2022

EMPLOYEE BENEFITS OVERVIEW




Your Benefits, Your Choice.

County of San Mateo Human Resources Department

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Welcome to the County of San Mateo!

Welcome to the 2022 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 2022 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 page 39.

For more information on COBRA, please refer to page 66.

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 2022?

MEDICAL – NEW HIRE INCENTIVE

- New employees hired between December 2021 through November 2022 who enrolls in the Blue Shield Access+ HMO plan within 30 days of becoming eligible will receive a **one-time** lump sum incentive of $900

DENTAL

- Cigna Dental HMO (DHMO) Plan is replacing the Delta Dental DHMO Plan starting January 1, 2022 **(we will continue to offer the current Cigna DPPO plan with no changes)**
- Same plan design, no charge for most dental services. Copays only typically apply for enhancements such as gold, high noble metal or porcelain used in molar restorations
- Orthodontic services for both adult and children are now at no charge ($1,000 copay with Delta DHMO)
- If you have questions before enrollment, call **800.Cigna24 (800.244.6224)** and select the **"Enrollment Information"** prompt

Cigna's 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**

VISION

- **KidsCare Plan added to the Buy-Up Plan**
  - The VSP KidsCare Plan is designed to meet the eye care and eyewear needs of active and growing children (up to 18 years of age) by providing **two** WellVision Exams® and one pair of glasses every year

For more information on these changes, visit https://www.smcgov.org/hr/health-benefits

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 **Blue Shield and Kaiser Permanente**.

blue of california

- **HMO** – a Health Maintenance Organization (HMO) in which patients seek medical care from a doctor participating in the plan's network. If you join Blue Shield, you select a PCP within Blue Shield's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated through your PCP and will require a referral or authorization. More information about Blue Shield's health plan benefits is available at https://www.smcgov.org/hr/health-benefits; click on Medical Plans.
- **Trio ACO HMO –** Trio is powered by a new innovation in healthcare: the accountable care organization (ACO). An ACO is a network of doctors and hospitals that share responsibility in providing high-quality coordinated care when needed while lowering the cost of delivering care more efficiently.

  Trio works similar to a traditional HMO plan.
- **PPO** – a Preferred Provider (PPO) plan allows members the choice and flexibility to receive medical services from a PPO network doctor or out-of-network doctor.
  - In Network (PPO): Medical services are provided through the Blue Shield PPO network. You are responsible for paying an annual deductible and a percentage of the cost of the services (generally 20% of Blue Shield's allowable amount).
  - Out-of-network: This allows you to access services through any licensed doctor or hospital. You are responsible for paying a deductible and a higher annual percentage of the cost of care (generally 40% of Blue Shield's allowable amount).

- **High Deductible Health Plan -** This is a plan that works in conjunction with a Health Savings Account (please see page 43). You use the same PPO Network that you would under the standard PPO plan. All of your preventative services are covered in full. You pay for the entire cost of non-preventive services until you satisfy your annual deductible. From that point, you pay 10% of the cost for non-preventive services until you reach your Calendar Year Maximum. At that point, do not pay out of pocket for any services the rest of the year.

Medical Benefits

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 page 43). 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 • Blue Shield Access+ HMO • Blue Shield Trio ACO • Kaiser Traditional HMO

Consider a 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 • Blue Shield Full PPO

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 • Blue Shield High Deductible Health Plan • 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.

Medical Benefits

NEW HIRE INCENTIVE PROGRAM

Any newly hired employee who is hired from December 2021 through November 2022 who elects to enroll in the Blue Shield Access + HMO plan during their new hire benefits election will receive a one-time lump sum payment of $900.

This is a one-time incentive for newly hired employees who enroll in the Blue Shield Access + HMO Plan!

NOTE:

This incentive payment will also include any extra-help employee who is newly hired as a Regular/Permanent employee, since the Blue Shield Access + HMO Plan was not previously available to extra help employees. This payment will be taxed according to your W2 tax exemption that you set up in Workday.

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)

Starting January 1, 2022, the County's DMHO plan will now be with Cigna. 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.

2022 Semi-Monthly Cost of Medical Benefits

ALL EMPLOYEES

Blue Shield HMO	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee Cost	**County Cost**	**Employee Cost**	**County Cost**	**Employee Cost**	**County Cost**	Semi-Monthly Premium	Monthly Premium
Employee Only	93.22	528.24	225.28	396.18	357.34	264.12	621.46	1242.92
Employee +1	186.44	1056.49	450.56	792.37	714.68	528.25	1242.93	2485.86
Employee + Family	263.81	1494.94	637.54	1121.21	1011.28	747.47	1758.75	3517.50

Blue Shield TRIO HMO	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee Cost	**County Cost**	**Employee Cost**	**County Cost**	**Employee Cost**	**County Cost**	Semi-Monthly Premium	Monthly Premium
Employee Only	72.21	409.19	174.51	306.89	276.80	204.60	481.40	962.80
Employee +1	144.42	818.38	349.01	613.79	553.61	409.19	962.80	1925.60
Employee + Family	204.35	1158.01	493.85	868.51	783.35	579.01	1362.36	2724.72

Blue Shield PPO	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee Cost	**County Cost**	**Employee Cost**	**County Cost**	**Employee Cost**	**County Cost**	Semi-Monthly Premium	Monthly Premium
Employee Only	198.19	594.56	346.83	445.92	495.47	297.28	792.75	1585.50
Employee +1	411.63	1234.89	720.35	926.17	1029.07	617.45	1646.52	3293.04
Employee + Family	598.97	1796.90	1048.19	1347.68	1497.42	898.45	2395.87	4791.74

Blue Shield HDHP	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee Cost	**County Cost**	**Employee Cost**	**County Cost**	**Employee Cost**	**County Cost**	Semi-Monthly Premium	Monthly Premium
Employee Only	77.08	436.79	186.28	327.59	295.47	218.40	513.87	1027.74
Employee +1	154.16	873.59	372.56	655.19	590.95	436.80	1027.75	2055.50
Employee + Family	218.14	1236.13	527.17	927.10	836.20	618.07	1454.27	2908.54

Kaiser HMO	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee Cost	**County Cost**	**Employee Cost**	**County Cost**	**Employee Cost**	**County Cost**	Semi-Monthly Premium[2]	Monthly Premium[2]
Employee Only	52.81	300.27	52.81	300.27	202.45	150.63	353.08	706.16
Employee +1	105.62	599.54	255.26	449.90	404.89	300.27	705.16	1410.32
Employee + Family	149.46	847.93	361.19	636.20	572.92	424.47	997.39	1994.78

Kaiser HDHP	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee Cost	**County Cost**	**Employee Cost**	**County Cost**	**Employee Cost**	**County Cost**	Semi-Monthly Premium[2]	Monthly Premium[2]
Employee Only	41.46	235.97	41.46	235.97	158.95	118.48	277.43	554.86
Employee +1	82.93	470.93	200.41	353.45	317.89	235.97	553.86	1107.72
Employee + Family	117.34	665.95	283.58	499.71	449.82	333.47	783.29	1566.58

OPERATING ENGINEERS

PPO, Dental & Vision	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee cost	County cost	Employee cost	County cost	Employee cost	County cost	Semi-Monthly Premium	Monthly Premium
Employee Only	44.65	401.85	145.11	301.39	245.57	200.93	446.50	893.00
Employee +1	89.30	803.70	290.22	602.78	491.15	401.85	893.00	1786.00
Employee + Family	120.55	1084.95	391.79	813.71	663.02	542.48	1205.50	2411.00

Operating Engineers Kaiser, Dental & Vision	*Full Time Employees*		*3/4 Time Employees*		*1/2 Time Employees*		Total	Total
	Employee cost	County cost	Employee cost	County cost	Employee cost	County cost	Semi-Monthly Premium	Monthly Premium
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

2022 Semi-Monthly Cost of Medical Benefits

DENTAL AND VISION CONTRIBUTIONS

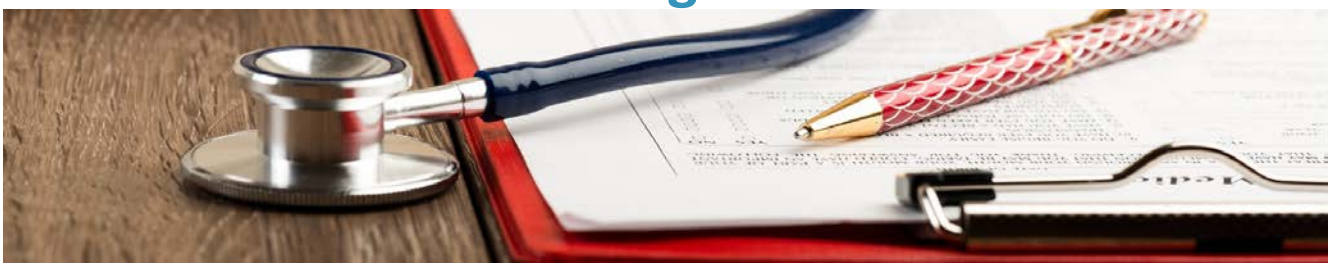
	Cigna Dental PPO			
	Core Dental Plan (No max, no ortho coverage)		*Management Buy up- Core plus Buy-Up (4k Ortho Coverage)*	
Management, Confidential, District Attorney/County Counsel, Sheriff Sergeant	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]
Employee Only	7.12	64.08	22.71	64.08
Employee + 1			39.85	
Employee + 2 ore more			52.32	

	Cigna Dental PPO							
	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)*	
All other represented employee groups	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]	Employee Cost	County Cost[1]
Employee Only	5.75	51.71	11.98	51.71	17.18	51.71	23.42	51.71
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		

	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.

	Blue Shield of CA		Kaiser Permanente	
	Access+[1]	TRIO	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
Access+ Specialist (Allows you to seek care from a specialist without a referral from your PCP)	$30 copay	$30 copay	Not applicable	Not applicable
Telemedicine	No charge	No charge	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				
Testing and Treatment	50% of allowable Charge	50% of allowable Charge	50% of allowable Charge	50% of allowable Charge after deductible
Assisted Reproductive Technology (ART) Services GIFT, In Vitro Fertilization (IVF), ZIFT, Transfer of cryopreserved embryos	Not Covered	Not Covered	50% of allowable Charge	50% of allowable Charge after deductible
Artificial Insemination	Not Covered	Not Covered	50% of allowable Charge	50% of allowable Charge after deductible
Family Planning				
Physicians Family Planning Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Vasectomy	$75/surgery	$75/surgery	$50 per procedure	Plan pays 90% after deductible
Tubal Ligation	Plan pays 100%	Plan pays 100%	$50 per procedure	Plan pays 90% after deductible

[1] New employees hired between December 2021 through November 2022 can receive a $900 incentive by enrolling in Blue Shield Access+ 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

	Blue Shield of CA		Kaiser Permanente	
	Access+[1]	TRIO	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 2021 through November 2022 can receive a $900 incentive by enrolling in Blue Shield Access+ 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.

	Blue Shield of CA		Kaiser Permanente	
	Access+	TRIO	Traditional HMO	HDHP
	In-Network	In-Network	In-Network	In-Network (After Plan Deductible)
Pharmacy				
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 Brand	$40 per prescription	$40 per prescription	$20 per prescription	$30 per prescription
Specialty Drugs	20% up to $100 max per prescription		$20 per prescription (30 day supply)	$30 per prescription
Supply Limit	30 days	30 days	100 days	30 days
Mail Order				
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 Brand	$80 per prescription	$80 per prescription	$20 per prescription	$60 per prescription
Specialty Drugs	Not Covered	Not Covered	$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

	Blue Shield of CA PPO Plan		Blue Shield of CA HDHP	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible				
Individual	$200	$500	$1,500	
Family	$200 (individual) $600 (family)	$500 (individual) $1,000 (family)	$2,800 (individual) $3,000 (family)	
Annual Out-of-Pocket Max				
Individual	$2,000	$4,000	$3,000	$6,000
Family	$2,000 (individual) $4,000 (family)	$4,000 (individual) $8,000 (family)	$3,000 (individual) $6,000 (family)	$6,000 (individual) $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 100%	Not Covered	Plan pays 100%	Not Covered
Preventive Services	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Not covered
Chiropractic and Acupuncture Care	Plan pays 80% after deductible (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)	Plan pays 90% after deductible (up to 20 visits per year) *Acupuncture: Not Covered*	Plan pays 50% after deductible (in-network limitations apply) *Acupuncture: Not Covered*
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per day)	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)
Infertility				
Testing and Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Assisted Reproductive Technology (ART) Services GIFT, In Vitro Fertilization (IVF), ZIFT, Transfer of cryopreserved embryos	Not Covered	Not Covered	Not Covered	Not Covered
Artificial Insemination	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

	Blue Shield of CA PPO Plan		Blue Shield of CA HDHP	
	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	Plan pays 80% after deductible	Not covered	Plan pays 90% after deductible	Not covered
Tubal Ligation	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Not covered
Hospital Services				
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)	$100 copay then plan pays 90% after deductible	Plan pays 60% after deductible (up to $600 per day)
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per day)	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)
Urgent Care	Plan pays 80%	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Emergency Room	$100 copay (waived if admitted)		$100 copay then plan pays 90% after deductible (copay waived if admitted)	
Mental Health Services				
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)	$100 copay then plan pays 90% after deductible	Plan pays 60% after deductible (up to $600 per day)
Outpatient	Plan pays 80%	Plan pays 60% after deductible (up to $350 per day)	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)
Substance Abuse Services				
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)	$100 copay then plan pays 90% after deductible	Plan pays 60% after deductible (up to $600 per day)
Residential Care	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $600 per day)
Outpatient	Plan pays 80%	Plan pays 60% after deductible (up to $350 per day)	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)

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

	Blue Shield of CA PPO Plan		Blue Shield of CA HDHP	
	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	**Freestanding SNF:** Plan pays 80% after deductible **Hospital-based:** Plan pays 60% after deductible (up to $600 per day)	Plan pays 90% after deductible	**Freestanding SNF:** Plan pays 90% after deductible **Hospital-based:** Plan pays 60% after deductible (up to $600 per day)

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

	Blue Shield of CA			
	PPO Plan		HDHP	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Pharmacy				
Tier 1	$15 per prescription	25% + $15 per prescription	$10 per prescription	25% + $10 per prescription
Tier 2	$30 per prescription	25% + $30 per prescription	$25 per prescription after deductible	25% + $25 per prescription
Tier 3	$45 per prescription	25% + $45 per prescription	$40 per prescription	25% + $40 per prescription
Tier 4 (excluding Specialty)	20% up to $100/prescription	20% up to $100 per prescription PLUS 25% of purchase price	30% up to $200 per prescription	30% up to $200 per prescription PLUS 25% of purchase price
Supply Limit	30 days	30 days	30 days	30 days
Mail Order				
Tier 1	$30 per prescription	Not covered	$20 per prescription	Not covered
Tier 2	$60 per prescription	Not covered	$50 per prescription	Not covered
Tier 3	$90 per prescription	Not covered	$80 per prescription	Not covered
Tier 4 (excluding Specialty)	20% up to $200/prescription	Not covered	30% up to $400/prescription	Not covered
Supply Limit	90 days	Not applicable	90 days	Not applicable
Specialty Drugs				
Specialty Drugs	20% up to $100 per prescription	Not covered	30% up to $200 per prescription	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

Dental

FOR REPRESENTED ACTIVES WITH LESS THAN 1 YEAR OF SERVICE

Dental Benefits	Cigna Dental HMO[NEW!]	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 NEW!	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 NEW!	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	$130 $150 for featured frame brands $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 **Blue Shield:** (877) 304-0504
Online visit 	Minor illnesses and conditions	• Common cold, flu, fever • Headache, migraine • Skin conditions • Allergies	24/7 **Kaiser:** www.kp.org **Blue Shield:** www.teladoc.com/bsc
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours **To locate a provider:** • Kaiser Permanente • Blue Shield of CA
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 • Blue Shield of CA
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 • Blue Shield of CA

Enhanced Services

blue of california

MOBILE APP

The Blue Shield of California app provides BSC members enhanced 24/7 service and ease-of-access to the information that matters most. As a member of Blue Shield of California, with the app you can:

- View your benefits, including information on custom benefits, general exclusions and benefit maximums
- Search for doctors and facilities by doctor specialty by location or by name
- Display your Blue Shield of California ID card
- Review your health care team, including your doctor's credentials, locations and contact information
- Learn about our benefit discount programs, like dental, vision and pharmacy
- Find urgent care

MICROSITE

Access all the information you need in one convenient place – paper-free and online. Get the best out of your benefits – visit blueshieldca.com/cosm. Blue Shield members will have 24/7 access to:

Plan information
View or download your latest health plan documents at any time.

Provider Directory
Find doctors, hospitals and specialists within Blue Shield's extensive networks by using their simple tool.

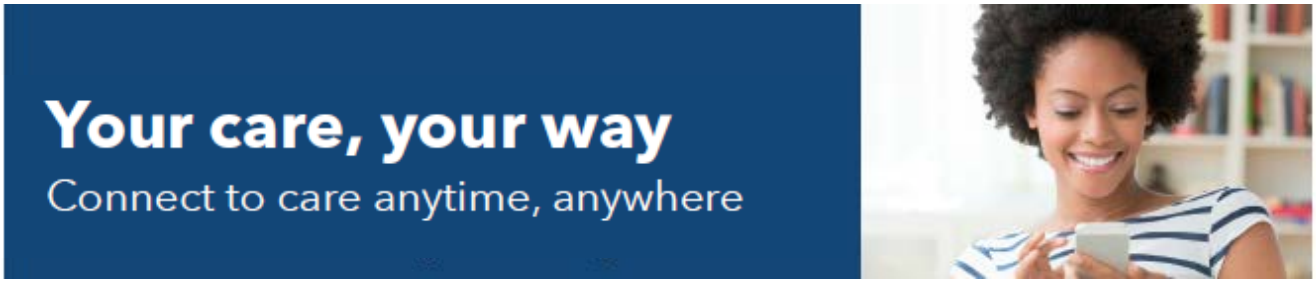
Member exclusive programs and services
Discover how healthy you can be with a variety of care options, health programs and wellness discounts.

Depending on the plan you are enrolled in, you may be eligible for enhanced services such as:

TELADOC	Talk to a medical doctor or mental health professional by phone or video	Shield Support	Support managing your needs for chronic health conditions
heal	in-person healthcare visits wherever you are – at home, in the office or even a hotel	CALLTHECAR Opening doors to better care	Access to non-emergency medical transportation for eligible Trio members
LifeSpring Home Nutrition	Healthy meals for qualified patients recovering from serious injury	Identity protection services	Since protecting your financial well-being is as important as protecting your health
LifeReferrals 24/7SM	Ready to help you with personal, family and work issues at any time.	NurseHelp 24/7SM	Ready to answer your health questions at any time, every day
Shield Concierge	Trio members can Get personalized help with benefits and claims, finding providers, and much more	Vaccines at a network retail pharmacy	Eligible PPO members can get their vaccines at retail pharmacies at no charge

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.

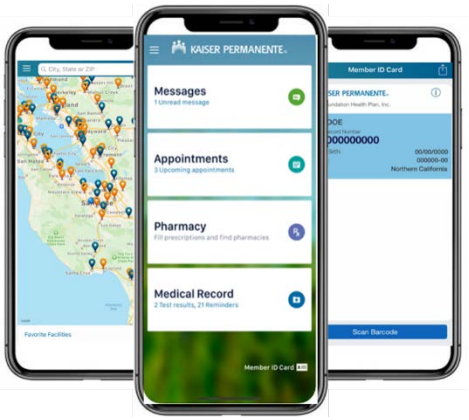
1 If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your Evidence of Coverage or other coverage documents.
2 These features are available when you receive care at Kaiser Permanente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

Enhanced Services

KAISER PERMANENTE MOBILE APP

It's convenient and easy to use

Not sure if you need an appointment? Get advice, then schedule an appointment from the quick service menu.



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

DIGITAL SELF CARE TOOLS

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

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

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

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

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

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

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

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

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 5 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 promote your health and well-being through a variety of health, fitness and educational programs, services and activities. By empowering employees with health education and lifestyle skills, the Employee Wellness Program plays a pivotal role in fostering a healthy work environment, high employee engagement and a productive workforce.

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

Preventive Health Services

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

'Culture of Health' Organizational Initiatives

- ✓ County Wellness Policy
- ✓ Designated Walking Routes
- ✓ County Wellness Committee
- ✓ Wellness Leadership Recognition Program
- ✓ Annual Signature Initiatives
- ✓ Wellness Grants Program
- ✓ Wellness Dividend Program
- ✓ Worksite Lactation Program

Wellness Classes & Services

- ✓ Activity Challenges
- ✓ Classes & Workshops (physical, emotional, and social wellbeing)
- ✓ Lifestyle Coaching
- ✓ Onsite Massage Therapy
- ✓ Babies & You Prenatal Health Program

Special Events

- ✓ Blood Drives
- ✓ Health Club Discounts
- ✓ Recreation Tournaments: Bowling, Softball, Pass the Pumpkin, Jump for Joy, Dance Off
- ✓ Department Wellness Retreats
- ✓ Annual Wellness Fair

Online Resources

- ✓ Emotional Wellbeing Videos
- ✓ Monthly Wellness Digest
- ✓ Activity and Nutrition Trackers
- ✓ MyPlans (customized health and wellness plans)
- ✓ Yammer Page with Collaborative Videos, Photos, and Recipes
- ✓ Employee Wellness Portal: PreventionCloud

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

Health and Wellness

blue of california

WELLVOLUTION

Wellvolution® is Blue Shield's digital platform for health and well-being. It offers apps and programs to help you achieve your health goals – at no extra cost. It offers the largest curated collection of scientifically-backed apps and programs designed to help you be more productive and healthy. This is where health lifestyles begin.

Wellvolution®'s wide array of healthy lifestyle programs can help you:

Lose weight

Maintain a healthy weight to avoid chronic health conditions like type 2 diabetes and heart disease by making healthy decisions.

Reduce stress

Become more resilient to stress by supporting your mental and emotional well-being with self-care, mindfulness, and meditation.

Sleep better

Get high-quality rest to support your mental and physical health, improve productivity, and maintain a healthy weight.

Eat better

Discover healthy, nutritious, and delicious food with balanced recipes and tools to help you make good choices wherever you are.

Move more

Keep active to avoid chronic health conditions, support mental health, build strength and flexibility, and improve energy levels.

Ditch cigarettes

Quit smoking now with techniques to help you stay smoke free and learn how to deal with your cravings and improve your health.

FITNESS YOUR WAY™

Fitness Your Way gives you access to more than 800 participating network fitness centers in California and more than 10,000 nationwide for just $25 per month.* This program is available through Tivity Health.®

Get basic-level access to a network of thousands of gyms nationwide[1] and get full access to an Online Health and Wellness Platform that includes thousands of fitness and wellness videos, live classes, and fitness programs. It's all included in your Fitness Your Way membership!

For more information on these benefits, visit the County's Blue Shield microsite at blueshieldca.com/cosm.

**Taxes may apply. Individuals must be at least 18 years old to purchase a membership.*

1 Fitness locations are not owned or operated by Tivity Health, Inc. or its affiliates. Fitness Your Way membership entitles member to use of the fitness location facilities and amenities available to the holder of a basic membership at the fitness locations

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 page 40)
Spousal benefit amount	$2,000	Up to $250,000
Cost for spousal benefit	None – County paid	Cost based on age (see rate sheet on page 40)
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

assist america®

ADMINISTERED BY THE STANDARD

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 2022, you can contribute a maximum of **$3,650** for employee only or **$7,300** for employee + one or more. This maximum includes both employer and employee contributions.

If you elect to enroll in one of the HDHP plans offered through Kaiser or Blue Shield, the County will fund 50% of the deductible for 2022.

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 balance's 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)

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 pre-tax payroll deduction, a spending account for medical-related expenses. These include money for co-pays, deductibles, and many other qualifies medical expenses. **The maximum amount you may contribute to a Healthcare Spending Account for the 2022 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, 2022** (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 1/1/2022-12/31/2022.**

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:

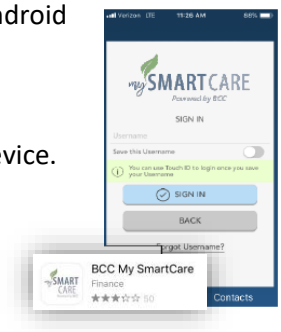
MY SMARTCARE ONLINE PORTAL

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 2022 contribution limit for the 457 Plan is $20,500. Employees age 50 or older may contribute up to an additional $6,500 for a total of $27,000.

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)
$4.39	$7.59	$9.72	$12.92

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 INSURANCE:

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

MyBenefits.Life®

THE EASY WAY TO GET BENEFITS INFO

Click to play video

GET MYBENEFITS.LIFE

On the web:

smcgov.mybenefits.life

On your smartphone

Download from the App Store or Google Play.

Login With Employer Key

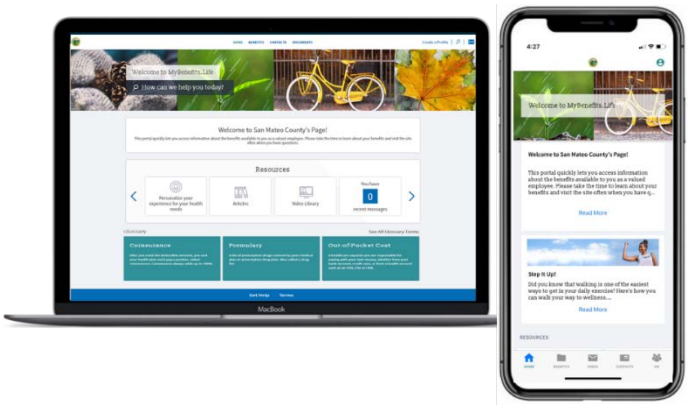
smcgov

MyBenefits.Life gives you all your benefits information in one place—at home, at work or on the go

You can bank online, book a vacation online, and read the news online. Why should your benefits information be any different? MyBenefits.Life is both a website and a mobile app that give you access to the benefits information you need, when you need it.

Here's what you'll find on MyBenefits.Life

Benefits	See benefit details and costs—for all plans you're eligible for, such as healthcare, disability, life insurance, and more
Documents	Important benefit plan notices ("the fine print")
Contacts	Find HR, benefits, and carrier contacts
Inbox	Get messages from your HR team
Search	Can't find it? Just search the site
Articles & Video Library	Have 2 minutes? Increase your benefits IQ with short explainer articles and videos
Glossary	HDHP? EOB? Coinsurance? Get the definitions in plain English
Get Help	Need help? Reach helpful resources



Contact Numbers

Kaiser Permanente (HMO and HDHP)		
Group #7056	www.kp.org	800-464-4000
Blue Shield TRIO Concierge		
Group #W0014027	www.blueshieldca.com	855-829-3566
Blue Shield of CA (HMO, PPO & HDHP)		
Group #W0014027	www.blueshieldca.com	855-256-9404
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)		
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

MEDICAL/GENERAL TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUG TERMS

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

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

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

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

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

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

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

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

DENTAL TERMS

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

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

Endodontics - Commonly known as root canal therapy.

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

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

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

Periodontics - Diagnosis and treatment of gum disease.

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

Important Plan Notices and Documents

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Call your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the County of San Mateo's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP.

You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

NOTICE OF CHOICE OF PROVIDERS

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

NON DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

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

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

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

HIPAA PRIVACY NOTICE

COUNTY OF SAN MATEO PRIVACY PRACTICES NOTICE

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

{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

MEDICARE PART D NOTICE

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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, 2021

Name of Entity: County of San Mateo

Contact: Human Resources- Benefits Division

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

Phone: (650) 363-1919

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

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

WHY AM I GETTING THIS NOTICE?

You're getting this notice because your coverage under the Plan will end on [enter date] due to [check appropriate box]:

☐ End of employment
☐ 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, 2021. Contact your State for more information on eligibility —

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: https://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx | Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: https://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: https://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: https://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: https://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – 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	Website: https://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718	
Kentucky Medicaid Website: https://chfs.ky.gov	
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852- 3345, ext 5218
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: https://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://dss.sd.gov Phone: 1-888-828-0059

NEW YORK – Medicaid	TEXAS – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: https://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	VERMONT– Medicaid
Website: https://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: https://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	WASHINGTON – Medicaid
Website: https://healthcare.oregon.gov/Pages/index.aspx https://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	WISCONSIN–Medicaid and CHIP
Website: https://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2020, 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 Options and 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 value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered By Your Employer

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

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

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

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

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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