2018 - 2019 Annual Enrollment Retiree Benefits Guide

County of Sonoma

ANNUAL ENROLLMENT

IS MARCH 19 THROUGH APRIL 6, 2018!

Tips

- Review this guide and visit http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/ to learn more about your retiree health plan options
- Review important changes in What's New For 2018 - 2019
- Check important dates for Annual Enrollment 2018 including the Annual Enrollment meeting schedule on page 3
- Contact CareCounsel at (888) 227-3334 if you have any questions on health plan benefits or need help choosing a plan
- Prepare for your transition from traditional to Medicare benefits
- You need to take action during Annual Enrollment **only** if you need to make a change; otherwise your current benefit elections will roll over for the new plan year
- Don't delay — enroll or make your changes on or before April 6, 2018

You are encouraged to keep this Benefits Guide throughout the year.

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2018 ANNUAL ENROLLMENT AND RETIREE BENEFITS GUIDE

This Guide is designed to help you understand your health benefit options and make informed decisions during Annual Enrollment and throughout the year. Included in this Guide:

- Information about your medical and dental plan options
- Monthly premium costs
- County of Sonoma Retiree Benefits Enrollment/Change Form
- Additional information and resources

You may view the Summary of Benefits and Coverage (SBC) information for each of the County's medical plans and Uniform Glossary online at: http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/.

This Benefits Guide gives you an overview of your benefits including eligibility, plan options, rates, how to enroll, and other important information. More detailed information is available in the official plan documents.

In the case of conflict between the information presented in this Benefits Guide and the official plan document, the plan document determines the coverage.

Items to Consider During The Annual Enrollment Period

Dependent data:

Gather this information before proceeding with enrollment: Names, birthdates, and Social Security numbers to complete your enrollment process.

Beneficiary designations:

There are no set deadlines for updating your life insurance beneficiary designations, but Annual Enrollment is a great time for you to review and update beneficiary information.

Personal information:

If your name, address, phone number, or e-mail information has changed, be sure to notify the HR Benefits Unit in writing at: benefits@sonoma-county.org or contact us at (707) 565-2900 to request a change form. It's important to keep your personal information up-to-date at all times.

ANNUAL ENROLLMENT MARCH 19 THROUGH APRIL 6

Annual Enrollment provides you an opportunity to evaluate your current medical and dental coverage and to elect the benefit plans that best fit your needs. This is also your once-a-year opportunity to make changes to your current benefit elections for the upcoming plan year, June 1, 2018 through May 31, 2019.

During Annual Enrollment you may:

- Change your medical or dental plan election(s)

- Enroll, drop, or waive coverage in one of the retiree dental plans
- Drop coverage for dependents

You only need to take action during Annual Enrollment if you are making one or more of the changes noted above. **Be sure to complete and submit the required form(s) to the County of Sonoma, Human Resources Benefits Unit by 5:00 p.m., Friday, April 6, 2018.**

If you want to continue your current benefit elections in the coming benefit year and all of your dependents continue to meet the plans' eligibility criteria, no action is necessary — your current benefits will continue, effective June 1, 2018.

IMPORTANT DATES

March 19, 2018	First day of annual enrollment
March 21, 2018	First annual enrollment meeting (see page 3 for complete schedule)
April 6, 2018	Last day of annual enrollment. Forms must be received by 5:00 p.m. in the HR Benefits Unit
June 1, 2018	Effective date of new benefit elections/changes

PREMIUM CHANGES REFLECTED ON PENSION CHECKS

The total cost of benefits change annually. All cost changes will be reflected on your May 2018 pension check for coverage effective June 1, 2018.

WHAT'S NEW FOR 2018 - 2019

The following is a summary of significant changes.

MEDICAL PLANS' PREMIUM INCREASES

Kaiser Permanente California Plans' premiums are increasing up to 6.6%, Kaiser Permanente Hawaii Plan premiums are increasing up to 9%, and Kaiser Permanente Northwest Plan premiums are increasing up to 4.8%. Sutter Health Plus Plans' premiums are increasing between 4.7% and 6.2%, Western Health Advantage Plans' premiums are increasing 6.7%, and the County Health Plans' premiums are remaining the same with no increase. See Medical Plan Premium charts starting on page 52.

ANNUAL ENROLLMENT MEETING SCHEDULE

Would you like more information about your benefit plan options? Take advantage of the opportunity to meet with representatives from UnitedHealthcare (AARP Medicare Supplemental Plan), Kaiser Permanente, Sutter Health Plus, Western Health Advantage, and the County of Sonoma Human Resources Benefits Unit. There will be separate meetings for retirees with Medicare and retirees without Medicare. Please make sure you attend the meeting most appropriate for your personal situation.

NON-MEDICARE (UNDER AGE 65) RETIREE INFORMATION SESSIONS

Presentations by Kaiser Permanente, Sutter Health Plus, and Western Health Advantage

DATE	TIME	LOCATION	STREET ADDRESS	ROOM
March 21	2:00 p.m. - 4:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 23	9:00 a.m. - 11:00 a.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	1:00 p.m. - 3:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 26	9:00 a.m. - 11:00 a.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	1:00 p.m. - 3:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers

MEDICARE (AGE 65 & OVER) RETIREE INFORMATION SESSIONS

Presentations by Kaiser Permanente and UHC-AARP

DATE	TIME	LOCATION	STREET ADDRESS	ROOM
March 29	9:00 a.m. - 11:00 a.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	1:00 p.m. - 3:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 30	9:00 a.m. - 11:00 a.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	1:00 p.m. - 3:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers

RETIREE ANNUAL ENROLLMENT ONE-ON-ONE HELP SESSIONS

Human Resources Benefits Unit staff will be available to assist you with completing Annual Enrollment election forms. Since Annual Enrollment occurs at the same time for active employees as retirees, you will be best served if you drop-in during the retiree Annual Enrollment one-on-one help session times listed below.

DATE	TIME	DEPT/LOCATION	STREET ADDRESS	ROOM
March 20	10:00 a.m. - 12:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room
	2:00 p.m. - 4:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room
March 21	4:00 p.m. - 5:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 22	3:30 p.m. - 5:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room
March 23	11:00 a.m. - 12:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	3:00 p.m. - 4:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 26	11:00 a.m. - 12:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	3:00 p.m. - 4:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 29	11:00 a.m. - 12:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	3:00 p.m. - 4:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
March 30	11:00 a.m. - 12:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
	3:00 p.m. - 4:00 p.m.	County Administration	575 Administration Dr. Ste. 102A	Board of Supervisors' Chambers
April 2	10:00 a.m. - 12:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room
	2:00 p.m. - 4:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room
April 5	10:00 a.m. - 12:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room
	2:00 p.m. - 4:00 p.m.	Human Resources	575 Administration Dr. Ste. 117C	Human Resources Small Training Room

KAISER SENIOR ADVANTAGE ENROLLMENT FORM

If you are making an election/change to enroll in or drop coverage in **Kaiser Senior Advantage**, you MUST contact the Human Resources Benefits Unit Customer Service at (707) 565-2900 to request an additional form.

AARP MEDICARE SUPPLEMENT AND MEDICARERX FORMS AND STEPS TO ENROLLMENT

To assist with enrollment in UnitedHealthcare's AARP Medicare Supplement and MedicareRx Plans, use the steps below. Each enrollee must complete ALL the following steps to enroll in the AARP Medicare Supplement and MedicareRx Plans:

1. Plan information and to enroll over the phone, **contact UnitedHealthcare (UHC) Customer Service at (877) 558-4759:**
   - AARP Medicare Supplement Insurance Plans Group # 1068
   - AARP® MedicareRx PDP Group # 3803

   Customer service representatives are available Monday through Sunday from 8:00 a.m. to 8:00 p.m. PST.

2. Complete the **County of Sonoma Retiree Benefits Enrollment/Change Form** found in the back of this booklet. Keep a copy and **send original form** along with the following completed forms if plan enrollment was not completed over the phone:
   - Original AARP Medicare Supplement Insurance Plan enrollment form mailed to you by UHC, and
   - Original AARP® MedicareRx Plan enrollment form mailed to you by UHC
   - Don't have these forms? If you did not receive the UnitedHealthcare enrollment form(s), immediately contact the Human Resources Benefits Unit and request the missing form(s) by calling or e-mailing:
     - Phone: (707) 565-2900; or
     - Email: benefits@sonoma-county.org

3. To enroll, send all original, completed, forms to:
   County of Sonoma Attn: HR Benefits Unit
   575 Administration Dr., Suite 117C
   Santa Rosa, CA 95403

Mail or drop off all required forms by 5:00 p.m., Friday, April 6, 2018. Even if you are unable to complete and submit the required enrollment forms by the April 6, 2018 deadline, you must return the **County of Sonoma Retiree Benefits Enrollment/Change Form** by April 6, 2018 to be considered for enrollment. The absolute last day to submit the required enrollment forms or enroll over the phone is April 6, 2018.

Things to Know…

- Once you and/or your dependents reach age 65, you must enroll in **Medicare Parts A & B** and submit a copy of your and/or dependent's Medicare card to Human Resources Benefits Unit within 30 days to be eligible for County sponsored plan coverage.
- **UnitedHealthcare's AARP Medicare Supplement & MedicareRx Plans** are individual plans with retirees paying their portion of the premium directly to UnitedHealthcare **after** the County contribution has been paid.
- The AARP Medicare Supplement Plans may have **premium increases** around the first of the year. UnitedHealthcare will notify you if there is an increase.
- Retirees who elect to enroll in UnitedHealthcare must enroll in both the AARP® Medicare Supplement Insurance Plan and AARP® MedicareRx Plan with the **same effective date** to be eligible for a County contribution.
    - If you are **enrolling in UnitedHealthcare for the first time or making a change to your current UnitedHealthcare plan**, please let the customer service agent know that you want a June 1, 2018 effective date.
    - Phone enrollment is encouraged due to ease-of-use by contacting UnitedHealthcare customer service at (877) 558-4759.
    - During AARP MedicareRx Plan phone enrollment, request the "payment coupon book" as your payment method to ensure you will receive the County Contribution toward your prescription drug plan enrollment. **Do not** sign-up for the ACH debit from your Social Security check.
    - Keep your UnitedHealthcare phone enrollment confirmation numbers for both the AARP Medicare Supplement Insurance Plan and the AARP MedicareRx Plan, as you will need to print these confirmation numbers on your required County of Sonoma Retiree Benefits Enrollment /Change Form found in the back of this guide.

MEDICAL PLAN ELIGIBILITY

Plan eligibility and plan benefits are based on an enrolled member's eligibility for Medicare. Use the information below to determine which plans are available to you and what plan benefits will be provided.

NON-MEDICARE PLANS

These plans are available to participants (Retiree or Eligible Dependent) not eligible for Medicare:

- County Health Plan EPO (Exclusive Provider Organization)
- County Health Plan PPO (Preferred Provider Organization)
- Kaiser Permanente HMO (Health Maintenance Organization)
- Kaiser Permanente Hawaii HMO
- Kaiser Permanente Northwest (OR/WA) HMO
- Kaiser Permanente Hospital Services DHMO (Deductible HMO Plan)
- Kaiser Permanente Deductible First HDHP (High Deductible Health Plan)
- Sutter Health Plus HMO (Health Maintenance Organization)
- Sutter Health Plus Hospital Services DHMO (Deductible HMO Plan)
- Sutter Health Plus Deductible First HDHP (High Deductible Health Plan)
- Western Health Advantage HMO (Health Maintenance Organization)
- Western Health Advantage Hospital Services DHMO (Deductible HMO Plan)
- Western Health Advantage Deductible First HDHP (High Deductible Health Plan)

PLANS FOR RETIREES AND DEPENDENTS ENROLLED IN MEDICARE

These plans are available to participants (Retiree or Eligible Dependent) enrolled in Medicare Parts A & B:

- AARP® Medicare Supplement Insurance Plan with MedicareRx Prescription Drug Plans (Does not allow "Split Enrollments" – Retiree and Eligible Dependent MUST have Medicare Parts A & B)
- County Health Plan EPO - Medicare will be the primary coverage for members with Medicare.

- County Health Plan PPO - Medicare will be the primary coverage for members with Medicare.
- Kaiser Permanente Senior Advantage

As you consider which plan is right for you, it's important to understand how Medicare and your County-offered medical plan benefits work together to provide your health care benefits.

SPLIT ENROLLMENTS

Kaiser Permanente allows split enrollments between the retiree and their eligible dependents. A retiree may choose Senior Advantage because he/she is eligible for Medicare Parts A & B and their spouse may be on the Kaiser Permanente HMO, DHMO, or HDHP plan. Likewise, the retiree may choose Kaiser Permanente HMO, DHMO, or HDHP plan and their Medicare eligible spouse is on Senior Advantage. The monthly rate the retiree pays is a combination of the Medicare and non-Medicare plan enrollments.

BRIEF DESCRIPTION OF MEDICAL PLANS

The following provides a brief description of how each plan works.

COUNTY HEALTH PLANS

The PPO and EPO medical plan options are self-funded, meaning the contributions from the County of Sonoma and eligible employees and retirees are used to pay plan benefits, including services provided to the members and claims administration. Anthem Blue Cross is the network provider and medical plan claims administrator for both the EPO and PPO plans. Plan members have access to more than 60,800 doctors and specialists that make up a strong local California network. Anthem Blue Cross has contracted with more than 90% of hospitals in California, including 400 acute care hospitals. If you reside within California, services are provided through the Prudent Buyer Plan network and if you reside outside of California, services are provided through BlueCard network. More than 96% of hospitals and more than 91% of physicians across the country contract with Anthem Blue Cross through the BlueCard® program.

To find a network provider, visit Anthem Blue Cross online or call (877) 800-7339.

COUNTY HEALTH PLAN EPO

The plan includes a network of preferred providers, including doctors, hospitals and other health care facilities, which participate in the Anthem Blue Cross Prudent Buyer PPO Plan network. Prescription drug coverage is provided through CVS/Caremark. The plans' network providers agree in advance to provide their services at a negotiated, discounted rate. All care in the County Health Plan EPO **must** be obtained within the plan network, except if you have an authorized referral from a network provider or if you have an emergency.

COUNTY HEALTH PLAN PPO

The plan includes a network of preferred providers, including doctors, hospitals and other health care facilities, which participate in the Anthem Blue Cross Prudent Buyer PPO Plan network within California and the Blue Card Program network outside of California. Prescription drug coverage is provided through CVS/Caremark. The plans' network providers agree in advance to provide their services at a negotiated, discounted rate. You may seek care from providers outside the network, but you will pay less out of your own pocket when you use a network provider.

- **Deductibles and Coinsurance** Services under the County Health Plans are subject to an annual deductible. As you incur medical expenses, you first pay the deductible out of your own pocket. Then, after meeting the deductible, you pay your share of the cost of your covered expenses (known as "coinsurance"), up to the plans' annual out-of-pocket maximum.

- **Out-of-Pocket Maximum** When you meet the annual out-of-pocket maximum, the plan will pay the full cost of covered expenses for the remainder of the benefit year. Covered expenses (e.g. coinsurance amounts) apply towards the out-of-pocket maximum.

Out-of-pocket costs incurred for non-covered services or supplies in excess of the plan's covered expenses (e.g. expenses incurred for out-of-network services that exceed the reasonable and customary charges allowed by the plan) **are not** applied toward the out-of-pocket maximum; these non-covered charges are the plan participant's financial responsibility. *Be sure you understand the amount you will be required to pay out of your own pocket* ***if you seek care out-of-network***.

IMPORTANT NOTE

Because providers are added to and dropped from the PPO or EPO network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the PPO or EPO or contact the network each time BEFORE you seek services.

COUNTY HEALTH PLAN PRESCRIPTION COVERAGE UNDER CVS/CAREMARK

For both the County EPO and the County PPO medical plan options, outpatient retail and mail order drugs are available through CVS/Caremark.

You are encouraged to select a generic drug when possible.
If a generic drug is not available, you pay the brand-name copay. If a generic drug is available but a brand-name drug is medically necessary, as prescribed by your doctor,

your doctor must request an exception to the plans' mandatory generic policy through CVS/Caremark **prior** to getting the prescription filled. If approved, you will be charged the brand-name copay. However, if you choose the brand-name drug, or the exception is not approved, the drug will be a covered expense but you will be responsible for the brand copay along with the difference between the brand and generic cost. **If you are taking a maintenance drug, it can be filled at any retail pharmacy twice. After the second fill, it must be filled at a CVS pharmacy or by mail order through CVS/Caremark.**

Direct all prescription benefit appeals to CVS/Caremark customer service at (800) 966-5772.

KAISER PERMANENTE PLANS

Easy Access: With Kaiser Permanente it's simple to find the care you need. Along with primary care, urgent care, emergency care, and labor and delivery members have convenient access to a wide choice of specialty services with facilities in Sonoma County, Marin County and access to Kaiser Permanente throughout California.

Personalized care: Whether you come into a Kaiser Permanente facility for a routine visit, urgent care, or emergency care, your doctors, nurses and specialist have access to your electronic medical record. You have expanded opportunities to interact with care team the way you want: in person, physician email, 24 hour advice nurse line, linked to your medical record, telephone appointments and video visits are possible.

To learn more about Kaiser Permanente, visit www.my.kp.org/sonomacounty or call member services at (800) 464-4000.

Coordination of Benefits with 2 or More HSA-Qualified High Deductible Health Plans (HDHP):
To better align with federal tax laws, starting January 1, 2018, Kaiser Permanente will coordinate benefits for members with 2 or more employer-sponsored Kaiser Permanente health savings account (HSA)-qualified HDHPs. Dual covered members who have 2 or more Kaiser Permanente plans that are not HSA-qualified HDHPs or who have a Kaiser Permanente HSA-qualified HDHP and a non-HSA-qualified HDHP will not be impacted by this change. Dual-covered members with Kaiser Permanente Individuals and Families (KPIF) HSA-qualified HDHPs with will also not be impacted by this change.

KAISER PERMANENTE TRADITIONAL HMO

The Traditional $10 Copay Plan provides doctor and specialist visits for a $10 copay. Prescription medication is covered at a copay of $5 for generic and $10 for brand (up to a 100 day supply). Hospitalization, radiology, and lab tests are also covered at no cost. Most preventive services are also covered at no cost under ACA guidelines. Generally, you must use Kaiser Permanente's physicians unless you have an out-of-area urgent or emergency situation or a referral.

KAISER PERMANENTE HOSPITAL SERVICES DHMO

For hospital related services including emergency room visits, inpatient stays and outpatient surgery, you pay the full cost of these services up to the deductible then a 20% coinsurance until you reach your out-of-pocket max. The out-of-pocket maximum includes the calendar year deductible, copayments, and coinsurance. For most primary care, specialist and urgent care visits you will pay a $20 copay. For prescription drugs you will pay $10 for a 30 day supply and $20 for a 100 day supply for generic and $30 for a 30 day and $60 for a 100 day supply for brand.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), through COBRA or another employer, may submit Kaiser out-of-pocket expenses for reimbursement.

Members can use Kaiser Permanente's online Cost Estimate Tool to obtain a personalized estimate of medical care costs for common tests and procedures at www.kp.org/memberestimate.

KAISER PERMANENTE DEDUCTIBLE FIRST HDHP

This plan requires a member to meet the calendar year deductible FIRST before ANY plan benefits will be paid, except covered preventive services. Members will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations etc., until the calendar deductible is met. Once the deductible is met, covered medical, hospital and prescription benefits will be provided for a copayment or coinsurance amount. While this plan does require a member to meet the deductible first, members who anticipate a hospital stay (such as a surgery or the birth of a child), may find this plan offers a lower total out-of-pocket cost. The calendar year out-of-pocket maximum includes: calendar year deductibles, copayments, and coinsurance.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible

Spending Account), through COBRA or another employer, may submit Kaiser out-of-pocket expenses for reimbursement.

Members can use Kaiser Permanente's online Cost Estimate Tool to obtain a personalized estimate of medical care costs for common tests and procedures at www.kp.org/memberestimate.

Take Note… If you (the retiree) elect to enroll in this Deductible First HDHP, which is an HSA-qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out of pocket medical expenses, the IRS does not allow you to also contribute to a Health Savings Account at the same time, as it is considered prohibited health coverage.

SUTTER HEALTH PLUS PLANS

Affordability. Access. Quality.
Sutter Health Plus is a local not-for-profit HMO that gives members affordable access to a network of high-quality providers. The health plan's network in Sonoma County includes Sutter Santa Rosa Regional Hospital and Novato Community Hospital (serving southern Sonoma County), Sutter Pacific Medical Foundation, Sutter Medical Group of the Redwoods, Sutter Santa Rosa Urgent Care, and Sutter Walk-In Care facility located in Petaluma.

Features and Benefits
Take a moment to learn about the Sutter Health Plus:

- Comprehensive benefits and coverage for hospitalization, urgent care, primary care, specialty care, X-ray, laboratory, prescription drug coverage and more
- Coverage for a variety of no-cost preventive care services to help prevent or detect health problems early on
- Easy to use online tools, such as:
    - A Member Portal that gives members access to important plan documents; eligibility, benefits and copay information; forms and resources; change primary care physician (PCP); request or print member identification cards
    - My Health Online (not offered by all providers) to schedule appointments, email doctors, view test results and access records
- Many Sutter Health Plus providers use an electronic health record
- Mail order pharmacy program and conveniently located retail pharmacies
- Coverage for emergency and urgent care anywhere in the world
- A year-round 24/7 nurse advice line
- Wellness Coaching Program to help with healthy weight, tobacco cessation and stress management—all at no additional out-of-pocket costs

Plan Offerings
Sutter Health Plus has three plan offerings available for county of Sonoma employees, to meet a variety of needs.

- Traditional $10 Copay Plan – ML42
- Hospital Services DHMO – ML21
- Deductible First HDHP – HD11

For more information about Sutter Health Plus or to view the plan comparisons, visit www.sutterhealthplus.org/sonoma-county or call Member Services (855) 315-5800.

SUTTER HEALTH PLUS TRADITIONAL HMO

Traditional HMO ML42 $10 copay plan for primary care, specialist or chiropractic visits. Chiropractic visits are limited to 20 visits per year. Prescription medications are available through retail or mail order at a copay range of $5 - $40.

SUTTER HEALTH PLUS HOSPITAL SERVICES DHMO

Hospital Services DHMO ML21 $20 copay plan for primary care, specialist or chiropractic visits. Chiropractic visits are limited to 20 visits per year. Prescription medications are available through retail or mail order at a copay range of $10 - $120. Tier 4 prescription medications are covered at a 20% coinsurance, not to exceed $100 per prescription.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), through COBRA or another employer, may submit Sutter Health Plus out-of-pocket expenses for reimbursement.

SUTTER HEALTH PLUS DEDUCTIBLE FIRST HDHP

The Sutter Health Plus HDHP HD11 offers a lower monthly premium and higher deductible limits than the two other HMO plans. After a member meets the deductible, the plan pays for a percentage of medical care until the member reaches the annual out-of-pocket maximum.

Deductible First HD11 $20 copay per visit for primary care and specialist visits after the deductible is met. Prescription medications are available through retail or mail order at a copay range of $10 - $120 after the deductible is met. Tier 4 prescription medications are covered at a 20% coinsurance, not to exceed $100 per prescription after the deductible is met.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), through COBRA or another employer, may submit Sutter Health Plus out-of-pocket expenses for reimbursement.

Take Note… If you (the retiree) elect to enroll in this Deductible First HDHP, which is an HSA-qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you

under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out of pocket medical expenses, the IRS does not allow you to also contribute to a Health Savings Account at the same time, as it is considered prohibited health coverage.

WESTERN HEALTH ADVANTAGE PLANS

With Western Health Advantage you don't have to settle for one medical group. Our unique Advantage Referral program gives you access to many of the specialist physicians across our eight medical groups, including: Canopy Health, Hill Physicians, John Muir Health, Meritage Medical Network, Mercy Medical Group, NorthBay Healthcare, UC San Francisco medical system, and Woodland Healthcare. We give you the freedom and flexibility you are looking for in a health plan.

Western Health Advantage has you covered. Enjoy the peace-of-mind that comes with 27 leading hospitals and major medical centers in Northern California, including five in Sonoma County (Healdsburg District Hospital, Petaluma Valley Hospital, Santa Rosa Memorial Hospital, Sonoma Valley Hospital, and Sonoma West Medical Center). You will also find conveniently located full-service care centers that offer a wide array of services under one roof — providing access to quality care in a neighborhood near you.

Most preventive services — such as well baby/child visits, immunizations, physicals, mammograms, and routine preventive screenings — are covered at no cost. Membership with WHA means value-added benefits including acupuncture and chiropractic services, mental health and substance abuse services, online wellness assessment, travel assistance, and more.

Like all HMOs, you must use Western Health Advantage's providers, except when you need emergency care.

- **New! WHA Expands into the Bay Area:** We are pleased to announce our expansion into four new counties: San Francisco, Alameda, Contra Costa, and part of San Mateo. With this expansion, we have added premier medical systems to our WHA network including John Muir Health and the UC San Francisco medical system through Canopy Health. The WHA network has grown to 5,800 doctors and specialists from eight medical groups. Please note that eligibility to enroll in the new Canopy Health expansion will require a member to live or work in the service area. You are encouraged to view our enhanced provider search at www.choosewha.com/directory.
- **New! Active & Fit Direct:** WHA has added more fitness options, including Active & Fit, which has over 9,000 fitness centers. Learn more at www.mywha.org/gyms.
- **New! Smart90 with Express Scripts:** WHA has more choices for getting 90-day supplies of prescriptions, including the Smart90 program, which allows three-month refills at Walgreens.

- New! $0 cost, high-value drugs: WHA has made certain non-preventive drugs available at no cost (after deductible, if applicable).

To learn more about Western Health Advantage, visit us at www.chooseWHA.com/Sonoma-county or call (888) 563-2250.

WESTERN HEALTH ADVANTAGE TRADITIONAL HMO

Primary care doctor and specialist visits are available for a $10 copay. Hospitalization, radiology, and lab tests are covered at no cost from Western Health Advantage HMO. Outpatient prescription medication is covered at a copay range of $5 - $20.

WESTERN HEALTH ADVANTAGE HOSPITAL SERVICES DHMO

The Hospital Services DHMO plan requires you to live within the plan's Northern California service area and to receive your non-emergency care from Western Health Advantage providers. You share in the cost of your care through copayments, coinsurance, and deductibles.

Most doctor's office visits, radiology services, lab tests and prescriptions are available for a copay or coinsurance amount, even before you have reached the calendar year deductible. Hospitalizations, residential treatment facility, emergency room care, in-patient, and out-patient surgeries are subject to the calendar year deductible before plan benefits will be paid.

See the Medical Plan Comparison Chart in this guide for more information about the benefits, deductibles, and out-of-pocket maximums.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), through COBRA or another employer, may submit Western Health Advantage out-of-pocket expenses for reimbursement.

WESTERN HEALTH ADVANTAGE DEDUCTIBLE FIRST HDHP

The Deductible First HDHP plan requires you to live within the plans' Northern California service area and to receive care from Western Health Advantage providers. This means you have access to Western Health Advantage providers only, except when you need emergency care. You share in the cost of your care through co-payments, coinsurance, and deductibles.

For any service other than preventative services, a member must meet the calendar year deductible FIRST before ANY plan benefits will be paid. A member will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations, etc., until the calendar year deductible is met. Once the deductible is satisfied, covered medical,

hospital, and prescription benefits will be provided for a copayment or coinsurance amount (if applicable).

See the Medical Plan Comparison Chart for more information about deductibles, out-of-pocket maximums, and plan benefits.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), through COBRA or another employer, may submit Western Health Advantage out-of-pocket expenses for reimbursement.

Take Note… If you (the retiree) elect to enroll in this Deductible First HDHP, which is an HSA-qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out of pocket medical expenses, the IRS does not allow you to also contribute to a Health Savings Account at the same time, as it is considered prohibited health coverage.

MEDICAL PLAN COMPARISON CHART - COUNTY PLANS		
Plan Information	**County Health Plan EPO** Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered**	**County Health Plan PPO** Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare)
GENERAL INFORMATION		
Health Plan Availability	Nationwide	Nationwide
Select A Primary Care Physician (PCP)	Does not require you to select a PCP	Does not require you to select a PCP
Seeing a Specialist	Allows you access to many types of services without receiving a referral or advance approval	Allows you access to many types of services without receiving a referral or advance approval
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Plan Year (June 1 - May 31) Medical Deductible	**Individual:** $500 **Family:** $1,500	**Individual:** $300 **Family:** $900
Plan Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	Medical/Prescription Drug **Individual:** $5,500/$1,100 **Family:** $11,500/$1,700	Medical/Prescription Drug **Individual:** $2,300/$1,100 **Family:** $4,900/$1,700
OFFICE VISITS AND PROFESSIONAL SERVICES		
Physician & Specialist Office Visits	**In-Network:** $50 copay, no deductible **Out-of-Network:** Not Covered	**In-Network:** $20 copay, no deductible **Out-of-Network:** 40% coinsurance after deductible
Preventive Care Birth to Age 18	**In-Network:** No charge, no deductible **Out-of-Network:** Not Covered	**In-Network:** No charge, no deductible **Out-of-Network:** 40% coinsurance after deductible
Preventive Care Adult Routine Care	**In-Network:** No charge, no deductible, one exam every 12 months **Out-of-Network:** Not Covered	**In-Network:** No charge, no deductible, one exam every 12 months **Out-of-Network:** 40% coinsurance after deductible.
Preventive Care Adult Routine OB/GYN	**In-Network:** No charge, no deductible **Out-of-Network:** Not Covered	**In-Network:** No charge, no deductible **Out-of-Network:** 40% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - COUNTY PLANS		
Plan Information	**County Health Plan EPO** Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered**	**County Health Plan PPO** Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare)
OFFICE VISITS AND PROFESSIONAL SERVICES		
Diagnostic Imaging, Lab and X-Ray	**In-Network:** 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
Physical Therapy (medically necessary treatment only)	**In-Network:** 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
Chiropractic and Acupuncture	**In-Network:** 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	**In-Network:** 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
Family Planning Counseling and Consultation	**In-Network:** $50 copay, no deductible **Out-of-Network:** Not Covered	**In-Network:** $20 copay, no deductible **Out-of-Network:** 40% coinsurance after deductible
Routine Eye Exams with Plan Optometrist	**In-Network:** No charge, no deductible **Out-of-Network:** Not Covered	**In-Network:** No charge, no deductible **Out-of-Network:** 40% coinsurance after deductible
Hearing Exam	**In-Network:** No charge, no deductible **Out-of-Network:** Not Covered	**In-Network:** No charge, no deductible **Out-of-Network:** 40% coinsurance after deductible
Allergy Injections (serum included)	**In-Network:** $50 copay per visit, no deductible **Out-of-Network:** Not Covered	**In-Network:** $20 copay per visit, no deductible **Out-of-Network:** 40% coinsurance after deductible
Infertility Services	**Evaluation (diagnosis) and surgical repair only** **In-Network:** $50 copay, no deductible **Out-of-Network:** Not Covered	**Evaluation (diagnosis) and surgical repair only** **In-Network:** $20 copay, no deductible **Out-of-Network:** 40% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - COUNTY PLANS		
Plan Information	**County Health Plan EPO** Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered**	**County Health Plan PPO** Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare)
SURGICAL AND HOSPITAL SERVICES		
Hospitalization and Physician/ Surgeon Services	**In-Network:** $500 copay plus 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** $125 per admission copay plus 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
Outpatient Surgery	**In-Network:** $500 copay plus 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
Maternity	**In-Network:** $250 copay plus 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** $125 per admission copay plus 10% coinsurance after deductible **Out-of-Network:** $125 per admission copay plus 40% coinsurance after deductible
Emergency Room	**In-Network:** $150 copay plus 20% coinsurance after deductible; Not Covered if non-emergency **Out-of-Network:** $150 copay plus 20% coinsurance after deductible; Not Covered if non-emergency (copays waived if admitted)	**In-Network:** $100 copay plus 10% coinsurance after deductible; If an emergency **Out-of-Network:** $100 copay plus 10% coinsurance after deductible; If an emergency (copays waived if admitted)
Ambulance	**In-Network:** 20% coinsurance after deductible **Out-of-Network:** 20% coinsurance after deductible if emergency, urgent care, or authorized by Primary Care Physician; otherwise not covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 10% coinsurance after deductible if emergency, urgent care, or authorized by Primary Care Physician; otherwise not covered
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	**In-Network:** $500 copay plus 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** $125 per admission copay plus 10% coinsurance after deductible **Out-of-Network:** $125 per admission copay plus 40% coinsurance after deductible
Skilled Nursing Facility	**In-Network:** Not Covered **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible; up to 100 days per plan year **Out-of-Network:** 40% coinsurance after deductible; up to 100 days per plan year

MEDICAL PLAN COMPARISON CHART - COUNTY PLANS		
Plan Information	**County Health Plan EPO** Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered**	**County Health Plan PPO** Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare)
SURGICAL AND HOSPITAL SERVICES		
Home Health	**In-Network:** Not Covered **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible; up to 100 visits per plan year **Out-of-Network:** 40% coinsurance after deductible; up to 100 visits per plan year
Urgent Care	**In-Network:** $50 copay, no deductible **Out-of-Network:** Not Covered	**In-Network:** $20 copay, no deductible **Out-of-Network:** 40% coinsurance, after deductible
Hearing Aids	One per ear every 36 months	One per ear every 36 months
Durable Medical Equipment (DME)	**In-Network:** 20% coinsurance after deductible **Out-of-Network:** Not Covered	**In-Network:** 10% coinsurance after deductible **Out-of-Network:** 40% coinsurance after deductible
PRESCRIPTION DRUGS		
Generic or Tier 1	$10 copay Up to 34 day supply	$5 copay Up to 34 day supply
Formulary Brand or Tier 2	$35 copay Up to 34 day supply	$20 copay Up to 34 day supply
Non-Formulary Brand or Tier 3	$70 copay Up to 34 day supply	$40 copay Up to 34 day supply
Mail Order Benefit Generic or Tier 1	$20 copay Up to 90 day supply	$10 copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	$70 copay Up to 90 day supply	$40 copay Up to 90 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	$140 copay Up to 90 day supply	$80 copay Up to 90 day supply
Mandatory Mail Order	Yes, through CVS Pharmacy Benefit	Yes, through CVS Pharmacy Benefit
Mandatory Generic Program	Yes	Yes

MEDICAL PLAN COMPARISON CHART - HMO PLANS

Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**Sutter Health Plus HMO - ML42** Group # 131802-000003 (Non-Medicare)	**Western Health Advantage HMO** Group # 950201-A001 (Non-Medicare)
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California.	Based on residential zip code. Must live in the Sutter Health Plus service area within Northern California	Based on residential zip code. Must live in service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	None	None	None
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$10 Copay	$10 Copay	$10 Copay
Preventive Care Birth to Age 18	No Charge	No Charge	No Charge
Preventive Care Adult Routine Care	No Charge	No Charge	No Charge
Preventive Care Adult Routine OB/GYN	No Charge	No Charge	No Charge

MEDICAL PLAN COMPARISON CHART - HMO PLANS			
Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**Sutter Health Plus HMO - ML42** Group # 131802-000003 (Non-Medicare)	**Western Health Advantage HMO** Group # 950201-A001 (Non-Medicare)
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-Ray	No Charge	No Charge	No Charge
Physical Therapy (medically necessary treatment only)	$10 Copay	$10 copay per visit	$10 copay per visit
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic:** $10 Copay Up to 20 visits per year (chiropractic services do not apply to out-of-pocket maximum) **Acupuncture:** PCP referral $10 copay LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	**Chiropractic:** $15 Copay Up to 20 visits per year **Acupuncture:** $15 Copay Up to 20 visits per year
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$10 copay individual therapy $5 copay group therapy	$10 copay individual therapy $5 copay group therapy	$10 copay individual or group therapy
Family Planning Counseling and Consultation	No Charge	No Charge	No Charge
Routine Eye Exams with Plan Optometrist	No Charge	No charge for annual refractive eye exam	No Charge
Hearing Exam	No Charge	No Charge	No Charge
Allergy Injections (serum included)	$3 Copay	$10 Copay	$3 Copay
Infertility Services	$10 Copay	50% Coinsurance (Infertility services do not apply to out-of-pocket maximum)	$10 Copay

MEDICAL PLAN COMPARISON CHART - HMO PLANS			
Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**Sutter Health Plus HMO - ML42** Group # 131802-000003 (Non-Medicare)	**Western Health Advantage HMO** Group # 950201-A001 (Non-Medicare)
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	**Facility Fee:** No charge **Physician/Surgeon Fee:** No charge	**Facility Fee:** No charge **Physician/Surgeon Fee:** No charge	**Facility Fee:** No charge **Physician/Surgeon Fee:** No charge
Outpatient Surgery	$10 Copay	$10 Copay per visit	$10 Copay
Maternity	No charge	No charge	No charge
Emergency Room	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)
Ambulance	$50 per trip	$50 per trip	$50 per trip
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	No charge	No charge	No charge
Skilled Nursing Facility	No Charge Up to 100 days per benefit period	No Charge Up to 100 days per benefit period	No Charge Up to 100 days per benefit period

MEDICAL PLAN COMPARISON CHART - HMO PLANS			
Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**Sutter Health Plus HMO - ML42** Group # 131802-000003 (Non-Medicare)	**Western Health Advantage HMO** Group # 950201-A001 (Non-Medicare)
PRESCRIPTION DRUGS			
Home Health	No Charge Up to 100 visits per year	No Charge Up to 100 visits per calendar year	No Charge Up to 100 visits per year
Urgent Care	$10 Copay	$15 Copay	$10 Copay
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% coinsurance in accordance with formulary	No charge	20% coinsurance
PRESCRIPTION DRUGS			
Generic or Tier 1	$5 Copay Up to 100 day supply	$5 Copay Up to 30 day supply	$5 Copay Up to 30 day supply
Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$10 Copay Up to 30 day supply	$10 Copay Up to 30 day supply
Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	**Tier 3** - $20 Copay Up to 30 day supply **Tier 4 (Specialty Drug)** - $20 Copay Up to a 30 day supply only	$20 Copay Up to 30 day supply
Mail Order Benefit Generic or Tier 1	$5 Copay Up to 100 day supply	$10 Copay Up to 100 day supply	$5 Copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$20 Copay Up to 100 day supply	$10 Copay Up to 90 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	$40 Copay Up to 100 day supply	$20 Copay Up to 90 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS

Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 9072-0006 (Non-Medicare)	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000007 (Non-Medicare)	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201 (Non-Medicare)
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California.	Based on residential zip code. Must live in the Sutter Health Plus service area within Northern California	Based on residential zip code. Must live in service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	**Individual:** $1,000 **Any One Member in a family of two or more:** $1,000 **Family of two or more:** $2,000	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $4,000 **Any One Member in a family of two or more:** $4,000 **Family of two or more:** $8,000	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000	**Individual:** $4,000 **Any One Member in a family of two or more:** $4,000 **Family of two or more:** $8,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS			
Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 9072-0006 (Non-Medicare)	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000007 (Non-Medicare)	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201 (Non-Medicare)
OFFICE VISITS AND PROFESSIONAL SERVICES			
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible
Diagnostic Imaging, Lab and X-Ray	**Diagnostic Lab:** $10 copay per encounter, no deductible **Diagnostic X-ray:** $10 copay per encounter, no deductible **CT/PET Scans & MRI:** $50 per procedure, no deductible	**Diagnostic Lab:** $20 copay, no deductible **Diagnostic X-ray:** $10 copay per procedure, no deductible **CT/PET Scans & MRI:** $50 per procedure, no deductible	**Diagnostic Lab:** no charge, no deductible **Diagnostic X-ray:** no charge, no deductible
Physical Therapy (medically necessary treatment only)	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic:** $20 Copay, no deductible up to 20 visits/year (chiropractic services do not apply to out-of-pocket maximum) **Acupuncture:** PCP referral $20 copay LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	**Chiropractic:** $15 Copay, no deductible Up to 20 visits per year **Acupuncture:** $15 Copay, no deductible Up to 20 visits per year
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$20 copay MH/SUD individual, no deductible $10 copay MH group, no deductible $5 copay SUD group, no deductible	$20 copay MH/SUD individual, no deductible $10 copay MH/SUD group, no deductible	$20 copay, no deductible
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	$20 copay, no deductible
Routine Eye Exams with Plan Optometrist	No charge, no deductible	No charge, no deductible	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	No charge, no deductible	$20 copay, no deductible	No charge, no deductible
Infertility Services	50% coinsurance, no deductible	50% coinsurance, no deductible (Infertility services do not apply to out-of-pocket maxim.)	50% coinsurance, no deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS			
Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 9072-0006 (Non-Medicare)	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000007 (Non-Medicare)	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201 (Non-Medicare)
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Maternity	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance	$150 per trip, no deductible	No charge after deductible	$150 per trip, no deductible
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	20% coinsurance, no deductible Up to 100 days per benefit period	20% coinsurance, after deductible Up to 100 days per benefit period	20% coinsurance after deductible Up to 100 days per benefit period

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS			
Plan Information	**Kaiser Permanente** **Hospital Serv. DHMO** Group # 9072-0006 (Non-Medicare)	**Sutter Health Plus** **Hospital Serv. DHMO - ML21** Group # 131802-000007 (Non-Medicare)	**Western Health Advantage** **Hospital Serv. DHMO** Group # 950201 (Non-Medicare)
PRESCRIPTION DRUGS			
Home Health	No Charge, No Deductible Up to 100 visits per year	No Charge, No Deductible Up to 100 visits per calendar year	No Charge, No Deductible Up to 100 visits per year
Urgent Care	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% coinsurance in accordance with formulary, no deductible	20% coinsurance after deductible	20% coinsurance, no deductible
PRESCRIPTION DRUGS			
Generic or Tier 1	$10 copay up to 30 day supply, no deductible	$10 copay up to 30 day supply, no deductible	$10 copay up to 30 day supply, no deductible
Formulary Brand or Tier 2	$30 copay up to 30 day supply, no deductible	$30 copay up to 30 day supply, no deductible	$30 copay up to 30 day supply, no deductible
Non-Formulary Brand or Tier 3	$30 copay up to 30 day supply, no deductible (Must be deemed medically necessary under the treatment of the Kaiser physician)	**Tier 3** - $60 copay up to 30 day supply, no deductible **Tier 4 (Specialty Drug)** - 20% coinsurance up to a maximum of $100 per prescription up to 30 day supply, no deductible	$50 copay up to 30 day supply, no deductible
Mail Order Benefit Generic or Tier 1	$20 copay up to 100 day supply, no deductible	$20 copay up to 100 day supply, no deductible	$20 copay up to 90 day supply, no deductible
Mail Order Benefit Formulary Brand or Tier 2	$60 copay up to 100 day supply, no deductible	$60 Copay up to 100 day supply, no deductible	$60 copay up to 90 day supply, no deductible
Mail Order Benefit Non-Formulary Brand or Tier 3	$60 copay up to 100 day supply, no deductible	$120 copay up to 100 day supply, no deductible	$100 copay up to 90 day supply, no deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	**Kaiser Permanente** **Deductible First HDHP** Group # 9072-0009 (Non-Medicare)	**Sutter Health Plus** **Deductible First HDHP - HD11** Group # 131802-000011 (Non-Medicare)	**Western Health Advantage** **Deductible First HDHP** Group # 950201
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California.	Based on residential zip code. Must live in the Sutter Health Plus service area within Northern California	Based on residential zip code. Must live in service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**Individual:** $1,350 **Any One Member in a family of two or more:** $2,700 **Family of two or more:** $2,700	**Individual:** $1,500 **Any One Member in a family of two or more:** $2,700 **Family of two or more:** $3,000	**Individual:** $1,350 **Any One Member in a family of two or more:** $2,700 **Family of two or more:** $2,700
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000	**Individual:** $3,000 **Any One Member in a family of two or more:** $3,000 **Family of two or more:** $6,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS			
Plan Information	**Kaiser Permanente** **Deductible First HDHP** Group # 9072-0009 (Non-Medicare)	**Sutter Health Plus** **Deductible First HDHP - HD11** Group # 131802-000011 (Non-Medicare)	**Western Health Advantage** **Deductible First HDHP** Group # 950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible
Diagnostic Imaging, Lab and X-Ray	**Diagnostic Lab:** $10 copay per encounter after deductible **Diagnostic X-ray:** $10 copay per encounter after deductible **CT/PET Scans & MRI:** $50 per procedure after deductible	**Diagnostic Lab:** $20 copay after deductible **Diagnostic X-ray:** $10 copay per procedure after deductible **CT/PET Scans & MRI:** $50 per procedure after deductible	No charge after deductible
Physical Therapy (medically necessary treatment only)	$20 Copay after deductible	$20 Copay after deductible	$20 Copay after deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic:** Not covered **Acupuncture:** PCP referral $20 copay after deductible LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	No charge after deductible, up to 20 visits per year.
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$20 copay MH/SUD individual, after deductible; $10 copay MH group, after deductible; $5 copay SUD group, after deductible	$20 Copay MH/SUD individual after deductible $10 copay MH/SUD group after deductible	$20 Copay after deductible
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	$20 Copay after deductible
Routine Eye Exams with Plan Optometrist	$20 Copay, no deductible	No charge, no deductible	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	$5 copay after deductible	$20 copay after deductible	$5 copay after deductible
Infertility Services	Not covered	Not covered	50% coinsurance, no deductible

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS			
Plan Information	**Kaiser Permanente** **Deductible First HDHP** Group # 9072-0009 (Non-Medicare)	**Sutter Health Plus** **Deductible First HDHP - HD11** Group # 131802-000011 (Non-Medicare)	**Western Health Advantage** **Deductible First HDHP** Group # 950201
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	$250 copay per admission after deductible	**Hospitalization Facility Fee:** $250 copay per day, up to 5 days after deductible **Inpatient Physician Services:** No charge after deductible	$250 copay per admission after deductible
Outpatient Surgery	$150 copay per procedure after deductible	**Outpatient Surgery Fee:** $20 copay per visit after deductible	$150 copay per procedure after deductible
Maternity	$250 copay per admission after deductible	**Delivery and hospital inpatient services**: $250 copay per day, up to 5 days after deductible	$250 copay per admission after deductible
Emergency Room	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible
Ambulance	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	$250 copay per admission after deductible	**MH/SUD Inpatient Facility:** $250 copay per day, up to 5 days after deductible **MH/SUD Inpatient Physician Services:** No charge after deductible	$250 copay per admission after deductible
Skilled Nursing Facility	$250 copay per admission after deductible Up to 100 days per benefit period	$100 copay per day up to 5 days after deductible Up to 100 days per benefit period	$250 copay per admission after deductible Up to 100 days per benefit period

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS			
Plan Information	**Kaiser Permanente** **Deductible First HDHP** Group # 9072-0009 (Non-Medicare)	**Sutter Health Plus** **Deductible First HDHP - HD11** Group # 131802-000011 (Non-Medicare)	**Western Health Advantage** **Deductible First HDHP** Group # 950201
PRESCRIPTION DRUGS			
Home Health	No Charge After Deductible Up to 100 visits per year	No Charge After Deductible. Up to 100 visits per calendar year	No Charge After Deductible Up to 100 visits per year
Urgent Care	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment (DME)	20% coinsurance in accordance with formulary after deductible	20% coinsurance after deductible	20% coinsurance after deductible
PRESCRIPTION DRUGS			
Generic or Tier 1	$10 copay up to 30 day supply after deductible	$10 copay up to 30 day supply after deductible	$10 copay up to 30 day supply after deductible
Formulary Brand or Tier 2	$30 copay up to 30 day supply after deductible	$30 copay up to 30 day supply after deductible	$30 copay up to 30 day supply after deductible
Non-Formulary Brand or Tier 3	$30 copay up to 30 day supply after deductible (Must be deemed medically necessary under the treatment of the Kaiser physician)	**Tier 3** - $60 copay up to 30 day supply after deductible **Tier 4 (Specialty Drug)** - 20% coinsurance ($100 per prescription maximum) up to 30 day supply after deductible	$50 copay up to 30 day supply after deductible
Mail Order Benefit Generic or Tier 1	$20 copay up to 100 day supply after deductible	$20 copay up to 100 day supply after deductible	$20 copay up to 90 day supply after deductible
Mail Order Benefit Formulary Brand or Tier 2	$60 copay up to 100 day supply after deductible	$60 copay up to 100 day supply after deductible	$60 copay up to 90 day supply after deductible
Mail Order Benefit Non-Formulary Brand or Tier 3	$60 copay up to 100 day supply after deductible	$120 copay up to 100 day supply after deductible	$100 copay up to 90 day supply after deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

MEDICAL PLAN COMPARISON CHART - MEDICARE PLANS		
Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare** Plans A-N available; Plan F used for example (Coverage varies by Plan selected)
GENERAL INFORMATION		
Health Plan Availability	Based on residential zip code. Must live in service area within California, Hawaii, and the Northwest (Oregon /Washington); rates vary by state	All states and select US territories
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Does not require you to select a PCP
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Allows you access to many types of services without receiving a referral or advance approval
Dependent Children Eligibility	Dependent child under age 26	Dependent child must have Medicare
Calendar Year Deductible	None	None (Plan F Example pays Part A and Part B Medicare deductibles for Medicare covered services)
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays, & Coinsurance)	**Individual:** $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more:** $3,000	Plan F has no out-of-pocket maximums
OFFICE VISITS AND PROFESSIONAL SERVICES		
Physician & Specialist Office Visits	$10 Copay	Plan F pays Part B deductible and coinsurance for Medicare covered services
Preventive Care Birth to Age 18	No charge	N/A
Preventive Care Adult Routine Care	No charge	No charge for Medicare-covered services
Preventive Care Adult Routine OB/GYN	No charge	No charge for Medicare-covered services

MEDICAL PLAN COMPARISON CHART - MEDICARE PLANS		
Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare** Plans A-N available; Plan F used for example (Coverage varies by Plan selected)
OFFICE VISITS AND PROFESSIONAL SERVICES		
Diagnostic Imaging, Lab and X-Ray	No charge	No charge for Medicare-covered services
Physical Therapy (medically necessary treatment only)	$10 co-pay	No charge for Medicare-covered services
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy (California Only)	No charge for Medicare-covered services
Mental Health (MH) & Substance Use Disorder (SUD) (Outpatient)	$10 co-pay individual therapy $5 co-pay group therapy	No charge after deductible
SURGICAL AND HOSPITAL SERVICES		
Hospitalization and Physician/ Surgeon Services	No charge	No charge, up to Medicare maximum days allowed
Outpatient Surgery	$10 co-pay	No charge for Medicare-covered services
Maternity	No charge	No charge, up to Medicare maximum days allowed
Emergency Room	$50 co-pay (waived if admitted)	No charge
Ambulance	$50 per trip	No charge
Mental Health (MH) & Substance Use Disorder (SUD) (Inpatient)	No charge	No charge, up to Medicare maximum days allowed
Skilled Nursing Facility	No charge Up to 100 days per benefit period	No charge, up to Medicare maximum days allowed

MEDICAL PLAN COMPARISON CHART - MEDICARE PLANS		
Plan Information	**Kaiser Permanente HMO and Senior Advantage** Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	**AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare** Plans A-N available; Plan F used for example (Coverage varies by Plan selected)
SURGICAL AND HOSPITAL SERVICES		
Home Health	No charge Up to 100 visits per year	No charge, up to Medicare maximum days allowed
Hearing Aids	Not covered	Not Covered (AARP membership discounts may apply)
PRESCRIPTION DRUGS		
Generic or Tier 1	$5 co-pay Up to 100 day supply	**Preferred Plan/Preferred Retail Pharmacy (AARP MedicareRx PDP-CA)** $4-7 co-pay Preferred Generic $8-17 co-pay Non-preferred Generic
Formulary Brand or Tier 2	$10 co-pay Up to 100 day supply	**Preferred Plan/Preferred Retail Pharmacy (AARP MedicareRx PDP-CA)** $34-38 co-pay Preferred Brand 31%-40% Non-Preferred Brand.
Non-Formulary Brand or Tier 3	$10 co-pay Up to 100 day supply	**Preferred Plan/Preferred Retail Pharmacy (AARP MedicareRx PDP-CA)** 33% coinsurance for Specialty
Mail Order Benefit Generic or Tier 1	$5 co-pay Up to 100 day supply	No charge for Preferred and Non-Preferred Generic
Mail Order Benefit Formulary Brand or Tier 2	$10 co-pay Up to 100 day supply	$87-99 Preferred Brand
Mail Order Benefit Non-Formulary Brand or Tier 3	$10 co-pay Up to 100 day supply	31%-40% Non-Preferred Brand 33% Speciality
Mandatory Mail Order	No	No
Mandatory Generic Program	N/A	No

HOW MEDICARE WORKS

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with end-stage renal disease. In general, those eligible to receive Social Security are automatically enrolled in Medicare Part A at age 65; if eligible. You should receive your Medicare card in the mail three months prior to your 65th birthday. Send the County of Sonoma, Human Resources Benefits Unit a copy as soon as you do.

IMPORTANT

Medicare eligible retirees and/or their Medicare eligible dependents need to provide proof of enrollment in **Medicare Parts A & B** to enroll in a County-offered retiree medical plan. You must provide a copy of your and your eligible dependent's Medicare card(s) to Human Resources Benefits Unit and complete the appropriate enrollment forms. **If you do not complete the forms and provide a copy of the Medicare card(s) in the timeframe requested, your County-offered coverage is subject to cancellation.**

If you have questions about your eligibility for and enrollment in Medicare, contact the Social Security Administration at (800) 772-1213 at least 90 days prior to your 65th birthday. If you are enrolled in a plan for Non-Medicare-eligible retirees (not including Sutter Health Plus or Western Health Advantage), when you become Medicare-eligible you may elect to remain covered with your current medical carrier or choose a different medical plan. More information is available at:
http://www.medicare.gov/pubs/pdf/10050.pdf

Once you are enrolled in Medicare Parts A & B, coverage is provided as follows:

- **Medicare Part A provides hospital insurance**. It helps pay for Medicare approved hospital stays, care in skilled nursing facilities, hospice care and hospital care from qualified Medicare providers. You typically do not pay a premium for Part A coverage if you paid enough Medicare taxes while you were working.
- **Medicare Part B provides medical insurance.** It helps pay for Medicare approved doctor services, outpatient care, certain preventive care services, diagnostic tests and some other services and supplies that Medicare Part A does not cover. In

most cases, the Medicare Part B premium is deducted monthly from your Social Security benefits. If you do not receive a Social Security check, you will be billed quarterly for the Part B premium by the Social Security Administration.

The County of Sonoma provides eligible retirees with reimbursement for the Medicare Part B premium (Effective June 1, 2009, frozen at $96.40 per month) beginning the month your Medicare Part B is effective. If you are eligible, this reimbursement is included in your monthly pension check. This benefit is limited to retirees hired before January 1, 2009 only and is not available to survivors of deceased retirees or retirees hired on or after January 1, 2009.

HOW THE COUNTY-OFFERED MEDICAL PLANS WORK WITH MEDICARE

Eligible retirees who are enrolled in Medicare Parts A and B, can participate in a County-offered retiree medical plan. Depending on the plan you elect, the plan provides, coordinates with, or supplements your Medicare Parts A and B coverage. Participation in one of the County-offered plans generally enhances the coverage you receive through Medicare Parts A and B. You pay a monthly premium in addition to your Medicare Part B premium for this coverage.

The following is a summary by plan of how Medicare and the County-offered plans work together to provide your benefits. Payments are generally based on the Medicare approved amount.

COUNTY HEALTH PLANS

If you choose to participate in one of the County Health Plans EPO or PPO, the benefits paid as you receive care are **coordinated with your Medicare Parts A and B coverage**. When you incur covered expenses under one of the County Health Plans, the cost will first be submitted to Medicare for payment. Under the County Health Plan EPO, Medicare retirees and/or Medicare dependents do not receive an additional payment other than Medicare on most services. Medicare usually pays 80% on services, which is the equivalent payment through the County Health Plan EPO plan. Then, the County Health Plan will pay an amount, based on the benefit provided for that type of expense (e.g., for an in-network doctor's office visit). Refer to the County Health Plan's Summary Plan Description for more information and examples of how County Health Plan benefits are coordinated with Medicare. Under the County Health Plan PPO, Medicare retirees and/or Medicare dependents must use a provider that is both a preferred provider and Medicare provider to receive benefits under the plan.

Under the County Health Plans you are required to meet a deductible and pay applicable copayments and coinsurance for services. You must use a Medicare provider to receive

benefits under the County Health Plans. You will receive a higher level of coverage when you use providers within the Anthem Blue Cross network based on your place of residence

Take Note…Coinsurance in the Medical Plan Comparison chart reflects the member's share of costs only. County health plans exclude "Private Contracts". **If a member goes to a provider that doesn't accept Medicare and the claim is subject to a Medicare Private Contract, the claim is also not covered by the County Health Plans.**

KAISER PERMANENTE SENIOR ADVANTAGE HMO PLAN

This plan is approved as a "Medicare Advantage" plan by Medicare. When you choose to participate in this plan, you agree to allow Kaiser Permanente to provide your Medicare Parts A and B benefits. In doing so, you authorize Medicare to pay your benefits directly to Kaiser Permanente. Under the HMO plan you pay a set copayment for most services you use. You must use Kaiser Permanente contracted providers for your care, except in an emergency.

COORDINATION OF BENEFITS (COB) EXAMPLES FOR THE CHP PLANS

Some members may have health benefits coverage from more than one source, such as Medicare. In these instances, benefit coverage is coordinated between primary and secondary payers.

Participating providers should obtain information from members as to whether the member has health benefits coverage from more than one source, and if so, provide this information to Anthem.

Coordination of benefits between different sources of coverage (payers) is governed by the terms of the member's benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, participating providers agree that in no event will payment from primary and secondary payers for covered services rendered to members exceed the rate specified in the provider agreement.

PRIMARY INSURANCE EXPLANATION OF BENEFITS

Participating providers must submit a copy of the Explanation of Benefits (EOB) that includes the primary payer's determination when submitting claims to Anthem. The services included in the claim submitted to Anthem should match the services included in the primary payer EOB. Authorization, certification or notification requirements under the member's benefit plan still apply in coordination of benefits situations.

Take Note… Some benefit plans require that the member update at designated time periods (e.g., annually) whether they have other health benefit coverage. Claims may be denied in the event the member fails to provide the required other coverage updates.

"LESSER OF" RULE

Based on the above, the 'Lesser Of' rule would apply to both Medicare and any other insurance coverage when benefits are coordinated when determining the allowed amount. Because of this language, it is important to note the provider may not bill the patient for the difference between what the plan allows and Medicare's allowance (which is usually lower).

CARVE-OUT METHOD

Also please note the Plan uses the "carve-out" method of COB. Carve-out guarantees that you receive the same benefit you would receive in the absence of the other plan or Medicare. Carve-out also means you do not receive 100 percent of the total covered charge unless you satisfy this plan's annual deductible and annual out-of-pocket maximum. With carve-out, if this plan's (as the secondary plan) normal benefit is greater than the primary plan's payment, then this plan will pay the difference between its normal plan benefit and the primary plan's payment. If this plan's normal benefit is equal to or less than the primary plan's payment, then no payment will be made by this plan.

The following examples of County Health Plans' Coordination of Benefits (COB) with Medicare are for illustrative purposes only:

EXAMPLE 1: CHP PPO – Inpatient Hospital (In-Network):

$8,800	Medicare allowance
-$7,540	Medicare payment
$1,260	Balance (Medicare's 2015 hospital deductible)

The CHP PPO Plan available benefit is then determined:

$8,800	Allowed Amount
- $300	Deductible
- $125	Per admission copay
$8,375	Balance
x 90%	Co-insurance
$7,537.50	Available CHP benefit

The next step is to determine the amounts paid by the CHP PPO plan and amount owed by the member. The Medicare allowed amount is $8,800. Medicare has paid $7,540. If Medicare did not exist, the CHP PPO plan would have paid $7,537.50. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed amount ($8,800) and the total amount paid ($7,540) of **$1,260 would be the total amount owed by the member**.

CHP EPO (Inpatient Hospital (In-Network)):

$8,800	Medicare allowance
- $7,540	Medicare payment
$1,260	Balance (Medicare's 2015 hospital deductible)

The CHP EPO Plan available benefit is then determined:

$8,800	Allowed Amount
- $500	Deductible
- $500	Per admission copay
$7,800	Balance
x 80%	Co-insurance
$6,240	Available CHP benefit

The COB Allowed Amount in this example is $8,800. Medicare has paid $7,540. If Medicare did not exist, the CHP EPO plan would have paid $6,240. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance

between the COB allowed amount ($8,800) and the total amount paid ($7,540) of **$1,260 would be the total amount owed by the member**.

EXAMPLE 2: CHP PPO – Outpatient Hospital (In-Network):

$2,600	Medicare allowance
- $147	Deductible
$2,453	Balance
x 80%	Co-insurance
$1,962.40	Medicare payment

The CHP PPO Plan available benefit is then determined:

$2,600	Allowed Amount
- $300	Deductible
$2,300	Balance
x 90%	Co-insurance
$2,070	Available CHP benefit

The COB Allowed Amount in this example is $2,600. Medicare has paid $1,962.40. If Medicare did not exist, the CHP PPO plan would have paid $2,070 so the difference of $107.60 would be paid by the CHP plan. The remaining balance between the COB allowed amount ($2,600) and the total amount paid by both plans ($2,070) of **$530 would be the total amount owed by the member**.

CHP EPO (Outpatient Hospital (In-Network)):

$2,600	Medicare allowance
- $147	Deductible
$2,453	Balance
x 80%	Co-insurance
$1,962.40	Medicare payment

The CHP EPO Plan available benefit is then determined:

$2,600	Allowed Amount
- $500	Deductible
- $500	Copay
$1,600	Balance
x 80%	Co-insurance
$1,280	Available CHP benefit

The COB Allowed Amount in this example is $2,600. Medicare has paid $1,962.40. If Medicare did not exist, the CHP EPO plan would have paid $1,280. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed amount ($2,600) and the total amount paid ($1,962.40) of **$637.60 would be the total amount owed by the member**.

EXAMPLE 3: CHP PPO – Professional (In-Network):

$100	Medicare allowance
- $80	Medicare payment
$20	Balance

$100	Allowed Amount
- $20	Co-payment
$80	Available CHP benefit

The COB Allowed Amount in this example is $100. Medicare has paid $80. If Medicare did not exist, the CHP PPO plan would have also paid $80. Therefore, the CHP does not pay a benefit in addition to Medicare in this example. The remaining balance between the COB allowed amount ($100) and the total amount paid in total by both plans ($80) of **$20 would be the total amount owed by the member**.

CHP EPO (Professional (In-Network)):

$100	Medicare allowance
- $80	Medicare payment
$20	Balance

$100	Allowed Amount
- $50	Co-payment
$50	Available CHP benefit

The COB Allowed Amount in this example is $100. Medicare has paid $80. If Medicare did not exist, the CHP EPO plan would have paid $50. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed amount ($100) and the total amount paid ($80) of **$20 would be the total amount owed by the member**. The provider would owe the member a $30 refund if the member paid the $50 copay at the time of service.

Coordinating benefits with other insurance coverage (OIC), other than Medicare, follows the same methodology as well.

AARP® MEDICARE SUPPLEMENT INSURANCE PLANS

Medicare participants may elect to purchase AARP® Medicare Supplement Insurance, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), if the retiree and eligible dependents are all at least age 65 and currently enrolled in both Medicare Parts A and B. A Medicare supplement insurance plan (also known as a "Medigap" plan) is designed to supplement some or all of the health care costs not covered by Medicare Part A and Part B.

The County offers a range of Medicare supplement insurance plans to our Medicare-eligible retirees to help pay for some or all of the retiree's out-of-pocket costs. AARP Medicare Supplement Insurance Plans offer Medicare-eligible retirees an opportunity to choose from a variety of standardized Medigap plans (e.g. Plans A-N). Each plan offers a different level of benefits, and monthly premiums vary accordingly.

Because there are so many plans and variables, we could not present all available plans in this guide. Instead, you must contact UnitedHealthcare for details. **The most popular plans are shown in this booklet for illustrative purposes only.**

Membership in AARP is required for the AARP Medicare Supplement Insurance Plans. If you are not a current member of AARP but wish to enroll in an AARP Medicare Supplement Plan, UnitedHealthcare will pay for your first year of AARP membership (this is not available to residents of New York); otherwise, you will be billed directly by AARP for the annual membership fee, currently $16.00 per household.

To learn more about the AARP Medicare Supplement Insurance Plans and to request a monthly premium quote, contact the plan's customer service at (877) 558-4759. If you should choose to enroll by phone, please be aware that this process takes some time. Set aside at least 1 hour to sign up with a customer service representative. The group numbers and an enrollment checklist are provided on page 5. Customer service representatives are available Monday through Sunday from 8:00 a.m. to 8:00 p.m. PST. Additional information is available on the following website: http://www.aarpmedsuppretirees.com.

These plans are underwritten by UnitedHealthcare Insurance Company. Unlike the County Health Plans and Kaiser Senior Advantage, AARP Medicare Supplement Plans may require medical underwriting if you are outside of the guaranteed issue period, and coverage can be underwritten or denied. If you are switching from a County medical

plan, you are eligible for guaranteed issue. In cases where coverage is denied, you and any enrolled dependent will remain in the coverage in place prior to the application to the Medicare supplement plan or have the option to change to another plan provided you do so before Annual Enrollment ends.

IMPORTANT NOTE

Unlike some other plans where the medical and prescription benefits are part of the same coverage, Medicare supplement insurance plans cannot include prescription drug benefits. As a result, the AARP Medicare Supplement Plans and the AARP MedicareRx Prescription Drug Plan require separate enrollment. County retirees who enroll in the Medicare supplement plan **must also enroll** in an AARP MedicareRx Plan. The AARP MedicareRx Plans are available to retirees across the U.S. and in the five U.S. territories. All enrollees in these plans (i.e. retiree and their dependents) must be enrolled in both Medicare Part A and Part B and be at least age 65 in order to elect the coverage.

If you enroll in ANY Medicare Advantage plan or Part D Prescription Drug plan other than those offered to County of Sonoma retirees as explained in this guide, you may be disenrolled from your County-offered coverage.

AARP® MEDICARERX PRESCRIPTION DRUG PLANS (PDP)

AARP MedicareRx Preferred and Saver Plus PDP offer a national pharmacy network with access to more than 68,000 pharmacies. The AARP MedicareRX Walgreen's PDP includes a preferred pharmacy network of over 8,100 Walgreens retails pharmacies (Including Duane Reade pharmacies). In addition, the plan's drug list includes thousands of brand-name and generic drugs. To assist in your decision, you can contact UnitedHealth-care at (877) 558-4759 with a list of medications and a representative will complete a needs assessment to find a plan that best fits your needs.

PART D DRUG BENEFITS

AARP MedicareRx Plans are Medicare Part D prescription drug plans (PDP). As a Medicare PDP, they are subject to changes implemented by the Patient Protection and Affordable Care Act (PPACA). The ACA requires Medicare Part D plans to gradually close the prescription drug coverage gap, known as the "donut hole." In 2018, retirees covered by a Medicare PDP, such as an AARP MedicareRx Plan, who reach the coverage gap, (when

CareCounsel can answer benefit plan questions and guide you through the decision process. See page 67 for a list of all CareCounsel services. Call (888) 227-3334

total costs you and your plan have spent reach $3,750) will pay 35% of the plan's cost for covered brand-name drugs and 44% for covered generic drugs. Additionally, the discount on generic drugs has increased from 49% to 56%. You can expect additional savings in the coming years on your covered brand-name and generic drugs while in the coverage gap, until the gap is minimized in 2020. Once your annual out-of-pocket drug costs exceed $5,000, Part D Catastrophic Coverage begins and only a small coinsurance or copayment is required. For more information, visit http://www.medicare.gov/partd/index.html or contact a UnitedHealthcare customer service representative at (877) 558-4759.

COMPARISON CHART AARP MEDICARERX PRESCRIPTION DRUG PLANS (PDP)

Copays and coinsurance vary by state and based on if you use a preferred retail pharmacy network or standard network pharmacy or mail order. Out of pocket costs shown below are based on the preferred retail pharmacy network and show the range for all states and territories. Not all drugs are covered on all plans. Evaluate each plan carefully before selecting.

Service	AARP MedicareRX Preferred Plan*	AARP MedicareRX Saver Plus Plan*	AARP MedicareRX Walgreens Plan*
Average Premiums	$83.32	$48.65	$27.39
Deductible	$0	$400	$0 Tiers 1-2, $400 Tiers 3-5
Tier 1 Preferred Generic	$2-$5 Copay 30 day supply	$1 Copay 30 day supply	$0 Copay 30 day supply
Tier 2 Non-Preferred Generic	$6-$15 Copay 30 day supply	$4-$14 Copay 30 day supply	$6 Copay 30 day supply
Tier 3 Preferred Brand	$32-$36 Copay 30 day supply	$24-$40 Copay 30 day supply	$31 Copay 30 day supply
Tier 4 Non-Preferred Brand	35%-40%	28%-41%	32%
Tier 5 Specialty	33%	25%	25%

Service	AARP MedicareRX Preferred Plan	AARP MedicareRX Saver Plus Plan)	AARP MedicareRX Walgreens Plan
Mail Order Benefit	Yes (Preferred Mail Tiers 1-2 $0 Copay, Tier 3 $81-$93 Copay)	Yes (Preferred Mail Tiers 1-2 $0 Copay, Tier 3 $46-$85 Copay)	Yes (Preferred Mail Tier 1 $0 Copay, Tier 2 $9 Copay, Tier 3 $81 Copay)
Mandatory Mail Order	No	No	No
Mandatory Generic Program	No	No	No

* Premiums and cost share vary by state. Deductibles/Premiums/Cost shares do not include US territories. Cost share is at Preferred Retail Pharmacy.

MEDICAL PLAN PREMIUMS

The total monthly medical plan premium costs for County-offered retiree medical plans vary based on the medical plan and coverage level you select.

COUNTY CONTRIBUTION FOR MEDICAL COVERAGE

Retirees and the County of Sonoma, if applicable, share in the cost of monthly premiums for medical coverage. The County makes a contribution toward the cost of the plan you choose. You are responsible for the difference between the total premium cost and the County's contribution. This amount is displayed as the Retiree cost in the Medical Plan Premium Comparison Chart.

Each eligible retiree who was hired before January 1, 2009 and enrolls as the subscriber in a County sponsored medical plan will receive a County contribution toward their medical plan premiums of up to $500 per month, regardless your date of hire, years of service, or your choice of medical plan and coverage level.

2018 - 2019 MEDICAL PLAN PREMIUM COST CHANGES

As is the case with most employers, the County typically expects an increase in the total medical premium costs from year-to-year. And because retirees pay the difference between the total premium cost and the County's contribution, the premium increases have a direct effect on the retirees cost.

REQUESTING PREMIUM RATES FOR ANNUAL ENROLLMENT

Total premiums for the AARP Medicare Supplement Insurance and AARP MedicareRx plans vary based on your location and other factors. To request a monthly premium quote, contact the UnitedHealthcare customer service at (877) 558-4759.

UnitedHealthcare customer service representatives are available Monday through Sunday from 8:00 a.m. to 8:00 p.m. PST.

It's important to understand UnitedHealthcare will provide you with a premium quote for the total cost of your medical and prescription coverage but may not have knowledge of the County's contribution to the total cost of your coverage until after you are enrolled. The County contributes toward the cost of your family's premiums. Because AARP Medicare Supplement Plans, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), offer many plan options and rates vary by region and other factors, we cannot publish the actual costs for each plan in this booklet. To arrive at your cost, obtain a quote from UnitedHealthcare for both a medical plan and a prescription plan. Subtract the County contribution from that total to arrive at your cost. For most people, the County contribution covers the majority of the cost. You will be billed directly by UnitedHealthcare if you have a share of cost.

HEALTH REIMBURSEMENT ACCOUNT (SCARE HRA, POST 2009 RETIREE HRA AND $10 RETIREE HRA)

The Health Reimbursement Account (HRA) program is administered by the P&A Group. The P&A Group can assist you with filing HRA reimbursement claims, checking your account balance, questions regarding your HRA benefits card, signing up for direct deposit, questions on HRA eligible expenses, and general information on your HRA. Account information is also available 24 hours a day, seven days a week online at www.padmin.com. Online access allows you to view your account information, enroll in direct deposit, upload claims, and request a new HRA benefits card. If you need assistance with your HRA, contact the P&A Group at (800) 688-2611, Monday through Friday from 5:30 a.m. to 7:00 p.m. PST or online at www.padmin.com.

MEDICAL PLAN PREMIUMS CHART (COUNTY CONTRIBUTION UP TO $500)						
COUNTY HEALTH PLANS EPO AND PPO						
	CHP EPO			CHP PPO		
	Total Monthly Premium (HRA Retiree)	County Contribution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contribution	Retiree Cost
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare						
Retiree without Medicare	$1,069.58	$500.00	$569.58	$1,295.90	$500.00	$795.90
Retiree and one dependent, No Medicare	$2,089.36	$500.00	$1,589.36	$2,547.36	$500.00	$2,047.36
Retiree and two or more dependents, No Medicare	$2,914.40	$500.00	$2,414.40	$3,559.80	$500.00	$3,059.80
Retiree Medicare Only Plans: All enrollees have Medicare						
Retiree with Medicare	$575.44	$500.00	$75.44	$697.18	$500.00	$197.18
Retiree and one dependent, all with Medicare	$1,150.88	$500.00	$650.88	$1,394.36	$500.00	$894.36
Retiree and two or more dependents, all with Medicare	$1,726.32	$500.00	$1,226.32	$2,091.54	$500.00	$1,591.54
Retiree Medicare Plans: Some enrollees have Medicare						
Retiree without Medicare and one dependent with Medicare	$1,645.02	$500.00	$1,145.02	$1,993.08	$500.00	$1,493.08
Retiree with Medicare and one dependent without Medicare	$1,645.02	$500.00	$1,145.02	$1,993.08	$500.00	$1,493.08
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$2,220.46	$500.00	$1,720.46	$2,690.26	$500.00	$2,190.26
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$2,220.46	$500.00	$1,720.46	$2,690.26	$500.00	$2,190.26
Retiree with Medicare and two or more dependents without Medicare	$2,664.80	$500.00	$2,164.80	$3,244.54	$500.00	$2,744.54
Retiree and one dependent without Medicare and one dependent with Medicare	$2,664.80	$500.00	$2,164.80	$3,244.54	$500.00	$2,744.54

MEDICAL PLAN PREMIUMS CHART (COUNTY CONTRIBUTION UP TO $500)

$10 CO-PAY PLANS

	Kaiser Traditional HMO			Sutter Health Plus HMO			Western Health Advantage HMO		
	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare									
Retiree without Medicare	$785.58	$500.00	$285.58	$609.76	$500.00	$109.76	$740.98	$500.00	$240.98
Retiree and one dependent, No Medicare	$1,571.16	$500.00	$1,071.16	$1,219.62	$500.00	$719.62	$1,481.98	$500.00	$981.98
Retiree and two or more dependents, No Medicare	$2,223.20	$500.00	$1,723.20	$1,725.96	$500.00	$1,225.96	$2,096.98	$500.00	$1,596.98
Retiree Medicare Only Plans: All enrollees have Medicare									
Retiree with Medicare	$335.18	$335.18	$0.00	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and one dependent, all with Medicare	$670.36	$500.00	$170.36	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and two or more dependents, all with Medicare	$1,005.54	$500.00	$505.54	N/A	N/A	N/A	N/A	N/A	N/A
Retiree Medicare Plans: Some enrollees have Medicare									
Retiree without Medicare and one dependent with Medicare	$1,120.76	$500.00	$620.76	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare and one dependent without Medicare	$1,120.76	$500.00	$620.76	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$1,322.40	$500.00	$822.40	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$1,455.94	$500.00	$955.94	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare and two or more dependents without Medicare	$1,772.80	$500.00	$1,272.80	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and one dependent without Medicare and one dependent with Medicare	$1,772.80	$500.00	$1,272.80	N/A	N/A	N/A	N/A	N/A	N/A

MEDICAL PLAN PREMIUMS CHART (COUNTY CONTRIBUTION UP TO $500)						
KAISER PERMANENTE OUT-OF-STATE PLANS						
	Hawaii			Northwest (OR/WA)		
	Total Monthly Premium (HRA Retiree)	County Contribution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contribution	Retiree Cost
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare						
Retiree without Medicare	$904.00	$500.00	$404.00	$961.93	$500.00	$461.93
Retiree and one dependent, No Medicare	$1,808.01	$500.00	$1,308.01	$1,923.86	$500.00	$1,423.86
Retiree and two or more dependents, No Medicare	$2,712.01	$500.00	$2,212.01	$2,885.80	$500.00	$2,385.80
Retiree Medicare Only Plans: All enrollees have Medicare						
Retiree with Medicare	$406.42	$406.42	$0.00	$298.47	$298.47	$0.00
Retiree and one dependent, all with Medicare	$812.84	$500.00	$312.84	$596.94	$500.00	$96.94
Retiree and two or more dependents, all with Medicare	$1,219.26	$500.00	$719.26	$895.41	$500.00	$395.41
Retiree Medicare Plans: Some enrollees have Medicare						
Retiree without Medicare and one dependent with Medicare	$1,310.42	$500.00	$810.42	$1,260.40	$500.00	$760.40
Retiree with Medicare and one dependent without Medicare	$1,310.42	$500.00	$810.42	$1,260.40	$500.00	$760.40
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$1,716.84	$500.00	$1,216.84	$1,558.88	$500.00	$1,058.88
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$1,716.84	$500.00	$1,216.84	$1,558.88	$500.00	$1,058.88
Retiree with Medicare and two or more dependents without Medicare	$2,214.43	$500.00	$1,714.43	$2,222.34	$500.00	$1,722.34
Retiree and one dependent without Medicare and one dependent with Medicare	$2,214.43	$500.00	$1,714.43	$2,222.34	$500.00	$1,722.34

MEDICAL PLAN PREMIUMS CHART (COUNTY CONTRIBUTION UP TO $500)

HOSPITAL SERVICES DEDUCTIBLE HMO PLANS

	Kaiser Hospital Services DHMO			Sutter Health Plus Hospital Services DHMO			Western Health Advantage Hospital Services DHMO		
	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare									
Retiree without Medicare	$632.52	$500.00	$132.52	$523.22	$500.00	$23.22	$599.28	$500.00	$99.28
Retiree and one dependent, No Medicare	$1,265.04	$500.00	$765.04	$1,046.48	$500.00	$546.48	$1,198.58	$500.00	$698.58
Retiree and two or more dependents, No Medicare	$1,790.04	$500.00	$1,290.04	$1,480.90	$500.00	$980.90	$1,696.02	$500.00	$1,196.02
Retiree Medicare Only Plans: All enrollees have Medicare									
Retiree with Medicare	$335.18	$335.18	$0.00	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and one dependent, all with Medicare	$670.36	$500.00	$170.36	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and two or more dependents, all with Medicare	$1,005.54	$500.00	$505.54	N/A	N/A	N/A	N/A	N/A	N/A
Retiree Medicare Plans: Some enrollees have Medicare									
Retiree without Medicare and one dependent with Medicare	$967.70	$500.00	$467.70	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare and one dependent without Medicare	$967.70	$500.00	$467.70	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$1,195.36	$500.00	$695.36	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$1,302.88	$500.00	$802.88	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare and two or more dependents without Medicare	$1,492.70	$500.00	$992.70	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and one dependent without Medicare and one dependent with Medicare	$1,492.70	$500.00	$992.70	N/A	N/A	N/A	N/A	N/A	N/A

MEDICAL PLAN PREMIUMS CHART (COUNTY CONTRIBUTION UP TO $500)

DEDUCTIBLE FIRST HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

	Kaiser Deductible First HDHP			Sutter Health Plus Deductible First HDHP			Western Health Deductible First HDHP		
	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost	Total Monthly Premium (HRA Retiree)	County Contri-bution	Retiree Cost
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare									
Retiree without Medicare	$586.94	$500.00	$86.94	$485.70	$485.70	$0.00	$556.66	$500.00	$56.66
Retiree and one dependent, No Medicare	$1,173.88	$500.00	$673.88	$971.40	$500.00	$471.40	$1,113.34	$500.00	$613.34
Retiree and two or more dependents, No Medicare	$1,661.04	$500.00	$1,161.04	$1,374.54	$500.00	$874.54	$1,575.36	$500.00	$1,075.36
Retiree Medicare Only Plans: All enrollees have Medicare									
Retiree with Medicare	$335.18	$335.18	$0.00	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and one dependent, all with Medicare	$670.36	$500.00	$170.36	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and two or more dependents, all with Medicare	$1,005.54	$500.00	$505.54	N/A	N/A	N/A	N/A	N/A	N/A
Retiree Medicare Plans: Some enrollees have Medicare									
Retiree without Medicare and one dependent with Medicare	$922.12	$500.00	$422.12	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare and one dependent without Medicare	$922.12	$500.00	$422.12	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$1,157.52	$500.00	$657.52	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$1,257.30	$500.00	$757.30	N/A	N/A	N/A	N/A	N/A	N/A
Retiree with Medicare and two or more dependents without Medicare	$1,409.28	$500.00	$909.28	N/A	N/A	N/A	N/A	N/A	N/A
Retiree and one dependent without Medicare and one dependent with Medicare	$1,409.28	$500.00	$909.28	N/A	N/A	N/A	N/A	N/A	N/A

DENTAL PLAN OPTIONS AND PREMIUMS

You can choose one of two retiree dental plans, offered through Delta Dental of California. The DeltaCare USA Dental HMO plan is for California residents only; the Delta Dental PPO plan provides worldwide coverage.

Note… Dentistry has changed in recent years and continues to change on a regular basis. Much of this change is due to new materials, new technology, and new scientific discoveries, as well as changes in the way dentists run their practices. It's the dentist's responsibility to inform the patient about all of the reasonable and appropriate services that are available, regardless of the patient's dental coverage. It's the patient's responsibility to ask the right questions about these options and treatment.

Always request a pre-treatment estimate of predetermination of benefits before having major dental work done. Don't be afraid to ask questions! Do not agree to any treatment unless you fully understand what condition is being treated, why it is being treated, and the costs of that treatment. When in doubt, contact Delta Dental.

To learn more about Delta Dental, visit us at www.DeltaDentalIns.com or call (800) 765-6003 for the Delta Dental PPO plan or (800) 422-4234 for DeltaCare USA Dental HMO plan.

HOW THE DENTAL PLANS WORK

Only a summary of plan benefits is being provided in this guide. For more detailed information, refer to the plan's evidence of coverage booklets, available through the County of Sonoma web site at: http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/.

Take note… The County administers dental plan benefits on a calendar year basis, from January 1 through December 31. This means your deductibles and plan maximum benefit levels accumulate over the calendar year and start over as of January 1 each year.

Plan Feature	DeltaCare USA DHMO	Delta Dental PPO
Who Can Enroll?	California residents only	No residency restrictions
Dental Provider Choice	You must use a DeltaCare USA contracted dentist	Use any dentist, but pay lower out-of-pocket costs when using a Delta Dental PPO contracted dentist. Note: If you visit a non-Delta Dental provider, the plan will reimburse you at contracted rates only, and you will need to file a claim with Delta Dental for reimbursement. To obtain a form and instructions for submitting your claim, visit the Delta Dental website at www.deltadentalins.com.
Diagnostic & Preventive	Plan pays 100% for most services	Plan pays 100% for most services, no deductible
Basic dental services	You pay set co-payments ranging from $0 to $250 for most services	Plan pays 80% of allowable charges
Crowns & Cast Restorations	You pay set co-payments ranging from $0 to $90 for most services	Plan pays 50% of allowable charges
Prosthodontics	You pay set co-payments ranging from $0 to $175 for most services	Plan pays 50% of allowable charges; coverage for implants is included under the plan.
Orthodontics	You pay $1,600 per child to age 19 and $1,800 per child age 19-26 or adult for 24 months of treatment. $75 per month member co-payment for treatment after 24 months. Additional start-up fees may apply.	Not covered
Deductible	$0	$50 per individual
Annual Maximum Dental Benefit	None	$1,000 per individual

DENTAL PLAN PREMIUMS

You pay the full cost for dental coverage. If you enroll in retiree dental coverage during Annual Enrollment Period, your coverage is effective June 1, 2018.

Monthly Dental Plan Premiums Effective June 1, 2018			
DeltaCare USA (DHMO)		**Delta Dental PPO**	
Retiree only	$29.49	Retiree only	$41.33
Retiree + 1	$50.14	Retiree + 1	$78.94
Retiree + 2 or more	$74.20	Retiree + 2 or more	$131.00

If you are interested in enrolling in a retiree dental plan, complete the Retiree Benefits Enrollment/Change Form and return to the County of Sonoma Human Resources Benefits Unit by 5:00 p.m., April 6, 2018.

County of Sonoma
Attn: Human Resources Benefits Unit
575 Administration Dr., Suite 117C
Santa Rosa, CA 95403

VISION AND LIFE INSURANCE BENEFITS AND PREMIUMS

VISION SERVICE PLAN - RETIREE SAVINGS PASS PROGRAM

County of Sonoma retirees and their dependents have access to discounts on vision care through the Vision Service Plan (VSP) Retiree Savings Pass Program. There is no cost to the retiree for this program. This program is only available through a VSP network doctor and has been enhanced to provide even more value when receiving an exam and materials.

Vision Service Plan - Retiree Savings Pass Program	
Service	**VSP Retiree Savings Pass Program Group #3001 2860**
WellVision Eye Exam	•$50 with purchase of a complete pair of prescription glasses. •20% off without purchase. •Once every calendar year.
Retinal Screening	Guaranteed pricing with WellVision Exam, not to exceed $39
Lenses	When a complete pair of prescription glasses are purchased - •Single vision: $40. •Lined Bifocals: $60. •Lined Trifocals: $75. •Polycarbonate for Children: $0.
Lens Enhancements	Average savings of 20-25% on lens enhancements; such as, progressive, scratch-resistant, and anti-reflective coatings when a complete pair of prescription glasses are purchased
Frames	25% savings when a complete pair of prescription glasses are purchased
Additional Pairs	Same savings as first pair
Sunglasses	20% savings
Contact Lenses	15% savings on contact lens fitting and evaluation
Contact Lens Rebates	Exclusive rebates on eligible contact lenses
Laser Vision Correction	Average 15% savings on the regular price or 5% on the promotional price

VSP does not issue plan ID cards; simply provide your name, social security number, date of birth, and identify yourself as a County of Sonoma retiree when scheduling an appointment with a VSP doctor.

Take note. . . The VSP Savings Pass Program is available at no cost to retirees. However, you must use a VSP network provider to receive the applicable discounts for services. You can find a VSP provider through the VSP web site at www.vsp.com or by calling the plan's customer service at (800) 877-7195.

Other VSP insurance plans may be available to you for purchase directly from VSP, but are not offered through the County of Sonoma. Contact VSP for more information.

THE HARTFORD LIFE INSURANCE

Retirees are offered a one-time opportunity at the time of retirement to enroll in life insurance. There is no opportunity to enroll or change coverage amount during the Annual Enrollment Period. The life insurance policy available is:

Coverage Amount	Monthly Premium
$10,000	$10.50

Retirees enrolled in the $2,000 life insurance policy will continue their enrollment at a cost of $2.10 per month.

DEPENDENT ELIGIBILITY

DEPENDENT ELIGIBILITY CRITERIA-MEDICAL PLANS

- Your lawfully married spouse
- Your domestic partner
- Your and/or your domestic partner's dependents to the end of the month in which the child reaches age 26 (whether married or unmarried) including:
  - Your son, daughter, step-son, step-daughter, legally adopted child, a child placed with you for adoption,or child for whom you are a legally appointed guardian
- Child under a QMCSO
- Eligible dependents may continue eligibility after age 26 if permanently and totally disabled and enrolled in the plan prior to attaining the age criteria.

DEPENDENT ELIGIBILITY CRITERIA-DENTAL PLANS

In general, the following individuals may be eligible for enrollment in your dental insurance coverage. Refer to the table below for the plans' respective dependent age limitations.

- Your lawfully married spouse
- Your domestic partner

- Your and/or your domestic partner's dependents to the end of the month in which the child reaches age 26 (whether married or unmarried) including:
  - A son, daughter, stepson, stepdaughter, legally adopted child, a child placed with you for adoption, eligible foster child, or child for whom you are the legally appointed guardian, and child under a QMCSO.
  - Child age 26 and older if disabled

The Dependent Age Limits chart below provides eligible dependent age limitations for enrollment in dental coverage. When reaching the age limit, coverage is effective through the end of the dependent's birth month. You may be held financially responsible for expenses incurred by an ineligible dependent if you neglect to drop that dependent from coverage.

Dependent Age Limits – Delta Dental	
DeltaCare USA DHMO	**Delta Dental PPO**
A child up to age 26. A child over the limiting age described above is eligible if incapable of supporting themselves due to a mental or physical disabling injury, illness or condition that began prior to reaching the limiting age, who is chiefly dependent upon the subscriber for support.	A child up to age 26. A child over the limiting age described above is eligible if incapable of supporting themselves due to a mental or physical disabling injury, illness or condition that began prior to reaching the limiting age, who is chiefly dependent upon the subscriber for support.

AFTER YOU ENROLL, WHEN ARE CHANGES ALLOWED?

This chart is only a summary of some of the permitted health plan changes and is not all inclusive

If you experience the following Event...	You may make the following change(s)* within 31 days of the Event...	YOU MAY NOT make these types of changes...
	Life / Family Events	
Marriage or Commencement of Domestic Partnership (DP)	• Enroll in or waive health coverage for your new spouse/DP and other newly eligible dependents[1] • Waive health coverage for newly eligible dependents if your coverage is also waived[1] • Change health plans	• Waive health coverage for yourself and previously eligible children[1] • Enroll if not already enrolled
Divorce, Legal Separation, or Termination or Domestic Partnership (DP)	• Cancel health coverage for your spouse/DP • Enroll yourself and your dependent children in health coverage if you or they were previously enrolled in your spouse/DP's health plan and only if a signed waiver is on file • Cancel health coverage for dependent children[2]	• Change health plans
Gain a child due to birth or adoption	• Enroll in or waive health coverage for the newly eligible dependent[1] ◆ Adoption placement papers are required as proof • Change health plans	
Previously ineligible child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if eligible and waiver is on file) • Change health plans, when options are available if necessary to accomodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (e.g., child reaches the maximum age for coverage)	• Drop the child who lost eligibility from your health coverage	• Change health plans
Death of a dependent (spouse or child)	• Drop the dependent from your health coverage • Enroll in health coverage if the event resulted in the loss of other group coverage and if a waiver is in place • Change health plans	
Retiree has become entitled to Medicare	• Change medical plans • Last opportunity to enroll yourself, your spouse, and dependent children in a medical plan, if previously waived. Eligibility for coverage will be permanently canceled if no enrollment within 60 days of Medicare eligibility	
Change of home address outside of plan service area	• Change health plans if you are enrolled in a medical or dental HMO and move out of their service area	
Death of retiree	• Eligible dependents must enroll at the time of the event or permanently lose eligibility[2]	• Surviving dependents must enroll or will be permanently canceled[2]
Covered person has become entitled to Medicaid, Medi-Cal, or SCHIP[2]	• Drop coverage for the Dependent who became entitled to Medicaid, Medi-Cal, or SCHIP with proof of Medicaid/Medi-Cal or SCHIP enrollment • Drop coverage for yourself with proof of your own Medicaid/Medi-Cal/SCHIP enrollment ◆ Documentation required	• Drop health coverage for yourself and any other covered individuals who are not newly Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person lost entitlement to Medicaid, Medi-Cal or SCHIP[2]	• Add the person who lost entitlement to Medicaid, Medi-Cal, or SCHIP • If you or an eligible dependent is gaining eligibility for premium assistance, may enroll those gaining eligibility for premium assistance only if not already enrolled in County coverage	• Drop coverage for yourself or any enrolled dependents • Change plans
	Employment Status Events	
You retire, transferring from active benefits to retiree benefits	• Change medical plans • Enroll in a retiree dental plan • Waive health coverage for yourself and/or dependents covered on your plan at the time of retirements provided they have other group coverage (one time option)[1 2] • Enroll dependents who are currently enrolled or listed as waived on your active employee medical coverage	
Spouse obtains medical or dental benefits in another group plan or public exchange	• Permanently cancel medical coverage for spouse • Waive dental coverage for spouse	• Change health plans • Waive health coverage[1]
Spouse loses coverage for medical and dental benefits in another group medical or dental plan (Proof of loss of other coverage is required)	• Enroll yourself and/or spouse in a health plan, if eligible and previously waived • Add dependent child(ren) to a medical plan if eligible and previously waived, only if waived along with retiree and retiree is also re-enrolled • Change health plans[1 2]	• Enroll dependent children in a medical plan unless the retiree is enrolling[2]

Effective Dates of Coverage for Mid-Plan Year Changes The benefit election changes from the previous table are effective as follows:
Canceling Coverage: Effective date of change is generally the **last day of the month after the event** that allowed the change. E.g. Spouse obtains other group coverage on the 1st of the month. Coverage for spouse ends on the last day of the prior month.
Adding newly eligible dependent: Effective date of change is generally the **first of the month following or coinciding with the event** that allowed the change. E.g. Married on 1st of the month. Coverage for new spouse is effective on the 1st of the same month. Married on the 2nd of the month. Coverage for new spouse is effective on the 1st of the following month.
New Retirees: Effective on the **1st of the month following or coinciding with the date of retirement.** E.g. Retired July 1st. Employee coverage ends June 30th, (Employee offered the choice of COBRA or the County's retiree coverage). If County retiree coverage elected then retiree coverage is effective on July 1st. Retired July 9th. Employee coverage ends July 31st, (if elected) retiree coverage is effective August 1st.
Exeception:
Birth/Adoption: Effective on the **1st of the month following date of birth/adoption**. Medical plans will cover a newborn under the subscriber's coverage from date of birth through the end of the birth month. Submit paperwork to Human Resources early and no later than 31 days from the date of birth to ensure continued medical coverage for the child

All rules above apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

[1] Waiving retiree medical is a one-time only option at the time of retirement or within 31 days of the event date for newly eligible dependents (e.g. marriage, adoption, birth). Once coverage under the County's retiree plan is waived the retiree is not offered retiree coverage again.

[2] Per the Salary Resolution, eligible dependent children not enrolled in retiree medical when the retiree is enrolled are not eligible for re-enrollment in retiree medical at any time in the future, not even upon the loss of other group coverage.

DROPPING ELIGIBLE DEPENDENTS:

Dependents dropped from coverage have limited or no re-enrollment rights. Review Section 15 of the County of Sonoma's Salary Resolution carefully before dropping coverage for eligible spouse and/or dependents.

WAIVING COVERAGE (WHEN COVERED BY OTHER GROUP INSURANCE)

Medical coverage can be waived only at the time of retirement or within 31 days of initial eligibility for newly eligible dependents. Re-enrollment is very limited. Read Section 15 of the County of Sonoma's Salary Resolution and the waiver language on the Retiree Benefits Enrollment and Change Form carefully before waiving coverage.

MEDICAL ENROLLMENT REQUIREMENTS

Medicare eligible retirees and/or Medicare eligible dependents must complete and sign enrollment paperwork the month prior to the effective date of the Medicare eligibility and provide a copy of their Medicare card(s) demonstrating enrollment in Medicare Part A and B.

PERMANENTLY CANCEL ALL COVERAGE

You may permanently cancel coverage at any time. However, you will give up all future re-enrollment rights. Read Section 15 of the County of Sonoma's Salary Resolution carefully before cancelling medical coverage.

CONTACT INFORMATION AND RESOURCES

CARECOUNSEL

Advocating for You and With You.
Navigating the complex world of health benefits can be a challenge, leaving you questioning if you have made the right choices for you and your family's best health. CareCounsel's health advocacy program is a confidential health advocacy benefit sponsored by the County that can help you understand and effectively navigate your health benefits. This service is available to County employees, retirees and their family members who are enrolled in County sponsored medical, dental and/or vision plans.

CareCounsel offers high touch and customized service backed by experience and depth. Here are just a few of the things CareCounsel can help you with:

- Choosing a health plan during Annual Enrollment
- Benefits education and assistance for all types of health plans (medical, dental, etc.)
- Getting the most of your healthcare dollars
- Helping you find physicians and get care
- Obtaining second opinions
- Troubleshooting medical claims/bills
- Grievances and appeals
- Navigating Medicare (when you turn 65 and ongoing)
- Helping you become a more proactive health consumer
- Access to the Stanford Health Library
- Stanford educational webinars and community education sessions
- Connecting you with expert healthcare resources

You can reach CareCounsel at (888) 227-3334 or via email at staff@carecounsel.com. Member Care Specialists are available 6:30 a.m. to 5:00 p.m. PST Monday through Friday. CareCounsel is a wholly owned subsidiary of Stanford Health Care.

COUNTY OF SONOMA HUMAN RESOURCES BENEFITS UNIT

Contact the Human Resources Benefits Unit with questions related to benefit eligibility and coverage, the Annual Enrollment process, and to request additional forms.

E-mail: benefits@sonoma-county.org
Phone: (707) 565-2900
Internet: http://hr.sonoma-county.org/for_retirees

County-Offered Health Plan Contact Information		
Plan	**Phone**	**Website**
County Health Plans *Administered by Anthem Blue Cross*	(877) 800-7339	www.anthem.com/ca
CVS/Caremark *County Health Plans' prescription drug provider* *Order Prescriptions, Obtain your Prescription History, Learn about Medications, Ask a Pharmacist*	(800) 966-5772	www.caremark.com
Kaiser Permanente California	(800) 464-4000	www.kp.org
Kaiser Permanente Hawaii	(800) 805-2739	www.kp.org
Kaiser Permanente Northwest	(877) 221-8221	www.kp.org
Sutter Health Plus HMO	(855) 315-5800	www.SutterHealthPlus.org
UnitedHealthcare Plans AARP® Medicare Supplement Insurance Plans AARP® MedicareRx Plans	(800) 54501797 TTY (877) 730-4192 (888) 867-5575	www.aarphealthcare.com www.aarpmedicarerx.com
Western Health Advantage HMO	(888) 563-2250	www.WesternHealth.com
Health Insurance Counseling and Advocacy Program (HICAP) Free and objective information and counseling about Medicare	(800) 434-0222	www.cahealthadvocates.org/HICAP/
Delta Dental of California Delta Dental PPO DeltaCare USA Dental HMO	(800) 765-6003 (800) 422-4234	www.deltadentalins.com
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
The Hartford Life & Accident Insurance Company	(888) 563-1124	www.thehartford.com
County Wellness Program	(707) 565-2900	www.sonomacounty.ca.gov/HR/Benefits/Healthy-Habits/
Sonoma County HIPAA Privacy Practices	(707) 565-4999	http://www.sonoma-county.org/privacy/privacy.htm

Contact your health plan carriers with questions related to your benefits coverage, to find network providers, to pre-authorize care as required, or to confirm that your residence is within the plans' service area.

REQUIRED NOTICES

The following notices are provided to participants in the County's health and welfare programs in compliance with state and federal regulations.

NOTICE OF GRANDFATHER STATUS

Some of the medical plan options sponsored by the County are considered grandfathered medical plans in accordance with the Affordable Care Act. The following notice is required by law.

This group health plan (sponsored by the County) believes that the Kaiser Hawaii and Kaiser Northwest HMO medical plan options are considered to be "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above noted plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the HR Benefits Unit at (707) 565-2900.

You may also contact the U.S. Department of Health and Human Services at http://www.healthreform.gov/.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

MEDICARE NOTICE OF CREDIBLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

The prescription drug coverage under the retiree plan options offered by the County are creditable and this is discussed in more detail in the Plan's Medicare Part D Notice of Creditable Coverage which is available later in this document or from the Human Resources Benefits Unit.

This information does not apply to retirees and dependents covered under a Medicare Advantage plan.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

A HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in a health Plan. You can get another copy of this Notice from the County of Sonoma Privacy Officer at (707) 565-4999 or www.sonoma-county.org/privacy/privacy.html.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because the group health plans offered by the County provide coverage for mastectomies, WHCRA applies to your plan. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable to medical and surgical services under the policy/plan.

If you have questions about this Notice, contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFITS AND COVERAGE (SBC) DOCUMENTS

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to

questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look how many pages the SBC should be (maximum 4-pages, 2-sided), the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

The SBC for each medical plan option is available by contacting the Human Resources Benefits Unit at benefits@sonoma-county.org or call (707) 565-2900, or on-line at http://hr.sonoma-county.org/.

COBRA COVERAGE REMINDER

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its qualified beneficiaries the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events for dependents enrolled in Retiree coverage typically include death of the retiree, divorce/legal separation from the retiree, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See https://www.healthcare.gov/. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a spe- cial enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs. That notice should be sent to HR Benefits Unit via first class mail and is to include the employee's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP):

Generally, the medical plans offered by the County do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider. However, the Kaiser Permanente, Sutter Health Plus HMO and Western Health Advantage HMO medical plans generally requires the designation of a primary care provider (PCP). 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. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your plan.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from the medical plan or the County or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier directly on the number on your medical card. Additional assistance is available from CareCounsel, Healthcare Advocates at 888-227-3334, or Sonoma County Human Resources Benefits Unit at benefits@sonoma-county.org or call 707-565-2900, or online at http://hr.sonoma-county.org/.

IMPORTANT NOTICE FROM THE COUNTY OF SONOMA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE - YOUR MEDICARE PART D NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the County of Sonoma 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 Sonoma has determined that the prescription drug coverage offered by the County-sponsored medical plans 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 current County coverage will be affected. For further information on how your coverage will be affected, please contact your benefit office or CareCounsel at the number below.

If you do decide to join a Medicare drug plan and drop your current County of Sonoma coverage, be aware that you and your dependents may not be able to get this coverage back.

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 the County of Sonoma 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. 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 the County of Sonoma 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 www.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 1-800-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 www.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:	March 1, 2018
Name of Entity/Sender:	County of Sonoma
Contact—Position/Office:	Human Resources Benefits Unit
Address:	575 Administration Dr., Suite 117C, Santa Rosa, CA 95403
Phone Number:	(707) 565-2900 or Benefits@sonoma-county.org

Health Insurance Counseling and Advocacy Program (HICAP): (800) 434-0222
Healthcare Advocacy, CareCounsel: (888) 227-3334

NEWBORNS' AND MOTHERS' HEALTH PROTECTION NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans (including medical plans sponsored by the County) generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your plan provider to precertify the extended stay. If you have questions about this Notice, contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

SPECIAL ENROLLMENT

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this a County-sponsored plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

County of Sonoma
Retiree Benefits Enrollment/Change Form

Retirees must complete all sections of this form.

SECTION 1A: Reason for Enrollment/Change (Mark all boxes that apply)	**SECTION 1B: Add/Drop Dependent Coverage (Mark all boxes that apply)**
Enter Event Date:_____ ❑ Annual Enrollment ❑ New Retiree ❑ Newly Medicare Eligible Retiree ❑ Newly Medicare Eligible Dependent ❑ Loss of Other Group Coverage ❑ Moved Out of the Service Area ❑ Cancel Medical Coverage (Irrevocable) ❑ Cancel Dental Coverage ❑ Cancel Life Insurance ❑ Life Insurance Beneficiary Change ❑ Address Change ❑ Name Change Previous Name:_____	Enter Event Date:_____ ❑ ADD Newly Acquired/ Eligible Dependent(s) due to: ❑ Marriage ❑ Domestic Partnership ❑ Birth/Adoption/Legal Guardianship ❑ QMSCO ❑ Loss of Other Group Coverage ❑ Medicaid ❑ Medicare ❑ Dependent(s) newly eligible for: ❑ Medicaid ❑ Medicare ❑ DROP/WAIVE Dependent(s)_____ Reason:_____ IMPORTANT! If you drop your spouse, domestic partner, or dependent child from Medical you cannot re-enroll them at a future date. Initial here_____ if dropping coverage for an eligible dependent while the retiree remains enrolled.

Internal / Vendor Use Only

ID # _____

Date of Retirement: _____

Benefits Effective Date: _____

Medicare (Retiree): ❑ YES ❑ NO

eP Entry Date/Initials: _____

Review Date/Initials: _____

SECTION 2: Retiree's Personal Information

Last Name	First Name	Middle Name

Social Security Number	Date of Birth	Gender (Check One)	Marital Status
		❑ Male ❑ Female	❑ Married ❑ Domestic Partner ❑ Single ❑ Widowed ❑ Divorced

Is your spouse, domestic partner, or dependent a County of Sonoma Employee or Retiree?	❑ Yes ❑ No	If yes, list name(s)

Residential Address (Required) ❑ Check Box if New Address	City	State	Zip Code

Mailing Address ❑ Check Box if Same as Residential	City	State	Zip Code

Phone Number	Other Phone Number	Email Address

SECTION 3: Medical Plan Election (Check all that apply and complete Section 6)

☐ **ANNUAL ENROLLMENT CHANGE ONLY**-I am electing to **CHANGE MY MEDICAL PLAN ELECTION**.

☐ I am a **NEWLY ELIGIBLE RETIREE/NEWLY MEDICARE ELIGIBLE RETIREE** making my medical plan election.

☐ I am electing to **ADD** medical coverage for my newly eligible dependent(s).

☐ I am electing to **CONTINUE** current enrollment in retiree medical coverage for myself and/or my eligible dependent(s).

☐ **NEW RETIREE ONLY** - I am electing to **WAIVE** medical coverage for myself and/or my dependent(s) as I/we have other group coverage. By waiving, I will not have the option of re-enrollment at any time unless I qualify under the limited provisions as defined in the Salary Resolution 95-0926. Medicare eligible Retirees are not eligible to Waive medical coverage. **If waiving medical coverage for yourself and/or your eligible dependent(s), you must also complete the Waiver of Medical Plan Acknowledgement (Section 8)**.

☐ I am electing to **DROP/CANCEL** medical coverage for myself and/or my dependent(s). (Applies to a current retiree not eligible to waive medical coverage). **I understand that by cancelling my medical coverage, I forfeit my opportunity to enroll in a County offered medical plan in the future.**

Retiree Without Medicare			
Select Level of Coverage and Plan Choice			
❑ Self	❑ Self + 1 Dependent (Complete Dependent Section)	❑ Self + 2 or More Dependents (Complete Dependent Section)	
County Health Plans			
❑ CHP PPO - CA (175130M053)	❑ CHP PPO – Out-of-State (175130M059)	❑ CHP EPO - CA (175130M102)	❑ CHP EPO – Out-of-State (175130M106)
Kaiser Permanente Plans			
❑ Kaiser Permanente HMO – CA (9072-0000)	❑ Kaiser Permanente Hospital Services DHMO (9072-0006)	❑ Kaiser Permanente Deductible First HDHP (9072-0009)	
Kaiser Permanente Out-of-State Plans			
❑ Kaiser Permanente HMO – Northwest (5613-002 AA)	❑ Kaiser Permanente HMO – Hawaii Region 12 (03003-058-86)		
Sutter Health Plus Plans			
❑ Sutter Health Plus HMO ML42–CA (131802-000004)	❑ Sutter Health Plus Hospital Services DHMO (131802-000007)	❑ Sutter Health Plus Deductible First HDHP (131802-000011)	

Sutter Health Plus (SHP) • To find a PCP please visit: www.sutterhealthplus.org/providersearch • If you do not select a PCP, one will be assigned to you • You have the opportunity to change your PCP by calling Member Services at 855-315-5800	Primary Care Physician (PCP) ID #

Western Health Advantage Plans		
❑ Western Health Advantage HMO – CA (950201-A001)	❑ Western Health Advantage Hospital Services DHMO (950201)	❑ Western Health Advantage Deductible First HDHP (950201)

Western Health Advantage (WHA) • To find a PCP please visit: www.westernhealth.com/search-for-providers • If you do not select a PCP, one will be assigned to you. • You have the opportunity to change your PCP by calling Member Services at 888-563-2250	Primary Care Physician (PCP) ID #

Retiree With Medicare Additional Enrollment Form Required			
Select Level of Coverage and Plan Choice			
❑ Self	❑ Self + 1 Dependent (Complete Dependent Section)	❑ Self + 2 or More Dependents (Complete Dependent Section)	
County Health Plans			
❑ CHP PPO - CA (175130M054)	❑ CHP PPO – Out-of-State (175130M060)	❑ CHP EPO - CA (175130M103)	❑ CHP EPO – Out-of-State (175130M107)
Kaiser Permanente Plans			
❑ Kaiser Permanente Senior Advantage HMO – CA (9072-0000)			
Kaiser Permanente Out-of-State Plans			
❑ Kaiser Permanente HMO – Northwest (5613-002 AA)	❑ Kaiser Permanente HMO – Hawaii Region 12 (03003-058-86)		
UnitedHealthcare (UHC) - AARP			
❑ UnitedHealthcare AARP Medicare Supplement Insurance (1068) & AARP Medicare Rx (3803)			
If you elected UnitedHealthcare through UHC – AARP Telephone Enrollment at (877) 558-4759, enter **confirmation numbers** for Self and Dependent as applicable.			
AARP Medicare Supplement Insurance - Self:		Medicare Rx - Self:	
AARP Medicare Supplement Insurance - Dependent:		Medicare Rx - Dependent:	

SECTION 4: Dental Plan Election (Check all that apply and complete Dependent Section, if applicable)

❑ Delta Dental PPO (03136-00001)	❑ DeltaCare USA Dental HMO (70247-00001)

- ❑ **ANNUAL ENROLLMENT** choice only-I am electing to **CHANGE** my dental plan election.
- ❑ I am a **NEWLY ELIGIBLE RETIREE** making my dental plan election.
- ❑ I am electing to **ADD** dental coverage for my newly eligible dependent(s).
- ❑ I am electing to **CONTINUE** current enrollment in dental coverage for myself and/or my eligible dependent(s).
- ❑ I am electing to **WAIVE** dental coverage for myself and my dependent(s) as I/we have other coverage.
- ❑ I am electing to **WAIVE** dental coverage for my dependent(s) only as they have other coverage.
- ❑ I am electing to **DROP** dental coverage for myself and my dependent(s).
- ❑ I am electing to **DROP** dental coverage for my dependent(s) only.
- ❑ I am currently **NOT COVERED** under a retiree dental plan and will not be enrolling at this time.

Internal Use Only

Effective Date: _____

If blank, effective date is the same as Benefits Effective Date on Page 1.

SECTION 5: Life Insurance (Sign and Date Section 8 for all enrollments and changes)

HARTFORD GROUP POLICY #: GL-673199

- ❑ I am a **NEWLY ELIGIBLE RETIREE** electing to **ENROLL** in life insurance coverage in the amount of $10,000
- ❑ I am electing to **CONTINUE** my current enrollment in life insurance coverage in the amount of $2,000
- ❑ I am electing to **CONTINUE** my current enrollment in life insurance coverage in the amount of $10,000
- ❑ I am electing to **DROP** current enrollment in life insurance coverage
- ❑ I did not enroll in life insurance at the time I retired and am therefore **NOT ELIGIBLE** to make any life insurance election

Retiree Basic Life Insurance (Initial here _____ if you have a life insurance beneficiary designation on file with the County of Sonoma and do not wish to update it. New retirees must designate a beneficiary below.)

You must designate a beneficiary to receive payment of this benefit in the event of your death. Indicate your beneficiary information below, only if you do not currently have a beneficiary on file or you wish to change your current beneficiary designation. However, new retirees must designate a beneficiary below. If you need more space, request a Beneficiary Designation Form from the County of Sonoma Human Resources Benefits Unit at 707-565-2900 or benefits@sonoma-county.org

Primary Beneficiary – Full Name	Address	Social Security #	% of Benefit	Relationship	Date of Birth
Contingent Beneficiary – Full Name (optional)	**Address**	**Social Security #**	**% of Benefit**	**Relationship**	**Date of Birth**

SECTION 6: Eligible Dependent Information (List ALL eligible dependents including spouse/domestic partner. Attach an additional sheet to list more than eight dependents.)

Spouse/Domestic Partner

Last Name, First Name, MI	Medical	Dental	Date of Birth	Social Security (Required)	Relationship
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage			
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes ❑ No

Child

Last Name, First Name, MI	Medical	Dental	Date of Birth	Social Security (Required)	Relationship
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage			
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes ❑ No

Child						
Last Name, First Name, MI	**Medical**	**Dental**	**Date of Birth**	**Social Security (Required)**	**Relationship**	
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage				
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**	
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes	❑ No
Child						
Last Name, First Name, MI	**Medical**	**Dental**	**Date of Birth**	**Social Security (Required)**	**Relationship**	
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage				
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**	
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes	❑ No
Child						
Last Name, First Name, MI	**Medical**	**Dental**	**Date of Birth**	**Social Security (Required)**	**Relationship**	
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage				
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**	
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes	❑ No
Child						
Last Name, First Name, MI	**Medical**	**Dental**	**Date of Birth**	**Social Security (Required)**	**Relationship**	
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage				
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**	
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes	❑ No
Child						
Last Name, First Name, MI	**Medical**	**Dental**	**Date of Birth**	**Social Security (Required)**	**Relationship**	
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage				
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**	
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes	❑ No
Child						
Last Name, First Name, MI	**Medical**	**Dental**	**Date of Birth**	**Social Security (Required)**	**Relationship**	
	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage	❑ Add ❑ Continue ❑ Delete ❑ Waive ❑ No Coverage				
Mailing Address (If different from Retiree)	**Gender (Check one)**	**Permanently Disabled**	**SHP and WHA Enrollees ONLY**	**Primary Care Physician ID #**	**Previously Seen**	
	❑ Male ❑ Female	❑ Yes ❑ No			❑ Yes	❑ No

SECTION 7: Required Signatures (If electing a Medical Plan, sign the appropriate Plan Agreement)

County Health Plan Agreement: County Health Plan PPO and County Health Plan EPO

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

REQUIREMENT FOR BINDING ARBITRATION ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU.

Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

_____

Retiree Signature and Date

Kaiser Permanente Benefit Plan Agreement: Kaiser Permanente HMO/Senior Advantage, Kaiser Hospital Services Deductible DHMO, or Kaiser Deductible First HDHP

Kaiser Foundation Health Plan Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

_____

Retiree Signature and Date

Sutter Health Plus Member Agreement: Sutter Health Plus HMO ML42 , Sutter Health Plus Hospital Services Deductible DHMO ML21, or Sutter Health Plus Deductible First HDHP HD11

BINDING ARBITRATION

Sutter Health Plus handles and resolves member disputes through grievance, appeal and independent medical review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and Evidence of Coverage and Disclosure Form.

_____

Retiree Signature and Date

Western Health Advantage Arbitration Agreement: Western Health Advantage HMO, Western Health Advantage Hospital Services DHMO, or Western Health Advantage Deductible First HDHP

Western Health Advantage Arbitration Agreement

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

_____

Retiree Signature and Date

SECTION 8: Retiree Waiver Policy Acknowledgement and Signature (Retiree signature and date is required for any waive of retiree or dependent enrollments and changes.)

Retiree Waiver Policy Acknowledgement

Retiree medical coverage provisions are outlined in the County of Sonoma Salary Resolution No 95-0926. In order to maintain eligibility for a County contribution and to participate in a County-offered retiree medical plan, an eligible retiree must enroll in a County offered retiree medical plan at the time of retirement unless the retiree waives medical insurance coverage for themselves and/or the retiree's eligible dependent(s) due to other group coverage. (Note: A retiree who is **not** covered by another group medical plan, may not waive coverage, but may drop/cancel coverage, which results in a forfeiture of future enrollment rights into a County-offered Retiree medical plan.)

The option to waive coverage is a **one-time option** available only at the time of retirement or upon initial eligibility for newly eligible dependents. A retiree who waives coverage has no annual enrollment rights.

A retiree who waives medical coverage will be allowed to re-enroll themselves and any eligible dependent(s), upon the following conditions being met:

1. The retiree must re-enroll **within 31 days** of the loss of other group insurance coverage and provide the County with evidence of the loss of coverage. Failure to provide proof of coverage loss will result in denial of enrollment and the retiree will forfeit future enrollment rights and County contributions, if applicable, towards the retiree medical plans.
2. At the latest, the retiree must re-enroll **no later than 60 days after the effective date of the retiree's Medicare eligibility for coverage**. A retiree, and any eligible dependent also being enrolled who is eligible for Medicare, must have Medicare Parts A and B <u>and</u> must provide proof of this Medicare coverage to the County of Sonoma's Human Resources Benefits Unit. Medicare assignment of benefits to County retiree medical plans is required for some County medical plans, such as Kaiser Permanente Senior Advantage and UHC AARP medical plan.
3. The retiree's re-enrollment is required in order for any eligible dependent(s) to be enrolled in a County offered medical plan, except as follows in #4 below.
4. The retiree may add an eligible dependent spouse or domestic partner at a later time provided the eligible dependent is enrolled in other group coverage since the date of retirement date.
5. Eligible dependent children must be enrolled at the time the retiree elects coverage.

By signing below, I acknowledge that:

- I have read and understand the information above.
- I have been given the opportunity to enroll or waive coverage for myself and my eligible dependents in a County-offered medical plan pursuant to the eligibility criteria outlined in the Salary Resolution and the health plan's document.
- I understand that failure to notify and provide proof of loss of other group coverage within 31 days, failure to obtain, assign benefits to a County retiree medical plan if applicable and provide proof of Medicare Parts A and B within 60 days of Medicare eligibility and/or failure to pay premiums will result in termination of County retiree medical benefits and forfeiture of County contribution, if applicable, to County retiree medical plans.
- I understand that I am required to notify County of Sonoma Human Resources Benefits if my eligibility or my dependent's eligibility for Medicare Parts A and B changes.

If I become eligible to make a change during the plan year, I must request the change within 31 days of the event.

_____

Retiree Signature and Date

SECTION 9: Retiree Declaration of Accurate Information, Retiree Responsibilities, and Authorization to Enroll and Payment of Premiums through Retiree Warrant Signature (Retiree signature and date is required for all new benefit enrollments and changes.)

I declare under penalty of perjury that:

- I agree to comply with the terms of the benefits group contracts in which I am enrolled;
- I authorize the Sonoma County Employees' Retirement Association (SCERA) to withhold all insurance premiums in excess of any County contribution for the benefits requested in accordance with the applicable Board of Supervisor's Resolution;
- I certify that all eligible dependents listed meet the medical plan's eligibility requirements;
- I will complete a new Retiree Benefits Enrollment/Change Form for myself and for my eligible dependents **within 31 days** of a change in benefit eligibility and that my failure to provide timely enrollment forms will result in denial for enrollment and loss of any future County plan contribution to a County retiree medical plan;
- I will inform the Human Resources Benefits Unit when I or any of my dependents become Medicare eligible;
- I understand that I, and my eligible enrolled dependents, will be required to obtain both Medicare Parts A and B and provide proof of such eligibility **within 60 days** from date of Medicare eligibility;
- I understand that if I and/or any of my eligible dependents fail to provide proof of enrollment in Medicare Parts A and B, fail to assign Medicare benefits to County retiree medical plans or fail to notify the County of a change in Medicare eligibility, it will result in the loss of my County retiree medical plan and therefore will be a forfeiture of any future County plan contribution, if applicable, to a County retiree medical plan or it will result in additional premiums owed on some plans;
- I certify that the information provided on this form is complete, true, and correct to the best of my knowledge; and
- I authorize SCERA to release to the County of Sonoma all information reasonably necessary to evaluate or administer my retiree health benefits.

_____

Retiree Signature and Date (Required)

23020500
COUNTY OF SONOMA
HUMAN RESOURCES DEPARTMENT - BENEFITS UNIT
575 ADMINISTRATION DRIVE, SUITE 117C
SANTA ROSA, CA 95403

RETURN SERVICE REQUESTED

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