2022

RETIREE BENEFITS OVERVIEW




Your Benefits, Your Choice.

County of San Mateo Human Resources Department

TABLE OF CONTENTS

Introduction to your 2022 Benefit Guide

Welcome to the 2022 Retiree Benefits Guide! Whether you are planning your retirement or if you have already retired from the County, we hope that you find the information in the Guide informative and useful. This Guide is intended to be a summary of benefits offered to you and your family in retirement (mainly health benefits).

All benefits are subject to change and there is no guarantee that these benefits will be continued indefinitely. The benefit descriptions are very general and are not intended to provide complete details about any or all plans. Exact specifications for all plans are included in the official Plan Documents, copies of which are available online at https://www.smcgov.org/hr/health-benefits or available at the Benefits Office (455 County Center 5th Floor, Redwood City, CA 94063).

Feel free to contact the County's Benefits Division at 650-363-1919, via email at benefits@smcgov.org or visit https://hr.smcgov.org/retiree-health-benefits-current-retirees if you have any questions about retiree health benefits.

Thank you.

The Benefits Team

What's New in 2022?

DENTAL

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

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

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

SILVER&FIT FOR KAISER PERMANENTE SENIOR ADVANTAGE (KPSA) MEMBERS

- Silver&Fit® Healthy Aging and Exercise Program is now available to all KPSA members
- Offers fitness memberships to a national network of 14,000+ fitness centers **at no additional cost**
- Visit www.silverandfit.com to locate fitness centers near you with the enhanced search or sign up for the Home Fitness program

Retiree Health FAQs

Does the County offer health benefits to retirees?

Yes, the County offers medical and dental plans for retirees similar to those offered to active employees. In addition, the County maintains medical plans for retirees and their dependents that have become Medicare eligible. There is no retiree health benefit for “deferred retirements”.

Am I eligible for retiree health benefits?

The rules pertaining to retiree health benefits are included in the applicable Memorandum of Understanding (MOU) or Board Resolution for your employee group (union). The MOUs and Resolutions are posted on the County’s website at https://hr.smcgov.org/employee-and-labor-relations or at page 15 (Summary of Health Benefits).

Generally speaking, any employee who retires from the SamCERA system can continue their group health plan coverage under a County Retiree health plan. Coverage must be continuous, meaning that an employee cannot retire and then decide to enroll in a County plan at a later time.

When are retiree health benefits effective?

Active benefits terminate on last day of the month following your termination date, and retiree health benefits commence on first day of the month following termination date.

When/how do I enroll in retiree health benefits?

If you want to continue your health coverage and enroll in one of the County's group retiree health plans, you must enroll within 30 days prior to your retirement date. With the exception of a pending disability retirement, if you do not enroll by your retirement date, you will have waived your right to continue your County coverage under a group plan. You will also have waived your right to use any sick leave hours accumulated as an active employee toward the cost of your retiree health insurance.

Please contact the County's Benefits Division at 650-363-1919 or via email at benefits@smcgov.org to schedule an appointment with a Benefits staff member approximately 30 days prior to your retirement date. At that meeting, a Benefits Partner will explain your retiree health options and answer any of your questions. You will also be asked to complete and sign the "Retiree Health Enrollment Form" at the back of this Benefits Guide.

Retiree Health FAQs

HEALTH PLAN OPTIONS IN RETIREMENT

What medical plan options do I have in retirement?

If you are under 65 years old, your plan options are the same as an active employee: Kaiser HMO, Blue Shield HMO, Blue Shield Trio, Blue Shield PPO, Blue Shield High Deductible Health Plan, Kaiser High Deductible Health Plan.

If you are over 65 years old, your Medicare plan options are Kaiser Senior Advantage HMO and Blue Shield Medicare Advantage PPO. **(High Deductible plans are not available once you are on Medicare.) See Medicare plan information on page 61.**

What is the County's Alternate Health Plan?

If you move out of an existing HMO coverage area and you have remaining sick leave credits, you have the option of enrolling in the County's Alternate Health Plan. Under this plan, you enroll in a major medical plan comparable to the plan options offered under the County's benefit package. The County pays a monthly contribution for your elected coverage. The payment is made via direct deposit into the account of your choice. The amount you will be reimbursed depends on the value of your sick leave hours but no more than the total cost of your monthly premium for the plan you have selected. It is important to remember that these payments are taxable income. Also, proof of other coverage is required (copy of your health plan card and proof of premium cost) on a yearly basis. You can always move back to a County plan at Open Enrollment or during a qualifying life event as long as there has been continuous coverage under the Alternate Health Plan and you still have available sick leave hours.

What are my options for medical, dental and vision insurance?

Based on your bargaining group's Memorandum of Understanding, you may be able to retire and keep your medical, dental, and vision plans. If your MOU does not allow you to keep all three plans and you opt to keep your County's medical plan, you may continue your dental coverage for 18 months through COBRA, or you can enroll in one of the County's Retiree Voluntary dental and vision plans.

For more information on COBRA, please refer to page 63.

IMPORTANT NOTE:

If you retiring within the next 12 months, buy up plans will not carryover in retirement unless you opt to pay for the full premium on COBRA for 18 months maximum.* Once you leave the County's dental plan and you opt for COBRA, you will only be eligible to enroll in the County's retiree voluntary dental plan.

Retiree Health FAQs

Can I keep my County life insurance in retirement?

If you wish to continue to be covered for life insurance, you may choose to port coverage to another group term life policy or convert your coverage to an individual policy. Note that the cost of continued coverage if you port to another group policy is generally less than if you convert to an individual whole life policy. You have 30 days from the date of termination to continue life insurance in retirement. Contact Standard Life Insurance at 800-628-8600 for more information.

Can I keep my money invested in Empower (formerly MassMutual) Deferred Compensation Account?

As a retiree, you can retain your 457 deferred compensation funds with the County's plan or you can roll the funds to another plan. You can also roll funds into your 457 plan. Contact Empower at 1-800-528-9009 for more information or visit www.viewmyretirement.com/sanmateocounty

COST OF RETIREE BENEFITS

Will the County help pay for my retiree health premiums?

If you enroll in a retiree health plan through the County, the County will contribute to your monthly retiree health premiums only if you have unused sick leave available when you retire. According to your MOU, the County may provide you with additional sick leave hours based on your years of service or if you retire due to a disability.

What if I don't have any sick leave when I retire or what happens when my sick leave credits expire?

You may still continue your County medical plan. However, you would be required to pay the full cost of the premium.

Retiree Health FAQs

How are sick leave credits used to pay for my health insurance in retirement?

Generally, 8 hours of unused sick leave pays for a portion of your County retiree health premium. In other words, if you have 96 hours of sick leave left at retirement, the County will pay a portion of your monthly premium for 12 months (96 divided by 8). Once your sick leave is exhausted, you can remain on the County's plan. However, you would be required to pay the full cost of the premium.

Some MOU's allow you to use less or more than 8 hours of sick leave per month. Changing the value of your sick leave can only occur at Open Enrollment or within 31 days of a qualifying life event.

How much will the County contribute toward my insurance premiums each month?

The County's monthly contribution toward health insurance premiums varies by bargaining group. Generally, 8 hours of unused sick leave equals between $400 and $700 based on your group's MOU, Board Resolution and your years of County service.

The amount of sick leave hours that you can use per month depends on your group's MOU or Board Resolution. The higher amount of sick leave hours you elect has a greater County contribution to your monthly premium. However, using a higher amount of hours would mean that your sick leave balance will exhaust faster. You can change your sick leave credits at Open Enrollment or within 31 days of a qualifying life event.

Example:

Retiree A and B have 120 hours of sick leave at retirement and are in the same bargaining unit. Retiree A chooses to use 8 hours of sick. Retiree B chooses to use 14 hours of sick leave. The County's contribution to Retiree B is higher because she is using more sick leave credits per month. However, the duration of the County's contribution to Retiree B's premiums will be shorter than the duration of the County's contribution to Retiree A.

	Retiree A	**Retiree B**
Sick leave at retirement	120 hours	120 hours
Sick leave credits used per month	8 credits	14 credits
County contribution per month	$400	$700
Duration of County contribution	15 months	9 months

For illustrative purposes only

Retiree Health FAQs

Additional information about retiree health benefits by bargaining group is located later in this guide. Complete details on an employee's retiree health benefits can be found in that employee's applicable Memorandum of Understanding located on the County's website at http://hr.smcgov.org/employee-and-labor-relations.

How do I pay for my insurance premiums?

If you retired before January 1, 2017, have a signed authorization, and already have a deduction from your pension check

- If you are using your sick leave credit to partially pay for your medical premiums, SamCERA will automatically deduct your premiums from your pension check.
- Once your sick leave credits have been exhausted and you want to pay for your premiums in full, you will receive a letter from Benefits Coordinators Corporation (BCC) with instructions on how you can pay for your premiums.

If you retired after January 1, 2017

- Bank account information will be required to deduct your monthly premium from the account that you noted on the Electronic Fund Transfer form.

- The County's 3rd party administrator for retiree health, Benefit Coordinators Corporation (BCC) will deduct your applicable premium one to two days after your pension is deposited.

Is my deduction for health insurance pre-tax?

No, all health insurance deductions for retirees are post-tax.

Am I taxed on the County's contribution to my retiree health insurance?

No, the County's contribution to your insurance is not included in a retiree's taxable income. There is one exception to this rule:

- Alternate Health Plan –For retirees who move out-of-area and opt for the Alternate Health Plan (discussed in more detail later in this Guide), the monthly County contribution is deposited in the retiree's bank account. This amount becomes taxable to the retiree.

Does the County's contribution cover my dependents?

Most MOU's allow retirees to apply the County's contribution toward coverage for retiree, spouse/domestic partner, or children up to age 26.

Retiree Health FAQs

If I don't want or need to use sick leave toward retiree health coverage, can I cash out my sick leave?

Unfortunately, the County prohibits employees from cashing out sick leave. If you don't use your hours towards either health or dental, you lose those hours.

Do the premiums change every year?

Yes. Although the County aggressively negotiates health plan renewals in an effort to control increasing benefit costs for retirees, health insurance premiums typically increase between 5% and 12% every year. Factors fueling increased costs include: increased use of new medical technologies, higher prescription drug costs, pressure on health insurance plans and the private sector to absorb higher costs as funding for public programs like Medicare and Medicaid decreases, and increased utilization due to the economic environment.

What are the current health premiums?

Please see page 41 for current medical and dental premiums.

OPTIONS FOR ENROLLING DEPENDENTS

Who is eligible to be on my retiree plan?

- Your current spouse or domestic partner.
- Your natural children, stepchildren, domestic partner's children, foster and/or adopted children under 26 years of age
- Your disabled children age 26 or older.
- A tax-qualified dependent

This is a brief description of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents. The plan documents will govern in the event of any conflict between this description and the plan documents.

Retiree Health FAQs

How can I make changes to my retiree health outside of Open Enrollment?

You must complete and submit the Retiree Change Form with the required documentation to the Benefits Division within 31 days of the qualifying life event.

All changes will become effective first of the following month upon receipt of the completed change form.

Retiree Health Change Forms can be obtained by contacting Benefits Division at 650-363-1919, via email at benefits@smcgov.org or visit https://hr.smcgov.org/retiree-health-benefits-current-retirees.

When can I add or remove my dependents?

You are responsible for notifying the Benefits Division to update your dependent status during the plan year by completing the Retiree Change Form (marriage, birth, death, divorce, dissolution of domestic partnership, ineligibility of dependent child due to age/school status, etc.). Such notification must be made within 31 days that the status change occurs. Failure to submit the change form in a timely manner may impact dependent eligibility for health care continuation under COBRA, and may result in you incurring liability for medical expenses for non-eligible dependents.

MAKING CHANGES TO MY PLANS

When can I cancel my coverage?

You may cancel your coverage at any time by submitting a completed Retiree Change Form via email at benefits@smcgov.org or fax at (650)599-1573. A Medicare Disenrollment Form may be required if you are cancelling your County's Medicare coverage. The effective date of your cancellation will generally be the first of the following month. Please note that once you cancel your medical coverage you cannot re-enroll back into a County health plan in the future.

What if I move out of the area during retirement?

If you move out of the area, you may need to switch to a different health plan that offers coverage in your new area. Contact Benefits Division at 650-363-1919 to assist you with this transition.

Can I switch my plan during annual Open Enrollment?

Yes, retirees can only switch plans during Open Enrollment in October unless they experience a qualifying life event (moving out of the service area).

Can I switch my plan at retirement?

No, the plan that you are enrolled in as an active employee is the same plan you will have when you retire. You will need to wait until Open Enrollment unless you are moving out of the HMO service area.

Retiree Health FAQs

Can my benefits change when I'm in retirement?

The County's contribution amount based on your sick leave credits do not change. This is set at the time you retire. What can change are the types of plans that are offered to retirees and the plan design (co-pay amounts, deductibles etc.).

Can I add/drop dependents to my health plan?

You may add/drop eligible dependents during the year if you experience a qualifying life event, i.e. death of a spouse, divorce, marriage, domestic partnership, birth of a child, etc. Any change to benefits must be made within 31 days of a qualifying life event and completed Retiree Change form and required documentation must be submitted to Benefits Division. Otherwise you may only make changes during the annual Open Enrollment period.

When does my coverage as an active employee end?

Upon retirement, your medical, dental and vision plan coverage as an active employee ends on the last day of the month following your date of retirement or loss of eligibility. Your coverage ends on the date of your retirement for your Flexible Spending Accounts, Group Life/AD&D, Long Term Disability, and Employee Assistance Program.

Can I cancel my benefits anytime?

As a retiree, you have the option of terminating your health coverage at any time. Once you decide to terminate coverage, however, you will forfeit the option of ever opting back in to the retirement health plans. You will only be eligible for the Voluntary Dental or Vision Plans.

TERMINATION OF VOLUNTARY DENTAL AND VISION PLAN PROVISION:

- Retirees who are cancelled because of non-payment of premiums will be excluded from participation in any of the Retiree Voluntary Benefits Plans in the future and will waive their right to enroll in any of the Retiree Voluntary Benefits Plans in the future.
- Please note: Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2022-December 2022.

About Medicare

Where do I find out about my medical benefits with Medicare?

If you are approaching 65 and reaching eligibility for Medicare, you will need to be aware of the transition process and any action that might be required on your part. The best resource for finding out about Medicare is the official publication, "Medicare & You", published annually by The Centers for Medicare and Medicaid Services (CMS). You can find this publication and other valuable information at www.Medicare.gov. You can also look in the Retiree Guide Benefits for Retirees Over 65.

What happens when I or one of my dependents become Medicare eligible?

Once retired, individuals must enroll in Medicare Part A and B three (3) months before their 65th birthday or risk paying a penalty to Social Security. You and your eligible family members must enroll in Medicare Part A and B or you will be dropped from coverage. The Benefits Division will send you a reminder letter 3 months prior to your or your covered dependents 65th birthday.

How do I enroll in Medicare?

About three (3) months before your 65th birthday, the Social Security office will send you information about enrolling in Medicare. You must enroll in both Medicare Part A (hospital coverage) and Part B (Outpatient coverage). You do not enroll in Part D (prescription drugs) because this benefit is already included in the County's plans.

Once you are enrolled in Medicare, you will need to choose from one of the Medicare plans (Kaiser Senior Advantage, or the Blue Shield Medicare Advantage PPO). You will need to complete an enrollment application form for the plan you elect. The enrollment form along with a copy of your Medicare Card showing both Medicare Part A and Part B must be returned to the County's Benefit Office benefits@smcgov.org or faxed to (650)599-1573prior to enrollment in the plan.

It is critical that you complete and submit this form before your 65th birthday. If you do not enroll in Medicare Part B during your Special Enrollment Period, you'll have to wait until the next General Enrollment Period, which is January 1 through March 31 of each year. You may then have to pay a higher Medicare Part B premium because you did not enroll in a timely manner.

About Medicare

What is an "Advantage" plan?

An Advantage plan is a managed care or HMO plan in which you "assign" your Medicare. Assigning your Medicare means that you are enrolled in Medicare through the plan (Kaiser Senior Advantage, Blue Shield Medicare Advantage PPO or United Healthcare-Secure Horizons). This means that when you choose to enroll in Kaiser Senior Advantage, Blue Shield Medicare Advantage PPO or United Healthcare -Secure Horizons, you assign your Medicare to the insurance plan. This means that Kaiser, Blue Shield or United Healthcare provides your Medicare Parts A and B coverage.

Do I need both my Medicare Card and my Kaiser, United HealthCare or Blue Shield Medicare PPO when I see medical services?

Your Medicare card is not needed for all Medicare plans.

Do I need to pay Part B premiums as a retiree on a County plan?

Yes. Part B premiums are set every year by the social security office. In order to remain on a County Medicare plan, you must pay your Part B premiums to the Social Security Office.

What if my spouse turns 65 before me?

If your spouse turns 65 before you, your spouse will receive a letter 3 months before their 65th birthday requesting a copy of the Medicare card and application for one of our Medicare plans. Once received, you will automatically be adjusted to a "split plan" upon receipt of your spouse's Medicare application and copy of the Medicare Card. You will remain in a non-Medicare plan and your spouse will be enrolled in the Medicare plan which may reduce your premium costs.

About Medicare

What are the options for Split Coverage Families?

Split families are those families that may have some members eligible for Medicare and some members who are not.

Employees 65 or over (Medicare-eligible) with Dependents under 65 (non-Medicare)

- **If you elect the Blue Shield Medicare Advantage PPO plan**, your non-Medicare dependents would go on either the Active Blue Shield PPO plan, or the Active HMO plan.
- **If you elect the Kaiser Senior Advantage Plan**, your non-Medicare dependents would stay on the Kaiser Active plan. The Senior Advantage plan is almost identical to Active plan.

Employees under 65 (non-Medicare) with Dependent(s) over 65 (Medicare-eligible)

- **If you are on the Active Blue Shield HMO plans**, your Medicare–eligible dependents would go on the Blue Shield Medicare Advantage PPO plan
- **If you are on the Active Kaiser plan,** your Medicare-eligible dependents would go on the Kaiser Senior Advantage plan.

Summary of Retiree Health Benefits

This is intended to be a summary of the County's retiree health benefits. Complete details on an employee's retiree health benefits can be found in that employee's applicable Memorandum of Understanding located on the County's website at www.co.sanmateo.ca.us/hr (click on Employee and Labor Relations).

Represented Group	Retiree Health Benefit
American Federation of State, County and Municipal Employees (AFSCME) Service Employees International Union SEIU) Probation and Detention Association (PDA) Law Enforcement Unit (LEU) – Deputy Sheriff's (Non-Safety) San Mateo County Council of Engineers (SMCCE) Building Construction Trades Council (BCTC)	If hired prior to January 1, 2011 for AFSCME (May 1, 2011 for PDA, January 23, 2011 for SEIU, and July 10, 2011 for SMCCE, BCTC, DSA non-safety-LEU) If the employee has 10-14 years of service, the County pays $440 toward the monthly premium for one plan (either health or dental) for every 8 hours of sick leave remaining upon retirement. The employee can use up to 14 hours of sick leave to pay for the monthly premium, and can enroll in the other plans through COBRA. If the employee has more than 20 years of service, the 8-hour sick leave conversion is reduced to 6 hours. Employees are credited with additional sick leave hours based on years of service. There may be an inflation factor of 2% for employees with 15-19 years of service and 4% for employees with 20+ years. If hired on/after January 1, 2011 for AFSCME (May 1, 2011 for PDA, January 23, 2011 for SEIU, and July 10, 2011 for SMCCE, BCTC, DSA non-safety- LEU) County pays $400 toward the monthly premium for one plan (either health or dental) for every 8 hours of sick leave remaining upon retirement. The employee can use up to 14 hours of sick leave to pay for the monthly premium, and can enroll in other plans through COBRA. Employees are credited with additional sick leave hours based on years of service. There may be an inflation factor of 2% for employees with 15-19 years of service and 4% for employees with 20+ years.

Summary of Retiree Health Benefits

Represented Group	Retiree Health Benefit
Union of American Physicians and Dentists (UAPD)	County pays $400 toward the monthly premium for one plan (either health, or dental or vision) for every 8 hours of sick leave remaining upon retirement. The employee can use up to 14 hours of sick leave to pay for the monthly premium, and can enroll in other plans through COBRA.
California Nurses Association (CNA) and Licensed Vocational Nurses (in AFSCME)	The County pays the full cost of the "Retiree Only" monthly premium for the retiree health plan for every 8 hours of sick leave remaining upon retirement up to a maximum of 240 months (for Licensed Vocational Nurses the maximum is 180 months). The employee can enroll in the dental and vision plans through COBRA.
Management, Confidential, Attorneys, Elected Officials	If hired before April 1, 2008 The County pays the full cost of the retiree + family monthly premium for the health, dental and vision plans for every 8 hours of sick leave remaining upon retirement. The employee can keep all three County plans in retirement. If hired between April 1, 2008 and December 31, 2010 The County pays $700 toward the monthly premium for the retiree health plan for every 8 hours of sick leave remaining upon retirement. The employee can keep all three County plans in retirement. The County pays the full cost of the dental and vision premiums for every 8 hours of sick leave upon retirement. The County also contributes $100 per month per employee to a post-employment health reimbursement account on a pre-tax basis. Upon retirement or termination, payments made for eligible premiums or medical expenses are not taxed. If hired on/after January 1, 2011 The County pays $400 toward the monthly premium for the retiree health plan for every 8 hours of sick leave remaining upon retirement.

Summary of Retiree Health Benefits

Represented Group	Retiree Health Benefit
Management, Confidential, Attorneys, Elected Officials	Elected Officials hired on/after January 1, 2011 For elective officers who retire concurrently with separation from County service, for each month of County service, the County will pay $400 toward the premium for one month of the retiree health plan and the full cost of one month of the dental and vision coverage.
Deputy Sheriff's Association (Safety)	Employees hired prior to April 1, 2011- Tier 1 Employees If employees agreed to a continued salary deduction into the retirement Tier 1 benefit, for each eight (8) hours of unused sick leave at time of retirement, the County shall pay for one month's premium for health, dental, and/or vision coverage for the employee and eligible dependents (if such dependents are enrolled in the plan at the time of retirement) provided that the County shall not be obligated to contribute in excess of $675 per month. Employees may increase the number of hours per month to be converted up to a maximum of fifty (50) hours of sick leave per month. Employees hired after June 30, 2011 and those employees in Tier 2 For each 8 hours of unused sick leave at time of retirement, the County shall pay for one month's premium for health, dental, and/or vision coverage for the employee and eligible dependents (if such dependents are enrolled in the plan at the time of retirement) provided that the County shall not be obligated to contribute in excess of $400 per month. Employees may increase the number of hours per month to be converted up to a maximum of fifty (50) hours of sick leave per month.

Medical Benefits for Retirees Under 65

The County's medical plans are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. For Early Retirees, the County offers a choice of medical plans through **Blue Shield and Kaiser Permanente.**

blue of california

Blue Shield HMO – a Health Maintenance Organization (HMO) in which patients seek medical care from a doctor participating in the plan's network. If you join Blue Shield, you select a PCP within Blue Shield's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated through your PCP and will require a referral or authorization.

Blue Shield Trio ACO HMO – Trio is powered by a new innovation in healthcare: the accountable care organization (ACO). An ACO is a network of doctors and hospitals that share responsibility in providing high-quality coordinated care when needed while lowering the cost of delivering care more efficiently.

Trio works similar to a traditional HMO plan.

Blue Shield PPO – a Preferred Provider (PPO) plan allows members the flexibility to receive medical services from a PPO network doctor or out-of-network doctor.

- In Network (PPO): Medical services are provided through the Blue Shield PPO network. You are responsible for paying an annual deductible and a percentage of the cost of the services (generally 20% of Blue Shield's allowable amount).
- Out-of-network: This allows you to access services through any licensed doctor or hospital. You are responsible for paying a deductible and a higher annual percentage of the cost of care (generally 40% of Blue Shield's allowable amount).

*Note: The Blue Shield Medical PPO Out of Area is closed to new enrollees. Please contact the Benefits Division for more information.

Blue Shield High Deductible Health Plan - This is a plan that works in conjunction with a Health Savings Account (please see page 51). You use the same PPO Network that you would under the standard PPO plan. All of your Preventative services are covered in full. You pay for the entire cost of non-preventive services until you satisfy your annual deductible. From that point, you pay 10% of the cost for non-preventive services until you reach your Calendar Year Maximum. At that point, do not pay out of pocket for any services the rest of the year.

Medical Benefits for Retirees Under 65

Kaiser Permanente Traditional HMO – a Health Maintenance Organization (HMO) in which patients seek medical care within the plan's own facilities. Under this plan, most services and medicines are covered with a small co-payment. You select your doctor, or Primary Care Provider (PCP), from the staff at a local Kaiser Permanente facility. All of your care is provided at a Kaiser facility. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency.

Kaiser Permanente High Deductible Health Plan - This is a plan that works in conjunction with a Health Savings Account (please see page 51). You use the same Kaiser facilities that you would under the standard Kaiser plan. All of your Preventative services are covered in full. You pay for the entire cost of non-preventive services until you satisfy your annual deductible. From that point, you pay 10% of the cost for non-preventive services until you reach your Calendar Year Maximum. At that point, do not pay out of pocket for any services the rest of the year.

Medical Benefits for Retirees Over 65

blue of california

Blue Shield Medicare Advantage PPO

- In Network (PPO): Medical services are provided through the Blue Shield GMAPD-PPO network within California and Blue Card national network nationwide. You are responsible for paying for copays and coinsurance as outlined in your Evidence of Coverage (EOC) materials.
- Out-of-network: **This plan will only pay for services provided by healthcare providers who accept Medicare.** You will be responsible for 100% of the cost if you still choose to see a doctor who does not accept Medicare (even if they are in the Blue Shield network).

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage– a Health Maintenance Organization (HMO) in which patients seek medical care within the plan's own facilities. Under this plan, most services and medicines are covered with a small co-payment. You select your doctor, or Primary Care Provider (PCP), from the staff at a local Kaiser Permanente facility. All of your care is provided at a Kaiser facility. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency. Early Retirees can remain on the Kaiser plan; once you reach age 65, you will need to enroll in the Kaiser Senior Advantage plan.

SecureHorizons® by UnitedHealthcare

*Note: This plan is closed to **new** enrollees. Please contact the Benefits Division for more information.

A Health Maintenance Organization (HMO) in which patients seek medical care from a doctor participating in the plan's network. If you join United Healthcare, you select a PCP within Secure Horizon's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated through your PCP and will require a referral or authorization.

Comparison of HMO Plans

UNDER 65

	Blue Shield HMO	Blue Shield TRIO HMO Plan	Kaiser Traditional HMO	Kaiser HDHP
	In-Network	In-Network	In-Network	In-Network
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit	$0 per individual $0 family limit	$1,500 per individual $2,800 (per member in a family of two or more) $3,000 family limit
Annual Out-of-Pocket Max Individual Family	$1,000 $3,000	$1,000 $3,000	$1,500 $3,000	$3,000 per individual $3,000 (per member in a family of two or more) $6,000 family limit
Physician/Professional Services				
Office Visits				
Physician & Specialist	$15 copay	$15 copay	$15 copay	Plan pays 90% after deductible
Access+ Specialist (Allows you to seek care from a specialist without a referral from your PCP)	$30 copay	$30 copay	Not applicable	Not applicable
Telemedicine	No Charge	No Charge	No Charge	No Charge
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic and Acupuncture Care	$10 copay (up to 30 visits per year)	$10 copay (up to 30 visits per year)	$15 copay (up to 20 visits per year)	Not covered
Lab and X-ray	Plan pays 100%	Plan pays 100%	$5 copay then plan pays 100%	Plan pays 90% after deductible
Infertility				
Testing and Treatment	50% of allowable Charge	50% of allowable Charge	50% of allowable Charge	50% of allowable Charge after deductible
Assisted Reproductive Technology (ART) Services GIFT, In Vitro Fertilization (IVF), ZIFT, Transfer of cryopreserved embryos	Not Covered	Not Covered	50% of allowable Charge	50% of allowable Charge after deductible
Artificial Insemination	Not Covered	Not Covered	50% of allowable Charge	50% of allowable Charge after deductible
Family Planning				
Physicians Family Planning Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Vasectomy	$75/surgery	$75/surgery	$50 per procedure	Plan pays 90% after deductible
Tubal Ligation	Plan pays 100%	Plan pays 100%	$50 per procedure	Plan pays 90% after deductible

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents.
In case of any discrepancies, the official plan documents will govern

Comparison of HMO Plans

UNDER 65

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

Prescription Drugs

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

	Blue Shield of CA		Kaiser Permanente	
	HMO	TRIO	Traditional HMO	HDHP
	In-Network	In-Network	In-Network	In-Network (After Plan Deductible)
Pharmacy				
Generic	$15 per prescription	$15 per prescription	$10 per prescription	$10 per prescription
Preferred Brand	$25 per prescription	$25 per prescription	$20 per prescription	$30 per prescription
Non-preferred Brand	$40 per prescription	$40 per prescription	$20 per prescription	$30 per prescription
Specialty Drugs	20% up to $100 max per prescription		$20 per prescription (30 day supply)	$30 per prescription
Supply Limit	30 days	30 days	100 days	30 days
Mail Order				
Generic	$30 per prescription	$30 per prescription	$10 per prescription	$20 per prescription
Preferred Brand	$50 per prescription	$50 per prescription	$20 per prescription	$60 per prescription
Non-preferred Brand	$80 per prescription	$80 per prescription	$20 per prescription	$60 per prescription
Specialty Drugs	Not Covered	Not Covered	$20 per prescription (30 day supply)	Not Covered
Supply Limit	90 days	90 days	100 days	100 days

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

Comparison of PPO Plans

UNDER 65

	Blue Shield PPO Plan		Blue Shield of CA HDHP	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible				
Individual	$200	$500	$1,500	
Family	$200 (individual) $600 (family)	$500 (individual) $1,000 (family)	$2,800 (individual) $3,000 (family)	
Annual Out-of-Pocket Max				
Individual	$2,000	$4,000	$3,000	$6,000
Family	$2,000 (individual) $4,000 (family)	$4,000 (individual) $8,000 (family)	$3,000 (individual) $6,000 (family)	$6,000 (individual) $12,000 (family)
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Physician/Professional Services				
Office Visits				
PCP & Specialist	Plan pays 80%	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Telemedicine	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Preventive Services	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Not covered
Chiropractic and Acupuncture Care	Plan pays 80% after deductible (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)	Plan pays 90% after deductible (up to 20 visits per year) *Acupuncture: Not Covered*	Plan pays 50% after deductible (in-network limitations apply) *Acupuncture: Not Covered*
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per day)	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)
Infertility				
Testing and Treatment	Not Covered	Not Covered	Not Covered	Not Covered
Assisted Reproductive Technology (ART) Services	Not Covered	Not Covered	Not Covered	Not Covered
GIFT, In Vitro Fertilization (IVF), ZIFT, Transfer of cryopreserved embryos	Not Covered	Not Covered	Not Covered	Not Covered
Artificial Insemination				

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

Comparison of PPO Plans

UNDER 65

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

Comparison of PPO Plans

UNDER 65

	Blue Shield PPO Plan		Blue Shield HDHP	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Other Services				
Transgender	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Orthotic and Prosthetic Devices	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility Up to 100 days per Member, per Benefit Period	Plan pays 80% after deductible	**Freestanding SNF:** Plan pays 80% after deductible **Hospital-based:** Plan pays 60% after deductible (up to $600 per day)	Plan pays 90% after deductible	**Freestanding SNF:** Plan pays 90% after deductible **Hospital-based:** Plan pays 60% after deductible (up to $600 per day)

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

Prescription Drugs

UNDER 65

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

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

Comparison of Health Plans

OVER 65

MEDICAL BENEFITS	BLUE SHIELD MEDICARE ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare ** Within Blue Shield Network and Accepts Medicare	BLUE SHIELD MEDICARE ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare ** Outside Blue Shield Network and Accepts Medicare	KAISER PERMANENETE SENIOR ADVANTAGE	UNITED HEALTHCARE SECURE HORIZONS HMO
Deductible	None		None	None
Maximum Annual Out of Pocket Maximum	1,500 per person		$1,500 per person $3,000 per family	$6,700 per person
Service Area	Nationwide. Emergency Care Worldwide		Limited to Kaiser Permanente medical facilities service areas. Worldwide in emergency only.	Limited to a 30-mile radius for Non-emergency Care. Emergency Care Worldwide
Choice of Doctors and Hospitals	Any provider or facility who accepts Medicare		Limited to Kaiser-Permanente doctors and hospitals except in emergency.	Limited to Provider Contracts
Inpatient/Room & Board	Covered in full	Covered in full	Covered in full	$250 copay
Out Patient Surgery	$10 copay	$10 copay	$10 per procedure	$125 copay
Emergency Room	$20 (waived if admitted)	$20 (waived if admitted)	$20 (waived if admitted)	$50 (waived if admitted)
Hospice Care	Provided any Medicare-certified hospice program.	Provided any Medicare-certified hospice program.	Provided by licensed hospice approved by the medical group and certified by Medicare.	Provided by licensed hospice approved by the medical group and certified by Medicare.
Skilled Nursing Facility (SNF)	Covered in full (days 1-100) for each stay in a Medicare- certified nursing facility. There is a limit for 100 days for each benefit period. If you go over the 100 day limit, you will be responsible for all costs	Covered in full (days 1-100) for each stay in a Medicare- certified nursing facility. There is a limit for 100 days for each benefit period. If you go over the 100 day limit, you will be responsible for all costs	Covered in full up to 100 days per benefit period.	Days 1-20: Covered in full Days 21-100: $50 copay per day up to 100 days in a SNF per benefits period.

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents.
In case of any discrepancies, the official plan documents will govern

Comparison of Health Plans

OVER 65

MEDICAL BENEFITS	BLUE SHIELD MEDICARE ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare ** Within Blue Shield Network and Accepts Medicare	BLUE SHIELD MEDICARE ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare ** Outside Blue Shield Network and Accepts Medicare	KAISER PERMANENETE SENIOR ADVANTAGE	UNITED HEALTHCARE SECURE HORIZONS HMO
Physician Care	$10 copay Primary Care Physician $20 copay Specialists	$10 copay Primary Care Physician $20 copay Specialists	$10 per office visit	$10 copay Primary Physician $20 copay Specialists
Preventive Care (including annual gynecological exams and mammograms)	Medicare assigned providers: Covered in full	Medicare assigned providers: Covered in full	Covered in full.	Covered in full.
Vision (Optical)	Medicare Covered: $20 copay Non-Medicare Covered: $10 copay ($150 combined allowance for lenses & frames every 24 months)	Medicare Covered: $20 copay Non-Medicare Covered: $10 copay ($150 combined allowance for lenses & frames every 24 months)	$10 per exam $150 combined allowance for lenses & frames every 24 months	$20 copay (1 exam every 12 months)
Dental Care	Not covered	Not covered	Not covered	Routine Cleaning: $15 copay/visit (per 6 months)
Hearing Services	$20 copay per visit Discount on hearing aids	$20 copay per visit Discount on hearing aids	Routine Exam: $10 copay Hearing Aids: Not covered	Covered in full. Routine hearing exam. $20 Specialist Hearing Aids: $500 every 36 months.
Acupuncture	For Medicare covered: $0 copay, 12 visits in 90 days): Non-Medicare covered: $15 copay up to 20 visits a year	For Medicare covered: $0 copay, 12 visits in 90 days): Non-Medicare covered: $15 copay up to 20 visits a year	$15 copay 20 combined visits	Covered under Medicare-50% coinsurance.
Chiropractic	For Medicare covered: $20 copay Non-Medicare covered: $15 copay up to 20 visits/year	For Medicare covered: $20 copay Non-Medicare covered: $15 copay up to 20 visits/year		
Prescriptions	***Please see next page***		**Retail:** $10 per prescription 100 day supply for most maintenance medications.	***Please see next page***

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

Comparison of Health Plans

OVER 65

PRESCRIPTION DRUG BENEFITS	blue california Medicare Advantage		SecureHorizons® by UnitedHealthcare	
	Retail (30 day supply)	Mail Order (90 day supply)	Retail (30 day supply)	Mail Order (90 day supply)
Stage 1: Annual Prescription Deductible	No deductible, this payment stage doesn't apply.		No deductible, this payment stage doesn't apply.	
Stage 2: Initial Coverage	You pay the following until your total out-of pocket drug costs reach **$4,430**		You pay the following until your total out-of pocket drug costs reach **$4,430**.	
Tier 1: Preferred Generic	$10 copay	$20 copay	$10 copay	$20 copay
Tier 2: Preferred Brand	$20 copay	$40 copay	$20 copay	$40 copay
Tier 3: Non-Preferred Drugs	$35 copay	$60 copay	$60 copay	$40 copay
Tier 4: Specialty Tier	30% coinsurance (up to a $150 copay max) per prescription	Not covered	$20 copay	$40 copay
Stage 3: Coverage Gap Stage	Because there is no coverage gap for the plan, this payment stage does not apply to you.		After your total drug costs reach **$4,430**, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach **$7,050**, your share of the cost for a covered drug will be **$0**.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the greater of: · 5% coinsurance, or · **$3.70** copay for generic (including brand drugs treated as generic) and a **$9.20** copay for all other drugs.	

Enhanced Services

blue of california

MOBILE APP

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

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

MICROSITE

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

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

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

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

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

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

Enhanced Services

blue of california

FOR MEDICARE ADVANTAGE PPO MEMBERS

SilverSneakers by Tivity Health

Blue Shield Medicare PPO members who want to be fit and active have access to SilverSneakers. SilverSneakers is a lifestyle program that can improve your overall health and well-being.

Medicare PPO Advantage members will have access to:

- Virtual exercise classes
- Social networking
- Online education
- Fitness locations
- Local resources

What To Expect From SilverSneakers

Work out from home
Skip the stress of trying to social distance at the gym. With live fitness sessions, keep up with your workout routine, without leaving home. Enjoy full-length live classes and workshops with SilverSneakers Live. www.silversneakers.com/live

Get more great features with the app
Download the SilverSneakers GO™ app and select workout programs you can tailor to your individual fitness level. You can use the app to schedule reminders, track your progress, and more.

For more information, call (866) 584-7389 [TTY: 711], Monday through Friday, 5 a.m. to 5 p.m. Pacific time or visit SilverSneakers.com.

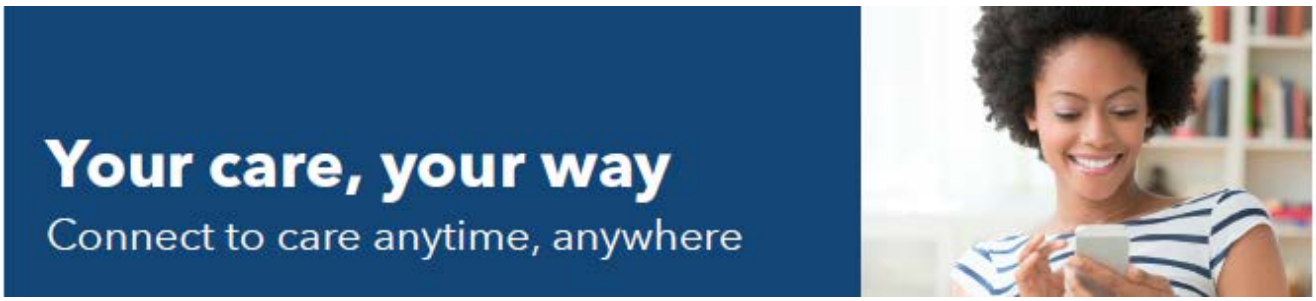
VISION COVERAGE THROUGH VISION SERVICE PLAN (VSP)

Vision benefit administered by Vision Service Plan (VSP) is included in your coverage under the Blue Shield Group Medicare Advantage PPO plan. VSP offers MA PPO members one of the largest national networks of independent doctors located in retail settings, neighborhood, and medical and professional settings which will provide you with the greatest access to the most high-quality doctors, including 8,100 provider settings in California.

- VSP Doctors are full service; providing you routine exams and dispensing a wide variety of materials that are included in your benefit plan
- You can lower any out of pocket expense by choosing a network provider for covered services
- A list of local participating providers may be located through the online directory at blueshieldca.com/fad
- As a VSP member through Blue Shield, you can also take advantage of additional savings through VSP's member offerings by visiting https://www.vsp.com/offers

Enhanced Services

KAISER PERMANENTE®



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

24/7 care advice

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

In-person visit

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

Email

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

Phone appointment

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

Video visit

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

E-visit

Get quick online care for common health problems.

Fill out a short questionnaire about your symptoms, and a physician will get back to you with a care plan and prescriptions (if appropriate) – usually within 2 hours.

Need care now?

Know before you go.

Urgent care

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition.

This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

Emergency care

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

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

1 If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your Evidence of Coverage or other coverage documents.

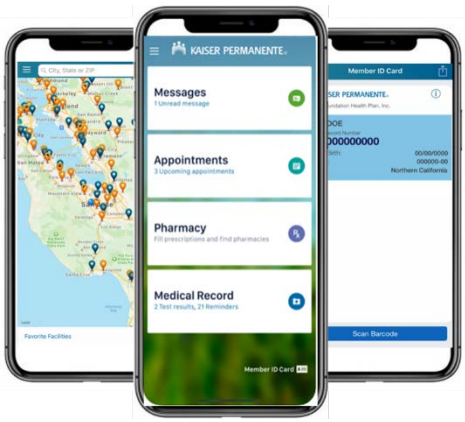
2 These features are available when you receive care at Kaiser Permanente facilities.

3 When appropriate and available.

Enhanced Services

KAISER PERMANENTE MOBILE APP

It's convenient and easy to use
Not sure if you need an appointment? Get advice, then schedule an appointment from the quick service menu.



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

DIGITAL SELF CARE TOOLS

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

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

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

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

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

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

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

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

Enhanced Services

Silver&Fit® HEALTHY AGING AND EXERCISE PROGRAM

The Silver&Fit® Healthy Aging and Exercise Program is available to Kaiser Permanente Senior Advantage members. Since you don't have to be a lifelong athlete to be active as an older adult, this program makes it easier for you to get fit and stay motivated - **at no additional cost**.

You can choose your preferred exercise program:

Fitness Center Membership

Choose from Silver&Fit's broad network of participating fitness centers where you can:

- Workout with cardio and strength-training equipment
- Access their amenities such as saunas or pools
- Attend Silver&Fit classes including yoga, swimming, strength and cardio training, and more

Home Fitness Program

Kaiser makes it way to fit fitness into your day – right where you're most comfortable. With home fitness program, you'll get:

- Up to 2 home fitness kits each calendar year which may include an instructional DVD and printed guide, and one Stay Fit kit, which includes your choice of a Fitbit® or Garmin® wearable device, yoga kit or strength exercise kit
- Access to online exercise classes, Signature Series Classes at silverandfit.com

TO SIGN UP

Register at SilverandFit.com or call 1-877-750-2746 (TTY 711), Monday through Friday, 5am to 6pm Pacific Standard Time.

*** The Silver&Fit Program is provided by American Specialty Health Fitness., Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). The Silver&Fit program is available to current members of participating Kaiser Permanente Group Medicare health plans. ***

Enhanced Services

VIRTUAL DOCTOR VISITS

With Virtual Doctor Visits, you're able to live video chat[1] with a doctor from your computer, tablet or smartphone — any time, day or night. You can ask questions, get a diagnosis, or even get medication prescribed and have it sent to your pharmacy. All you need is a strong internet connection. **You may want to prepare ahead by setting up an account for a Virtual Doctor Visit so you're all set when it's time to make an appointment.** Doctor on Demand and AmWell are part of the UnitedHealthcare provider network bringing you this innovative service.[2]

TWO WAYS TO ACCESS VIRTUAL DOCTOR VISITS

On your computer:

Visit uhcvirtualvisits.com and set up your account with either AmWell or Doctor on Demand.

On your tablet or smartphone:

Download the Doctor on Demand App

Or, download the American Well app

If you are experiencing a medical emergency, you should seek appropriate emergency medical assistance such as calling "911".

[1] The device you use must be webcam-enabled.

[2] Providers listed may not be available in every area. Other providers are available in our network. Contact the Customer service number on the back of your Member ID card for more information.

CAREGIVER SERVICES THROUGH CARELINX

CareLinx — a nationwide community of over 500,000+ pre-screened, professional caregivers you can trust. CareLinx helps you easily find care uniquely matched to your needs. Caregivers can assist you with things such as:

- Access to transportation
- Medication reminders
- Companionship
- Assistance with your mobility
- Light housekeeping
- Personal care and hygiene
- Meal preparation and grocery shopping
- Help to stay active

As a UnitedHealthcare member, you may receive a one-time offer of 4 hours of free in-home care after your first purchase of 10 hours of care.

UHC wants to help you continue to live an enjoyable, independent lifestyle in your own home. You'll receive a **one-time offer** of 4 hours of free in-home care after your first purchase of 10 hours of care.

To take advantage of this offer call **CareLinx at 1-866-586-0799**, 8 a.m.–9 a.m. CT, Monday–Friday, 10 a.m.–6 a.m. CT, Saturday–Sunday.

For additional information, you can also visit www.carelinx.com/uhcgroupretiree

Voluntary Dental Benefits

The County offers two voluntary dental plans through Cigna for retirees: **DHMO and PPO plans.**

DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO)

Starting January 1, 2022, the County's DMHO plan will now be with Cigna. Here's how a DHMO plan works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then you **pay a fixed portion** of that cost, in addition to any allowable charge for upgraded materials (such as gold, high noble metal or porcelain used in molar restorations), complex rehabilitation or characterizations (for dentures). And your plan pays the rest. **There are no annual maximums and no deductibles**.

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) plan in which dental services are provided through the Blue Shield PPO network. You can choose any dentist in any location inside or outside of the Cigna network. How much you pay for dental services depends on how long you have worked for the County, your represented group, and whether you choose a participating Cigna dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Cigna (the "allowable amount") and the dentist's charges. Pre-authorization from Cigna is recommended for charges of $200 or more. Orthodontic treatment is not a covered service.

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

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

Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2022 through December 2022

Voluntary Dental Plans

Dental Benefits	Cigna Dental HMO (Voluntary)	Cigna Dental PPO (Voluntary)	
Diagnostic and Preventive	**Member Pays:**	**In Network**	**Out of Network[1]**
Office Visit	No Charge	No Charge	Plan Pays 80% (no deductible)
Teeth Cleaning	No Charge		
X-Rays	No Charge		
Sealants - *per tooth*	No Charge		
Restorative			
Amalgam Filling - *1-3 surfaces*	No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Composite Filling - *1-3 surfaces*	No Charge		
Periodontics			
Scaling and Root Planning - per quad	No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Gingivectomy (Per Quadrant)	No Charge		
Osseous Surgery	No Charge		
Endodontics (Root Canal Therapy)			
Pulp Cap	No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Therapeutic Pulpotomy	No Charge		
Root Canal Therapy - (anterior, bicuspid, molar)	No Charge		
Prosthodontics			
Immediate - Upper or Lower	No Charge	Plan Pays 50% (after deductible)	Plan Pays 50% (after deductible)
Complete - Upper or Lower	No Charge		
Partial Denture - Upper or Lower	No Charge		
Crown and Bridge			
Inlay / Onlay	No Charge	Plan Pays 50% (after deductible)	Plan Pays 50% (after deductible)
Crown - Porcelain/Ceramic Substrate	No Charge		
Crown - Porcelain Fused to High Noble Metal	No Charge		
Crown - Full Cast High Noble Metal	No Charge		
Oral Surgery (Extractions)			
Impacted tooth: soft tissue	No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Impacted tooth: partial bony	No Charge		
Impacted tooth: full bony	No Charge		
Implants			
Implants	Not Covered	Plan Pays 50%	Plan Pays 50%
Orthodontics - comprehensive			
Child	No Charge	Not Covered	
Adult	No Charge		
Calendar Year Maximum			
Individual	N/A	$1,500	$1,500
Calendar Year Deductible			
Individual / Family	N/A	$50 / $150	

1 Based on Maximum Allowable Charge (In Network Fee Level)

Note: Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2022-December 2022

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

Dental Plans

Dental Benefits	Cigna Dental PPO (Represented)		Cigna Dental PPO (Management)	
Diagnostic and Preventive	**In Network**	**Out of Network[1]**	**In Network**	**Out of Network[1]**
Office Visit Teeth Cleaning X-Rays Sealants - *per tooth*	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Restorative				
Amalgam Filling - *1-3 surfaces* Composite Filling - *1-3 surfaces*	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Periodontics				
Scaling and Root Planning - per quad Gingivectomy (Per Quadrant) Osseous Surgery	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Endodontics (Root Canal Therapy)				
Pulp Cap Therapeutic Pulpotomy Root Canal Therapy - (anterior, bicuspid, molar)	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Prosthodontics				
Immediate - Upper or Lower Complete - Upper or Lower Partial Denture - Upper or Lower	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Crown and Bridge				
Inlay / Onlay Crown - Porcelain/Ceramic Substrate Crown - Porcelain Fused to High Noble Metal Crown - Full Cast High Noble Metal	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Oral Surgery (Extractions)				
Impacted tooth: soft tissue Impacted tooth: partial bony Impacted tooth: full bony	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Implants				
Implants	Plan Pays 50% Up to $1,000	Plan Pays 50% Up to $1,000	Plan Pays 100%	Plan Pays 100%
Orthodontics - comprehensive				
Child Adult	Not Covered		Not Covered	
Calendar Year Maximum				
Individual	$2,500	$2,500	None	
Calendar Year Deductible				
Individual / Family	None		None	

1 Based on Maximum Allowable Charge (In Network Fee Level)

Note: The opportunity to stay in a represented or management dental plan upon retirement is based on your Union's Memorandum of Understanding (MOU) or the Board Resolution.
If at any time you terminate this coverage, you will be waiving your right to return to this plan and will only have the option of enrolling in one of the Voluntary Plans.

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

Voluntary Vision Plan

VSP

More information about the VSP plan is available online at http://hr.smcgov.org/employee-benefits; click on Vision Plan.

Looking for the Perfect Pair?
Visit eyeconic.com!
VSP's online store lets you use apply your benefits directly to your purchase.

Vision Benefits	In Network	Out-of-Network Reimbursement
Exam Copay	$10	Up to $50
Prescription Glasses Copay	$10	Up to $70
Annual Eye Exam	Covered in Full	Up to $50
Single Lenses	Covered in Full	Up to $50
Bifocal Lenses*	Covered in Full	Up to $75
Trifocal Lenses*	Covered in Full	Up to $100
Contacts Fit & Follow Up Exams	15% Discount	No Benefit
Contact Lenses**		
Elective	Up to $150; 15% off over $150	Up to $105
Medically Necessary	Covered in Full	Up to $210
Frames	$130 Allowance; 20% off over $130 $70 Costco/Walmart/ Sam's Club frames	Up to $70
Benefit Frequency		
Exam	Every 12 Months	
Lenses	Every 12 Months	
Frames	Every 24 Months	

* Progressive bifocals may be purchased for the difference in cost

** Contact lenses are in lieu of spectacle lenses and frames

Note: Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2022-December 2022

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

2022 Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES UNDER 65

CARRIER	MONTHLY PREMIUM
BLUE SHIELD HMO	
Employee Only	1,242.92
Employee +1	2,485.86
Employee + Family	3,517.50
BLUE SHIELD TRIO HMO	
Employee Only	962.80
Employee +1	1,925.60
Employee + Family	2,724.72
BLUE SHIELD HDHP	
Employee Only	1,027.74
Employee +1	2,055.50
Employee + Family	2,908.54
BLUE SHIELD PPO	
Employee Only	1,585.50
Employee +1	3,293.04
Employee + Family	4,791.74
BLUE SHIELD PPO (Out-Of-Area) –Closed to New Enrollees	
Employee Only	1,242.92
Employee +1	2,485.86
Employee + Family	3,517.50
KAISER HMO	
Employee Only	704.16
Employee +1	1,408.32
Employee + Family	1,992.78
KAISER HDHP	
Employee Only	552.86
Employee +1	1,105.72
Employee + Family	1,564.58

2022 Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES 65 AND OVER

BLUE SHIELD MEDICARE ADVANTAGE PPO (MAPPO)

Single - Retiree with Medicare	400.20
Two-Party - Both with Medicare	800.40
Two-Party - Ret w/o Medicare (PPO), Spouse with Medicare (PPO)	1,985.70
Two-Party - Ret with Medicare (PPO), Spouse w/o (PPO)	2,107.74
Family - Ret with Med (PPO) + Spouse and Child without (PPO)	3,606.44
Family - Ret with Med, Spouse with Medicare & Child(ren) with Medicare	1,200.60

BLUE SHIELD ACCESS+ HMO and PPO (Medicare)

Two-Party - Ret with Medicare (PPO), Spouse w/o (HMO)	1,643.14
Two-Party - Ret w/o Medicare (HMO), Spouse with Medicare (PPO)	1,643.12
Family - Ret with Med (PPO) + Spouse and Child without (HMO)	2,674.78
Family - Ret & Spouse with Med (PPO) & Child without Medicare (HMO)	2,043.34

BLUE SHIELD HMO TRIO and PPO (Medicare)

Two-Party - Ret with Medicare (PPO), Spouse w/o (TRIO HMO)	1,363.00
Two-Party - Ret w/o Medicare (TRIO HMO), Spouse with Medicare (PPO)	1,363.00
Family - Ret with Med (PPO) + Spouse and Child without (TRIO HMO)	2,162.12
Family - Ret & Spouse with (PPO) & Child without Medicare (TRIO HMO)	1,763.20

BLUE SHIELD PPO (Out of Area)[1]

Two-Party - Ret with Medicare (PPO), Spouse w/o (OOA PPO)	1,643.14
Two-Party - Ret (OOA PPO) + Spouse with Medicare (PPO)	1,643.12
Family - Ret (OOA PPO) + Spouse with Medicare (PPO) + Child (OOA PPO)	2,886.06

[1] Closed to new enrollees.

2022 Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES 65 AND OVER

KAISER SENIOR ADVANTAGE

Single - Subscriber with Medicare	334.40
Two-Party - Subscriber with Medicare & Spouse with Medicare	668.80
Two-Party - Subscriber with Medicare & Dependent without Medicare	1,038.56
Two-Party - Subscriber without Medicare & Spouse with Medicare	1,038.56
Family - Subscriber with Medicare & Children without Medicare	1,623.02
Family - Subscriber with Medicare, Spouse without Medicare, & Child without Medicare	1,623.02
Family - Subscriber without Medicare, Spouse with Medicare, and Child without Medicare	1,623.02
Family - Subscriber with Medicare, Spouse with Medicare, and Children without Medicare	1,253.26
Family - Subscriber with Medicare, Spouse without Medicare, and Children without Medicare	1,623.02
Family - Subscriber without Medicare, Spouse with Medicare, and Children without Medicare	1,623.02
Family - Subscriber without Medicare, Spouse with Medicare, and Children with Medicare	1,372.96
Family - Subscriber with Medicare, Spouse with Medicare, and Children with Medicare	1,003.20

UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE[1]

Single - Retiree with Medicare	363.75
Two-Party - Both with Medicare	727.50

2022 Monthly Cost of Voluntary Dental & Vision Benefits

VOLUNTARY CIGNA DENTAL DHMO

Single	27.63
Two-Party	46.97
Family	71.84

VOLUNTARY CIGNA DENTAL PPO

Single	41.48
Two-Party	79.86
Family	143.26

VOLUNTARY VISION SERVICE PLAN (VSP)

Single	8.83
Two-Party	17.65
Family	28.41

MANAGEMENT AND REPRESENTED DENTAL RATES

If your Represented Union or Board Resolution provides you the opportunity to stay in a represented or management dental plan upon retirement, you will be able to continue on this plan when your available sick leave credits expire.

You will be charged the regular rate for this coverage. If at any time you terminate this coverage, you will be waiving your right to return to this plan and will only have the option of enrolling in one of the Voluntary dental plans during the open enrollment period.

CIGNA DENTAL DHMO

Management	42.98
Represented	42.98

CIGNA DENTAL PPO

Management	142.40
Represented	114.92

VISION SERVICE PLAN (VSP)

Management (Composite Rate)	16.52

2022 Monthly Cost of Health Benefit

OPERATING ENGINEERS

UNDER 65

PPO, DENTAL AND VISION

Employee Only	893.00
Employee +1	1,786.00
Employee + Family	2,411.00

KAISER, DENTAL AND VISION

Employee Only	947.00
Employee +1	1,708.00
Employee + Family	2,228.00

OVER 65

KAISER (MEDICARE)

Single - Subscriber with Medicare	430.00
Two-Party - Subscriber with Medicare & Spouse with Medicare	860.00
Family - Subscriber with Medicare, Spouse with Medicare, and Children with Medicare	1,265.00

PPO (MEDICARE)

Single - Subscriber with Medicare	893.00
Two-Party - Subscriber with Medicare & Spouse with Medicare	1,786.00
Family - Subscriber with Medicare, Spouse with Medicare, and Children with Medicare	2,411.00

Retiree Billing Process with BCC

Thirty (30) to ninety (90) days before you officially retire, you should meet with a Benefits Partner to complete your retiree paperwork which will include (among others) the Retiree Enrollment Form and BCC Electronic Fund Transfer Form (EFT).

WHAT TO EXPECT FROM BCC:

1. Last business day of the month, pension funds are deposited your bank account.
2. On the last business day of the coverage month, BCC will pull funds from your bank account for premium payment of benefits.
3. Use your bank statement as confirmation of payment.
4. Changes to banking accounts must be provided to BCC Customer Service at 800-685-6100 or to the Benefits Division at benefits@smcgov.org.

Preventive Care Screening Benefits

You take your car in for maintenance. Why not do the same for yourself?

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

What is Preventive Care?

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

Not all exams and tests are considered preventive

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

TYPICAL SCREENINGS FOR ADULTS

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

Preventive care for women should include breast and gynecological exams

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

Should I skip my checkup due to COVID-19?

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

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

Health and Wellness

The Wellness Program is designed to promote your health and well-being through a variety of health, fitness and educational programs, services and activities. By empowering retirees with health education and lifestyle skills, the Wellness Program plays a pivotal role in adopting a healthy lifestyle not just to live a long life, but a quality life where each person continues to be engaged and connected with others.

As a County retiree, you are encouraged to be proactive and take good care of your health. You can attend most health programs and classes at little or no cost to you. Listed below are the wellness programs that you can participate in:

Wellness Classes & Services

· Group Exercises Classes
· Mental Wellbeing Classes
· Nutrition Classes
· Physical Activity Classes
· Physical Activity Team Challenges
· Weight Loss Team Challenges
· Onsite Massage Therapy

Health Improvement Classes & Services

· Diabetes & Pre-diabetes Prevention Classes
· Heart Healthy Classes
· Mindfulness Meditation

Special Events/Community Outreach

· Blood Drives
· Farmers Market
· Health Club Information and Discounts
· Recreation tournaments: Basketball, Bowling, Soccer, Softball, Volleyball…

Health and Wellness

blue of california

Health and Wellness

- Flexible gym membership programs
- Weight management programs (under Wellvolution Diabetes Prevention Program)

Alternative Care (via American Specialty Health Group network)

- 25% off usual & customary fees on acupuncture, chiropractic & massage therapy services

Discount Hearing Program

- 30% to 60% off manufacturers' SRP on major brands through EPIC Hearing Healthcare. To learn more, call EPIC at (866) 956-5400 or visit **epichearing.com**

Vision Discounts

- Discounts on LASIK surgery. To find out if you are a potential candidate, call (877) 437-6110 or visit qualsight.com/-lasikca
- Get a 15% discount for services from NVISION Laser Eye Centers. To learn more, call NVISION at (877) 91-NVISION or (877) 916-8474, or visit NVISIONcenters.com to find a provider.

Learn more

See all the ways you can save money and take better care of yourself at www.blueshieldca.com/wellnessdiscounts

KAISER PERMANENTE

Wellness Programs

Complimentary programs can help you:

- Lose weight
- Eat healthier
- Quit smoking
- Reduce stress
- Manage ongoing conditions like diabetes or depression

kp.org/healthylifestyles

Member Discounts

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

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

kp.org/choosehealthy

Health Classes

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

CLASSPASS IS AVAILABLE!

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

Members can get:

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

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

Health and Wellness

UnitedHealthcare

Renew Active™ Fitness Program
Available with your UnitedHealthcare® Medicare Advantage plan at no additional cost.

Stay Fit
Work out where you want, whether that's at a gym or fitness location or from your home.

- A free gym membership
- Access to our extensive, nationwide network of gyms and fitness locations. It's the largest of all Medicare fitness programs*
- A personalized fitness plan
- Allows you to bring your caregiver to the gym with you, at no additional cost
- Access to thousands of workout videos with Fitbit PremiumTM — no Fitbit® device is needed

Stay Focused
An online brain health program from AARP® Staying Sharp® with exclusive content for Renew Active members.

- Online brain health assessment
- Brain health content and tools
- The Brain Health Staycation and Find Your Calm guides

Stay Connected
Connect with other health-minded members.

- Social activities at local health and wellness classes and events
- Step challenges with other members through the Fitbit Community for Renew Active — no Fitbit device is needed

Living Healthier with Renew
Renew Active is a key part of Renew, which offers a wide variety of health and wellness resources and activities that help inspire you to take charge of your health every day. Renew includes brain games, healthy recipes, learning courses, fitness activities, Renew magazine and more.

YOUR CODE IS KEY

Every Renew Active member has a unique confirmation code.
Write it down and use it to access your gym membership, create an account on AARP® Staying Sharp®, join the Fitbit® Community for Renew Active and gain access to Fitbit Premium™.

How to find your unique Renew Active confirmation code:

1. Sign into your plan website.
2. Click **Health & Wellness** in the upper right-hand corner.
3. Look for **Renew Active** on the right side of the page.
4. Your Renew Active Confirmation Code will start with a letter, followed by 9 digits. You will see it at the bottom of the screen.
5. If you have any questions or to get your confirmation code, please call Customer Service at the number on the back of your member ID card.

Health Savings Account

ADMINISTERED BY BENEFITS COORDINATION CORPORATION (BCC)

A Health Savings Account (HSA) is a special "tax advantaged" account owned by an individual that is used in conjunction with a High Deductible Health Plan (HDHP).

- This account comes with a debit card that you can use to pay for qualified medical expenses. For a detailed list of qualified medical expenses and further information, please refer to the plan documents. You will also be able to access your account online at the My SmartCare website
- Since your medical expenses may change within the year, you may change (increase or decrease) your contributions at any time
- In 2022, you can contribute a maximum of **$3,650** for employee only or **$7,300** for employee + one or more. This maximum includes both employer and employee contributions.

This money to help pay for qualified medical expenses.

- If you have remaining funds at the end of the year, they will roll over into next year, there is no "use it or lose it" rule.
- These funds can also earn interest or you can choose to invest the funds using the online investment tool. (Plan minimums apply)
- If you decide you do not want to be enrolled in the HDHP plan, this account stays with you.
- You may only contribute to the account if you are enrolled in a HDHP plan.

You may not continue to contribute to an HSA account once you are enrolled in Medicare. When you turn 65, you can use any unused funds in the account for any purpose, penalty free, but you will be subject to ordinary income tax.

FEES

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

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

Health Savings Account

DEBIT CARD

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

MY SMARTCARE MOBILE APP:

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

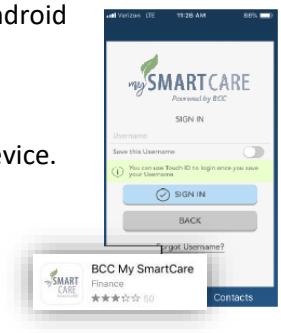
MY SMARTCARE ONLINE PORTAL

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

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

MY SMARTCARE MOBILE APP

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



New Users

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

MY SMARTCARE REGISTRATION GUIDE

- When registering as a new user, My SmartCare will walk you through a series of registration questions followed by a secure authentication process to validate you as a user.
- Use your **Social Security Number** as your Employee ID.
- Use your **Benefits Debit Card number or your Employer ID (BCCCSM)** as your **Registration ID**.
- By registering with My SmartCare, you will have the option to receive important push notifications (account balance, grace period, year-end reminders; notice of debit card mailed, etc.) via e-mail or text message. You can manage these notifications in your My SmartCare communication settings.
- You have the option to save your User ID to your mobile device by choosing 'ON' next to "Save this Online ID". This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial log in.

CUSTOMER SERVICE

800-685-6100
customersupport@benxcel.com

Additional Voluntary Benefits

You can sign up for this program any time throughout the year!

PET INSURANCE

Pet insurance protects your pet's health—and your budget. Your pet will have coverage for check-ups, accidents or illnesses, and significant medical problems – depending on the plan you choose. Plus, you'll have your choice of vets worldwide.

You can enroll for **My Pet Protection®** and **My Pet Protection with Wellness®.** All members receive free access to Vet Helpline, 24/7 telephone access to veterinary experts who can provide pet health guidance, answer general questions and identify urgent care needs.

You're not limited to just a few providers—you can visit any veterinarian worldwide.

URL: www.petinsurance.com/cosmretirees
Phone Number: 844.208.1108

IMPORTANT REMINDERS:

- When calling Nationwide, identify yourself as a **County of San Mateo Retiree** to take advantage of County rates and discounts.
- ***Two policies are offered: one with basic coverage and another with expanded Wellness features for your pet.***
- ***Multi-pet discounts are available.***
- There is a 14-day waiting period from date of application and payment of premium.
- Premium payments can be made via check, EFT, or credit card. Some fees may apply.
- 2 months of premium payment is required at time of enrollment.
- Please note that the County of San Mateo does not administer these plans.
- For plan information and administration, please contact Nationwide directly.

Additional Voluntary Benefits

You can sign up for this program any time throughout the year!

AUTO & HOME INSURANCE

Auto and home insurance offers competitive coverage and special savings, as well as free, no-obligation quotes from three leading carriers.

It's simple to comparison shop and potentially save money. Have your current policy out and ready when calling or submitting requests for quotes online. Having your current coverage and deductibles handy will provide for a better comparison quote.

NOTE: Multi-plans provide a higher discount rate so getting a quote for bundled auto and home policies could provide better overall savings.

In addition to auto and home insurance, you can apply for many different types of personal insurance coverage, including Condo, Renters, Fire, Boat, RV and Motorcycle. Visit the carrier websites below or call the carriers directly to start the quote process. Coverage and policy availability will vary by state.

YOU CAN CHOOSE FROM THE FOLLOWING CARRIERS:

Liberty Mutual INSURANCE	Webpage: https://www.libertymutual.com/countyofsanmateo Phone Number: 844.224.1114
FARMERS INSURANCE (formerly Metlife)	Webpage: https://www.myautohome.metlife.com Phone Number: 800.438.6381
TRAVELERS	Webpage: https://www.travelers.com/affinity/sponsor/countyofsanmateo Phone Number: 888.695.4640

IMPORTANT REMINDERS:

- When calling carriers, identify yourself as a **County of San Mateo Retiree** to take advantage of County rates and discounts.
- Premium payments can be made via check, EFT, or credit card. Some fees may apply.
- Please note that the County of San Mateo does not administer these plans.
- For plan information and administration, please contact the individual providers directly.

Key Carrier Contacts At-A-Glance

BLUE SHIELD TRIO CONCIERGE		
Group #W0014027	www.blueshieldca.com	(855) 829-3566
BLUE SHIELD HMO (Under 65) **BLUE SHIELD PPO** (Under 65) **BLUE SHIELD MEDICARE ADVANTAGE PPO** (65+)		
Group # W0014027	www.blueshieldca.com	(855) 256-9404 (under 65) (800) 776-4466 (65+)
KAISER PERMANENTE SENIOR ADVANTAGE (65+) **TRADITIONAL HMO** (UNDER 65)		
Group #7056-**0005**	www.kp.org	(800) 464-4000
UNITED HEALTHCARE GROUP MEDICARE ADVANTAGE HMO (65+)		
Group #515318	www.uhcretiree.com	(877) 714-0178
CIGNA DENTAL (DHMO & PPO)		
Group # 3340005	www.cigna.com	(800) 244-6224
VSP (VISION)		
Group #25600	www.vsp.com	(800) 877-7195
THE STANDARD (Life)		
Group #649107	www.standard.com	(800) 628-8600
EMPOWER (FORMERLY MASS MUTUAL) (Deferred Compensation)		
County of San Mateo	www.viewmyretirement.com/sanmateocounty	(800) 743-5274
SAN MATEO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION (SamCERA – Pension)		
County of San Mateo	www.samcera.org	(650) 599-1234
BENEFIT COORDINATORS CORPORATION (BCC)		
County of San Mateo	https://www.mywealthcareonline.com/bccsmartcare/	(800) 685-6100
OTHER RESOURCES		
California Health Insurance Advocacy Program (HICAP)	Free help with Medicare benefits and long term care insurance, including counseling, advocacy and general information	(800) 434-0222 (650) 627-9350 (San Mateo office) www.cahealthadvocates.org
Medicare	Official government site with all your Medicare information	(800) MEDICARE www.medicare.gov

Key Terms

MEDICAL/GENERAL TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUG TERMS

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

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

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

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

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

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

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

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

DENTAL TERMS

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

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

Endodontics - Commonly known as root canal therapy.

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

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

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

Periodontics - Diagnosis and treatment of gum disease.

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

Important Plan Notices and Documents

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

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

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

NOTICE OF CHOICE OF PROVIDERS

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

HIPAA PRIVACY NOTICE

COUNTY OF SAN MATEO PRIVACY PRACTICES NOTICE

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

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

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

Summary of Our Privacy Practices

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

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

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

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

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

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

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

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

Office: Benefits Division

Telephone: (650)363-1919

E-mail: benefits@smcgov.org

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

MEDICARE PART D NOTICE

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2022

Name of Entity: County of San Mateo

Contact: Human Resources- Benefits Division

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

Phone: (650) 363-1919

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

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

WHY AM I GETTING THIS NOTICE?

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

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

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

WHAT'S COBRA CONTINUATION COVERAGE?

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

WHO ARE THE QUALIFIED BENEFICIARIES?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

CAN I EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?

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

For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/general/topic/health-plans/cobra

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-

cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

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

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

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

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

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?

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

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

CAN I ENROLL IN ANOTHER GROUP HEALTH PLAN?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

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

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

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

FOR MORE INFORMATION

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

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

IMPORTANT INFORMATION ABOUT PAYMENT

FIRST PAYMENT FOR CONTINUATION COVERAGE

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

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

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

GRACE PERIODS FOR PERIODIC PAYMENTS

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

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

COUNTY OF SAN MATEO
HUMAN RESOURCES DEPARTMENT

RETIREE HEALTH ENROLLMENT FORM

Benefits Division
455 County Center, 5th Fl.
Redwood City, CA 94063
Phone: (650) 363-1919
Fax: (650) 599-1573
E-Mail: benefits@smcgov.org

SECTION 1a. RETIREE INFORMATION

LAST NAME | FIRST NAME | MIDDLE INITIAL | PARTICIPANT ID (CSM + 9-digit EID)

SOCIAL SECURITY # | DATE OF BIRTH | GENDER | MARITAL STATUS

CELLPHONE NUMBER | HOME NUMBER | EMAIL ADDRESS

STREET ADDRESS **NO PO BOX**

CITY | STATE | ZIP

SECTION 1b. RETIREE MEDICARE INFORMATION – COMPLETE ONLY IF ENROLLING IN A MEDICARE MEDICAL PLAN

MEDICARE NUMBER | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

SECTION 2. HR BENEFITS USE ONLY

DATE OF HIRE | TERM DATE | EFFECTIVE DATE OF RETIREE HEALTH | EMPLOYEE GROUP

SICK LEAVE HOURS @ RET | DISABILITY ADJ. | OTHER ADJ. | TOTAL SICK LEAVE HRS | SICK LEAVE HRS TO USE/MO. | CONTRIBUTION AMT

DIVISION | PAYROLL # | OCCUPATION CODE | PAYROLL ID | YRS OF SERVICE | JUDGE? | ANNUITANT CODE

SECTION 3a: COVERAGE ELECTION

MEDICAL ☐ WAIVE[1] ☐ Alternative Health Plan

Under 65 Plans
- ☐ Blue Shield HMO
- ☐ Blue Shield HMO Trio
- ☐ Blue Shield PPO
- ☐ Blue Shield PPO HDHP
- ☐ Kaiser HMO
- ☐ Kaiser HMO HDHP
- ☐ Op Eng Kaiser
- ☐ Op Eng PPO

Over 65 Plans
- ☐ Blue Shield Medicare Advantage PPO
- ☐ Kaiser Sr. Advantage

Coverage Election
- ☐ Retiree Only
- ☐ Retiree + 1
- ☐ Retiree + Family

DENTAL ☐ WAIVE
- ☐ Cigna DHMO - Represented
- ☐ Cigna DHMO - Management
- ☐ Cigna DPPO - Represented
- ☐ Cigna DPPO - Management
- ☐ Voluntary Cigna DHMO
- ☐ Voluntary Cigna DPPO

Coverage Election
- ☐ Retiree Only
- ☐ Retiree + 1
- ☐ Retiree + Family

VISION ☐ WAIVE
- ☐ VSP Represented
- ☐ VSP Management
- ☐ Voluntary Vision Service Plan

Coverage Election
- ☐ Retiree Only
- ☐ Retiree + 1
- ☐ Retiree + Family

Please note: COBRA coverage election is through our COBRA Administrator, BCC. Please refer to the COBRA Notification and FAQ.

SECTION 3b. DEPENDENT INFORMATION FOR RETIREE COVERAGE

LAST NAME | FIRST NAME
SOCIAL SECURITY # | DATE OF BIRTH

Gender: ☐ Male ☐ Female
Benefits: ☐ Medical ☐ Dental ☐ Vision
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: MEDICARE # | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

LAST NAME | FIRST NAME
SOCIAL SECURITY # | DATE OF BIRTH

Gender: ☐ Male ☐ Female
Benefits: ☐ Medical ☐ Dental ☐ Vision
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: MEDICARE # | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

LAST NAME | FIRST NAME
SOCIAL SECURITY # | DATE OF BIRTH

Gender: ☐ Male ☐ Female
Benefits: ☐ Medical ☐ Dental ☐ Vision
Relationship: ☐ Spouse ☐ Domestic Partner ☐ Child

COMPLETE ONLY IF ENROLLING IN MEDICARE PLAN: MEDICARE # | PART A EFFECTIVE DATE | PART B EFFECTIVE DATE

(Note: If you have more than three children, please attach a separate sheet of paper with the above information.)

Have you included stepchildren as dependents? ☐ NO ☐ YES - If "yes" indicate name/s:

Do your stepchildren reside with you? ☐ NO ☐ YES Are they dependent upon you for support and maintenance? ☐ NO ☐ YES

SECTION 4: INDIVIDUALS ENROLLING IN A MEDICARE MEDICAL PLAN REQUIRED ACKNOWLEDGEMENT, INFORMATION AND SIGNATURES

By completing this enrollment application, I agree to the following:

Blue Shield of California/Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Blue Shield of California/Kaiser Permanente serves a specific service area. If I move out of the area that Blue Shield of California/Kaiser Permanente serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue Shield of California/Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Member Handbook or Evidence of Coverage document from Blue Shield of California/Kaiser Permanente when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield of California/Kaiser Permanente coverage begins, I must get all of my health care from Blue Shield of California/Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield of California/Kaiser Permanente and other services contained in my Blue Shield of California/Kaiser Permanente Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR Blue Shield of California/Kaiser Permanente WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield of California/Kaiser Permanente, he/she may be paid based on my enrollment in Blue Shield of California/Kaiser Permanente.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Blue Shield of California/Kaiser

Permanente will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Option to request materials in language other than English (language preference) or in accessible formats.

Please contact Blue Shield of California Medicare Rx Plan at (888) 239-6469 [TTY 711] if you need information in an accessible format or language other English. Office hours are 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday) from April 1 through September 30.

Kaiser Permanente: Please contact Kaiser Permanente at 1-800-443-0815 if you need information in an accessible format or language other than English. Office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call 711.

MEDICARE MEMBER 1

Will you have other prescription drug coverage in addition to Blue Shield/Kaiser Permanente? ☐ YES ☐ NO

If yes, please list your other coverage and identification (ID) number(s) for that coverage.

NAME OF OTHER COVERAGE | ID NUMBER FOR OTHER COVERAGE

EMPLOYER OR UNION NAME | GROUP NUMBER

NAME AND SIGNATURE | DATE

MEDICARE MEMBER 2

Will you have other prescription drug coverage in addition to Blue Shield/Kaiser Permanente? ☐ YES ☐ NO

If yes, please list your other coverage and identification (ID) number(s) for that coverage.

NAME OF OTHER COVERAGE | ID NUMBER FOR OTHER COVERAGE

EMPLOYER OR UNION NAME | GROUP NUMBER

NAME AND SIGNATURE | DATE

SECTION 5: FINAL SIGNATURE

RETIREE SIGNATURE | DATE | BENEFITS PARTNER SIGNATURE | DATE

FOR HR USE ONLY

BENEFITS PARTNER TO COMPLETE:

FOR AFSCME RETIREES ON OR AFTER 6/12/2022:

- ☐ Add RHRA Lump Sum Contribution Plan in Workday date: _____
- ☐ Add RHRA Limp Sum Contribution to EIB Tracker date: _____

Initial: _____

Date: _____

FOR RETIREE DESK TO COMPLETE

- ☐ SamCERA Notice
- ☐ Retiree Log
- ☐ BCC Entry
- ☐ Sick Leave Entry (WD)
- ☐ Deduction EFT sent
- ☐ Medicare EFT Entered

Initial: _____

Date: _____

COUNTY OF SAN MATEO
HUMAN RESOURCES DEPARTMENT
RETIREE HEALTH ENROLLMENT FORM

Benefits Division
455 County Center, 5th Fl.
Redwood City, CA 94063
Phone: (650) 363-1919
Fax: (650) 599-1573
E-Mail: benefits@smcgov.org

LAST NAME	FIRST NAME	MIDDLE INITIAL	PARTICIPANT ID (CSM + 9-digit EID)

DATE OF HIRE	TERM DATE	EFFECTIVE DATE OF RETIREE HEALTH	EMPLOYEE GROUP

- ☐ I have received a copy of the County's Retiree Benefits Guide and understand the retiree health benefits afforded to me under the Memorandum of Understanding (MOU) or Resolution for my employee group.
- ☐ I understand that my active benefits terminate on the last day of the month of my termination date, and that my retiree health benefits commence on first day of the month following termination date. Your coverage ends on the date of your termination for your Flexible Spending Accounts (FSA), Group Life/AD&D, Long Term Disability (LTD), and Employee Assistance Program (EAP).
- ☐ I understand that the County will only contribute to the cost of my retiree health premiums if I have unused sick leave at retirement (or additional sick leave credits are provided to me per MOU or Resolution). If I have no sick leave at the time of retirement or if I exhaust all of my sick leave credits, I can remain on the County's retiree health plan and pay the full premium cost.
- ☐ I understand that I can change my retiree health elections or the amount of sick leave credits I use per month (up to 14 hours per month) during Open Enrollment in October every year. Changing the sick leave credit amount increases or decreases the County's monthly contribution to my premium cost.
- ☐ I understand that I must notify the Benefits office in the event of a divorce, marriage, death of spouse – or any other life event that impacts your benefit elections, and that changes to benefits must be made within 30 days of the life event.
- ☐ I understand that if I move out an existing HMO coverage area, I may have the option of enrolling the County's Alternate Health Plan. If I elect the Alternate Health Plan, I am required to show proof of alternate coverage and cost of coverage on an annual basis.
- ☐ I understand that if I drop my retiree health coverage, I waive all my rights to use any remaining sick leave credits, and I will only be allowed to enroll in the Voluntary Dental and Voluntary Vision Plans. I will not be able to re -enroll in the County's Health Plans at a later date.
- ☐ For County AFSCME members hired prior to 6/12/2022 and retired after 6/12/2022, I understand that I can defer enrollment in a County Retiree Health plan only once provided I waived and deferred enrollment for all three benefit types(medical, dental, vision). Enrollment back into a County plan can only happen once during Open Enrollment or with a qualified life event.
- ☐ I understand that I have 30 days from the date of termination to elect to continue my life insurance in retirement. Contact Standard Life Insurance at 800-378-4668 ext. 6785 for more information. (Group # 649107)
- ☐ I understand that survivor benefits extend to my spouse and family, provided they are currently enrolled on my plan and a designated beneficiary with SamCERA.
- ☐ I understand that I am responsible for paying any premium cost not covered by the County's contribution. I have submitted the Electronic Fund Transfer (EFT) form to the County of San Mateo and the cost will be deducted through EFT. I understand that I will be billed for any amount that was not deducted from my account.
- ☐ I understand and agree that BCC will deduct from my account any insurance premium rate changes, or at the expiration of my sick-leave credits.
- ☐ I understand that I will receive a letter 3 months prior to my sick leave running out. At which time I may request any or all of my coverage be termed in writing. Otherwise, my coverage will continue and I will be responsible for the premiums.
- ☐ I understand that I am required to apply for Medicare Part A and B when I turn 65 and I must enroll in one of the County's Medicare Health Plans. I understand that this applies to any Medicare eligible dependents as well, and that medical benefits will be terminated if this is not completed.

SICK LEAVE CREDIT (not applicable to County AFSCME members hired prior to 6/12/2022 and retired after 6/12/2022)

I elect to use _____ sick leave credits per month toward the cost of my retiree health benefits. Based on this election, my sick leave credits is estimated to expire on _____, after which I will be responsible for paying the entire of cost of the insurance. For computation of estimated sick leave credits, see worksheet.

RETIREE SIGNATURE	DATE	BENEFITS PARTNER SIGNATURE	DATE

Ver06072022

INDIVIDUAL ELECTRONIC FUNDS TRANSFER (EFT)

Group Name: County of San Mateo **Customer Number:** CSM

Customer Name: _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

☐ Select this box to authorize an ***Invoice/Premium EFT Payment***

Name of Financial Institution: _____

Bank Routing Number: _____ Account Number: _____

Account Name: _____ ☐ Checking Account ☐ Savings Account

If Electronic Debit Authorization (EDA) is required, instruct financial institution to set the authorization as:

Bank Filter

Submitting Bank (ODFI): **Dollar Bank**

Company Name (Acct Name): **Benefit Coordinators Corp.**

Contract Number: **2251453488**

--- Attach Check Here ---

Please attach a voided check and return this form to:
San Mateo County, Benefits Department
455 County Center, 5th Floor
Redwood City, CA 94063

TERMS: This authority is to remain in full force and effect in conjunction with the Agreement until BCC and the financial institution have received written notification of its termination in such time and in such manner as to afford BCC and the financial institution a reasonable time to act accordingly. In the event that my electronic debit or transfer is returned, I agree that a $25 returned-item fee will be charged automatically to my account.

_____ _____
Signature Date

_____ _____
Print Name Phone Number

Rev 10.2016