

COUNTY OF SONOMA

Human Resources Benefits Unit • (707) 565-2900 • benefits@sonoma-county.org

2019-2020 EMPLOYEE BENEFITS GUIDE



COUNTY OF SONOMA

BENEFITS ENROLLMENT GUIDE

Tips

- ❖ Contact CareCounsel at (888) 227-3334 if you have any questions on health plan benefits or need help choosing a plan.
- ❖ Enroll or make changes using Employee Self-Service at <https://ngssprod.sonomacounty.ca.gov:7012/selfServiceADF/faces/ssLogin>
- ❖ Don't delay – enroll or make your changes within **31 days** of your eligibility or event date.
- ❖ Select the right coverage level. Review the medical plan comparison charts (19-34), dental and vision benefits (pages 35-38), and life insurance information (pages 39-42).
- ❖ You need to take action during the Annual Enrollment Period **only** if you need to make a change; otherwise your current elections will rollover for the new plan year.
- ❖ Detailed benefit plan information and more can be found in the Benefits Guide or online at: <http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/>

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. For information about your other County benefits, please go to <http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/>.

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

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AS YOU ENROLL

The County of Sonoma offers a comprehensive health and welfare benefits program designed to meet the needs of our diverse workforce.

This Benefits Guide is designed to help you make informed decisions regarding your benefit elections as a newly eligible employee and during the 2019 Annual Enrollment Period. It highlights your options and key program features to consider before making enrollment elections. Your benefit eligibility is

determined by the terms of your applicable Memorandum of Understanding, employee contract, or Salary Resolution. You will also find in this Benefits Guide medical plan comparison charts for convenient at-a-glance referencing, enrollment instructions, and plan contact information. Please review your materials carefully, and choose the plans that best meet your needs.

The benefits and premium costs contained in this Benefits Guide are effective June 1, 2019 through May 31, 2020.

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 beneficiary designations, but the Annual Enrollment Period is a great time for you to update them to ensure they are current.

Personal information:

If you've moved or changed your contact information, be sure to enter the change in Employee Self-Service. If you changed your name, notify your Payroll Clerk. It's important to keep your personal information up-to-date at all times.

We encourage you to use this Benefits Guide as a reference throughout the plan year. If you have questions, contact the Human Resources Benefits Unit or the plan providers directly. Plan phone numbers and web sites are listed in the Contact Information section on page 49 of this Benefits Guide.

ANNUAL ENROLLMENT

Annual Enrollment is **Monday, March 11, 2019 through Friday, March 29, 2019.**

During this period, you may:

- Enroll in coverage
- Change your medical plan
- Add/Drop/Waive dependents from your coverage
- Decline medical coverage
- Waive medical coverage (if enrolled in other Group Coverage or Covered CA)

BENEFIT ELIGIBILITY

Benefits must be offered to you through a Memorandum of Understanding (MOU), Contract, or Salary Resolution.

To be eligible for the medical, dental, and vision benefits listed in this Benefits Guide, you must be an employee in a permanently allocated position scheduled to work a minimum of 32 hours per pay period (.40 FTE) and have received pay for at least one half of your scheduled hours (or be on an approved leave pursuant to applicable law or MOU, Contract, or Salary Resolution provision).

DEPENDENT ELIGIBILITY

If you are eligible to participate in County-sponsored medical and dental plans, your eligible dependents may also participate. Your eligible dependents include:

- ❖ Your lawfully married spouse
- ❖ Your domestic partner
- ❖ Your or your spouse/domestic partner's dependents including son, daughter, step-son, step-daughter, legally adopted child, a child placed with you for adoption, eligible foster child, or child for whom you are the legally appointed guardian
- ❖ Child under a QMCSO



Dependent coverage will end the last day of the month in which the dependent turns age 26. See your Memorandum of Understanding or Salary Resolution to verify dependent eligibility. An exception is available for an unmarried dependent child over the plan's age limit, who is chiefly dependent upon the subscriber for support, and is incapable of supporting one's self due to mental or physical disability incurred prior to reaching the limiting age.



Part-time employees in allocated positions of thirty-two 32 hours or more bi-weekly, (.40 FTE minimum) are eligible to participate in the County’s medical, dental, and vision plans and the County’s contribution toward their premiums is pro-rated. The County’s contribution is based on the number of qualifying hours compared to a full-time employee. Qualifying hours include hours worked and qualified leave hours. Contact your Payroll Clerk if you have questions regarding your eligibility for a pro-rated County contribution.

The County contribution is prorated for eligible part-time employees, with the following exceptions:

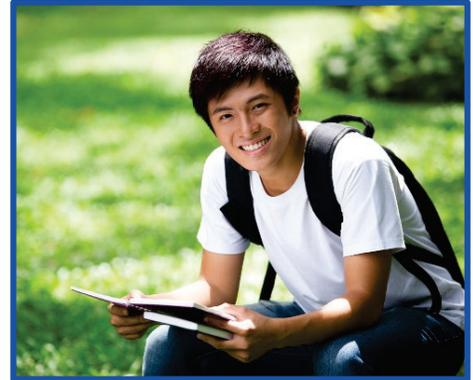
Bargaining Unit(s)	Exceptions
SCLEMA (44), SCPA (45), SAL RES BOS (49), SAL RES MGMT (50), SAL RES CNF (51), SAL RES DH (52), SCPDIA (55), and SCDPDAA (60), Unrepresented (00)	Employees in .75 FTE positions (60 hours or more bi-weekly) are eligible to receive the full County contribution for medical, dental, and vision plans.

Dual Coverage Not Allowed Reminder... An eligible employee/retiree and his/her eligible dependent(s) may be enrolled in a County-offered medical plan, but are allowed only to enroll either as a subscriber in a County-offered medical plan or, as the dependent spouse/domestic partner of another eligible County employee/retiree, but not both. If an employee/retiree is also eligible to cover his/her dependent child/children, each child will be allowed to enroll as a dependent on only one employee’s or retiree’s plan (i.e., a retiree and his or her dependents cannot be covered by more than one County-offered plan).



SOCIAL SECURITY NUMBERS FOR YOUR DEPENDENTS ARE REQUIRED!

You are required to provide a Social Security number (SSN) or a Federal Tax Identification number (TIN) for your dependent(s) when you enroll them in a County-sponsored medical plan. The County needs this information to comply with IRS reporting and the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173). 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 provide the Social Security number to the Human Resources Benefits Unit.



This Annual Enrollment Period is your opportunity to add, drop, or waive coverage for your dependents and to ensure that our records accurately reflect your benefit elections. **If an eligible dependent is not listed in Employee Self-Service in each of your benefit plans (i.e. medical, dental, vision, and dependent life insurance), that dependent will not be covered and will not be able to access benefits when seeking services.** Dependents who are no longer eligible should be removed from coverage and failure to do so in a timely manner may result in your liability to repay the Plan if any benefits are paid to or on behalf of an ineligible person.

DEPENDENT VERIFICATION

All dependents added to County medical plans will be required to show proof of dependency. Please use the chart below to determine what documentation to provide to the HR Benefits Unit for each dependent you are enrolling in medical coverage.

Dependent Type	Documents required for Verifying Eligibility
Spouse	Marriage Certificate
Domestic Partner	County of Sonoma Affidavit of Domestic Partnership or Declaration of Partnership files with the California Secretary of State (per MOU or salary resolution)
Natural Child(ren)	Birth Certificate
Step Child(ren)	Birth Certificate -and- Marriage Certificate showing Spouse as parent
Child(ren) Legally Adopted/Ward	Court Documentation (Must include presiding Judge Signature & Court)
Child(ren) of Domestic Partner	Birth Certificate -and- County of Sonoma Affidavit of Domestic Partnership or Declaration of Partnership filed with the California Secretary of State (per MOU or salary resolution)

PLANNING TO RETIRE NEXT YEAR?

If so, read the Retiree Health and Welfare benefits booklet on the Human Resources website and Section 15 of the Salary Resolution about dependent eligibility at retirement, as well as write to benefits@sonoma-county.org and request a pre-determination for your eligibility for retiree health coverage and County contributions.



WHAT IF I WANT TO MAKE A CHANGE NEXT YEAR?

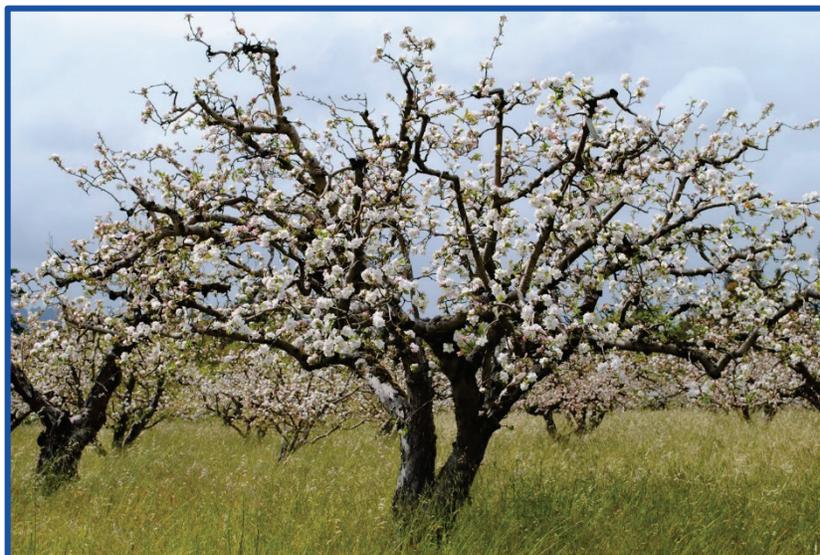
In accordance with a federal law, which grants the ability for employers to offer non-taxable benefits to employees, plan elections are irrevocable for the plan year unless a qualifying mid-year Change-in-Status event is experienced. Requirements of a mid-year change are:

1. Requested change must be consistent with the qualifying mid-year event;
2. Meet the guidelines of County contracts/agreements, plan documents, and IRC Section 125; and
3. Be received by the HR Benefits Unit within 31 days of the qualifying mid-year event

To view a summary of the most common qualifying mid-year Change-in-Status events, please refer to the Section 125 Change-of-Status Events and Mid-Year Enrollment Changes matrix on pages 43-45 of this Benefits Guide.

KEY ITEMS TO CONSIDER IN CHOOSING A MEDICAL PLAN

- ❖ Compare benefit coverage levels and premium costs carefully to see which option best fits your needs.
- ❖ In the CHP PPO, you may obtain services from either In-Network (preferred) or Out-of-Network (non-preferred) providers, but you will pay less out of your own pocket when you use an In-Network provider.
- ❖ In the CHP EPO, (Exclusive Provider Organization) all services must be obtained from within the EPO network; there are no Out-of-Network benefits, except in an emergency or if you have an authorized referral from a network provider.
- ❖ The deductible plans have significant differences in out-of-pocket costs.
- ❖ Dependents must be enrolled in the same plan as yourself. Review the “Service Areas” of the medical plan you are interested in to ensure you are eligible for enrollment based on where you live.
- ❖ Medical plan costs vary based on the plan and coverage you select. (You and the County share the cost of the premiums.) You pay your share of the cost through payroll deductions for the premiums and when you use services; such as when you pay the cost for deductibles, copays, and the coinsurance.



MEDICAL BENEFITS

The County of Sonoma cares about your health and well-being and is pleased to offer you a choice of medical plan options. You are eligible to choose from the following medical plans:

- ❖ County Health Plan EPO (Exclusive Provider Organization)
- ❖ County Health Plan PPO (Preferred Provider Organization)
- ❖ Kaiser Permanente HMO (Health Maintenance Organization)
- ❖ 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)



When you enroll in a medical plan, you also decide if you want to enroll your eligible dependents in coverage. You can choose one of three coverage levels, as follows:

- ❖ Self only
- ❖ Self and 1 dependent
- ❖ Self and 2 or more dependents

If you want dependents to be covered, your eligible dependents must be enrolled in the same medical, dental and vision plans as you select.

SUMMARY OF BENEFITS AND COVERAGE

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/>.

COUNTY CONTRIBUTION FOR MEDICAL COVERAGE



You and the County share in the costs of your medical plan benefits. The plans are funded through the County's and your contributions toward medical plan premiums; costs are incurred as plan participants seek medical care and claims are paid for that care. As is the case with most health plans, the total medical premium costs increase from year-to-year. In addition, because employees pay the difference between the total premium cost and the County's contribution, premium increases have a direct effect on your contribution cost.

The relationship between premiums and plan participant's use of the plans is important to understand – because plan utilization is a key driver of the premium rates. This means that your decisions as you use your plan benefits can make a difference.

Use your benefits wisely

- ❖ Be aware of the costs of the services you select
- ❖ Use in-network providers when possible
- ❖ Choose generic drugs when possible
- ❖ Commit to making healthy lifestyle choices to avoid chronic health conditions

Statistics have shown that 50% of medical costs are the result of our own behavioral choices, such as whether we choose to exercise, maintain a healthy weight, use tobacco products, etc. Making the choice to live healthier is one way you can help keep future costs down. Actively participate in the County's wellness program, Healthy Habits. Let your doctor know that cost is important to you. Talk to your doctor about the cost of care to see if there are more affordable ways to achieve the desired outcome. Do not avoid necessary treatment due to cost. Preventive treatment is shown to save costs in the long run by identifying issues early. Visit <http://healthyhabits.sonoma-county.org> for more information on how to make healthy choices.

2019 - 2020 MEDICAL PLAN PREMIUM CHART

All Bargaining Units Semi-Monthly Rates			
Plan	Total Premium Cost	County Contribution	Employee Contribution
County Health Plan EPO			
Single	\$566.34	\$314.50	\$251.84
Two-Party	\$1,106.32	\$628.50	\$477.82
Family	\$1,543.17	\$889.50	\$653.67
County Health Plan PPO			
Single	\$686.18	\$314.50	\$371.68
Two-Party	\$1,348.83	\$628.50	\$720.33
Family	\$1,884.91	\$889.50	\$995.41
Kaiser Permanente Traditional HMO			
Single	\$431.87	\$314.50	\$117.37
Two-Party	\$863.74	\$628.50	\$235.24
Family	\$1,222.19	\$889.50	\$332.69
Sutter Health Plus Traditional HMO			
Single	\$322.87	\$314.50	\$8.37
Two-Party	\$645.80	\$628.50	\$17.30
Family	\$913.90	\$889.50	\$24.40
Western Health Advantage Traditional HMO			
Single	\$390.60	\$314.50	\$76.10
Two-Party	\$781.21	\$628.50	\$152.71
Family	\$1,105.40	\$889.50	\$215.90
Kaiser Permanente Hospital Services DHMO			
Single	\$347.73	\$314.50	\$33.23
Two-Party	\$695.46	\$628.50	\$66.96
Family	\$984.08	\$889.50	\$94.58
Sutter Health Plus Hospital Services DHMO			
Single	\$227.04	\$227.04	\$0.00
Two-Party	\$554.10	\$554.10	\$0.00
Family	\$784.11	\$784.11	\$0.00
Western Health Advantage Hospital Services DHMO			
Single	\$315.91	\$314.50	\$1.41
Two-Party	\$631.83	\$628.50	\$3.33
Family	\$894.03	\$889.50	\$4.53

2019 - 2020 MEDICAL PLAN PREMIUM CHART

All Bargaining Units Semi-Monthly Rates			
Plan	Total Premium Cost	County Contribution	Employee Contribution
Kaiser Permanente Deductible First HDHP			
Single	\$322.67	\$314.50	\$8.17
Two-Party	\$645.34	\$628.50	\$16.84
Family	\$913.16	\$889.50	\$23.66
Sutter Health Plus Deductible First HDHP			
Single	\$257.17	\$257.17	\$0.00
Two-Party	\$514.26	\$514.26	\$0.00
Family	\$727.93	\$727.93	\$0.00
Western Health Advantage Deductible First HDHP			
Single	\$293.65	\$293.65	\$0.00
Two-Party	\$587.30	\$587.30	\$0.00
Family	\$831.03	\$831.03	\$0.00

County contributions listed in this guide are current as of March 1, 2019. County contributions are determined by a MOU, salary resolution or contract. Changes to the County contributions made on or after March 2, 2019 can be found on the County of Sonoma website at:

<http://sonomacounty.ca.gov/HR/Benefits/Semi-Monthly-Medical-Plan-Premiums/>.

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 (800) 759-3030.



County Health Plan Prescription Coverage under CVS/Caremark. If a generic drug is not available, you will pay the brand-name copay. If a generic 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 (800) 966-5772.

COUNTY HEALTH PLAN EPO

The County Health Plan EPO is an exclusive provider organizations (EPO). The EPO is a network of Hospitals, Physicians, medical laboratories, and other Health Care Providers who are located within a Service Area and who have agreed to provide Medically Necessary services and supplies for favorable negotiated discount fees applicable only to EPO Plan participants.

❖ **Under the EPO Plan there is coverage ONLY when you use an EPO provider.**

➤ 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.

The EPO Plan offers you affordable out-of-pocket costs, with access to the doctors and hospitals you trust. You are free to visit any doctor or hospital in the EPO network when you pay an affordable copay or deductible, without the hassle of filling out claim forms. Covered services must be provided by EPO network providers. Most doctor and specialist office visits are available at a \$50 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 80% after the deductible (\$500 per individual or \$1,500 per family) is met.

COUNTY HEALTH PLAN PPO

The County Health Plan PPO is a preferred provider organizations (PPO). A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. Under a PPO plan, you may choose the level of benefits you receive based on the providers you use when you receive care. Most in-network doctor and specialist office visits are available at a \$20 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 90% after the deductible (\$300 per individual or \$900 per family) is met.

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.



KAISER PERMANENTE®

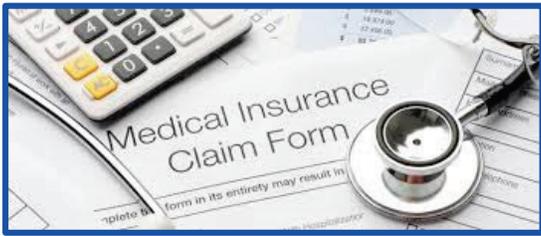
Personalized care: Whether you come into a Kaiser Permanente facility for a routine visit, urgent care, or emergency care, your doctors, nurses, and specialists have access to your electronic medical record. You have expanded opportunities to interact with care team the way you want: in person, physician 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 us at www.my.KP.org/sonomacounty or call (800) 464-4000.

Coordination of Benefits with 2 or More HSA-Qualified HDHPs: 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 high deductible health plans (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 for brand \$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.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), 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 year 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.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), 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 employee) elect to enroll in this Deductible First HDHP, which qualifies as 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, spanning 15 counties located in Northern California. 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:
 - o 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
 - o 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
- **New!** Sutter Health Plus has partnered with Express Scripts for your Mail Order and Retail prescription services.
- Mail order and retail pharmacy networks and copay tiers will not change
- 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 – HD 11

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. Tier 4 prescription medications are covered at a \$20 copayment up to a maximum 30-day supply.

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.

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

SUTTER HEALTH PLUS DEDUCTIBLE FIRST HDHP

The Sutter Health Plus HDHP HD 11 offers a lower monthly premium and higher deductible limits than the two other Sutter 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 HD 11 \$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.

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

Take Note... If you (the employee) elect to enroll in this Deductible First HDHP, which qualifies as 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.

WESTERN HEALTH ADVANTAGE PLANS

Since 1996, we've been a reliable partner in the communities we serve. We are known for acting with integrity and for interacting honestly with our partners. We build personal relationships with our members, providers, and communities. As a provider sponsored health plan, we support the doctor-patient relationship and offer access to quality doctors and hospitals.



Members can choose a primary care physician (PCP) from reputable medical groups including, Hill Physicians, Meritage Medical Network, St. Joseph Health Medical Network, Mercy Medical Group, Woodland Clinic Medical Group, or NorthBay Healthcare. With WHA, members have choices for specialist referrals beyond their PCP's medical group. Visit mywha.org/referral for additional information.

Enjoy the peace-of-mind that comes with 29 leading hospitals and major medical centers in Northern California, including four in Sonoma County (Healdsburg District Hospital, Petaluma Valley Hospital, Santa Rosa Memorial 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.

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. Most preventive services — such as well baby/child visits, immunizations, physicals, mammograms, and routine preventive screenings — are covered at no cost.

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

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.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), 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.

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

Take Note... If you (the employee) elect to enroll in this Deductible First HDHP, which qualifies as 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 # 175130M100 (CA) CVS/Caremark Group # 3439-1004	County Health Plan PPO Group # 175130M051 (CA) CVS/Caremark Group # 3439-1002
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 # 175130M100 (CA) CVS/Caremark Group # 3439-1004	County Health Plan PPO Group # 175130M051 (CA) CVS/Caremark Group # 3439-1002
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: Office Visit: \$50 copay, no deductible, Other Outpatient: 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: Office Visit: \$50 copay, no deductible, Other Outpatient: 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
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: \$125 per admission copay plus 40% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - COUNTY PLANS

Plan Information	County Health Plan EPO Group # 175130M100 (CA) CVS/Caremark Group # 3439-1004	County Health Plan PPO Group # 175130M051 (CA) CVS/Caremark Group # 3439-1002
SURGICAL AND HOSPITAL SERVICES		
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
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

MEDICAL PLAN COMPARISON CHART - COUNTY PLANS

Plan Information	County Health Plan EPO Group # 175130M100 (CA) CVS/Caremark Group # 3439-1004	County Health Plan PPO Group # 175130M051 (CA) CVS/Caremark Group # 3439-1002
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

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/>.

MEDICAL PLAN COMPARISON CHART - HMO PLANS

Plan Information	Kaiser Permanente HMO Group # 602483-0003	Sutter Health Plus HMO - ML42 Group # 131802-000001	Western Health Advantage HMO Group # 950201-A000
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California.	Based on residential zip code. Must live or work 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 <small>(Including Deductibles, Copays, & Coinsurance)</small>	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 Group # 602483-0003	Sutter Health Plus HMO - ML42 Group # 131802-000001	Western Health Advantage HMO Group # 950201-A000
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	\$10 Copay
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 maximums) 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
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

MEDICAL PLAN COMPARISON CHART - HMO PLANS

Plan Information	Kaiser Permanente HMO Group # 602483-0003	Sutter Health Plus HMO - ML42 Group # 131802-000001	Western Health Advantage HMO Group # 950201-A000
SURGICAL AND HOSPITAL SERVICES			
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
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

MEDICAL PLAN COMPARISON CHART - HMO PLANS

Plan Information	Kaiser Permanente HMO Group # 602483-0003	Sutter Health Plus HMO - ML42 Group # 131802-000001	Western Health Advantage HMO Group # 950201-A000
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

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/>.

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS

Plan Information	Kaiser Permanente Hospital Serv. DHMO Group # 602484-0006	Sutter Health Plus Hospital Serv. DHMO - ML21 Group # 131802-000005	Western Health Advantage Hospital Serv. DHMO 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 or work 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: \$1,000 Any One Member in a family of two or more: \$1,000 Family of two or more: \$2,000	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 <small>(Including Deductibles, Copays, & Coinsurance)</small>	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: \$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
Preventive Care Adult Routine OB/GYN	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 # 602484-0006	Sutter Health Plus Hospital Serv. DHMO - ML21 Group # 131802-000005	Western Health Advantage Hospital Serv. DHMO Group # 950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
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 per year (Chiropractic services do not apply to out-of-pocket maximums) 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 maximum)	50% coinsurance, no deductible
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/ Surgeon Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS

Plan Information	Kaiser Permanente Hospital Serv. DHMO Group # 602484-0006	Sutter Health Plus Hospital Serv. DHMO - ML21 Group # 131802-000005	Western Health Advantage Hospital Serv. DHMO Group # 950201
SURGICAL AND HOSPITAL SERVICES			
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
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

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE HMO PLANS

Plan Information	Kaiser Permanente Hospital Serv. DHMO Group # 602484-0006	Sutter Health Plus Hospital Serv. DHMO - ML21 Group # 131802-000005	Western Health Advantage Hospital Serv. DHMO Group # 950201
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 <small>(Must be deemed medically necessary under the treatment of the Kaiser physician)</small>	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

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/>.

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	Kaiser Permanente Deductible First HDHP Group # 602484-0009	Sutter Health Plus Deductible First HDHP - HD 11 Group # 131802-000009	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 or work 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 <small>(Including Deductibles, Copays, & Coinsurance)</small>	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
Preventive Care Adult Routine OB/GYN	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 # 602484-0009	Sutter Health Plus Deductible First HDHP - HD 11 Group # 131802-000009	Western Health Advantage Deductible First HDHP Group # 950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-Ray	Diagnostic Lab: \$10 copay per encounter after deductible Diagnostic X-ray: \$10 copay per encounter 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
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

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	Kaiser Permanente Deductible First HDHP Group # 602484-0009	Sutter Health Plus Deductible First HDHP - HD 11 Group # 131802-000009	Western Health Advantage Deductible First HDHP Group # 950201
SURGICAL AND HOSPITAL SERVICES			
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 per trip, after deductible	\$100 copay per trip, after deductible	\$100 copay per trip, 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
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% co-insurance in accordance with formulary after deductible	20% coinsurance after deductible	20% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - HIGH DEDUCTIBLE HEALTH PLANS

Plan Information	Kaiser Permanente Deductible First HDHP Group # 602484-0009	Sutter Health Plus Deductible First HDHP - HD 11 Group # 131802-000009	Western Health Advantage Deductible First HDHP Group # 950201
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 <small>(Must be deemed medically necessary under the treatment of the Kaiser physician)</small>	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

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/>.

DENTAL BENEFITS



Dental coverage is an important part of your benefits package and regular dental care is key to your overall health. The County is pleased to offer Delta Dental PPO as your dental plan option.

The Delta Dental PPO Network is available nationwide and allows you the freedom to visit any licensed dentist or specialist of your choice. Participating dentists have agreed to accept pre-negotiated fees for dental procedures, and are prohibited from billing a patient above the predetermined amount (balance billing). This arrangement results in protection and savings for patients.

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 your dentist to submit a pre-treatment estimate to Delta Dental 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.

2019 - 2020 DENTAL PREMIUMS

Payroll premium deductions for eligible full-time employees' dental coverage vary based on bargaining unit, as noted in the table below. The County contribution for dental coverage provided to eligible part-time employees is prorated, as described elsewhere in this booklet.

Bargaining Unit	Total Semi-Monthly Premium Cost	County Contribution	Employee Contribution
All Units (Except ESC)	\$59.22	\$59.22	\$0.00
ESC	\$59.22	\$46.18	\$13.04

DELTA DENTAL PPO PLAN BENEFIT HIGHLIGHTS

Delta Dental PPO Group #03126	
Dental Services	All Units
Diagnostic & Preventive	Plan pays 80% of allowable charges; an extra annual dental exam and cleaning is included during pregnancy
Basic Dental Services	Plan pays 80% of allowable charges
Crowns & Cast Restorations	Plan pays 80% of allowable charges
Prosthodontics	Plan pays 80% of allowable charges; coverage for implants is included under the plan
Orthodontics	Plan pays 50% of allowable charges, up to a lifetime maximum of \$6,000 per member
Deductible	\$0
Calendar Year Maximum Dental Benefits	\$3,000 per person per calendar year; Diagnostic and Preventative benefits are exempt from the calendar year maximum only when received from a Delta Dental PPO provider.



VISION BENEFITS



Get the best in eye care and eyewear with COUNTY OF SONOMA and VSP® Vision Care.

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we’re the only national not-for-profit vision care company, you can trust that we’ll always put your wellness first.

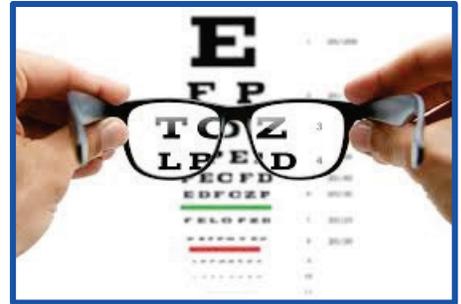
You’ll like what you see with VSP...

Value and Savings. You’ll enjoy more value and the lowest out-of-pocket costs.

High Quality Vision Care. You’ll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.

Choice of Providers. The decision is yours to make—choose a VSP provider or any out-of-network provider.

Great Eyewear. It’s easy to find the perfect frame at a price that fits your budget.



2019 - 2020 VISION PREMIUMS

Bargaining Unit	Total Semi-Monthly Premium Cost	County Contribution	Employee Contribution
All Units	\$7.85	\$7.85	\$0.00

VISION SERVICE PLAN (VSP) BENEFIT HIGHLIGHTS

Vision premiums are paid in full by the County for full-time employees, and premiums are prorated for eligible part-time employees. Vision coverage cannot be waived by eligible full-time employees.

VSP Group #1243-7001-0025

Benefit	Description	Copay	Frequency
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness KIDSCARE: Provides up to 2 fully covered \ WellVision exams, if needed 	\$0	Every 12 months
Prescription Glasses			
Frame	<ul style="list-style-type: none"> \$125 allowance for a wide selection of frames \$145 allowance for featured frame brands like Anne Klein, bebe*, ck Calvin Klein, Flexon*, Lacoste, Nike, Nine West, and more 20% savings on the amount over your allowance \$70 allowance for Costco frames KIDSCARE: Frames every 12 months / \$125 allowance or \$145 allowance for featured frame brands 	\$0	Every 24 months
Lenses	<ul style="list-style-type: none"> Single vision, lines bifocal, and lined trifocal lenses KIDSCARE: Lenses every 12 months, plus additional lenses with a prescription change Polycarbonate lenses for dependent children 	\$0	Every 12 months
ENHANCEMENTS	<ul style="list-style-type: none"> REPAIR & REPLACE: Lenses and frames needing repair or replacement if damaged or broken - frames covered up to allowances Average savings of 35-40% on other lens enhancements 	\$0	Every 12 months
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$105 allowance for contacts and contact lens exams (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation) 	\$0	Every 12 months
Computer Vision Care			
Frame	<ul style="list-style-type: none"> \$105 allowance for a wide selection of frames \$125 allowance for featured frame brands 20% savings on the amount over your allowance 	\$0	Every 24 months
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, lines trifocal, and occupational lenses 	\$0	Every 12 months
Diabetic Eyecare Plus Program	<ul style="list-style-type: none"> Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. 	\$20	As needed
Extra Savings	Glasses and Sunglasses <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to www.vsp.com/specialoffers for details. 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. 		
	Retinal Screening <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 		
	Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the regular price of 5% off the promotional price; discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor 		
Your Coverage with Out-of-Network Providers			
Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.			
Exam up to \$45	Lined Bifocal Lenses up to \$65	Progressive Lenses up to \$85	
Frame up to \$45	Lines Trifocal Lenses up to \$85	Contacts up to \$105	Single Vision Lenses . . . up to \$45
VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on application laws, benefits may vary by location.			

LIFE INSURANCE

BASIC AND SUPPLEMENTAL LIFE INSURANCE



- Basic Life Insurance, AD&D, and Supplemental Life Insurance are insured by The Hartford Life Ins. Co.
- All regular full-time employees and regular part-time employees, in an allocated position of 60 hours (.75 FTE) or more per pay period, receive Basic Life Insurance and AD&D benefits paid by the County.
- Part-time DSA, SCLEA, and ESC employees working less than 60 hours per pay period can purchase Basic, Supplemental, and Dependent Life Insurance at their own expense.
 - o The rate for \$25,000 of basic life insurance is \$0.80 bi-weekly
 - o The rate for SCLEA for 1 time Base Annual Salary equals \$0.000835 x base salary
 - o To be eligible to purchase Supplemental Life Insurance and/or Dependent Life Insurance the part-time DSA, SCLEA, and ESC employee must purchase Basic Life Insurance.
- All regular full-time employees and regular part-time employees, in an allocated position of 60 hours (.75 FTE) or more per pay period, may also purchase Supplemental Life Insurance coverage.
- The maximum amount of life insurance, Basic Life and Supplemental Life combined, cannot exceed \$500,000.
- To be eligible to Purchase Supplemental Life Insurance the employee **must have** Basic Life Insurance coverage.

LEVELS OF COVERAGE

The Hartford Group # GL-673199		
Bargaining Units	Basic Life and AD&D Insurance 100% Paid by the County*	Supplemental Life Employee Paid**
Unrepresented (00)	1.5 times the base Annual Salary	Increments of \$10,000 (up to a Combined Total of \$500,000).
DSA (46, 47)	\$25,000	1, 2, 3 or 4 times your Basic Life Amount
Confidential (51)	1.5 times the Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount
Administrative Management (50) Board of Supervisors (49) Department & Agency Heads (52) DSLEM (43), SCDPDAA (60), SCLEMA (44), SCPA (45)	2 times the Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount

Bargaining Units	Basic Life and AD&D Insurance 100% Paid by the County*	Supplemental Life Employee Paid**
SEIU (01, 05, 10, 25, 80, 95) Local 39 (85), SCLEA (30, 40, 41, 70) SCPDIA (55)	1 time the Base Annual Salary	Increments of \$10,000 (up to a Combined Total of \$500,000)
WCE (21)	1 time the Base Annual Salary	1, 2, 3 or 4 times your Base Annual Salary
ESC (75)	\$25,000	1, 2, 3, 4 or 5 times your Base Annual Salary

* Part-time employees working <60 hours per pay period in DSA, ESC, SCLEA bargaining unit pay the cost if they elect coverage.

** The maximum amount of Life Insurance, Basic Life and Supplemental Life combined, cannot exceed \$500,000.

GUARANTEE ISSUE

Guarantee Issue is the amount of Supplemental Life Insurance that you are automatically approved for without providing evidence of good health.

Newly hired or newly eligible employees

If you are a new hire or newly eligible employee and submit your election within 31 days of eligibility, you are automatically approved for a Guarantee Issue of 1, 2, or 3 times your Basic Life Insurance amount not to exceed \$250,000.

During Annual Enrollment

- If you are currently enrolled in Supplemental Life Insurance and haven't yet reached the maximum Guarantee Issue, you can elect to increase your coverage by 1 increment level not to exceed \$250,000 without providing evidence of good health.
- **If you are not enrolled in Supplemental Life Insurance, you may elect Supplemental Life Insurance coverage for the first time, but there is not a Guarantee Issue.** Any level of coverage you elect is subject to approval by The Hartford and evidence of good health is required. No payroll deductions will be taken until your application is approved by The Hartford.

SUPPLEMENTAL LIFE INSURANCE COST

The cost of supplemental coverage is based on your age on the last calendar day of the year (December 31) and the amount of insurance you select. Current rates for each \$10,000 in supplemental life insurance coverage are listed in the table to the right.

Example: 30 year old employee interested in \$20K of supplemental life insurance:
 $\$8.17 \times 2$ (chart price is for each \$10K) =
 $\$16.34$ per year; $\$.62$ each pay period.

Insurance amounts are rounded to the nearest thousandth.

2019-2020 Employee Supplemental Life Insurance Premiums per \$10,000 of Coverage		
Age	Bi-Weekly Rate	Annual Rate
29 and under	\$0.28	\$7.20
30 – 34	\$0.31	\$8.17
35 – 39	\$0.39	\$10.20
40 – 44	\$0.59	\$15.37
45 – 49	\$0.86	\$22.44
50 – 54	\$1.37	\$35.77
55 – 59	\$2.28	\$59.40
60 – 64	\$3.38	\$88.08
65 – 69	\$5.53	\$144.35
70 – 74	\$10.12	\$264.13

DEPENDENT LIFE INSURANCE

You can also purchase dependent life insurance coverage for your spouse/domestic partner and any dependent child through the end of the month they turn age 26. The benefit provided for dependent coverage is \$5,000 for each eligible family member. The premium is \$0.23 bi-weekly; which covers all eligible members of your family. You must have basic life insurance coverage in order to purchase dependent life insurance.

The benefit provided for dependent coverage is a payment to the employee of \$5,000 for each eligible family member.

KEY POINTS TO CONSIDER ABOUT LIFE INSURANCE

- You pay the full cost of supplemental and dependent coverage on a post-tax basis.
- Especially if you are the sole wage-earner in your family, think about whether or not you need more protection than the County-paid basic coverage provides.
- Consider whether you have enough money to cover funeral and/or legal expenses in the event of a death of a spouse, domestic partner, or children. Dependent life insurance may help with these expenses.
- Be sure to designate a beneficiary (or beneficiaries) for your employee life insurance and keep them up-to-date (basic and supplemental). The Hartford Beneficiary Form is located in the main menu of Employee Self-Service.
- **Help is available for funeral planning and coping with a loss of your loved one, as well as other valuable services at www.thehartford.com/employee-benefits/value-added-services.**



EFFECTIVE DATE OF MID-YEAR CHANGES

Elections shall be effective prospectively. Generally, elections that add or change coverage will be effective on the first day of the month following or coinciding with the date the completed Employee Enrollment/Change Form and applicable supporting documentation is received by the Human Resources Benefits Unit. (The exception is that when enrollment is requested for a newborn, newly adopted child or child placed for adoption, coverage is effective on the date of birth or adoption or placement for adoption). For New Hires, elections are effective on the first day of the month following the date of hire in a benefits-eligible position, including those hired on the first day of the month.



Elections that cancel or drop coverage will be effective on the last day of the month following or coinciding with the date the completed Employee Enrollment/Change Form and applicable supporting documentation is received by the Human Resources Benefits Unit.

If your coverage was terminated or lapsed while on leave, you will need to complete a new Employee Enrollment/Change Form upon return from your leave. Your coverage will be effective on the first day of the month following your return from leave. If you are returning from a Military leave of absence, your coverage will be effective on the date you return from leave.

You will be billed for any premiums owed as a result of your re-enrollment and for the addition of any eligible dependents. If the Change-in-Status event results in a decrease in premiums, you will receive a refund on a subsequent pay warrant for the premium overpayment. To reduce the amount of premiums owed or to avoid incurring an overpayment of premiums, you are encouraged to submit your paperwork as soon as possible.

FOR NEWBORN CHILDREN



Newborn children must be enrolled in County plan coverage to receive benefits under the plan. Failure to request enrollment for your newborn in a County plan within 31 days of the date of birth will result in your newborn not having coverage from date and time of birth forward for most plans. You will be liable for any services and/or expenses incurred for that newborn who is not timely and properly enrolled.

To enroll your newborn, submit a completed Employee Election/Change Form to the Human Resources Benefits Unit. If enrollment is requested timely, coverage must be retroactively effective to the date of birth, adoption or placement for adoption. You are encouraged to request newborn enrollment and submit enrollment paperwork as soon as possible (and no later than 31 days after the date of birth) to avoid non-coverage for your newborn child.

When properly enrolled, the newborn will be assigned under the medical group to which the parent is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

<i>Life / Family Events</i>		
If you experience the following Event...	You may make the following change(s) ¹ within 31 days of the Event...	YOU MAY NOT make these types of Changes
Marriage or Commencement of Domestic Partnership (DP)	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll your new spouse/DP and other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans 	<ul style="list-style-type: none"> • Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	<ul style="list-style-type: none"> • Drop your spouse/DP from your health coverage • Drop dependent child(ren) if show proof of other coverage under spouse's plan • Children of a Domestic Partner MUST be dropped (regardless of whether they enroll in other coverage) as they are no longer eligible dependents • Enroll yourself and your dependent children if you or at least one dependent child was previously enrolled in your spouse/DP's plan and lost eligibility • Change health plans 	<ul style="list-style-type: none"> • Drop health coverage for yourself
Gain a child due to birth or adoption	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Adoption placement papers are required • Change health plans 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals without proof of enrollment in spouse/DP's plan
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	<ul style="list-style-type: none"> • Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Drop child named on QMCSO if required by QMCSO • Change health plans, when options are available, to accommodate the child named on the QMCSO 	<ul style="list-style-type: none"> • Drop health coverage for yourself • 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) or death of a dependent child	<ul style="list-style-type: none"> • Drop the child who lost eligibility from your health coverage • Change health plans to accommodate newly removed dependent(s) and remaining covered individuals 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Death of a spouse/DP	<ul style="list-style-type: none"> • Drop the deceased dependent from your health coverage • Enroll yourself and/or any eligible children if lost eligibility under spouse's/DP's plan • Change health plans 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to Medicare	<ul style="list-style-type: none"> • Drop coverage for the Dependent who became entitled to Medicare, with proof of Medicare enrollment • If Employee becomes entitled to Medicare, may drop all coverage (self and dependents) <ul style="list-style-type: none"> o Documentation required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Change of home address outside of plan service area that causes a loss of eligibility for coverage	<ul style="list-style-type: none"> • If you are enrolled in an HMO and move out of their service area, then you can change health plans 	<ul style="list-style-type: none"> • Cannot add eligible dependents • Does not apply to County Health Plan, dental or vision coverage

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

<i>Life / Family Events</i>		
If you experience the following Event...	You may make the following change(s) ² within 60 days of the Event...	YOU MAY NOT make these types of Changes
Covered person has become entitled to Medicaid, Medi-Cal, or SCHIP ²	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> o Documentation required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Drop coverage for yourself or any enrolled dependents • Change plans
<i>Employment Status Events</i>		
If you experience the following Event...	You may make the following change(s) ¹ within 31 days of the Event...	YOU MAY NOT make these types of Changes
You become newly eligible for benefits due to change in employment status or bargaining group	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents 	<ul style="list-style-type: none"> • Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse/DP obtains health benefits in another group health plan	<ul style="list-style-type: none"> • Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage if they enroll in spouse's or DP's coverage • Drop coverage for yourself if you enroll in your spouse's/DP's coverage <ul style="list-style-type: none"> o Proof of coverage in the other health plan required 	<ul style="list-style-type: none"> • Change health plans. • Add any eligible dependents to your health coverage. • Enroll yourself if you are not currently enrolled
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage or eligibility for health benefits in another group, individual, or exchange health plan. You or your dependents exhaust COBRA coverage under other group health plan.	<ul style="list-style-type: none"> • Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans <ul style="list-style-type: none"> o Proof of loss of other coverage is required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	<ul style="list-style-type: none"> • You must drop coverage for yourself and any enrolled Dependents because you are no longer eligible for coverage 	<ul style="list-style-type: none"> • Add any Dependents

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code.
This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

<i>Employment Status Events</i>		
If you experience the following Event...	You may make the following change(s) ¹ within 31 days of the Event...	YOU MAY NOT make these types of Changes
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase	<ul style="list-style-type: none"> • Drop coverage for yourself (only if there is a significant cost change and there is no other similar health plan option available) • Change health plans to a less expensive plan 	<ul style="list-style-type: none"> • No change is allowed unless the reduction in hours causes a loss of eligibility or a loss or significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.
You experience an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution	<ul style="list-style-type: none"> • You may suspend coverage for yourself and dependents while on leave and reinstate coverage upon return to work if you are still eligible then 	<ul style="list-style-type: none"> • Add or Drop any dependents, change plans, or enroll if not currently enrolled
You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution	<ul style="list-style-type: none"> • Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans 	<ul style="list-style-type: none"> • No change is allowed unless the increase in hours results in new eligibility or a significant change in the employer subsidy for health (not FSA) coverage
You return from Military leave	<ul style="list-style-type: none"> • Prior elections at beginning of leave are reinstated unless another Change Event has occurred which permits the change 	
You, your spouse, or dependents enroll in a Qualified Health Plan through a Public health Insurance Marketplace	<ul style="list-style-type: none"> • Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself <ul style="list-style-type: none"> ◦ Proof of enrollment in Marketplace Coverage is required 	<ul style="list-style-type: none"> • Add any dependents, change plans, or enroll yourself if not currently enrolled

¹ Rules apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

² You have 60 days from loss or eligibility determination of Medicare, Medicaid, Medi-Cal, or SCHIP to request special enrollment.

REVIEW YOUR BENEFITS

PRE-TAX INSURANCE BENEFITS

County employees generally pay for their health benefits on a pre-tax basis. If a County employee's dependent is considered an Internal Revenue Service (IRS) qualified dependent, the County contribution for the dependent's benefit is also tax free and the employee's share of cost is paid on a pre-tax basis. When you enroll your dependent(s) in a County medical or dental plan, you must indicate whether each is an IRS-Qualified or Non-Qualified tax dependent.

IS MY DEPENDENT IRS-QUALIFIED?

In accordance with the law, the County's benefits coverage can be provided on a tax-free basis to any eligible spouse, or eligible child of the employee until the end of the month in which the child becomes ineligible for County health plans. If your eligible dependent is your own natural child, your step child, adopted child, child lawfully placed for adoption, or eligible foster child, you may indicate each as IRS Qualified regardless of the child's marital or student status or whether or not the child is claimed as a dependent on your taxes.

Covered dependents who may not be eligible for tax-free health care (and requires an employee to indicate that a dependent is non-IRS Qualified) applies to your domestic partner and any children of your domestic partner (unless you have adopted the children) or dependents for whom you are the legal guardian, as these individuals are not always recognized as federal tax dependents, and therefore are IRS non-qualified, unless they meet the definition of Qualifying Child or Qualifying Relative as defined by the IRS.

To be an IRS Qualified Dependent a dependent must fall into one of two categories defined by the IRS. They must be either a Qualifying Child, or a Qualifying Relative. There are specific tests that must be met under each of these categories for them to be considered IRS Qualified Dependents. Refer to the Overview of the Rules for Claiming an Exemption for a Dependent in IRS Publication 17 at <https://www.irs.gov/pub/irs-pdf/p17.pdf>.

Note: The above information is about taxation only. You are strongly encouraged to check with a tax professional or the IRS at <http://www.irs.gov/> to clarify any questions you may have about your dependents' tax status.

CONTACT INFORMATION AND RESOURCES

At the County of Sonoma, we're committed to helping our employees, retirees, and their families enjoy optimal health. That's why we've teamed up with community wellness partners to bring you a range of useful programs and wellness tools.

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:

- Compare health plan options and the differences between plan coverage
- Benefits education and assistance for all types of health plans (medical, dental, etc.)
- Getting the most of your healthcare dollars
- Locate network doctors, hospitals and ancillary services
- Obtaining second opinions
- Troubleshooting medical claims/bills
- Provide support for 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 contact form at www.carecounsel.com or staff@carecounsel.com. Member Care Specialists are available 6:30 a.m. to 5:00 p.m. PST Monday - Friday. CareCounsel is a wholly owned subsidiary of Stanford Health Care.



Keep CareCounsel at your fingertips; scan the QR code and save their contact information:

1. Focus smart phone camera on QR code
2. Select "Add 'CareCounsel'" to contacts from the banner at the top of the screen
3. Select "Save" in the upper, right-hand corner of the contact information
4. Call, email, visit web page or share the contact with your dependents via contact info

CUSTOMER SERVICE SUPPORT



Visit the insurance company websites for additional resources. Contact the Human Resources Benefits Unit with questions related to your eligibility, coverage, and Annual Enrollment Period.

E-mail: Benefits@Sonoma-County.org **Phone:** (707) 565-2900

Internet: <http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/>

Please note: Staffing resources are limited. When calling, leave one clear message rather than multiple messages. Your call will be returned as soon as possible. Please do not call to confirm receipt of your election. Print a copy of your election as proof of completion.

COUNTY-OFFERED PLAN CONTACT INFORMATION

Contact your health plan carriers with questions related to your benefits coverage, to find network providers, preauthorize care as required, and confirm your residence is within the plans' service areas.

Plan	Phone	Website
County Health Plans (PPO & EPO) <i>Administered by Anthem Blue Cross</i> Summary of Benefits and Coverage (SBC)	(800) 759-3030	www.anthem.com/ca http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
CVS/Caremark <i>County Health Plans' prescription drug provider</i>	(800) 966-5772	www.caremark.com
Kaiser Permanente Plans Summary of Benefits and Coverage (SBC)	(800) 464-4000	www.my.kp.org/sonomacounty www.kp.org http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
Sutter Health Plus HMO Summary of Benefits and Coverage (SBC)	(855) 315-5800	www.sutterhealthplus.org/sonomacounty http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
Western Health Advantage HMO Summary of Benefits and Coverage (SBC)	(888) 563-2250	www.westernhealth.com/mywha/welcome-to-wha/county-of-sonoma http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/
Delta Dental Plan Group # 03126	(800) 765-6003	www.deltadentalins.com
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
The Hartford	(888) 563-1124	www.thehartford.com
County Wellness Program	(707) 565-2900	http://sonomacounty.ca.gov/HR/Benefits/Healthy-Habits/
Sonoma County HIPAA Privacy Practices	(707) 565-5703	http://hr.sonomacounty.org/content.aspx?sid=1024&id=1225

APPEALS PROCESS

General Information

In the event an employee or beneficiary believes that a request or claim for a benefit under a health and welfare, flexible spending account, or salary savings plan has been improperly denied, he or she may appeal the decision within the parameters set forth in the following procedure.

Appeals for claims that are denied solely by one of the County's benefit carriers must be submitted within the guidelines established by that carrier. Employee Benefits, if requested to do so, will act as an advocate and will assist to ensure that the appeal receives due consideration.

Timeframes

Any employee or beneficiary whose request or claim for benefits is denied has the right to request a review by filing an appeal in writing directly with the Employee Benefits Unit. Appeals must be submitted within 180 calendar days of the notice of denial or adverse decision. The appeal should include the basis for the appeal, as well as any supporting documentation. Within 180 calendar days of the date the appeal is received, the Employee Benefits Unit will review the facts and respond in writing with its findings. Should special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 15 days. The Employee Benefits Unit will provide written notification if an extension is needed.

If the appeal does not contain sufficient information to make a decision, an extension may be granted to obtain such information. The appellant will be notified in writing of the extension which will specifically describe the required information and will be afforded 15 calendar days from the date of the notice to provide the specified information.

Upon timely delivery of the requested information, and within 15 calendar days, the Employee Benefits Unit will report its findings. Should the requested information not be received by Employee Benefits within the time specified, the Employee Benefits Unit will make a decision without it, in which case, the decision is final and is not eligible for a second appeal.

FSA Appeals for Denied Claims: FSA participants have 60 days from the date a claim denial is mailed to participant to submit a written appeal for review, and the Employee Benefits Unit has 60 days from the date the appeal is received to provide a final decision. Please refer to the FSA plan document for more information about the plan and its appeal process.

Notification

Note: All approvals are subject to carrier contract limitations.

Notice of the appeal decision will include the following:

1. The Employee Benefits Unit's decision;
2. The specific reason(s) for the appeal determination;
3. A reference to the specific plan provision(s) on which the determination is based;
4. A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on when adverse determination has been made;
5. With the exception of appeals processed without the necessary information as described above, a statement outlining the voluntary second level appeals process will be included in the letter. If the appellant disagrees with the Employee Benefits Unit's decision and there is additional information that was not included in the first appeal which supports the position, a second appeal can be made to the attention of the Employee Benefits Manager, whose decision will be final. Such appeals must be received within 15 calendar days of the first appeal decision notice.

Please contact HR Benefits Unit with questions or concerns about the appeals process by calling (707) 565-2900.

REQUIRED NOTICES

MEDICARE NOTICE OF CREDITABLE 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 County-sponsored medical plans is or is not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the County are or are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage below.

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?

As an employee, if you decide to join a Medicare drug plan, your current active employee County of Sonoma coverage will not be affected. As a retiree, if you decide to join a Medicare drug plan, your current retiree County of Sonoma 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 will 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...

See contact information 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 (1 (800) 633-4227). TTY users should call 1 (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 1 (800) 772-1213 (TTY 1 (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, 2019
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

WOMEN’S HEALTH AND CANCER RIGHTS ACT NOTICE

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. All stages of 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
4. 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.

NEWBORNS’ AND MOTHER’S HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, (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 EVENT NOTICE

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.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAX PAYER IDENTIFICATION (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.

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.

This Plan's 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) 565-5703 or www.sonoma-county.org/privacy/privacy.html.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH THE COUNTY OF SONOMA

If you are in a benefits-eligible position and choose not to be covered by one of County of Sonoma's medical plan options, remember that you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

If you choose to not be covered by a medical plan sponsored by County of Sonoma at this enrollment time, your next opportunity to enroll for County of Sonoma's medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of County of Sonoma's plan year.

IRS FORM 1095

Under the Affordable Care Act, starting in early 2016, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095. The 1095 form should be provided to you by the end of March 2019.

For each month of 2018 that you were enrolled in a medical plan, this 1095 form documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage or MEC," meaning group medical plan coverage.

In December 2019 Congress passed a new law that reduces the Individual Mandate penalty to zero starting in 2019. If you receive a 1095 form, you do not need to attach the form to your personal income tax return or wait to receive the form before filling your tax return. If you receive a form this year, **you should keep it in a safe place** with your other tax records because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095 will also be provided to the IRS.)

KEEP THE COUNTY NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly furnish to the County's HR Benefits Unit information regarding change of name, address, marriage, divorce or legal separation, change in Domestic Partnership status, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give the County a timely notice of the above noted events may:

- a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,
- d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future [medical, dental, and/or vision] benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility 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): The Kaiser, Sutter, and Western Health Advantage medical plan 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. Until you make this designation, the health insurance company designates one for you. 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 the health insurance company at the number provided on page 49

Direct Access to OB/GYN Providers: You do not need prior authorization (pre-approval) from Kaiser, Sutter, Western Health Advantage, Anthem 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 health plan carrier at the phone number or website address provided on page 49.



FAMILY CARE AND MEDICAL LEAVE (CFRA LEAVE) AND PREGNANCY DISABILITY LEAVE

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse. While the law provides only unpaid leave, employees may choose or employers may require use of accrued paid leave while taking CFRA leave under certain circumstances.

Even if you are not eligible for CFRA leave, if you are disabled by pregnancy, childbirth or a related medical condition, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement—for pregnancy disability it is to the same position and for CFRA it is to the same or a comparable position—at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days' advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events that are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you a leave for pregnancy disability or for your own serious health condition. We also may require certification from the health care provider of your child, parent or spouse, who has a serious health condition, before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or reduced work schedule.

If you are taking a leave for the birth, adoption, or foster care placement of a child, the basic minimum duration of the leave is two weeks, and you must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact Human Resources Benefits Unit at (707) 565-2900 .



YOUR RIGHTS UNDER USERRA THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

Publication Date — April 2017

EMPLOYER NOTICE ABOUT THE HEALTH INSURANCE MARKETPLACE

As your employer, the County should distribute a notice to new employees when they are first hired. The notice is at least two pages long. To help you recognize the notice, here is a snapshot of a portion of the first page of the Notice:



New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Benefits Unit at (707) 565-2900 or Benefits@sonoma-county.org

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

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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp x	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	KANSAS – Medicaid
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

<p align="center">KENTUCKY – Medicaid</p> <p>Website: https://chfs.ky.gov Phone: 1-800-635-2570</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>	<p align="center">OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>
<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</p>	<p align="center">PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">RHODE ISLAND – Medicaid</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347</p>

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

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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



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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