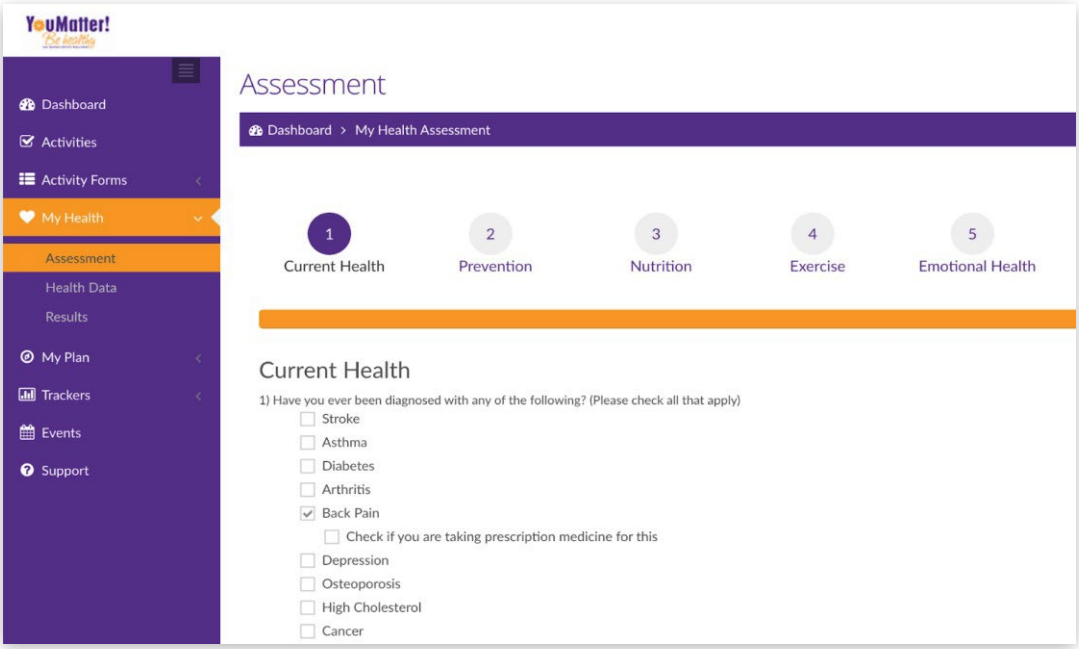
Spouses / Partners *(must be listed in Workday)*:
Using your computer or mobile device, go to https://www.preventioncloud.com

- **Spouse/Partner Username**
  FIRST NAME + LAST NAME + Year of birth (JOHNDOE1968)
- **Password**
  Birthdate (MMDDYYYY) - ***Once logged in, you will be prompted to change your password***

Spouses / Partners

COMPLETE YOUR ONLINE HEALTH ASSESSMENT

1. Log into your PreventionCloud Wellness Portal.
2. Select '**Online Health Assessment**' located below your homepage.
3. Answer all questions to the best of your knowledge and click **'Continue'** after you complete each page until you see your results.



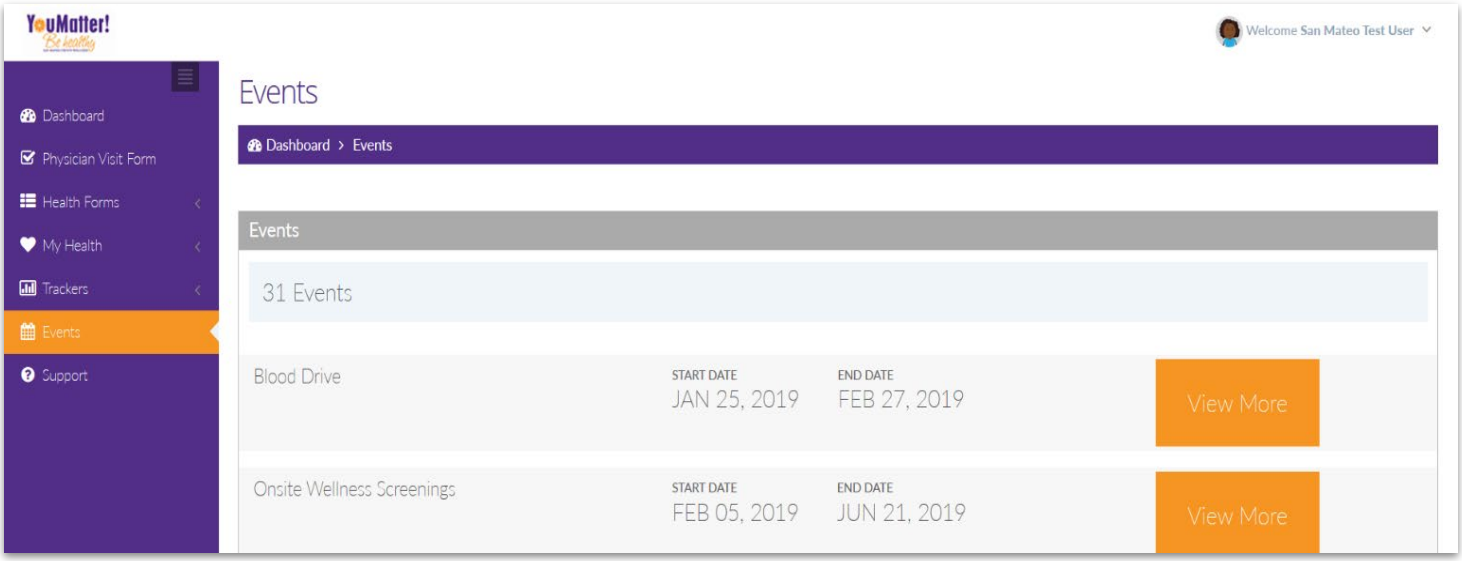
PREVENTIONCLOUD TIP

It is optional for you to complete the 'Biometrics' section. When you attend a Wellness Screening (onsite, physician, or lab), your results will be entered into that section. However, you can still complete this section if you choose.

YouMatter! Be healthy
SAN MATEO COUNTY WELLNESS

REGISTRATION FOR YOUR WELLNESS ACTIVITIES

1. Select **'All Event Registration'** located below your wellness banner.
2. Find the activity of your choice and select the **'Join'** or **'View More'** button.
3. Choose the date you'd like to participate and confirm your registration.



PREVENTIONCLOUD TIP

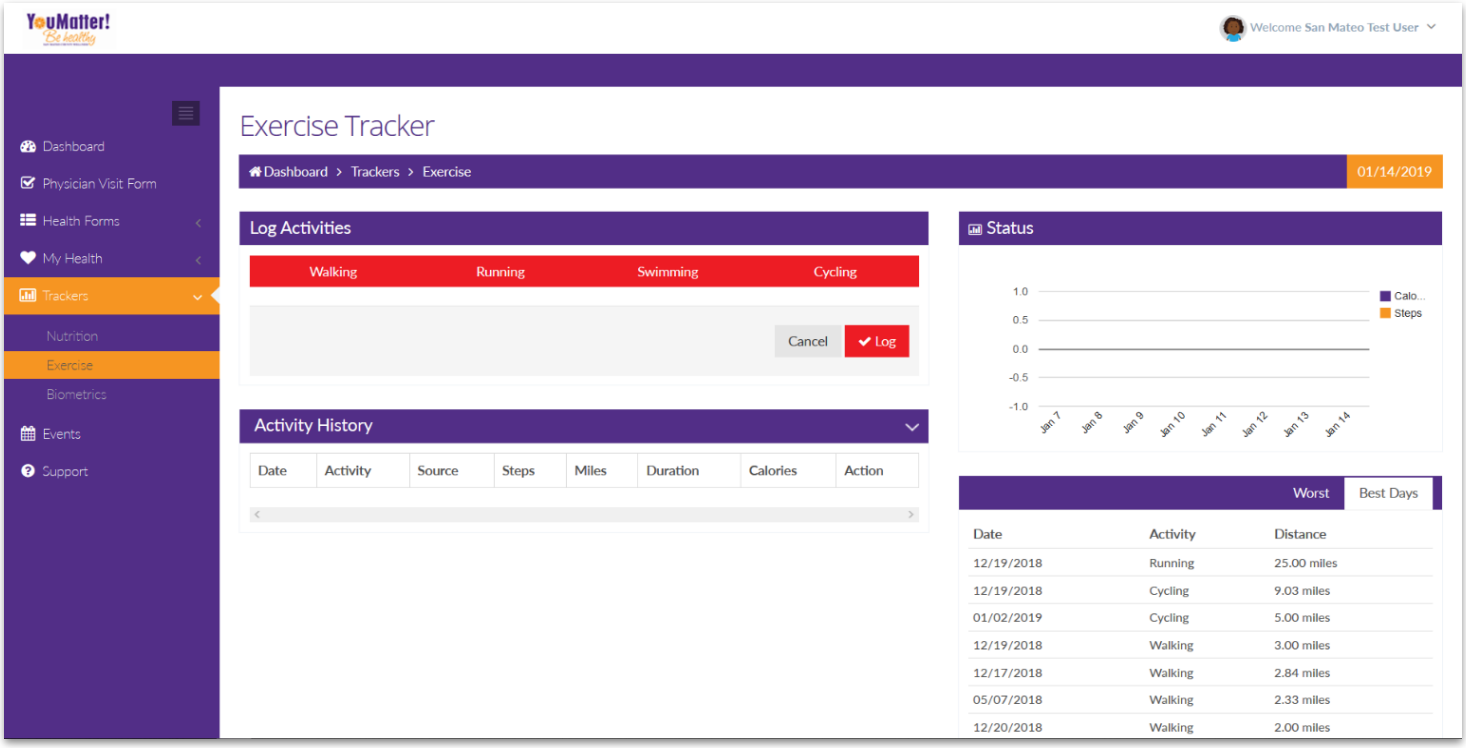
The PreventionCloud Wellness Portal is available to employees and their spouses who are enrolled in / waived a San Mateo County medical plan. All other employee groups have access to LMS Wellness.

TRACKERS – NUTRITION, EXERCISE & BIOMETRICS

1. Select **'Trackers'** on the left menu.
2. Choose either **'Exercise', 'Nutrition', or 'Biometrics'**.
3. Log your physical activity, food / water intake, or screening results.

PREVENTIONCLOUD TIP

You can log previous data by selecting the date in the top right corner and enter the information for that date.



If you have any questions, please contact the Wellness Team at wellness@smcgov.org.

Health and Wellness

WELL-BEING TOOLS

Your good health starts here. Your health goals lead the way. Wherever they take you, we'll keep finding new ways to join you – with the latest information and inspiration to support you in your journey.

Log into your Aetna Health Member Website at www.aetna.com today to get started.

Discover a Healthier You
Improve your health and well-being.

Stay Healthy
Access your personalized health & wellness programs.

Living healthy >
Take small steps to break bad habits and create good ones. Explore expert tips that empower you to eat better, get active, sleep well, stress less, and care for your mind, body and spirit.

Managing health >
Real people. Real conditions. Hear member stories about mood disorders, weight loss, cancer, diabetes and other health challenges. And find support to help improve recovery.

Healthy Lifestyle Coaching Program

Support in achieving your best health, however you define it.

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

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

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

Health and Wellness

Health & Wellness Discounts

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

At Home Products

Save on blood pressure monitors, activity trackers, electrotherapy TENS units, EKG devices and more.

Natural Products & Services

Discounts on acupuncture, chiropractic, massage and nutrition, along with a variety of wellness products.

Fitness

Save on gym memberships, virtual fitness programs, workout apparel, sports accessories and more.

Lasik

Discounted rates on Lasik screening, surgery and follow-up care.

Vision Care

Save on eye exams, frames, lenses, contact lenses and sunglasses.

Dental Health

Special discounts on sonic toothbrushes, oral care kits, teeth whitening kits and other dental accessories.

Hearing

Save on hearing exams, hearing aids and accessories and hearing aid repairs.

Weight Management

Save on meal plans, healthy home meal deliveries, workout programs, scales and healthy weight resources.

Senior Wellness

Discounted medical alert systems in-home care and meal delivery.

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

Health and Wellness

KAISER PERMANENTE®

Take advantage of these extra perks from Kaiser Permanente — from personal health coaching to reduced rates on alternative medical therapies.

Sign up for healthy lifestyle programs

With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our complimentary programs can help you:

- Lose weight, eat healthier
- Quit smoking, reduce stress
- Manage ongoing conditions like diabetes or depression

Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor.

kp.org/healthylifestyles
kp.org/vidasana (en español)

Get a wellness coach

If you need a little extra support, we offer Wellness Coaching by Phone at no cost. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals.

kp.org/wellnesscoach

Enjoy reduced rates

Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program.[4] These include:

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

kp.org/choosehealthy

Join health classes

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

kp.org/classes
kp.org/clases (en español)

CLASSPASS AVAILABLE!

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

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

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

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 $750,000 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 https://www.smcgov.org/hr/life-insurance

	BASIC LIFE INSURANCE	SUPPLEMENTAL (Additional) LIFE INSURANCE
Employee benefit amount	$9,000 - $50,000 based on terms of MOU / Resolution	Up to $750,000
Cost for employee benefit	None – County paid	Cost based on age (see rate sheet on the following pages)
Spousal benefit amount	$2,000	Up to $250,000
Cost for spousal benefit	None – County paid	Cost based on age (see rate sheet on the following pages)
Dependent child benefit amount (birth to age 24)	$2,000	$10,000
Cost of dependent child benefit	None – County paid	$ 0.882 per $1,000

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 https://www.smcgov.org/hr/health-benefits; click on Life Insurance.

Supplemental (Additional) Life Insurance

RATE CALCULATION WORKSHEET

Active Employee Rates

Age	Rate Per $1,000
Under Age 25	$0.03
Age 25-29	$0.03
Age 30-34	$0.04
Age 35-39	$0.05
Age 40-44	$0.05
Age 45-49	$0.08
Age 50-54	$0.13
Age 55-59	$0.24
Age 60-64	$0.38
Age 65-69	$0.76
Age 70 or over	$1.20

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: _____

Sample monthly premium computation:
40 year old employee requesting $250,000 = 250 x $0.05= ***$12.50 per***

Spouse Rates

Age	Rate Per $1,000
Under Age 25	$0.03
Age 25-29	$0.03
Age 30-34	$0.04
Age 35-39	$0.05
Age 40-44	$0.05
Age 45-49	$0.08
Age 50-54	$0.13
Age 55-59	$0.24
Age 60-64	$0.38
Age 65-69	$0.76
Age 70 or over	$1.20

To calculate your monthly premium:

1. Amount Elected: Write the amount of units you want. (1 unit = $1,000) Line 1: _____

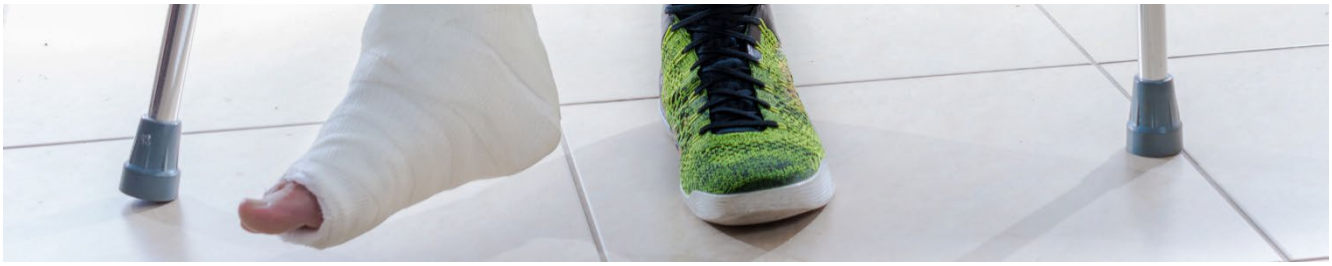
2. Write your age-based rate from the table to the left. Line 2: _____

3. Multiple Line 1 by Line 2. This is your monthly premium amount. Line 3: _____

Sample monthly premium computation:
28 year old spouse requesting $35,000 = 35 x $0.03= ***$1 .05 per month***

*** Rates applicable until 12.31.2023*

Short Term Disability Insurance



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.

BASIC STD	
Eligibility	Employees who are not enrolled in CA SDI
Benefit Amount	$95 per week (not to exceed 70% of pre-disability earnings) reduced by Deductible income
Benefit Cost	$1.95 semi-monthly
Benefit Duration	18 weeks
Benefit waiting period (sickness or accident(	14 days

Travel Assistance

ADMINISTERED BY THE STANDARD

assist america®

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]
You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else: **+1.609.986.1234**

Text: **+1.609.334.0807**

Email:
medservices@assistamerica.com

SECURITY THAT TRAVELS WITH YOU

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Download on the App Store | GET IT ON Google Play

Reference Number:
01-AA-STD-5201

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com

[1] Travel Assistance is provided through an arrangement with Assist America, Inc. and 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. Assist America, Inc. 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] Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

[3] Must be arranged by Assist America, Inc.

Health Savings Account

ADMINISTERED BY BENEFITS COORDINATION CORPORATION (BCC)

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 the My SmartCare website
- Since your medical expenses may change within the year, you may change (increase or decrease) your contributions at any time
- In 2023, you can contribute a maximum of **$3,850** for employee only or **$7,750** for employee + one or more. This maximum includes both employer and employee contributions.

Click to play video

If you elect to enroll in one of the HDHP plans offered through Kaiser or Aetna, the County will fund 50% of the deductible for 2023.

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.

FEES

The monthly fee associated with enrollees' cash funds is charged to the County and there is no cost to employees. The only applicable employee/enrollee fees would be:

1. A monthly investment fee if you have investments on your HSA and your cash balance each month is less than $3,000. The fee is waived for cash balances above the average of $3,000 and,
2. A quarterly paper statement fee is charged to employees/enrollees. This fee can be avoided if you sign up for electronic statements.

Flexible Spending Account

ADMINISTERED BY BENEFITS COORDINATION CORPORATION (BCC)

Click to play video

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). You must enroll through Workday during open enrollment or within 31 days of a qualifying event.

HEALTHCARE SPENDING ACCOUNT

This account will reimburse you with pre-tax dollars for eligible healthcare expenses not reimbursed under your family's healthcare plans. 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. **The maximum amount you may contribute to a Healthcare Spending Account for the 2023 Plan Year is $2,850.** 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, 2023** (minimum of $5 up to $550) will automatically be rolled over for use in the next plan year.

ESTIMATE CAREFULLY!

If you don't spend all the money in your account, you can roll over up to $550 to use the following year. Any additional remaining balance will be forfeited.

TO FIND OUT MORE

- My SmartCare website
- Eligible Expenses – now include more over-the-counter items!

Participants will have until March 31st to **submit claims** for **expenses incurred during 1/1/2023-12/31/2023.**

Flexible Spending Account

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.

Estimate 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. Members will have until March 31st to submit claims for expenses incurred during said plan year.)*

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.

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:

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

BCC My SmartCare

FOR HEALTH SAVINGS AND FLEXIBLE SPENDING ACCOUNT MEMBERS

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:

MY SMARTCARE ONLINE PORTAL

1) Go to: https://www.mywealthcareonline.com/bccsmartcare/

2) Click 'REGISTER' at the top right corner of the screen to begin

MY SMARTCARE MOBILE APP

1. Open the app store from your iOS or Android powered device.
2. Search "BCCSmartCare".
3. Install and open the free app to your device.
4. Sign in using your existing My SmartCare login and password OR click "Register" if you are a new user.

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.
- 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.

MY SMARTCARE REGISTRATION GUIDE

- When registering as a new user, My SmartCare will walk you through a series of registration questions followed by a secure authentication process to validate you as a user.
- Use your **Social Security Number** as your Employee ID.
- Use your **Benefits Debit Card number or your Employer ID (BCCCSM)** as your **Registration ID**.
- By registering with My SmartCare, you will have the option to receive important push notifications (account balance, grace period, year-end reminders; notice of debit card mailed, etc.) via e-mail or text message. You can manage these notifications in your My SmartCare communication settings.
- 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 log in.

CUSTOMER SERVICE

800-685-6100
customersupport@benxcel.com

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 2023 contribution limit for the 457 Plan is $22,500. Employees age 50 or older may contribute up to an additional $7,500 for a total of $30,000.

Pre-Retirement Catch-Up

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 $41,000, 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 Empower Retirement Specialist at 1-888-593-0259.

Please note that you may not contribute to the additional Age 50+ catch-up ($6,500) and pre-retirement catch-up (supplemental $20,500) simultaneously.

Employees may enroll at any time during the year.

For more information, visit www.viewmyretirement.com\sanmateocounty.

Voluntary Benefits

AlliantCHOICE plus

County of San Mateo offers a number of voluntary insurance policies through AlliantCH0ICE Plus.

Why purchase benefits through AlliantCHOICE Plus? The plans offered to you provide coverage unique to your needs, above what core benefits provide. You also receive the benefit of group cost savings and the convenience of payroll deduction. You will recognize the trusted national companies-and value-behind these benefits. And more, AlliantCHOICE Plus offers a resource that is accessible year-round to gather information on the products you select at open enrollment, or to enroll in plans that are available anytime - like auto insurance.

These plans are available during voluntary benefits enrollment period only

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 - $200
- TOTAL EXAMPLE BENEFIT: $1,100

Sample Per Paycheck Rates:

Employee	Employee + Spouse/DP	Employee + Dependent Child(ren)	Employee + SP/DP + Dependent Child(ren)
$2.19	$3.80	$4.86	$6.46

Please access AlliantCHOICE Plus through the Workday link to see a full schedule of benefits and to enroll in any of the Voluntary Benefits.

Voluntary Benefits

AlliantCHOICE plus

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:

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

*This plan 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.

Please access AlliantCHOICE Plus through the Workday link to see a full schedule of benefits and to enroll in any of the Voluntary Benefits.

Voluntary Benefits

AlliantCHOICE plus

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.

Sample Per Paycheck Rates:

Employee	Employee + Spouse/DP	Employee + Dependent Child(ren)	Employee + SP/DP + Dep Child(ren)
$5.25	$10.53	$8.48	$13.76

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.

LEGAL PLAN:

Metlife Legal Plans (formerly Hyatt Legal Plans) is affordable legal protection for you and your family. American Bar Association statistics show that the average person has two or three legal needs every year, but the fear of expensive legal fees or simply not having an attorney to call are typical impediments to these needs being met. This plan offers comprehensive legal coverage on common legal matters through a nationwide network of more than 18,000 attorneys.

The plan covers services such as preparing a will, buying or selling a home, traffic ticket defense, will preparation or power of attorney, personal bankruptcy, elder law matters, and much, much more. County employees can take advantage of the special group discounted rates - the plan costs just **$9.40 per paycheck**, which is paid through the convenience of payroll deduction. When you use a Plan Attorney for covered services, there are - no deductibles, no co-payments, no claim forms and no limits on usage. It's like having an attorney on retainer for an affordable monthly cost.

Please access AlliantCHOICE Plus through the Workday link to see a full schedule of benefits and to enroll in any of the Voluntary Benefits.

Voluntary Benefits

AlliantCHOICE plus

Sign up for these programs any time throughout the year!

PET INSURANCE:

Pet care costs have steadily increased which means your furry family member could need coverage that your savings can't cover. Nationwide provides benefits for your pet(s) –and now you can choose from two levels of reimbursement: 70% or 50%. Below is a summary of the My Pet Protection plan.

my pet protection®

What's covered? Reimburse a straightforward 70% or 50% of your vet bill. $7,500 maximum annual benefit and a low $250 deductible.	
Use any vet / Vet Helpline access 24/7	✓
Accidents, including poisonings and allergic reactions	✓
Injuries, including cuts, sprains and broken bones	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓
Serious/chronic illnesses[2], including cancer and diabetes	✓
Hereditary and congenital conditions[1]	✓
Surgeries and hospitalization, including X-rays, MRI and CT scans	✓
Prescription medications and therapeutic diets	✓
Vet*helpline*access 24/7, available via phone, chat, or email. Unlimited help for everything from general pet questions to identifying urgent care needs	✓
Annual deductible	$250

[1]*Pre-existing conditions are not covered. Any illness or injury a pet had prior to start of policy will be considered pre-existing.*

PLAN CHANGES EFFECTIVE OCTOBER 1, 2021

CURRENT PLANS	PLAN OVERVIEW	PLAN CHANGES EFFECTIVE 10/01/2021	PLAN OVERVIEW EFFECTIVE 10/01/2021
My Pet Protection	90%*, 70% or 50% claim reimbursement (employee elects plan type)	My Pet Protection	70% or 50% claim reimbursement only (employee elects plan type)
My Pet Protection with Wellness*	90%*, 70% or 50% claim reimbursement (employee elects plan type)		**NO WELLNESS OPTION AVAILABLE**

90% and WELLNESS- CLOSED TO NEW ENROLLMENT EFFECTIVE 10/01/2021**- Any ***current policyholder who already has a 90% coverage and/or Wellness policy can maintain that coverage for as long as the policy is in-force.

Voluntary Benefits

AlliantCHOICE plus

PET INSURANCE

NEW RATES EFFECTIVE SEPTEMBER 23, 2021

Semi-Monthly Rates as of 9/23/2021 for New Policies		
	My Pet Protection with no Wellness Option	
	50%	**70%**
Dog	$16.38	$21.84
Cat	$9.83	$13.11

Semi-Monthly Rates for GRANDFATHERED ONLY PLANS (existing policy holders after 09/23/2021) ** These plans are closed to new enrollment after 9/23/2021 **				
	My Pet Protection	**My Pet Protection with Wellness**		
	90%	***50%***	***70%***	***90%***
Dog	$27.31	$28.58	$38.10	$47.63
Cat	$16.38	$17.15	$22.86	$28.58

Policy rates are guaranteed for one year from policy effective date, no mid-term rate changes.
After State approval, policy is subject to rate adjustments at the individual member's renewal.

Additional Coverages include:

- Boarding/kennel fees if a family member is hospitalized due to injury or illness ($500 annual limit)
- Advertising/reward fees for pets that go missing during the policy term ($500 annual limit)
- Pet replacement costs if a missing pet is not found within sixty (60) days ($500 annual limit)*
- Mortality coverage for euthanization due to illness/injury and cremation/burial fees ($1,000 annual limit)*

*If no proof of purchase is provided, max payout is $150 for replacement benefit.

NEED COVERAGE FOR YOUR BIRD OR EXOTIC PET?

If you would like to enroll your bird or other exotic pet, please contact Nationwide by calling 833-634-7132 and selecting Nationwide from the menu.

Please access AlliantCHOICE Plus through the Workday link to see a full schedule of benefits and to enroll in any of the Voluntary Benefits.

*Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states. †Pet owners receive a 5% multiple-pet discount by insuring two to three pets or a 10% discount on each policy for four or more pets

Voluntary Benefits

AlliantCHOICE plus

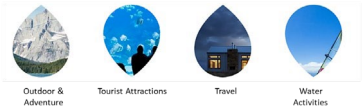
LIFEBALANCE DISCOUNT PROGRAM

LifeBalance

Health, Happiness, and Savings

LifeBalance is dedicated to connecting members to the things we all love most -- fun family time, the great outdoors, health, fitness, travel, sports, the arts, and above all, a good deal. Because LifeBalance believes that happiness and fulfillment are found when we stick to one guiding principle: Never get so busy making a living that you never make a life.

With LifeBalance, you can save on the activities and purchases that leave you feeling fit, happy, and fulfilled. Savings are available in a wide variety of discount categories, including:



And that's just the beginning! You'll enjoy savings at these vendors and thousands more.

AUTO & HOME INSURANCE:

Now benefit eligible County employees have access to three Auto & Home carriers: Farmers GroupSelect℠, Travelers and Liberty Mutual! By purchasing Auto & Home insurance through the County, you have access to discounts for buying as a group AND an additional discount for paying for your policy through convenient payroll deduction. Most applicants find they can save between 5-20% on their premiums when they purchase through their employer.

Coverage options are the same as you would find with any Auto & Home carrier such as renters, boat, motorcycle, watercraft or personal excess liability. To get a quote, use the links in the "Enrollment Process" section of the product page on AlliantCHOICE Plus. The link will take you to a landing page where you can enter information about your current coverage to understand what your premiums could be with the new carrier. Most employees bind their coverage by speaking directly with an agent from the selected carrier to ensure there aren't any additional features or discounts they might have missed in their quote request.

Premiums for your Auto & Home policy(ies) will be passed through to AlliantCHOICE Plus and incorporated into your total per paycheck deduction.

Need more information?

PLEASE CONTACT ALLIANTCHOICE+ DIRECTLY.

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

Please access AlliantCHOICE Plus through the Workday link to see a full schedule of benefits and to enroll in any of the Voluntary Benefits.

Additional Benefits

SMC SHIFT (FORMERLY COMMUTE ALTERNATIVES PROGRAM)

The County of San Mateo offers incentives and services to employees who are able to, or are interested in, commuting to work in a way which is not driving alone. This includes a Transit Subsidy which covers the costs of public transportation or vanpool through a $150 per employee per month subsidy, or through pre-tax payment options, and the Commute Cash Program which gives $2 per day (about $500 per year!) for walking, biking, carpooling and teleworking.

The County of San Mateo is committed to reducing traffic and air pollution, conserving energy, and improving the quality of life for county employees and the community. Shift can get your workday off to a better start and free you from the cost and stress of driving alone. For more information, visit our 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 the 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

Additional Benefits

TUITION REIMBURSEMENT

The County's Tuition Reimbursement Program provides financial assistance for Regular and Term employees who are participating in job-related degree, certificate programs, or job skill enhancement workshops.

The current level of reimbursement is up to $263 for college courses under 3 units (and workshops less than 30 hours in length) and up to $438 for courses of 3 units or more (or workshops over 30 hours in length). Funds may only be applied to tuition and do not cover equipment, parking passes, etc. Up to $50 per course for books will be reimbursed for community college, undergraduate level and graduate level courses. For more information about Tuition Reimbursement, visit https://hr.smcgov.org/tuition-reimbursement-program.

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 https://www.smcgov.org/hr/health-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 https://www.smcgov.org/hr/voluntary-time-vto.

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 https://www.smcgov.org/hr/employee-referral-program

Additional Benefits

WORKER'S COMPENSATION

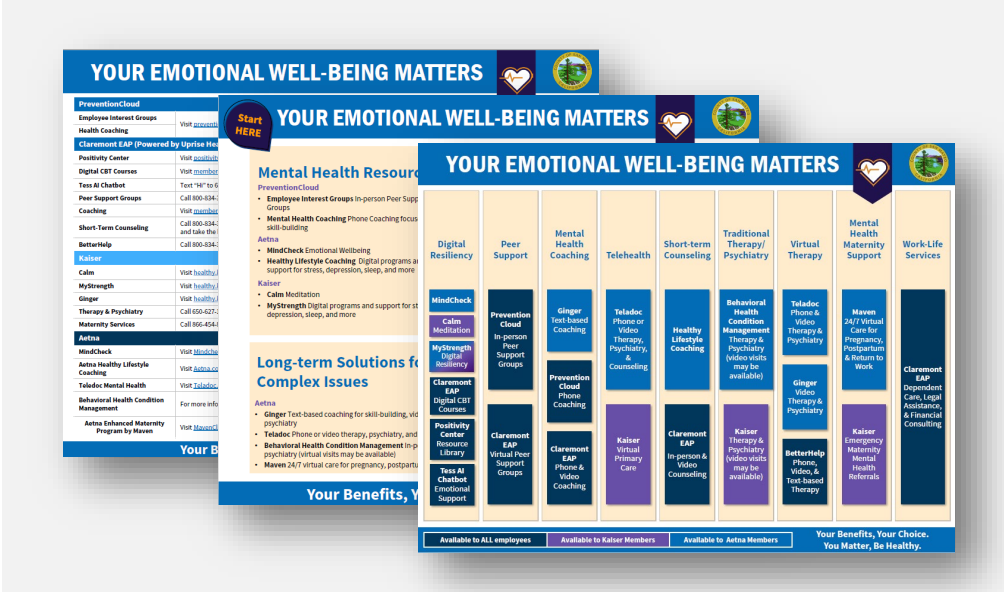
All County employees are covered by the County's Worker's Compensation Policy for any job-related injury, including first-aid type injuries and work-related illnesses. To read more about the types of injuries qualify as "job-related," please visit the County's Worker's Compensation page: https://www.smcgov.org/hr/workers-compensation

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: https://www.smcgov.org/hr/telework-guide-and-resources

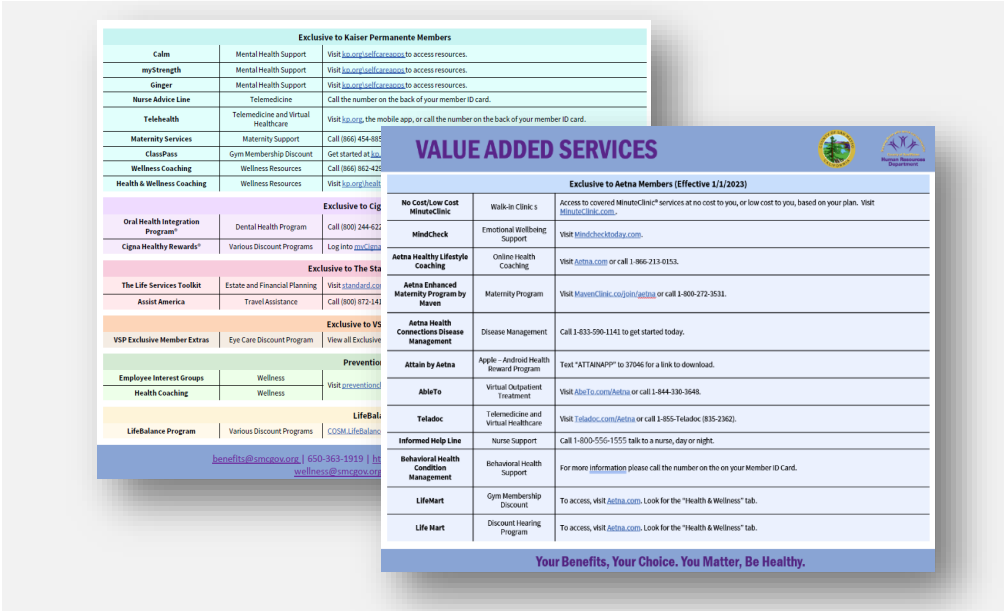
Additional Benefits Resources

Mental Health Flyer - County of San Mateo offers mental and behavioral health benefits through various sources. The Behavioral Health Resource Flyer is an easy-to-read tool that displays ALL County mental and behavioral health benefits for employees and those benefits that are specific to you based on your selected County Health Insurance carrier. This tool provides you with resources based on your needs and it details how to access the various benefits.



https://www.smcgov.org/media/125856

Value Added Services Flyer - County of San Mateo offers many value-added services through your health benefits. The Value-Added Flyer is an easy-to-read tool that displays value-added services offered by each benefits carrier. This tool provides you with a list of services organized by carrier and it details how to access the various services.



https://www.smcgov.org/media/136771

Plan Contacts

Kaiser Permanente (HMO and HDHP)		
Group #7056	www.kp.org	800-464-4000
Aetna (HMO, AVN HMO, OAMC PPO, HDHP OAMC PPO)		
Group #187677 for the AVN, HMO, OAMC, and PPO plans	www.aetnaresource.com/p/cosm	Aetna Concierge Team 833-576-2494 Customer Service for AVN, HMO, OAMC, and PPO plans
Cigna (Dental — HMO & PPO)		
Group # 3340005	www.cigna.com	800-244-6224
Vision Service Plan (VSP)		
Group #00256000	www.vsp.com	800-877-7195
The Standard (Life)		
Group #649107	www.standard.com	(t) 800-628-8600 (f) 888-414-0389
The Standard (Disability)		
Group #645866	www.standard.com	(t) 800-368-2859 (f) 800-378-6053
AlliantChoice+ (Voluntary Benefits)		
	choiceplus@alliant.com	(833) 634-7132
Assist America (Travel Assistance)		
01-AA-STD-5201	medservices@assistamerica.com	800-872-1414 (US, Canada, PR, US VI & Bermuda) +1-609-986-1234 (Everywhere else)
Claremont Employee Assistance Program (EAP)		
County of San Mateo	www.claremonteap.com	800-834-3773
Empower Retirement (Deferred Compensation)		
County of San Mateo	www.retiresmart.com	800-743-5274
Benefit Coordinators Corporation (FSA, HSA, COBRA)		
CSM	www.benefitcc.wealthcareportal.com	(800) 685-6100
SAN MATEO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION (SamCERA – Pension)		
County of San Mateo	www.samcera.org	(650) 599-1234

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

GLOSSARY

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

IMPORTANT PLAN INFORMATION

Women's Health and Cancer Rights Act

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

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

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

Newborns' and Mothers' Health Protection Act

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

Notice of Choice Providers

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

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

HIPAA Notice of Special Enrollment Rights

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

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

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

Availability of Privacy Practices Notice

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.61% in 2022 of your modified adjusted household income.

Notice of Availability of Alternative Standard for Wellness Plan

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

Notice Regarding Wellness Program

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

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

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

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

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

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

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

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

Medicare Part D Notice

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

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

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

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

Contact the person listed below for further information [or call [the County of San Mateo Human Re-sources Department- Benefits Division at (650)363-1919. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of San Mateo changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2023
Name of Entity: County of San Mateo
Contact: Human Resources- Benefits Division
Address: 455 County Center, 5th Floor Redwood City, CA 94063
Phone: (650) 363-1919

HIPAA PRIVACY NOTICE

COUNTY OF SAN MATEO PRIVACY PRACTICES NOTICE

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

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

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

Summary of Our Privacy Practices

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

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

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

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

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

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

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

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

Office: Benefits Division

Telephone:(650) 363-1919

E-mail: benefits@smcgov.org

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

Notice of Certain Deadline Extensions and Summary of Material Modifications

Prepared for the County of San Mateo Participants

This document provides notice of the potential expiration of the deadline relief that began on March 1, 2020 and an explanation of how that expiration will affect certain deadlines tolled under prior guidance applicable to ERISA plans. Specifically deadlines cannot be tolled for longer than one-year, **so depending on the date an individual action would have been required, some deadline extensions will be expiring on February 28, 2021. Whether deadlines are tolled or resume will depend on the specific date you were required to take action or provide notice to the plan.** This is a Summary of Material Modifications ("Summary") to the extent those extensions applied to ERISA benefits under the County of San Mateo's ("the Plan"). You should take the time to read this Summary carefully and keep it with the Summary Plan Description ("SPD") document that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact the County of San Mateo's during normal business hours at 650-363-1919 or benefits@smcgov.org.

End of Relief Period Extending Certain Deadlines in Response to the COVID-19 Crisis will Depend on the Date an Individual Action Would Have been Required with some Deadlines resuming Feb. 28, 2021

On April 28, 2020 Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning **March 1, 2020**. Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
    - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
    - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
    - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
- The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

The period that these deadlines can be tolled is limited to one year. On Feb. 28, 2021, one year from March 1, 2020, some of the above timelines will no longer be tolled.

Individual timeframes listed above that are subject to deadline relief will have the applicable deadlines disregarded only until the earlier of: (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On those individualized applicable dates, the timeframes for employees/participants with periods that were previously tolled will resume.

Examples and Explanations:

> If a qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the individual can wait until February 28, 2021, which is the earlier of 1 year from March 1, 2020 or the end of the Outbreak Period. Because the individual had 60 days to elect before the start of the Outbreak he or she would need to make an election by February 28, 2021.
>
> If a qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the Notice delays that election requirement until the earlier of 1 year from that date (March 1, 2022) or the end of the Outbreak Period, with the possibility of an additional 60-day extension.
>
> If an individual experienced the birth of a child in February 2021 and the National Emergency was declared over July 1, 2021 **(hypothetically)**, the employee would have 60 days from the end of the National Emergency plus 30 days under HIPAA to give notice of the birth to request enrollment from the plan, September 29, 2021.

Again, if you have any questions regarding these changes to the Plan or your specific circumstances, please contact the County of San Mateo during normal business hours at 650-363-1919 or benefits@smcgov.org.

NON DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

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

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

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

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

IMPORTANT INFORMATION ABOUT PAYMENT

FIRST PAYMENT FOR CONTINUATION COVERAGE

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

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

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

GRACE PERIODS FOR PERIODIC PAYMENTS

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

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

Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Optionsand Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83% of your household income for the year 2021, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

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

_____

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

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

PART B: Information About Health Coverage Offered By Your Employer

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

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

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

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

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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


COUNTY OF SAN MATEO
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County of San Mateo
Human Resources
Department

10/7/2022