

2027 RETIREE BENEFITS



Your Benefits, Your Choice



CONTENTS



IMPORTANT NOTE:

This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents available online at <https://hr.smcgov.org/retiree-health-benefits-current-retirees>.

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GETTING STARTED

2027 BENEFITS

January 1, 2027
through
December 31, 2027

IMPORTANT NOTE:

This guide is a summary overview and does not provide a complete description of all benefit provisions.

For more detailed information, please refer to your plan documents available online at

<https://www.smcgov.org/hr/retirement-benefits>

Whether you're planning your retirement or already retired, County of San Mateo supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and achieve a balanced and healthier well-being. Review the coverage and tools available to you to make the most of your benefits package.

Email: benefits@smcgov.org | **Phone:** (650) 363-1919 |

Website: <https://hr.smcgov.org/retiree-health-benefits-current-retirees>

Wellness Email: wellness@smcgov.org

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 in the Summary of Health Benefits section of this guide.

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.

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, Aetna HMO, Aetna Value Network (AVN) HMO , Aetna OAMC, Aetna 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 UnitedHealthcare® UHC Medicare Advantage PPO. **(High Deductible plans are not available once you are on Medicare.)**

RETIREE HEALTH FAQs (CONT.)

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 may 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 the Important Plan Notices and Documents section of this guide.

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.

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.

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.

RETIREE HEALTH FAQs (CONT.)

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.

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 (CONT.)

How do I pay for my insurance premiums?

- 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.

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 the cost section of this guide for current medical and dental premiums.

RETIREE HEALTH FAQs (CONT.)

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

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://www.smcgov.org/hr/retirement-benefits>

When can I add or remove 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.

RETIREE HEALTH FAQs (CONT.)

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 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.

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.).

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 any time?

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 Provisions:

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 Benefit Plans in the future.

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

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 UnitedHealthcare 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)599-1573 prior 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.

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 or UnitedHealthcare UHC Medicare Advantage PPO). This means that when you choose to enroll in Kaiser Senior Advantage or UnitedHealthcare UHC Medicare Advantage PPO, you assign your Medicare to the insurance plan. This means that Kaiser or UnitedHealthcare provides your Medicare Parts A and B coverage.

Do I need both my Medicare Card and my Kaiser or UnitedHealthcare Medicare PPO ID Card when I see medical services?

You only need your Kaiser or UnitedHealthcare UHC Medicare Advantage PPO ID Card. Your Medicare card is not needed for all Medicare plans.

ABOUT MEDICARE (CONT.)

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.

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 Dependent(s) under 65 (non-Medicare):

- **If you elect the UnitedHealthcare Medicare Advantage PPO plan**, your non-Medicare dependents would go on either the non-Medicare Aetna OAMC plan, Aetna AVN plan or Aetna 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 Aetna AVN or HMO plans**, your Medicare-eligible dependents would go on the UnitedHealthcare 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 BENEFITS

Represented Group	Retiree Health Benefit
American Federation of State, County and Municipal Employees (AFSCME) – COURTS, San Mateo County Council of Engineers (SMCCE), Building Construction Trades Council (BCTC)	If hired prior to January 1, 2011 for AFSCME (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 (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 BENEFITS

Represented Group	Retiree Health Benefit
American Federation of State, County and Municipal Employees (AFSCME) – COUNTY ONLY	If hired prior to June 11, 2022 retired on or after 6/12/2022 Post-65 and Pre-65 Benefit A monthly County contribution is provided based on years of service and age. This contribution can be used towards County medical, dental and/or vision plan premium Any remaining contribution amount that remains AFTER the premium/s is paid in full will be deposited into the retiree's RHRA on a monthly basis. If not enrolled in a County retiree benefit plan/s, the full monthly contribution will be deposited into the retiree's RHRA on a monthly basis. If hired on/after June 12, 2022 All employees will pay a semi-monthly contribution of \$25 into their RHRA account. After 5 years of continuous service under an AFSCME (County) union, the County will deposit a contribution of \$3000 into their RHRA and the County will begin paying a semi-monthly County contribution of \$25 into the employee's RHRA. A time of retirement, employees can opt to keep the County medical, dental and vision and pay the full cost of premiums with the option to use their RHRA fund to offset the monthly premium cost.

SUMMARY OF RETIREE 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 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.
Probation and Detention Association (PDA), Deputy Sheriff's Association (Safety) (DSA), Organization of Sheriff's Sergeants (OSS)	If hired prior to (1/8/2023 for PDA, 2/5/2023 DSA and OSS) and retired on or after (1/8/2023 for PDA and 2/5/2023 for DSA and OSS) Pre-65 Benefit A monthly County contribution is provided based on years of service and age. This contribution can be used towards County medical, dental and/or vision plan premium. Any remaining contribution amount that remains AFTER the premium/s is paid in full will be deposited into the retiree's RHRA on a monthly basis. If not enrolled in a County retiree benefit plan/s, the full monthly contribution will be deposited into the retiree's RHRA on a monthly basis. If hired after (1/8/2023 for PDA, 2/5/2023 DSA and OSS) All employees will pay a semi-monthly contribution of \$50 into their RHRA account. After 5 years of continuous service under an AFSCME (County) union, the County will deposit a contribution of \$3000 into their RHRA and the County will begin paying a semi-monthly County contribution of \$25 into the employee's RHRA. A time of retirement, employees can opt to keep the County medical, dental and vision and pay the full cost of premiums with the option to use their RHRA fund to offset the monthly premium cost.

SUMMARY OF RETIREE BENEFITS

Represented Group	Retiree Health Benefit
Law Enforcement Unit (LEU) – Deputy Sheriff’s (Non-Safety)	If hired prior to February 18, 2024 retired on or after 2/18/2024 Post-65 and Pre-65 Benefit A monthly County contribution is provided based on years of service and age. This contribution can be used towards County medical, dental and/or vision plan premium. Any remaining contribution amount that remains AFTER the premium/s is paid in full will be deposited into the retiree’s RHRA on a monthly basis. If not enrolled in a County retiree benefit plan/s, the full monthly contribution will be deposited into the retiree’s RHRA on a monthly basis. If hired on/after February 18, 2024 All employees will pay a semi-monthly contribution of \$50 into their RHRA account. After 5 years of continuous service under an AFSCME (County) union, the County will deposit a contribution of \$3000 into their RHRA and the County will begin paying a semi-monthly County contribution of \$25 into the employee’s RHRA. At time of retirement, employees can opt to keep the County medical, dental and vision and pay the full cost of premiums with the option to use their RHRA fund to offset the monthly premium cost.

WHAT'S NEW IN 2027?

What's new or changing

Aetna & Kaiser HDHP Plans

Changes to Deductible and Out-of-Pocket Limits

If you are enrolled in either the Aetna OAMC PPO HDHP or Kaiser HDHP plans, the individual minimum deductible will increase from \$1,700 to **\$1,750** for 2027. For a family, or individual within a family, it will increase from \$3,400 to **\$3,500**.





MEDICAL

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video



- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

Email: benefits@smcgov.org | Phone: (650) 363-1919 | Website: www.smcgov.org/hr/employee-benefits
Wellness Email: wellness@smcgov.org | Wellness Portal: smcgov.sharepoint.com/sites/wellness

WHICH PLAN IS RIGHT FOR YOU?



BUILDING AND CONSTRUCTION TRADES COUNCIL OPTION

Eligible employees who are members of the Building and Construction Trades Council also have the option of choosing the Operating Engineer's plan which includes health (either a PPO or a Kaiser HMO plan), dental and vision benefits.

For more information about the Operating Engineers Plan, contact Benefits Division at 650-363-1919 or email benefits@smcgov.org.

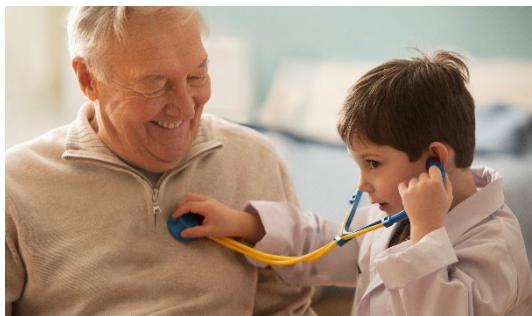
The County's medical plans are designed to help maintain wellness and protect you and your family from major financial hardships in the event of illness or injury. The County offers a choice of medical plans through Aetna and Kaiser Permanente.

Aetna Medical Plans for Retirees Under 65

- **Health Maintenance Organization (HMO)** – Patients seek medical care from a doctor participating in the plan's network. If you join Aetna, you select a PCP and medical group within Aetna's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated by your PCP/medical group and will require a referral or authorization. More information about Aetna's health plan benefits is available at <https://www.smcgov.org/hr/health-benefits>; click on Medical Plans.
- **Aetna Value Network (AVN) HMO** – The Aetna Value Network (AVN) plan is also an HMO, but the provider network is only in California and Nevada and is comprised of a preferred list of medical groups. In all other aspects, the AVN plan works the same as the HMO described above.
- **OAMC PPO** – a Preferred Provider (PPO) plan allows members the choice and flexibility to receive medical services from an in-network doctor or out-of-network doctor.
 - **In Network:** Medical services are provided through the Aetna Managed Choice POS (Open Access) network (OAMC for short). You are responsible for paying an annual deductible and a percentage of the cost of the services (generally 20% of Aetna's allowable amount).
 - **Out-of-network:** This allows you to access services through any licensed doctor or hospital. You are responsible for paying a deductible and a higher annual percentage of the cost of care (generally 40% of Aetna's allowable amount).
- **High Deductible Health Plan**** - You use the same OAMC PPO Network that you would under the standard plan. All of your preventative services are covered in full. You pay for the entire cost of non-preventive services until you satisfy your annual deductible. From that point, you pay 10% of the cost for non-preventive services until you reach your Calendar Year Maximum. At that point, you do not pay out of pocket for any services for the remainder of the year.

Visit www.smcgov.org/hr/health-benefits and select Health Benefits to learn more about our health plans.

WHICH PLAN IS RIGHT FOR YOU?



BUILDING AND CONSTRUCTION TRADES COUNCIL OPTION

Eligible employees who are members of the Building and Construction Trades Council also have the option of choosing the Operating Engineer's plan which includes health (either a PPO or a Kaiser HMO plan), dental and vision benefits.

For more information about the Operating Engineers Plan, contact Benefits Division at 650-363-1919 or email benefits@smcgov.org.

Kaiser Permanente Medical Plans for Retirees Under 65

- **Health Maintenance Organization (HMO)** – 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.
- **High Deductible Health Plan**** – 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, you do not pay out of pocket for any services for the remainder of the year.

Visit www.smcgov.org/hr/health-benefits and select Health Benefits to learn more about our health plans.

****Note:** If you have a Health Saving Account as an active employee, your account will move to a retail account with Avidia Bank upon retirement. You will receive your new login information to review and manage your account. You will also receive a new debit card from Avidia Bank to access the balance in your retail account.

You can no longer access your HSA through BCC/SmartCare after retirement.

For more information, you may contact Avidia Bank at:

Avidia Bank

42 Main St.

Hudson, MA 01749

(855) 248-6311

hsainfo@avidiabank.com

www.avidiabank.com

WHICH PLAN IS RIGHT FOR YOU?



Medical Benefits for Retirees 65 and Over

Plans To Consider

- UnitedHealthcare Medicare Advantage PPO
- Kaiser Permanente Senior Advantage HMO

The UnitedHealthcare Medicare Advantage PPO Plan gives you the flexibility to see any licensed provider or hospital nationwide.

- Your cost is the same for any provider in or out of network, as long as they accept Medicare and your UnitedHealthcare plan.
- You have the option to choose a Primary Care Provider (PCP), but it is not required.
- No referrals are needed.
- This plan also includes Medicare Part D prescription coverage.
- Most services and medications are covered with a small co-payment.

The Kaiser Permanente Senior Advantage Plan

- Patients seek medical care within the plan's own facilities.
- 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.

Visit <https://www.smcgov.org/hr/medicare-information-retiree> and select Health Benefits to learn more about our health plans.

Medical HMO Plans – Under 65

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay.

	Aetna Full HMO	Aetna AVN HMO	Kaiser Traditional HMO	Kaiser HDHP
	In-Network Only	In-Network Only	In-Network Only	In-Network Only
Calendar Year Deductible¹				
Individual	\$0	\$0	\$0	\$1,750
Individual within a Family	\$0	\$0	\$0	\$3,500
Family	\$0	\$0	\$0	\$3,500
Calendar Year Out-of-Pocket Maximum^{1,2}				
Individual	\$1,000	\$1,000	\$1,500	\$3,500
Individual within a Family	\$3,000	\$3,000	\$3,000	\$3,500
Family	\$3,000	\$3,000	\$3,000	\$7,000
Office Visit				
Primary Care	\$15 copay	\$15 copay	\$15 copay	10% after deductible
Specialist	\$15 copay	\$15 copay	\$15 copay	10% after deductible
Online Visit	\$15 copay	\$15 copay	No charge	No charge
Preventive Services	No charge	No charge	No charge	No charge
Chiropractic and Acupuncture Care (up to 30 visits/year)	\$10 copay	\$10 copay	\$15 copay	Not covered
Lab and X-ray	No charge	No charge	\$5 copay	10% after deductible
Urgent Care	\$15 copay	\$15 copay	\$15 copay	10% after deductible
Emergency Room (copay waived if admitted)	\$100 copay	\$100 copay	\$100 copay	10% after deductible
Inpatient Hospitalization	\$100 per admission	\$100 per admission	\$100 copay	10% after deductible
Outpatient Surgery	\$50 copay	\$50 copay	\$50 copay	10% after deductible
Infertility (refer to EOC for details)				
Diagnosis and Treatment	Artificial insemination and the diagnosis and treatment of the underlying medical condition. (Cost share is based on the type of service and where it is performed)	Artificial insemination and the diagnosis and treatment of the underlying medical condition. (Cost share is based on the type of service and where it is performed)	50%	50% after deductible
Assisted Reproductive Technology (ART)	Not Covered	Not Covered	50% coinsurance (one treatment cycle per lifetime)	50% coinsurance (one treatment cycle per lifetime)
Family Planning				
Physicians Family Planning Services	No charge	No charge	No charge	No charge
Vasectomy	Cost share is based on where performed	Cost share is based on where performed	\$50 per procedure	10% after deductible
Tubal Ligation	No charge	No charge	\$50 per procedure	10% after deductible

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

²All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medical HMO Plans – Under 65

PRESCRIPTION DRUGS

	Aetna Full HMO	Aetna AVN HMO	Kaiser Traditional HMO	Kaiser HDHP
	In-Network Only	In-Network Only	In-Network Only	In-Network Only
PRESCRIPTION DRUGS				
Calendar Year Deductible	None	None	None	Combined with medical
Out-of-Pocket Maximum	Combined with medical	Combined with medical	Combined with medical	Combined with medical
Retail- 30 Day Supply \$0 Chronic Drug List Preferred Generic Preferred Brand Non-Preferred Generic and Brand Specialty ³	No charge \$15 copay \$25 copay \$40 copay 20% up to \$200 max	No charge \$15 copay \$25 copay \$40 copay 20% up to \$200 max	No charge (100-day supply) \$10 copay (100-day supply) \$20 copay (100-day supply) \$20 copay (100-day supply) \$20 copay	No charge \$10 copay \$30 copay \$30 copay \$30 copay
Mail Order- 90 Day Supply \$0 Chronic Drug List Preferred Generic Preferred Brand Non-Preferred Generic and Brand Specialty ³	No charge \$30 copay \$50 copay \$80 copay 20% up to \$200 max	No charge \$30 copay \$50 copay \$80 copay 20% up to \$200 max	No charge \$10 copay \$20 copay \$20 copay \$20 copay (30-day supply)	No charge \$20 copay \$60 copay \$60 copay Not covered



Medical PPO Plan – Under 65

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Aetna OAMC PPO (\$300 Deductible)	
	In-Network	Out-of-Network
Calendar Year Deductible¹ Individual Family	\$300 \$900	
Calendar Year Out-of-Pocket Maximum¹ Individual Family	\$2,000 \$4,000	\$3,000 \$6,000
Office Visit Primary Care Specialist	20% ² 20% ²	40% ² 40% ²
Online Visit	20% ²	Not covered
Preventive Services	No charge	40% ²
Chiropractic (up to 30 visits/year)	20% ²	40% ²
Acupuncture (up to 20 visits/year)	20% ²	40% ²
Lab and X-ray	20% ²	40% ²
Urgent Care	20% ²	40% ²
Emergency Room (copay waived if admitted)	No charge	
Inpatient Hospitalization	No charge	30% ²
Outpatient Surgery	No charge	30% ²
Infertility (refer to EOC for details) Diagnosis and Treatment	Artificial insemination and the diagnosis and treatment of the underlying medical condition. (Cost share is based on the type of service and where it is performed)	
Assisted Reproductive Technology (ART)	Not Covered	
Family Planning Physicians Family Planning Services	No charge	40% ²
Vasectomy	Cost share is based on where performed	Not covered
Tubal Ligation	No charge	40% ²

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

²After deductible.

³All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medical PPO Plan – Under 65

PRESCRIPTION DRUGS

	Aetna OAMC PPO (\$300 Deductible)	
	In-Network	Out-of-Network
PRESCRIPTION DRUGS		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail- 30 Day Supply \$0 Chronic Drug List Preferred Generic Preferred Brand Non-Preferred Generic and Brand Specialty ³	No charge \$10 copay \$20 copay \$35 copay 30% up to \$200 max	25% up to \$250 max 25% up to \$250 max 25% up to \$250 max 25% up to \$250 max Not covered
Mail Order- 90 Day Supply \$0 Chronic Drug List Preferred Generic Preferred Brand Non-Preferred Generic and Brand Specialty ³	No charge \$20 copay \$40 copay \$70 copay 30% up to \$100 max	Not covered Not covered Not covered Not covered Not covered



Medical HDHP – Under 65

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	Aetna OAMC PPO HDHP	
	In-Network	Out-of-Network
Calendar Year Deductible¹		
Individual	\$1,750	\$3,000
Individual Within a Family	\$3,500	\$3,500
Family	\$3,500	\$6,000
Calendar Year Out-of-Pocket Maximum¹		
Individual	\$3,500	\$6,000
Individual Within a Family	\$3,500	\$6,000
Family	\$7,000	\$12,000
Office Visit		
Primary Care	10% ²	40% ²
Specialist	10% ²	40% ²
Online Visit	10% ² (deductible waived)	Not covered
Preventive Services	No charge	Not covered
Chiropractic (up to 30 visits/year)	10% ²	50% ²
Acupuncture (up to 20 visits/year)	10% ²	40% ²
Lab and X-ray	10% ²	40% ²
Urgent Care	10% ²	40% ²
Emergency Room (copay waived if admitted)	10% ²	
Inpatient Hospitalization	10% ²	40% ²
Outpatient Surgery	10% ²	40% ²
Infertility (refer to EOC for details) Diagnosis and Treatment	Artificial insemination and the diagnosis and treatment of the underlying medical condition. (Cost share is based on the type of service and where it is performed)	Artificial insemination and the diagnosis and treatment of the underlying medical condition. (Cost share is based on the type of service and where it is performed)
Assisted Reproductive Technology (ART)	Not Covered	Not Covered
Family Planning		
Physicians Family Planning Services	No charge	Not covered
Vasectomy	10% ²	Not covered
Tubal Ligation	No charge	40% ²

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

²After deductible.

³Must use Aetna's Specialty Rx network.

Medical HDHP – Under 65

PRESCRIPTION DRUGS

	Aetna OAMC PPO HDHP	
	In-Network	Out-of-Network
PRESCRIPTION DRUGS		
Calendar Year Deductible	Combined with medical	Combined with medical
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail- 30 Day Supply \$0 Chronic Drug List Preferred Generic Preferred Brand Non-Preferred Generic and Brand Specialty ³	No charge \$10 copay \$25 copay \$40 copay 30% up to \$200 max	25% up to \$250 max 25% up to \$250 max 25% up to \$250 max 25% up to \$250 max Not covered
Mail Order- 90 Day Supply \$0 Chronic Drug List Preferred Generic Preferred Brand Non-Preferred Generic and Brand Specialty ³	No charge \$20 copay \$50 copay \$80 copay 30% up to \$100 max	Not covered Not covered Not covered Not covered Not covered



Medical Plans – 65 and Over

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	UnitedHealthcare Medicare Advantage PPO		Kaiser Senior Advantage HMO
	In-Network	Out-of-Network	In-Network
Calendar Year Deductible¹	None	None	None
Calendar Year Out-of-Pocket Maximum¹	\$1,500/member	\$1,500/member	\$1,500/member \$3,000/family
Office Visit Primary Care Specialist	\$10 copay \$20 copay	\$10 copay \$20 copay	\$10 copay \$10 copay
Online Visit	\$10 copay	\$10 copay	No charge
Preventive Services	No charge	No charge	No charge
Chiropractic (up to 20 visits/year)	\$15 copay	\$15 copay	\$15 copay (combined with acupuncture)
Acupuncture (up to 20 visits/year)	\$15 copay (Medicare 12 visits in 90 days)	\$15 copay	\$15 copay (combined with chiropractic)
Eyeglasses or Contact Lenses Reimbursement	\$150 allowance (every 12 months)	\$150 allowance (every 12 months)	\$150 allowance (every 24 months)
Lab and X-ray	No charge	No charge	No charge
Urgent Care	\$10 copay	\$10 copay	\$20 copay
Emergency Room	\$20 copay (waived if admitted)	\$20 copay (waived if admitted)	\$20 copay
Inpatient Hospitalization	No charge	No charge	No charge
Outpatient Surgery	\$10 copay	\$10 copay	\$10 copay
PRESCRIPTION DRUGS			
Calendar Year Deductible	None	None	None
Out-of-Pocket Maximum	Combined w/medical	Combined w/medical	Combined w/medical
Retail³ Generic Preferred Brand Non-Preferred Brand Specialty Day Supply	\$9 copay/\$10 copay (preferred/standard) \$20 copay \$35 copay 30% up to \$150 max 30	Not Covered Not covered Not covered Not covered N/A	\$10 copay \$10 copay Not covered Not Covered 100
Mail Order Generic Preferred Brand Non-Preferred Brand Day Supply	\$18 copay/\$20 copay (preferred/standard) \$40 copay \$60 copay 90	Not Covered Not covered Not covered N/A	\$10 copay \$10 copay Not covered 100

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1 through December 31.

²After deductible.

³If you reside in a long-term care facility, your cost share is the same as a 30-day supply at a retail pharmacy and you may receive up to a 31-day supply.

YOUR MONTHLY BENEFIT COSTS

RETIREEES UNDER 65

	Monthly Premium
Aetna Full HMO	
Retiree Only	\$2,089.64
Retiree + 1	\$4,179.30
Retiree + Family	\$5,913.68
Aetna AVN HMO	
Retiree Only	\$1,618.72
Retiree + 1	\$3,237.34
Retiree + Family	\$4,580.86
Aetna HDHP OAMC PPO	
Retiree Only	\$1,727.88
Retiree + 1	\$3,455.74
Retiree + Family	\$4,889.90
Aetna OAMC PPO (\$300 Deductible)	
Retiree Only	\$2,445.96
Retiree + 1	\$4,891.90
Retiree + Family	\$6,921.98
Kaiser HMO	
Retiree Only	\$1,149.02
Retiree + 1	\$2,298.04
Retiree + Family	\$3,251.74
Kaiser HDHP	
Retiree Only	\$914.54
Retiree + 1	\$1,829.08
Retiree + Family	\$2,588.16

YOUR MONTHLY BENEFIT COSTS

RETIREES 65 AND OVER

	Monthly Premium
UnitedHealthcare UHC MAPPO (Medicare)	
Single – Retiree w/ Medicare	\$619.07
Two-Party – Both w/ Medicare	\$1,238.14
Aetna Full HMO and UHC MAPPO (Medicare)	
Two-Party – Retiree w/ Medicare (PPO), Spouse w/o (HMO)	\$2,708.73
Two-Party – Retiree w/o Medicare (HMO), Spouse w/ Medicare (PPO)	\$2,708.71
Family – Retiree w/ Med (PPO) + Spouse and Child w/o (HMO)	\$4,443.11
Family – Retiree & Spouse w/ Med (PPO) & Child w/o Medicare (HMO)	\$3,327.80
Aetna AVN HMO and UHC MAPPO (Medicare)	
Two-Party – Retiree w/ Medicare (PPO), Spouse w/o (AVM HMO)	\$2,237.69
Two-Party – Retiree w/o Medicare (AVN HMO), Spouse w/ Medicare (PPO)	\$2,237.79
Family – Retiree w/ Med (PPO) + Spouse and Child w/o (AVN HMO)	\$3,581.21
Family – Retiree & Spouse w/ (PPO) & Child w/o Medicare (AVN HMO)	\$2,856.76
Aetna OAMC PPO (\$300 Deductible) and UHC MAPPO (Medicare)	
Two-Party – Retiree w/ Medicare (PPO), Spouse w/o (OOA PPO)	\$3,065.01
Two-Party – Retiree (OOA PPO) + Spouse w/ Medicare (PPO)	\$3,065.03
Family – Retiree (OOA PPO) + Spouse w/ Medicare (PPO) + Child (OOA PPO)	\$5,510.97

YOUR MONTHLY BENEFIT COSTS

RETIREEES 65 AND OVER

	Monthly Premium
Kaiser HMO (Senior Advantage Medicare Combo Rates)	
Single – Retiree w/ Medicare	\$386.06
Two-Party – Retiree w/ Medicare & Spouse w/ Medicare	\$772.12
Two-Party – Retiree w/ Medicare & Dependent w/o Medicare	\$1,535.08
Two-Party – Retiree w/o Medicare & Spouse w/ Medicare	\$1,535.08
Family – Retiree w/ Medicare & Children w/o Medicare	\$2,488.78
Family – Retiree w/ Medicare, Spouse w/o Medicare & Child w/o Medicare	\$2,488.78
Family – Retiree w/o Medicare, Spouse w/o Medicare & Child w/o Medicare	\$2,488.78
Family – Retiree w/ Medicare, Spouse w/ Medicare & Children w/o Medicare	\$1,725.82
Family – Retiree w/ Medicare, Spouse w/o Medicare & Children w/o Medicare	\$2,488.78
Family – Retiree w/o Medicare, Spouse w/ Medicare & Children w/o Medicare	\$2,488.78
Family – Retiree w/o Medicare, Spouse w/ Medicare & Children w/ Medicare	\$1,921.14
Family – Retiree w/ Medicare, Spouse w/ Medicare & Children w/ Medicare	\$1,158.18

YOUR MONTHLY BENEFIT COSTS

OPERATING ENGINEERS

UNDER 65	Monthly Premium
Operating Engineers PPO, Dental & Vision	
Retiree Only	\$1,418.00
Retiree + 1	\$2,835.00
Retiree + Family	\$3,827.00
Operating Engineers Kaiser, Dental & Vision	
Retiree Only	\$1,264.00
Retiree + 1	\$2,529.00
Retiree + Family	\$3,298.00

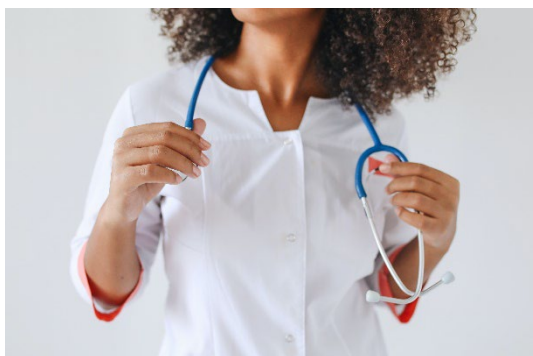
65 AND OVER	Monthly Premium
Operating Engineers PPO (Medicare)	
Single – Retiree w/ Medicare	\$697.00
Two-Party – Retiree w/ Medicare & Spouse w/ Medicare	\$1,394.00
Family – Retiree w/ Medicare, Spouse w/ Medicare & Children w/ Medicare	\$2,069.00
Operating Engineers Kaiser (Medicare)	
Single – Retiree w/ Medicare	\$557.00
Two-Party – Retiree w/ Medicare & Spouse w/ Medicare	\$1,115.00
Family – Retiree w/ Medicare, Spouse w/ Medicare & Children w/ Medicare	\$1,650.00

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	- Identifying symptoms - Decide if immediate care is needed - Home treatment options and advice	24/7	\$0
Online visit 	Many non-emergency health conditions	- Cold, flu, allergies - Headache, migraine - Skin conditions, rashes - Minor injuries - Mental health concerns	24/7	\$
Office visit 	Routine medical care and overall health management	- Preventive care - Illnesses, injuries - Managing existing conditions	Office Hours	\$\$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	- Stitches - Sprains - Animal bites - Ear-nose-throat infections	Office Hours, or up to 24/7	\$\$\$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	- Suspected heart attack or stroke - Major bone breaks - Excessive bleeding - Severe pain - Difficulty breathing	24/7	\$\$\$\$\$

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

Take Pro-active Steps to Maintain Good Health
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, sex, and medical history.

Visit www.healthcare.gov/coverage/preventive-care-benefits 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 generally not 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.

UNITEDHEALTHCARE RESOURCES



REGISTER ONLINE

UnitedHealthcare members can sign up for an online account to learn more about your plan. Visit retiree.uhc.com and click Sign in or Register.

24/7 Provider Support

24/7 Provider Support was designed specifically to help make your health decisions simple and convenient by providing immediate answers to your health questions anytime, anywhere – 24 hours a day, 7 days a week – at no additional cost.

Virtual Visits

Amwell®, Doctor on Demand™ and Teladoc® are part of the UnitedHealthcare provider network bringing you Virtual Doctor Visits. See a doctor or talk to a behavioral health specialist anytime using live video chat from your computer, tablet, or smartphone.

With **Virtual Doctor Visits**, you can ask questions, get a diagnosis, or even get medication prescribed and have it sent to your pharmacy. Register and complete a brief Medical History today so you're set up and ready to go when you need care. You can request a doctor visit whenever you need one or schedule one at a time that's convenient for you.

With **Behavioral Health Visits**, you can speak to a behavioral health specialist for addiction, depression, anxiety, stress, loss and behavioral health medication management.

You can access virtual visits on your computer by visiting your [member portal](#), click on "Find Care" and then "Virtual Care." On your tablet or smartphone, download the American Well, Doctor on Demand, or Teladoc app. You can also call 800-TELADOC (800-835-2362) to set up your account and request a visit by phone.

UnitedHealthcare Healthy at Home

UnitedHealthcare Healthy at Home provides you the support you need to recover from hospital and skilled nursing facility stays. You may be eligible to receive 28 home-delivered meals, up to 12 one-way rides to and from medical appointments and the pharmacy, and up to 6 hours of in-home care to assist with daily activities; all at no cost to you. Call the customer service number on your UnitedHealthcare member ID card for more information.

UnitedHealthcare Hearing

With UnitedHealthcare Hearing, you can receive a hearing exam and up to 50% off a wide selection of name-brand and private-labeled custom-programmed hearing aids. Plus, you'll receive personalized care and follow-up support from experienced hearing providers. Visit uhchearing.com/retiree to learn more. Call **(866) 445-2071** to request an initial hearing exam and consultation.

UNITEDHEALTHCARE RESOURCES



UnitedHealthcare HouseCalls®

HouseCalls is a yearly in-home health and wellness visit available at no extra cost. Receive up to an hour of 1-on-1 time with a licensed health care practitioner in the comfort of your own home.

- Perform a head-to-toe exam, health screenings and answer your health questions
- Review your medical history and medications
- Send a summary of your visit to you and your primary care provider

Schedule a visit online at retiree.uhc.com or call **(800) 207-1667**.

Health & Wellness

UnitedHealthcare helps inspire you to take charge of your health and wellness every day by providing a wide variety of useful resources and activities, including healthy recipes, fitness activities, wellness education, caregiver resources and more – at no additional cost.

Health & Wellness Rewards

You may be eligible to earn rewards for completing and reporting eligible health-related activities such as your annual physical or wellness visit. Members can sign in at retiree.uhc.com and select **Rewards** on the right side of the home page to learn more.

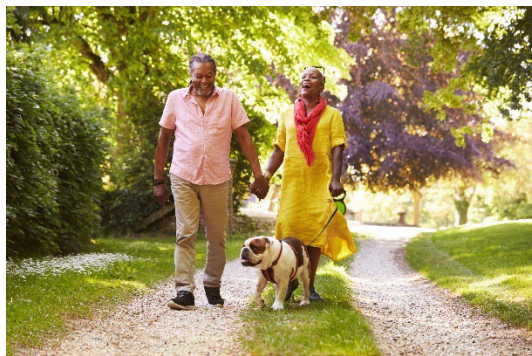
SilverSneakers

SilverSneakers is more than a traditional fitness program. It's an opportunity to improve your health, gain confidence and connect with your community - **at no additional cost**. You can choose any of the following exercise programs:

- **At the gym:** Thousands of participating locations nationwide with various amenities, ability to enroll at multiple locations at any time, classes designed for all levels and abilities
- **At home or on the go:** Live online classes and workshops, on-demand videos available 24/7, SilverSneakers GO mobile app with personalized program resources and adjustable workout plans.
- **In your community:** Group activities and classes offered outside the gym, events including shared meals, holiday celebrations and class socials.

Visit SilverSneakers.com/StartHere or call **(888) 423-4632**.

KAISER RESOURCES



FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

24/7 Care Advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (833) 574-2273.

Healthy Lifestyle Programs

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

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

Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor. Learn more at kp.org/healthylifestyles or kp.org/vidasana (en español).

Health Classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at kp.org/classes – some may require a fee.

Personal Wellness Coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at kp.org/wellnesscoach.

KAISER RESOURCES



MY HEALTH MANAGER

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](#) or download the Kaiser Permanente app from the App StoreSM or Google Play[®].

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

One Pass

One Pass 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 any of the following exercise programs:

- **At the gym:** Access to the largest nationwide network of gyms and fitness locations.
- **Brain Training:** Get a complete brain workout, including an initial cognitive test and an ongoing brain training program featuring a collection of games and activities to keep you engaged.
- **At home:** Work out at home with live, digital fitness classes or on-demand workouts. Plus, use our custom workout builder to create routines tailored to your fitness level and interests.
- **With new friends:** Join a group class or find local clubs and social events that match your interests — there are many great ways to connect with others who share your passions.

To learn more, visit kp.org/health-wellness/fitness-offerings, or call **(877) 614-0618**.

Over-the-Counter (OTC) Wellness Benefit

The County's KPSA Medicare HMO plan includes a \$70 quarterly benefit for OTC health and wellness products delivered to their home at no additional cost. OTC health and wellness product includes:

- Vitamins and minerals, allergy, cough, and cold remedies
- Antacids, laxatives, stomach aids, pain reliever and fever reducers
- First aid kits, joint support, and incontinence products
- Blood pressure monitor and thermometers
- Diabetic supplies such as compression stocking and sharp containers



DENTAL

NOTE

Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2027 through December 2027.

FIND A PROVIDER

The Cigna DHMO and DPPO plans have different networks. Visit www.cigna.com to check if your provider is in-network.

- DHMO Network: Cigna Dental Care Access Plus
- DPPO Network: Total Cigna DPPO

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

Dental Health Maintenance Organization (DHMO)

When you get a dental service with the DHMO, 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, complex rehabilitation, or characterizations. Your plan pays the rest. There are no annual maximums and no deductibles.

Preferred Provider Organization (PPO)

Services are provided through Cigna's PPO network. However, you can choose any dentist in any location inside or outside of the Cigna network. How much you pay for dental services depends on how long you have worked for the County, your represented group, and whether you choose a participating Cigna dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Cigna (the "allowable amount") and the dentist's charges. Pre-authorization from Cigna is recommended for charges of \$250 or more. Orthodontic treatment is not a covered service.

Voluntary Dental

Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January-December). You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

	Cigna DHMO	Cigna DPPO	
	In-Network Only	In-Network	Out-of-Network ¹
Calendar Year Deductible Individual Family	None	\$50 \$150	\$50 \$150
Calendar Year Plan Maximum	None	\$1,500	\$1,500
Diagnostic & Preventive Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-rays Fluoride Application	100%	100%	80%
Basic Services Amalgam/Composite Fillings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Oral Surgery	100%	80% ²	70% ²
Major Services Crown Repair Restorative - Inlays and Crowns Prosthodontics Complex Oral Surgery	100%	50% ²	50% ²
Implants	Not covered	50% ²	50% ²
Orthodontia (Adults and children)	100%	Not covered	Not covered

¹Based on maximum allowable charge (in-network fee level)

²After deductible

What you need to know about this plan



Features:

With the HMO, you must choose a primary dentist within your network. With the PPO, you can see any provider, but you'll pay more out of network.

Where can I get more details?

Visit the Cigna website or download the Cigna mobile app.

Dental

The opportunity to stay in a represented or management dental plan upon retirement is based on your Union's Memorandum (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 on one of the Voluntary plans. You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

	Cigna DPPO (Represented)		Cigna DPPO (Management)	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Calendar Year Deductible	None	None	None	None
Calendar Year Plan Maximum	\$2,500	\$2,500	None	None
Diagnostic & Preventive Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-rays Fluoride Application	85%	85%	100%	100%
Basic Services Amalgam/Composite Fillings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Oral Surgery	85%	85%	100%	100%
Major Services Crown Repair Restorative - Inlays and Crowns Prosthodontics Complex Oral Surgery	85%	85%	100%	100%
Implants	85% (calendar year maximum of \$1,000)	85% (calendar year maximum of \$1,000)	100%	100%
Orthodontics	Not covered	Not covered	Not covered	Not covered

¹Based on maximum allowable charge (in-network fee level)

What you need to know about this plan



Features:

Where can I get more details?

With the PPO, you can see any provider, but you'll pay more out of network

Visit the Cigna website or download the Cigna mobile app.



VOLUNTARY VISION

OUR PLAN

Voluntary VSP Plan

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

Click to play video



Voluntary VSP Vision

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

	VSP Signature Plan	
	In-Network	Out-of-Network
Exams Benefit Materials Frequency	\$10 copay \$10 copay Once every 12 months	Up to \$50 Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Covered in full Covered in full Covered in full Once every 12 months	Up to \$50 Up to \$75 Up to 100 Once every 12 months
Frames Benefit Frequency	\$170 allowance + 20% off remaining balance 95 allowance for Costco/Walmart/Sam’s Club Once every 24 months	Up to \$70 Once every 24 months
Contacts (Elective)* Conventional Frequency	\$170 allowance Once every 12 months	Up to \$105 Once every 12 months

*In lieu of frames

What you need to know about this plan

Features:

What other services are covered?

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Looking for the perfect pair?

See any provider, but you’ll pay more out of network.

Additional lens enhancements, such as progressive lenses, are also available.

If you have an HSA, you can use your account to pay for eyeglasses. Look for moderately priced frames and remember that your benefit is higher in-network.

Visit VSP’s online store, [Eyeconic](#), to apply your benefits directly to your purchase.

YOUR MONTHLY BENEFIT COSTS

Dental	Monthly Premium
Voluntary Cigna Dental HMO	
Single	\$27.63
Two-Party	\$50.26
Family	\$76.87
Voluntary Cigna Dental PPO	
Single	\$41.48
Two-Party	\$79.86
Family	\$143.26

Vision	Monthly Premium
Voluntary VSP Vision	
Single	\$9.34
Two-Party	\$18.68
Family	\$30.06

Management and Represented Dental Rates

If your Represented Union or Board Resolution providers, you have 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.

Dental	Monthly Premium
Cigna Dental HMO	
Management	\$45.99
Represented	\$45.99
Cigna Dental PPO	
Management	\$128.52
Represented	\$103.72
Vision	Monthly Premium
VSP Vision	
Management	\$16.02



VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Home and Auto Insurance

Pet Insurance

You're unique—and so are your benefit needs

Voluntary benefits through AlliantCHOICE Plus are optional coverages that help you customize your benefits package to your individual needs.

There are AlliantCHOICE Plus plans to help save money on protection for your pets, home, and auto.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

PLANS TO KEEP YOU AND YOUR FAMILY SECURE, CONTINUED



THINGS TO CONSIDER

Rates are determined by the age of the pet, breed or size, state of residence, species, and plan choice. Note that pre-existing conditions are not covered. Any illness or injury a pet had prior to start of policy will be considered pre-existing.

Home and Auto Insurance

Your home, its contents, and your car would be expensive, perhaps even unaffordable, to replace. County of San Mateo has partnered with InsureOne to provide you with access to special group rates on home and auto insurance. The InsureOne Premier program gives you access to an online quoting platform, dedicated service team, and experienced California agents who will compare insurance quotes across the many carriers. Retirees can call AlliantCHOICE Plus at 833-634-7132 to connect with InsureOne.

MetLife Pet Insurance

No matter what unpredictable antics furry family members get into, a family isn't complete without them. MetLife Pet Insurance can help pet parents protect their wallet and their pet when faced with an unexpected trip to the vet.

Why choose MetLife Pet Insurance?

- Flexible coverage with up to 90% reimbursement
- The freedom to visit any U.S. licensed vet
- Optional Preventive Care coverage
- 24/7 access to Vet Chat via the MetLife Pet mobile app
- Discounts and offers on pet care, where available
- MetLife Pet mobile app to manage pet's health and wellness, submit & track claims and find nearby pet services

To learn more, visit quote.metlifepetinsurance.com. For enrollment questions, call 888-383-0713.



IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Billing Process
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify County of San Mateo if your domestic partner is your tax dependent.

RETIREE BILLING PROCESS WITH BCC

Thirty (30) 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).

*If retiring at age 65 years of age or over, contact the Benefits Division 90 days before you officially retire.

What to Expect from BCC:

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

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number/Email	Website	Policy No.
Medical	Kaiser Permanente	800-464-4000	KP.org	Group #7056-0005
Medical	Aetna	833-576-2494	Aetnaresource.com	Group #187677
Medical	UnitedHealthcare	800-207-1667	Retiree.uhc.com	Group #15481
Dental	Cigna	800-244-6224	Cigna.com	Group #3340005
Vision	VSP	800-877-7195	Vsp.com	Group #25600
Life	The Standard	800-628-8600	Standard.com	Group #649107
Deferred Compensation Plan	Empower Retirement	800-743-5274	Retiresmart.com	Count of San Mateo
Retirement	SamCERA	650-599-1234	Samcera.org	County of San Mateo
HSA	Avidia Bank	855-248-6311 hsainfo@avidiabank.com	Avidiabank.com	
Medicare	California Health Insurance Advocacy Program (HICAP)	800-434-0222 San Mateo Office: 650-627-9350	Cahealthadvocates.org	
Medicare		800-MEDICARE	Medicare.gov	

GLOSSARY

-A-

AD&D Insurance

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

Allowed Amount

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

Ambulatory Surgery Center (ASC)

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

Annual Limit

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

-B-

Balance Billing

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

Beneficiary

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

Brand Name Drug

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

-C-

COBRA

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

Claim

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

Coinsurance

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

Copayment

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

-D-

Deductible

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

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

Dental Basic Services

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

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

Dental Major Services

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

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage

13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

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

Excluded Service

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

-F-

Formulary

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

-G-

Generic Drug

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

Grandfathered

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

-H-

Health Reimbursement Account (HRA)

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

Healthcare Flexible Spending Account (FSA)

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

High Deductible Health Plan (HDHP)

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

GLOSSARY

-I-

In-Network

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

-L-

Life Insurance

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

Long Term Disability Insurance

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

-M-

Mail Order

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

-O-

Open Enrollment

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

Out-of-Network

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

Out-of-Pocket Cost

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

Out-of-Pocket Maximum

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

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

Outpatient Care

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

-P-

Participating Pharmacy

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

Plan Year

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

Preferred Drug

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

Preventive Care Services

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

Primary Care Provider (PCP)

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

-S-

Short Term Disability Insurance

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

-T-

Telehealth / Telemedicine / Teledoc

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

-U-

UCR (Usual, Customary, and Reasonable)

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

Urgent Care

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

-V-

Vaccinations

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

Voluntary Benefit

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

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on the SMC Website:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Availability of Privacy Practices Notice:**
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **Notice of Availability of Alternative Standard for Wellness Plans:** Describes right to alternatives ways of participating in employer's wellness program
- **ACA Disclaimer**
- **Notice Regarding Wellness Program:** Describes voluntary nature of wellness program that includes biometrics and/or a Health Risk Assessment (HRA)
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **HIPAA Privacy Notice**
- **Non-Discriminatory Testing For Cafeteria Plans Governed Under Code Section 125**
- **Model Cobra Continuation Coverage Election Notice**
- **New Health Insurance Marketplace Coverage Options and Your Health Coverage**
- **PART B: Information About Health Coverage Offered By Your Employer**

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

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 the Kaiser and Aetna plans is, 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 Kaiser and Aetna plans is 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. 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](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	January 1, 2027
Name of Entity/Sender:	County of San Mateo
Contact-Position/Office:	Human Resources – Benefits Division
Address:	455 County Center, 5th Floor Redwood City, CA 94063
Phone Number:	650-363-1919

Women's Health and Cancer Rights Act

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

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

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

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in 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 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 County of San Mateo's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

Availability of Privacy Practices Notice

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

Notice of Choice of Providers

The County of San Mateo's HMO plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the HMO plans designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

For children, you may designate a pediatrician as the primary care provider.

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

Michelle's Law

The County of San Mateo plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify the Benefits Division as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Notice of Availability of Alternative Standard for Wellness Plan

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 10.22% in 2027 of your modified adjusted household income.

Notice Regarding Wellness Program

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

Wellness Dividend program participants will receive a financial incentive for completing dividend-eligible activities through PreventionCloud. Although you are not required to complete an HRA or participate in any biometric screenings, employees who do so will receive \$600.

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

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

Protections from Disclosure of Medical Information

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Wellness at wellness@smcgov.org.

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

- If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov/.
- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
- If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.
- If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: myalhipp.com

Phone: (855) 692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program

Website: myakhipp.com

Phone: (866) 251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid eligibility:

health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: myarhipp.com

Phone: (855) MyARHIPP (692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance

Phone: (916) 445-8322 | Fax: (916) 440-5676

Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado website: healthfirstcolorado.com

Health First Colorado Member Contact Center: (800) 221-3943 (TTY: 711)

CHP+: hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service: (800) 359-1991 (TTY: 711)

Health Insurance Buy-In Program (HIBI): mycohibi.com

HIBI Customer Service: (855) 692-6442

Florida – Medicaid

Website:

flmedicaidtprecovery.com/flmedicaidtprecovery.com/hip

Phone: (877) 357-3268

Georgia – Medicaid

GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: (678) 564-1162, press 1

GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: (678) 564-1162, press 2

Illinois – Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: abe.illinois.gov
HIPP Hotline Number: (217) 524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: in.gov/fssa/dfr
Family and Social Services Administration
Phone: (800) 403-0864
Member Services phone: (800) 457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid website: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid

Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: (855) 459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP website: kynect.ky.gov
Phone: (877) 524-4718
Medicaid website: chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid

Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofc/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid

Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HSHSHIPPPProgram@mt.gov

Nebraska – Medicaid

Website: accessnebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid

Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: (603) 271-5218
Toll free number for the HIPP program: (800) 852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid and CHIP

Website: nj.gov/humanservices/dmahs/individuals-families/familycare
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP phone: (800) 701-0710 (TTY: 711)

New York – Medicaid

Website: health.ny.gov/health_care/medicaid

Phone: (800) 541-2831

North Carolina – Medicaid

Website: medicaid.ncdhhs.gov

Phone: (919) 855-4100

North Dakota – Medicaid

Website: hhs.nd.gov/healthcare

Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP

Website: insureoklahoma.org

Phone: (888) 365-3742

Oregon – Medicaid

Website: healthcare.oregon.gov

Phone: (800) 699-9075

Pennsylvania – Medicaid and CHIP

Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: (800) 692-7462

CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx

CHIP phone: (800) 986-KIDS (5437)

Rhode Island – Medicaid and CHIP

Website: eohhs.ri.gov

Phone: (855) 697-4347 or (401) 462-0311 (Direct Rlte Share Line)

South Carolina – Medicaid

Website: scdhhs.gov

Phone: (888) 549-0820

South Dakota – Medicaid

Website: dss.sd.gov

Phone: (888) 828-0059

Texas – Medicaid

Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program

Phone: (800) 440-0493

Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

website: medicaid.utah.gov/upp

Phone: (888) 222-2542

Email: upp@utah.gov

Adult Expansion website: medicaid.utah.gov/expansion

Utah Medicaid Buyout Program website:

medicaid.utah.gov/buyout-program

CHIP website: chip.utah.gov

Vermont – Medicaid

Website: dvha.vermont.gov/members/medicaid/hipp-program

Phone: (800) 250-8427

Virginia – Medicaid and CHIP

Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid

Website: hca.wa.gov

Phone: (800) 562-3022

West Virginia – Medicaid and CHIP

Website: bms.wv.gov

Website: mywvhipp.com

Medicaid phone: (304) 558-1700

CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP

Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: (800) 362-3002

Wyoming – Medicaid

Website:

health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: (800) 251-1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

NON DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

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

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

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

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

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

WHY AM I GETTING THIS NOTICE?

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

- | | |
|--|---|
| ☐ End of employment | ☐ 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/ebsa/publications/cobraemployee.html>.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?

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

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

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

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

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

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

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if

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

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

CAN I ENROLL IN ANOTHER GROUP HEALTH PLAN?

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

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

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

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

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

FOR MORE INFORMATION

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

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

IMPORTANT INFORMATION ABOUT PAYMENT

FIRST PAYMENT FOR CONTINUATION COVERAGE

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

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

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

GRACE PERIODS FOR PERIODIC PAYMENTS

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

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



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered By Your Employer

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

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

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

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

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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

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

☐ Yes (Continue)

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

☐ No (STOP and return this form to employee)

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

☐ Yes (go to question 15)

☐ No (STOP and return form to employee)

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

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

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

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

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

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

☐ Employer won't offer health coverage

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

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

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

