2024

EXTRA HELP BENEFITS OVERVIEW




Your Benefits, Your Choice.

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Welcome to the County of San Mateo!

ABOUT EXTRA-HELP EMPLOYMENT

In our efforts to become a more agile organization, the County of San Mateo created **extra-help** employment. Extra help are primarily used to staff seasonal assignments and assist departments during brief periods of heightened workloads.

As an extra-help employee, your length of assignment may vary but only up to a maximum of 1,040 hours unless additional time is approved by Human Resources.

Please note that while you are eligible for County sponsored medical plan, there are no retirement benefits included.

The benefits described herein are offered to eligible employees of the County of San Mateo. All benefits are subject to change and there is no guarantee that these benefits will be continued indefinitely. The descriptions are very general and are not intended to provide complete details about any or all plans. **Exact specifications for all plans are provided in the official Plan Documents, copies of which are available** https://www.smcgov.org/hr/health-benefits**.**

Who You Can Cover

WHO IS ELIGIBLE?

Any extra help employee who are determined to have averaged working 30 hours per week during the initial measurement period.

You can enroll the following family members in the Kaiser Traditional HMO or High Deductible Health 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 19 or older.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of County of San Mateo cannot also be covered as a dependent.
- Employees who work less than 30 hours per week, or employees residing outside the United States.

WHEN CAN I ENROLL?

In order to comply with the Affordable Care Act (ACA), the County of San Mateo will determine your eligibility for benefits based using the Look Back Measurement Method. Upon hire, you will be placed in an **Initial Measurement Period (IMP)** for one year after which, your coverage will begin **first of the month** after your IMP ends.

Refer to the next page for additional information on how your eligibility is determined.

Open enrollment for next plan year is generally held in October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to submit a Workday event within 31 days if you have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31 days to make your change in Workday.

ADDING OR REMOVING DEPENDENTS?

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

When You Become Eligible For Benefits

INITIAL MEASUREMENT PERIOD

Extra help employees are primarily utilized by the County to staff seasonal assignments and assist departments during brief periods of heightened workloads. Length of assignment may vary – maximum of 1040 hours unless additional time is approved.

If you are hired as an extra help employee, a position where your hours vary and the County is unable to determine— as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an **Initial Measurement Period (IMP)** of twelve (12) months to determine whether you are a full-time employee. Your IMP will begin on the first of the month following your date of hire and will last for 12 months.

If, during your IMP, you average 30 or more hours a week over that 12 month period, you will be then considered as full time employee and, if otherwise eligible for benefits, you will be offered coverage when you IMP ends. There is a thirty (30) days administrative period and coverage will then start the first of the month following the administrative period. Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

HOW IT WORKS

Below is an illustration of how the County will measure Extra-Help employees:

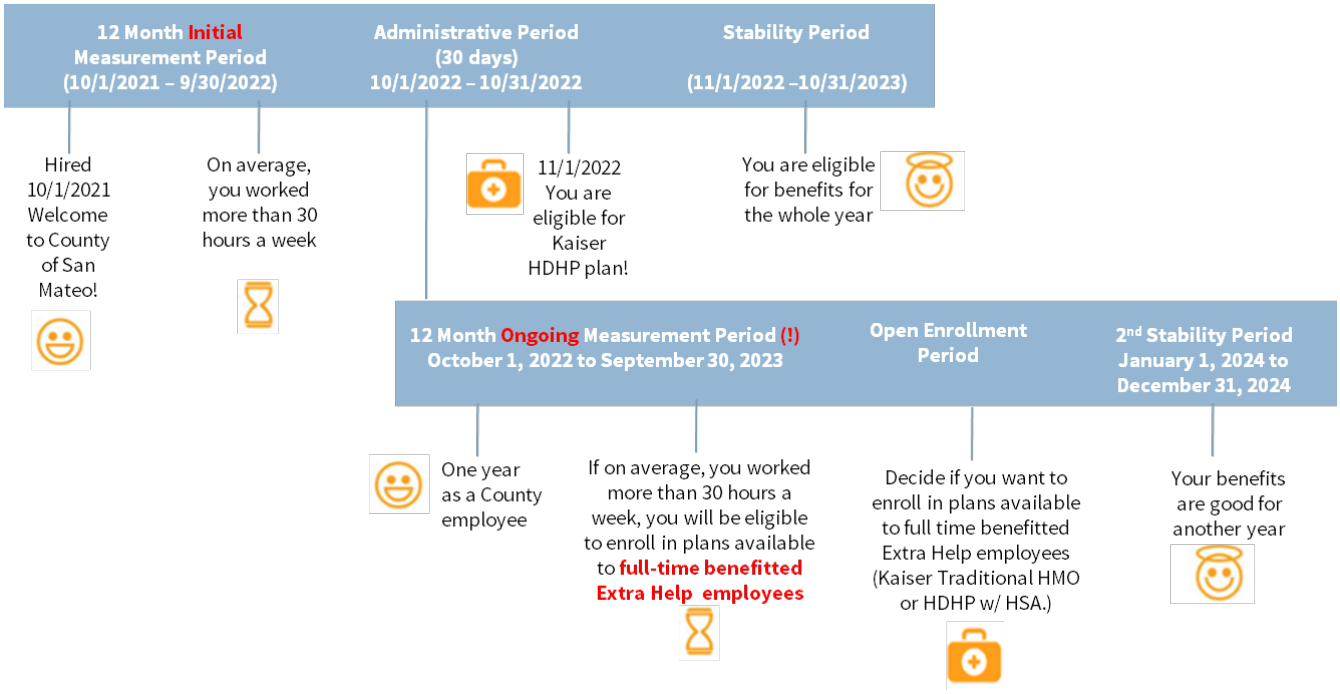
When You Become Eligible For Benefits

ONGOING MEASUREMENT PERIOD

If you are hired as an extra help employee, a position where your hours vary and the County is unable to determine— as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal or relief employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will also be placed in an **Ongoing Measurement Period (OMP)** of twelve (12) months from October to October to determine whether you are a full-time employee. Your 12-month OMP will begin in October of each year employed and ends in October as long as you continue employment.

If, during your OMP, you average 30 or more hours a week over that 12 month period, you will then be considered as full time employee and, if otherwise eligible for benefits, you will be offered coverage during the Open Enrollment period. Your full-time benefited status will remain in effect from January to December. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Here is an illustration on how the Ongoing Measurement Period (OMP) runs concurrent with your Initial Measurement Period (IMP).



(!) If you are still employed with the County of San Mateo by the end of your Ongoing Measurement Period, your medical coverage will extend until Dec. 31, 2024

What Medical Plans You Are Eligible For

KAISER PERMANENTE®

TRADITIONAL HMO PLAN

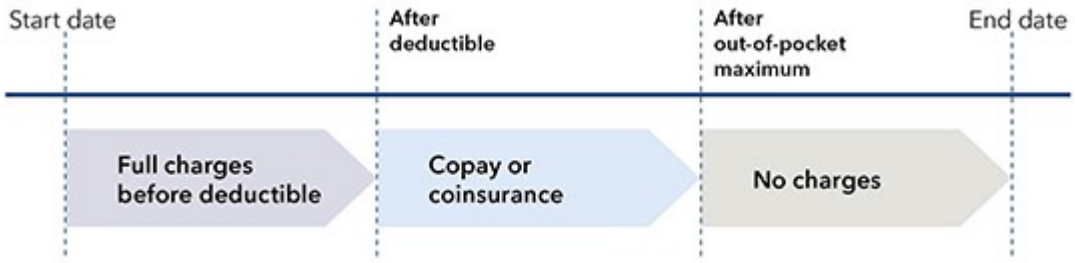
Health Maintenance Organization (HMO) in which patients seek medical care within the plan's own facilities. Under this plan, most services and medicines are covered with a small co-payment. You select your doctor, or Primary Care Provider (PCP), from the staff at a local Kaiser Permanente facility. All of your care is provided at a Kaiser facility. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency. More information about Kaiser's health plan benefits is available at https://www.smcgov.org/hr/health-benefits; click on medical plans.

HMO HIGH DEDUCTIBLE HEALTH PLAN

Kaiser Permanente High Deductible Health Plan, is considered a Minimum Essential Plan under the ACA criteria.

In a deductible plan, there's a fixed amount of money—the deductible—members must pay in a calendar year before we'll pay for certain covered services. After you meet your deductible, you'll only need to pay a copayment (copay) or coinsurance for most covered services until you reach an annual limit called your out-of-pocket maximum.

Once you meet your annual out-of-pocket maximum, Kaiser Permanente will pay for most covered services in full until the end of the calendar year.



Please remember that not all covered services are subject to the deductible. For example, certain preventive care visits (and in some plans, prescription drugs) are available to you right away for only a copay, whether or not you've reached your deductible. Copays for these services don't apply toward your deductible. In most cases, however, they'll count toward your out-of-pocket maximum.

The HDHP comes with a Health Savings Account (HSA) that is administered by BCC. The County will contribute up to half of your deductible ($750.00 for $1,500 deductible or $1,500 for $3,000 deductible per pay period to your HSA. You can also contribute towards your HSA account pre-tax, which will be deducted from your paycheck.

For more information how a High Deductible Health Plan works, please refer to the High Deductible Health Plan & HAS section of this Guide.

Dependent Eligibility Verification

All employees adding dependents will be asked to submit documentation verifying eligibility of their covered dependents. The following chart is an easy guide to which form and documents must be submitted. Failure to submit appropriate documentation will result in dependent's ineligibility for coverage.

DEPENDENT TYPE	ELIGIBILITY DEFINITION	DOCUMENTS REQUIRED FOR VERIFYING ELIGIBILITY
Spouse	• Person to whom you are legally married	• Marriage Certificate
Domestic Partners At least 18 years old	• Meet County Domestic Partner Eligibility Requirements • Must be at least 6 months between any domestic partnerships	• County of San Mateo Affidavit of Domestic Partnership **-or-** • Declaration of Partnership filed with the California Secretary of State
Natural Child(ren) Under Age 26	• Minor or Adult Child(ren) of Employee who is under age 26yrs	• Birth Certificate
Step Child(ren) Under Age 26	• Minor or Adult Child(ren) of Employee Spouse who is under age 26yrs	• Birth Certificate **–and-** • Marriage Certificate showing Spouse as Parent
Children Legally Adopted/Wards	• Minor or Adult Child(ren) legally adopted by Employee who is married or unmarried under age 26yrs	• Court documentation (Must include presiding Judge Signature & Court Seal)
Children of Domestic Partners Under Age 26	• Minor or Adult Child(ren) of Employee Domestic Partner who is under age 26yrs	• County of San Mateo Affidavit of Domestic Partnership **–and-** • Birth Certificate
Disabled Children No age limit	• Natural Child, Step Child or Adopted Child of Employee who is over age 26yrs and incapable of self-care due to physical or mental illness.	• Birth Certificate **–and-** • Certification of Disability from Social Security **-or-** • Document of Disability from Physician if not SSA Certified
Other Qualifying Relatives Under Age 26	• Meets Requirements of IRS Code. Sec. 105(b) • under age 26yrs	• Birth Certificate Showing Individual to be an Eligible Relative –**and-** • County of San Mateo Affidavit of Tax Qualifying Dependent

PLEASE NOTE: The deduction for a domestic partner **is not** a pre-tax qualified deduction. Since this is not a pre-tax qualified deduction, County employees will be assessed imputed taxable income on their W2 tax statement at the end of the year that needs to be reported when filing taxes. It is recommend consult with a qualified tax specialist or accountant for any additional questions.

Both the Affidavit of Tax Qualifying Dependent and the Affidavit for Domestic Partnership are available online at https://www.smcgov.org/hr/health-benefits; click on Benefits Forms.

When You Can Make Changes to Your Benefits

Other than during the annual "open enrollment" period, you may not change your coverage unless you experience a qualifying event. Qualifying events include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, registration or dissolution of domestic partnership, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status**, including the start or termination of employment by you, your spouse, or your dependent child
- **Permanent change in work schedule**, including a significant increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring *coverage* for your child or dependent foster child
- **An event that is a special enrollment event under HIPAA (**the Health Insurance Portability and Accountability Act), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
    - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage

Removing Dependents

- Dependents who gain other coverage elsewhere must be dropped within 31 days. Proof of other group coverage will need to be uploaded in the Workday Event

IMPORTANT!—THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any changes you make must be consistent with the change in status,
2. You must make the changes within 31 days of the date the *event* (marriage, birth, etc.) occurs,
3. With the exception of births, life events take effect the first of the following month after the life event effective date.

When Your Benefits Terminate

Your medical coverage ends on the last day of the month following your date of termination or loss of eligibility. For example, if your termination date is March 14, your benefits will end on March 31. If termination date is March 31, benefits will end on March 31.

You may continue benefits during a family leave of absence according to federal guidelines and in conjunction with the County's policy for a limited period of time after termination, or under your federal and state COBRA rights. Your coverage ends on the date of your termination for your Health Savings Spending Accounts (HSA).

For more information on COBRA, please refer to the Important Plan Information section of this guide.

BENEFITS DURING FAMILY AND MEDICAL LEAVE AND CALIFORNIA FAMILY RIGHTS ACT

An employee taking family/medical leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave (for a maximum of 12 work-weeks) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The County will continue to make the same premium contributions as if the employee had continued working. The continued participation in health benefits begins on the date leave first begins under the Family and Medical Leave Act (e.g. for pregnancy disability leaves) or under the Family and Medical Leave Act/CFRA (e.g. for all other family care and medical leaves).

In some instances, the County may recover premiums it paid to maintain health coverage for you if you fail to return to work following pregnancy disability leave.

Employees on family/medical leave who are not eligible for continued paid coverage may continue their group health insurance coverage at their own expense in conjunction with the federal COBRA guidelines. Employees should contact the Human Resources department for further information. Under most circumstances, upon return from family/medical leave, an employee will be reinstated to his or her original job or to an equivalent pay, benefits, and other employment terms and conditions. However, an employee has no greater right to reinstatement than if he or she had been continuously employed rather than on leave. For example, if an employee on family/medical leave would have been laid off or terminated had he or she not gone on leave, or if the employee's job is eliminated during the leave and no equivalent or comparable job is available, then the employee would not be entitled to reinstatement.

An employee's use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.

Preventive Care Screening Benefits

YOU TAKE YOUR CAR IN FOR MAINTENANCE. WHY NOT DO THE SAME FOR YOURSELF?

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

WHAT IS PREVENTIVE CARE?

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

NOT ALL EXAMS AND TESTS ARE CONSIDERED PREVENTIVE

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

TYPICAL SCREENINGS FOR ADULTS

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

Preventive care for women should include breast and gynecological exams

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

Should I skip my checkup due to COVID-19?

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

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

High Deductible Health Plan & HSA

The County's Kaiser medical plan is designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury.

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN (HDHP)?

HDHP is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. If you enroll in a HDHP with the County, you will also be automatically enrolled in a Health Savings Account (HSA) to which the County will contribute up to half of your deductible ($750.00 for $1,500 deductible or $1,500 for $3,000 deductible) through a bi-weekly deposit into your HSA account to help you pay for your costs before the deductible and other out-of-pocket costs. You can also contribute pre-tax money from your paycheck into your HSA.

HOW DOES THE HDHP WORK?

There is a deductible of either $1,500 (if you are enrolled in single) or $3,000 (if you are enrolled in the 2-party tier or family tier). If you are enrolled in a HDHP plan, you are responsible for the full cost of any medical services you incur until you meet your deductible, then co-payments apply. For more details about reaching your deductible and out-of-pocket maximum, please refer to the Kaiser Permanente Evidence of Coverage or Summary of Benefits.

All County plans, including the new HDHP plans, provide 100% coverage for preventive care from in- network providers, with no deductibles or copays. This means that you and your family can receive the important preventive care services you need to manage your health, such as routine physical exams and screenings all covered at 100%, with no out-of-pocket costs.

HOW DOES THE HSA WORK WITH THE HDHP PLAN?

If you choose a HDHP plan, you will be automatically enrolled in a Health Savings Account through OPTUM. For 2024, the County will contribute up to half of your deductible ($750.00 for $1,500 deductible or $1,500 for $3,000 deductible per pay period to your HSA. You can also choose to set aside pre-tax money to offset your deductible. If you still have money in your account after you meet your deductible, you can use it for co-pays and other eligible costs.

Tax benefits of an HSA are three-fold: your additional voluntary contributions are pre-tax, interest earned is tax-free, and HSA distributions are tax-free if they are used to pay for qualified medical expenses. Your HSA belongs to you. That means that you can keep it even if you change employers, decide to drop the plan at a later time, or retire. Interest earned on your HSA account is tax-free, and tax-free withdrawals may be made for qualified medical expenses. Unused funds and interest are carried over, without limit, from year to year. Your funds will accumulate without a maximum cap.

High Deductible Health Plan & HSA

WHAT CAN I USE THE FUNDS IN MY HSA FOR?

Your HSA can be used to pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care insurance premiums, LASIK surgery and some nursing services.

When you become Medicare enrolled you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are Medicare enrolled.

For the complete list of IRS-allowable expenses, you can request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and select "Forms and Publications." Please note, however, while health insurance premiums are listed as an allowable expense they are not reimbursable from HSAs, unless you are receiving Federal unemployment compensation.

CAN I USE MY HSA TO PAY FOR NON-HEALTH RELATED EXPENSES?

Yes. You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20 percent tax penalty on the amount withdrawn.

I ONLY HAVE SINGLE COVERAGE. CAN I USE MY HSA TO PAY FOR MY SPOUSE'S OR OTHER FAMILY MEMBER'S UNCOVERED MEDICAL EXPENSES?

Yes. You may use your HSA funds to cover eligible expenses of your spouse and/or other eligible family members.

HOW SHOULD I DECIDE IF A HDHP IS RIGHT FOR ME?

If your medical expenses are generally limited to routine or preventive care, you may want to consider an HDHP, especially since the County is contributing a significant portion of the deductible- 50% for 2024. An HSA is also a tool you can use to make additional voluntary contributions to accelerate the accumulation of funds for future or retiree medical expenses. A HDHP plan also offers protection from unexpected accidents or illnesses at a lower premium cost.

WHAT IF I HAVE A CATASTROPHIC EVENT? WHAT IS MY FINANCIAL RISK IF I AM ENROLLED IN A HDHP PLAN?

Your out-of-pocket expenses for covered medical services are limited to the catastrophic in-network limit of $3,000 for Self-Only coverage and $6,000 for 2-Party and Family coverage. Once you hit this limit in expenses in a calendar year, your medical services are 100% covered and you will not incur additional out-of-pocket covered medical expenses including doctor visits co-pays and prescriptions.

High Deductible Health Plan & HSA

HOW WILL I KNOW WHEN I MEET MY DEDUCTIBLE?

Your deductible "resets" at the start of each plan (calendar) year. When you visit your doctor or have a procedure, your provider submits a claim to your health plan. Your plan will track the cost of the service and apply eligible costs to your deductible. To find out what your plan considers to be an eligible cost, read through your plan documents or contact your plan with any questions.

The Explanation of Benefits (EOB) form that your plan sends after you receive a service will show whether you have met your deductible or not. If you are still below the limit, your EOB will say that the plan has not paid for the service and you will need to pay the full cost. If you have met your deductible, your EOB will show how much your plan paid, according to its rules. You can also call your plan and ask how close you are to meeting your deductible.

It's a smart idea to keep track on your end, too. Be sure to keep a record and copy of all your healthcare receipts and claims, along with how much should be applied to your deductible. That way you can make sure that your health plan is recording your payments and applying them to your deductible correctly.

Employees are responsible for making sure that they are not enrolled in an FSA or other type of health benefit disqualifying for an HSA. It is ultimately the enrollee's responsibility to follow IRS rules

HOW CAN I RECEIVE THE MOST VALUE FROM A HDHP PLAN?

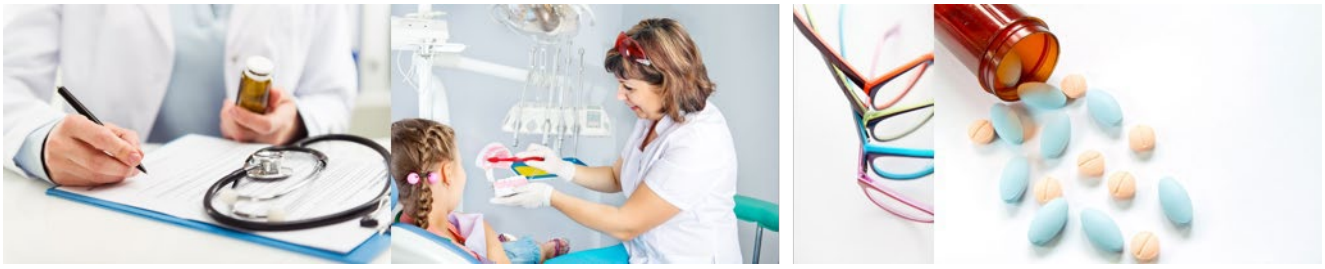
You can get the most value from your HDHP my actively managing your health care:

- Know the plan and how you use your medical care. Knowing how your plan works and keeping track of how much you've paid each plan year are the first steps to knowing how to use your plan well.
- Use preventive care. Take advantage of your 100% in-network preventive care so you can stay healthy and detect problems before they become serious.
- Lead a healthy lifestyle. Not only will you feel better, but you may end up spending less on health care – less of your own money – and saving more of your HSA for future health care needs.
- Know the costs and look for appropriate alternatives. Taking financial responsibility is another part of using the plan. You can save money by shopping for the best local, in-network rates and by budgeting your expenses so you can set aside enough money in your HSA. You should also consider alternative means of care and discuss them with your provider (e.g. generic instead of brand drugs, an X-ray instead of an MRI, going to your primary care physician or an urgent care facility rather than an emergency room for non-life threatening medical conditions, etc.).

BEFORE MY VISIT, HOW CAN I FIND OUT HOW MUCH I'LL NEED TO PAY?

Call the Kaiser Member services at (800) 464-4000. Remember that estimates are based on the services you're scheduled to receive and may not be exactly what you'll owe for your visit.

HSA Qualified Medical Expenses



To help you determine whether an expense qualifies for tax-free reimbursement under your HSA, Internal Revenue Code Section 213(d) states that eligible expenses must be made for "medical care." This is defined as amounts paid for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

Qualified medical expenses are eligible for reimbursement through your HSA as long as they are not reimbursed through insurance or other sources. The examples and requirements below are subject to change by the IRS.

EXAMPLES OF QUALIFIED MEDICAL EXPENSES

This list includes some examples of qualified medical expenses:

- Acupuncture
- Alcoholism treatment
- Ambulance services
- Artificial limb or prosthesis
- Artificial teeth
- Birth control pills
- Braille books/magazines (portion of costs)
- Car adaptations (for a person with a disability)
- Chiropractors
- Christian Science practitioners
- Contact lenses (including saline solution and cleaner)
- Crutches
- Dental treatment (x-rays, fillings, extractions, dentures, braces, etc.)
- Diagnostic devices (such as a blood sugar test kit)
- Doctors' fees
- Drug addiction treatment
- Eyeglasses (including eye examinations)
- Eye surgery (including laser eye surgery)
- Fertility enhancement (including in-vitro fertilization)
- Guide dog (for visually impaired or hearing impaired)
- Hearing aids and hearing aid batteries
- Hospital services (including meals and lodging)
- Insulin
- Laboratory fees
- Lactation assistance supplies
- Prescription medicines or drugs
- Nursing home
- Nursing services
- Operations or surgery
- Psychiatric care
- Psychologist
- Telephone equipment for hearing impaired
- Telephone equipment for visually impaired
- Therapy or counseling
- Transplants
- Transportation for medical care
- Vasectomy
- Wheelchair
- X-rays

Cost of Plans

WHAT IS THE COST TO ENROLL IN THE COUNTY'S HEALTH PLAN?

Both employees and the County share in the cost of your health coverage. The amount of the premium you are responsible for depends on your employment status (full-time, 3/4 time or 1/2 time), the number of your dependents (if any) covered.

The employee portion of the premiums is automatically deducted from your paycheck on a semi-monthly pre-tax basis.

The tables below list each health plan's monthly premium cost for both the employee and County.

KAISER PERMANENTE HEALTH PLANS

(Semi-monthly Cost)

	Employee Only		**Employee + 1**		**Employee + Family**	
PLAN	Employee Cost	County Cost	Employee Cost	County Cost	Employee Cost	County Cost
Traditional HMO	$67.30	$382.34	$515.94	$382.34	$888.31	$382.34
High Deductible Health Plan	$53.53	$304.34	$410.40	$304.34	$706.60	$304.34

Comparison of Health Plans

KAISER PERMANENTE®

	Traditional HMO	HDHP
Annual Deductible	$0 per individual $0 family limit	$1,600 per individual $3,200 (per member in a family of two or more) $3,200 family limit
Annual Out-of-Pocket Max Individual Family	$1,500 $3,000	$3,000 per individual $3,000 (per member in a family of two or more) $6,000 family limit
Physician/Professional Services		
Office Visits Physician & Specialist	$15 copay	Plan pays 90% after deductible
Designated Walk-in Clinic Visit (e.g., CVS HealthHUB or CVS MinuteClinic)	Not applicable	Not applicable
Telemedicine	No charge	No charge
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic and Acupuncture Care	$15 copay (up to 20 visits per year)	Not covered
Lab and X-ray	$5 copay then plan pays 100%	Plan pays 90% after deductible
Infertility (Please refer to the EOC for additional details)		
Diagnosis and treatment of infertility	50% coinsurance	50% coinsurance after deductible
Assisted reproductive technology ("ART") Services	50% coinsurance (one treatment cycle lifetime maximum)	50% coinsurance (one treatment cycle lifetime maximum)
Family Planning		
Physicians Family Planning Services	Plan pays 100%	Plan pays 100%
Vasectomy	$50 per procedure	Plan pays 90% after deductible
Tubal Ligation	$50 per procedure	Plan pays 90% after deductible

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

Comparison of Health Plans

KAISER PERMANENTE®

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

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

Prescription Drugs

KAISER PERMANENTE

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

	Traditional HMO	HDHP
Pharmacy		
Value Drug List (chronic)	Plan pays 100%	Plan pays 100%
Preferred Generic	$10 per prescription	$10 per prescription
Preferred Brand	$20 per prescription	$30 per prescription
Non-Preferred Generic and Brand	$20 per prescription	$30 per prescription
Specialty Drugs	$20 per prescription (30-day supply)	$30 per prescription
Supply Limit	100 days	30 days
Mail Order		
Value Drug List (chronic)	Plan pays 100%	Plan pays 100%
Preferred Generic	$10 per prescription	$20 per prescription
Preferred Brand	$20 per prescription	$60 per prescription
Non-Preferred Generic and Brand	$20 per prescription	$60 per prescription
Specialty Drugs	$20 per prescription (30-day supply)	Not Covered
Supply Limit	100 days	100 days

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

Getting Care the Way You Want It

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

24/7 care advice

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

In-person visit

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

Email

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

Phone appointment

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

Video visit

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

E-visit

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

Need care now? Know before you go.

Urgent care

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

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

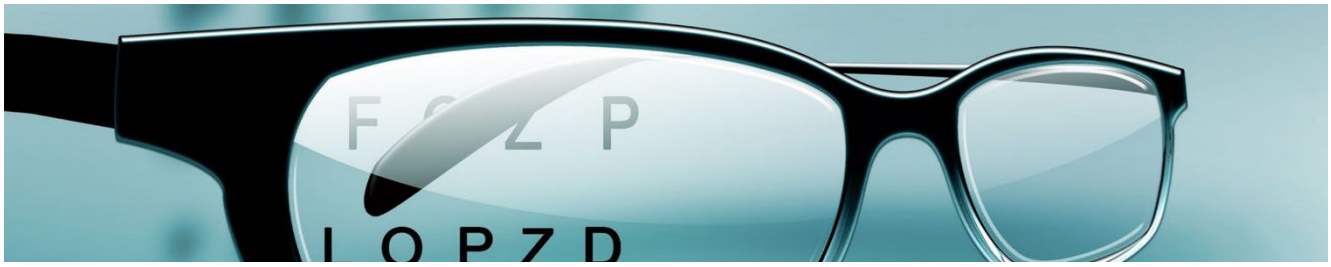
Emergency care

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

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

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

Vision



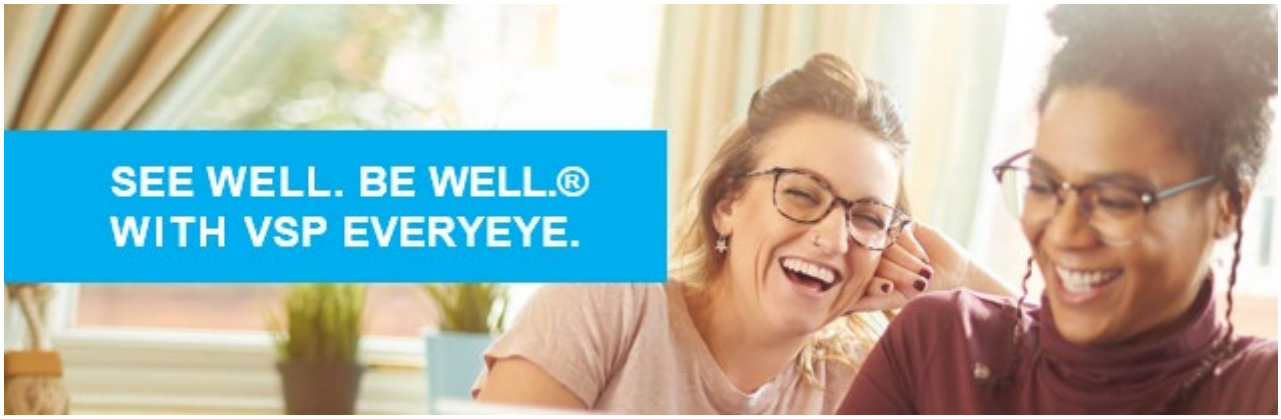
As a County of San Mateo Extra Help employee, you have access to vision care through VSP's EveryEye starting 7/1/2024. When you visit a VSP contracted provider and provide them with your information, they will be able to see your discounts and benefits.

To learn more about your benefits, you may call VSP at 800.877.7195 or create an account at vsp.com.

Benefit Summary	
EveryEye Plan through a VSP Doctor	
Exam / $20 Copay	WellVision Exam, covered **every calendar year** Retinal Imaging exam covered every calendar year after a $39 Copay
Lenses	25% off frames – when a complete pair of prescription glasses is purchased
Lens Enhancements	Single Vision Lenses: $40 Lined Bifocal Lenses: $60 Lined Trifocal Lenses: $75 Average of 30% off lens enhancements like anti-glare coating Children receive a covered-in-full upgrade to impact-resistant lenses
Non-prescription Glasses	20% off unlimited additional pairs of non-prescription glasses/sunglasses per prescription
Contact Lenses	15% off contact lens exam (evaluation and fitting exam)

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

Vision Features



Eye care is healthcare. Taking care of your eyes is an important part of your overall health. If now is not the right time to enroll in your full-service plan, we've got you covered and you can still protect your eyes with VSP EveryEye™ coverage featuring Exam Plus Savings Plan™. You'll get the personalized eye care you deserve when you visit an in-network VSP® provider, giving your eyes the love they deserve.

VSP® Vision Care

GET TO KNOW YOUR BENEFITS

With VSP, you'll get great care from an in-network doctor and qualify for savings on glasses. Here's a look at what you get with your **VSP EveryEye** coverage:

- An annual WellVision Exam® for just a $20 copay
- A retinal screening for no more than a $39 copay
- 15% off a contact lens exam
- 25% off frames (when a complete pair of prescription glasses is purchased)
- Single vision lenses for just $40
- An average of 30% off lens enhancements like anti-glare coatings
- Children receive a covered-in-full upgrade to impact-resistant lenses
- 20% off unlimited additional pairs of non-prescription glasses/sunglasses

ONCE YOUR BENEFIT IS IN EFFECT, HERE'S HOW IT WORKS

Create an account on vsp.com.
Here you can view your coverage details, find an in-network provider, and discover money-saving offers.

Find your in-network doctor.
Maximize your benefits at a Premier Program location, now including thousands of private practice doctors and more than 700 Visionworks® retail locations nationwide. Once you've found an in-network provider, be sure to schedule your annual eye exam.

Enjoy more savings and offers.
As a VSP member, you get access to more than $3,000 in savings with **VSP Exclusive Member Extras.***

Questions? Visit vsp.com or call us at 800.877.7195

*Promotions like special offers and rebates are continually evaluated and subject to change without notice. Some exclusions may apply

Enhanced Services

1. BEFORE YOUR VISIT - Get a cost estimate

   Use our online Estimates tool

   Visit kp.org/costestimates for an estimate of what you'll pay for many common services. Estimates are based on your plan benefits and whether you've reached your deductible — so you get personalized information every time.

   Call us for an estimate

   If you can't get an estimate for a service online, call 1-800-390-3507, weekdays from 7 a.m. to 5p.m.

2. DURING YOUR VISIT - Know What To Expect

   Make a payment when you check in

   When you come in for care, you'll be asked to make a payment for your scheduled services. Your payment may only cover part of what you owe for your visit, especially if you get any additional services. In that case, you'll get a bill for the difference later.

   Expect a bill for additional services

   During your visit, your doctor may decide you also need services that weren't scheduled — like a blood test or an X-ray. When you go to the lab or Radiology Department, you'll make a payment for these services. If what you pay doesn't cover everything you owe, you'll get a bill later.

   Costs for non-preventive care

   Preventive care services are a good way to catch health problems early. That's why they're covered at no cost or at a copay.* But sometimes when you come in for preventive care, you'll get non-preventive services, too. For example, during a routine physical exam, your doctor might remove a mole for testing. Because mole removal and testing are non-preventive, you'll get a bill for them later.

Enhanced Services

3. AFTER YOUR VISIT - Manage Your Bills and Costs

Understanding your bills

You'll get a bill after most visits. It will show the charges for the services you got, what you paid, what your health plan paid, and the amount you owe. Depending on the care you received, you may get a physician bill, a hospital bill, or both. If you've signed up for electronic billing, you'll get an email alert instead of a paper bill.

Paying your bill

You have several convenient options:

- Online or on your mobile device: You can check bill history, make a payment, and manage payment methods online at kp.org/paymedicalbills or by using the Kaiser Permanente app.
- By mail: Send your payment in the return envelope that came with your bill.
- By phone: Call us at 1-800-390-3507, weekdays from 7 a.m. to 5 p.m.

Tracking your expenses

You can also track your costs and see how close you are to reaching your deductible and out-of-pocket maximum. Once you reach your deductible, you'll pay a copay or coinsurance for covered services instead of the full charges. If you reach your out-of-pocket maximum, you won't pay for covered services for the rest of the year.*

- Check your Explanation of Benefits (EOB): You'll get an EOB for your records. It isn't a bill. It's a summary that shows the services you received, how much they cost, and how much your health plan paid. Use it to keep track of your expenses, your deductible, and your out-of-pocket maximum. To see your EOBs online, visit kp.org/mydocuments.
- Visit kp.org/costestimates: It's a quick, easy way to check your progress toward reaching your deductible and out-of-pocket maximum.
- Track your costs online, anytime: Sign on to kp.org and go to "My Coverage and Costs" to see your claims summary. It lists the charges for services you've received.

Visit kp.org/choosepaperless to switch to electronic bills, EOBs, and more.

**Depending on your plan, for a small number of services, you may need to keep paying copays or coinsurance after reaching your out-of-pocket maximum.*

Enhanced Services

ADDITIONAL RESOURCES

Do you have an HSA?

You can use the money in your health reimbursement arrangement (HRA), health savings account (HSA), or flexible spending account (FSA) to pay for care.[1] Just use the debit card for your account, if you have one, when you check in for your visit or when paying a bill later. Be sure to keep all receipts, bills, and EOBs in case you need to document your expenses later.

Have questions or need help paying for care?

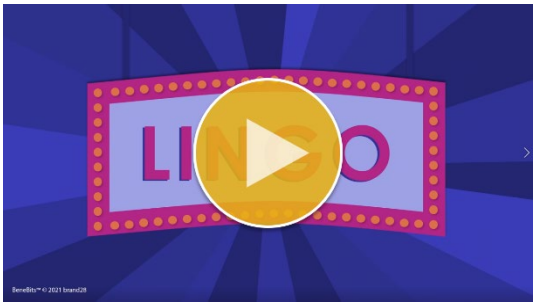
If you have questions about your costs or bills, call 1-800-390-3507, weekdays from 7 a.m. to 5 p.m. You can also get information about financial assistance and payment options for members who need help paying for care.

For information about your plan or benefits, call our Member Service Contact Center at 1-800-464-4000 or 711 (TTY), 24 hours a day, 7 days a week (closed holidays).

IMPORTANT TERMS

Here are some terms to help you understand your plan. See your Evidence of Coverage for your plan details, including the date your deductible and out-of-pocket maximum will start over.

Insurance Lingo



Click to play video

DEDUCTIBLE: The amount you pay each year for covered services before Kaiser Permanente starts paying. Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.

COPAY: The set amount you pay for covered services — for example, a $10 copay for an office visit.

COINSURANCE: A percentage of the charges that you pay for covered services. For example, a 20% coinsurance for a $200 procedure means you pay $40.

OUT-OF-POCKET MAXIMUM: The maximum amount you'll pay for covered services each year. For a small number of services, you may need to keep paying copays or coinsurance after reaching your out-of-pocket maximum.[2]

[1]Section 213(d) in IRS Publication 502, Medical and Dental Expenses, available at irs.gov/publications. Your employer may limit which qualified medical expenses HRA funds can be used for.

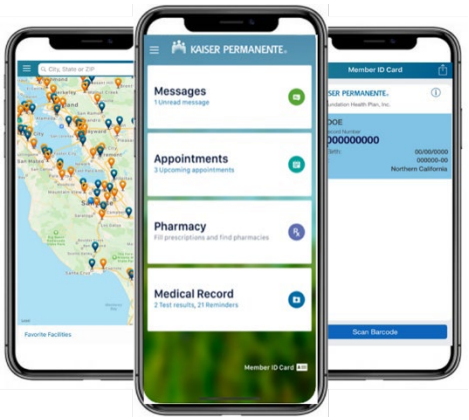
[2]For HSA-qualified plans, once you reach your out-of-pocket maximum, you won't have to pay anything for covered services for the rest of the year.

Enhanced Services

KAISER PERMANENTE®

KAISER PERMANENTE MOBILE APP

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



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

DIGITAL SELF-CARE TOOLS

Everyone needs support for total health — mind, body, and spirit. These apps can help you build resilience, set goals, and take meaningful steps toward becoming healthier and happier. Choose the areas you want to focus on — including managing depression, reducing stress, improving sleep, and more.

- Evidence-based and proven effective
- Hand-picked by Kaiser Permanente physicians
- Confidential and easy to use

Calm

Calm is an app for daily use that uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. With guided meditations, programs taught by world-renowned experts, sleep stories narrated by celebrities, mindful movement videos, and more, Calm offers something for everyone.

myStrength

myStrength offers personalized programs with interactive activities, daily health trackers to monitor and maintain your progress, in-the-moment coping tools, and more. It's designed to help you set goals and work toward them in ways that work for you — by making positive changes that support your mental, emotional, and overall well-being.

myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc.

Get the apps at **kp.org/selfcareapps**.

Health Savings Account

ADMINISTERED BY BENEFITS COORDINATION CORPORATION (BCC)

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

- This account comes with a debit card that you can use to pay for qualified medical expenses. For a detailed list of qualified medical expenses and further information, please refer to the plan documents. You will also be able to access your account online at the My SmartCare website
- You may change (increase or decrease) your contributions at any time
- In 2024, you can contribute a maximum of **$4,150** for employee only or **$8,300** for employee + one or more. This maximum includes both employer and employee contributions.
- Please Note: BCC uses Avidia Bank as the custodial bank that will hold your HSA funds. You may receive an email from Avidia Bank requesting for additional documents to complete the verification process required to open a Health Savings Account (HSA). Please follow the instructions and respond promptly to establish your HSA.

Click to play video

If you elect to enroll the Kaiser High Deductible Health Plan, the County will fund 50% of the deductible for 2024.

This money to help pay for qualified medical expenses.

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

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

FEES

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

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

BCC My SmartCare

FOR HEALTH SAVINGS AND FLEXIBLE SPENDING ACCOUNT MEMBERS

DEBIT CARD

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

MY SMARTCARE MOBILE APP:

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

MY SMARTCARE ONLINE PORTAL

1) Go to: https://benefitcc.wealthcareportal.com/Page/Home

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

MY SMARTCARE MOBILE APP

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

ASSISTANCE? QUESTIONS?

Contact BCC's Customer Service Call Center toll free or email them:

CUSTOMER SERVICE

800-685-6100

customersupport@benxcel.com

MY SMARTCARE REGISTRATION INSTRUCTIONS

- When registering as a new user, My SmartCare will walk you through a series of registration questions followed by a secure authentication process to validate you as a user.
- Enter your name and zip code
- If you have received a benefit debit card, check the box to enter the card number and expedite the registration process
- You will receive a special code for verification. Check your email or text messages and enter the code provided
- Create a username and password for your account
- Select four security questions and provide your answers. For your security, these questions may be randomly asked during subsequent logins.
- Confirm your email address.
- By registering with My SmartCare, you will have the option to receive important push notifications (account balance, grace period, year-end reminders; notice of debit card mailed, etc.) via e-mail or text message. You can manage these notifications in your My SmartCare communication settings.
- You have the option to save your User ID to your mobile device by choosing 'ON' next to "Save this Online ID". This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial log in.

Health and Wellness

Take advantage of these extra perks from Kaiser Permanente — from personal health coaching to reduced rates on alternative medical therapies.

Sign up for healthy lifestyle programs[3]

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

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

Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor.

kp.org/healthylifestyles

kp.org/vidasana (en español)

Enjoy reduced rates

Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program.4 These include:

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

kp.org/choosehealthy

Get a wellness coach

If you need a little extra support, we offer Wellness Coaching by Phone at no cost. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals.

kp.org/wellnesscoach

Join health classes

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

kp.org/classes

kp.org/clases (en español)

Health and Wellness

The Employee Wellness Program is designed to help you improve or maintain your health and wellbeing through a variety of classes, services, challenges, surveys, recreation events, and activities. Employees are empowered with health education, social support, and strategies to achieve long-term health and wellness goals. The Employee Wellness Program plays a pivotal role in fostering a healthy and safe work environment, high employee engagement, a productive workforce, and a sense of care and wellbeing.

As a County employee, you are strongly encouraged to regularly participate in the Employee Wellness Program. You can attend most activities and classes on County time at no cost to you. The County uses a Whole Person Wellbeing model and organizes offerings into 3 areas of wellness: Physical, Emotional, and Social.

Physical Wellness

- ✓ Flu Clinics
- ✓ Wellness Screenings
- ✓ Online Health Assessment
- ✓ Smoking Cessation Program
- ✓ Weight Loss Challenges
- ✓ Nutrition Counseling
- ✓ Health Coaching
- ✓ Gym Discounts
- ✓ Physical Activity Challenges

Emotional Wellness

- ✓ Stress Management Classes
- ✓ Mindfulness Classes
- ✓ Massage Therapy Program
- ✓ Emotional Wellbeing Videos
- ✓ Yoga in the Park
- ✓ Take-a-Hike Program
- ✓ Art & Music Therapy Classes
- ✓ EAP Workshops
- ✓ Mental Health Apps from Kaiser

Social & Family Wellness

- ✓ Bright Horizons College Coaching
- ✓ Childcare Discounts & Tuition Assistance Program
- ✓ Recreation Events & Socials
- ✓ Employee Wellness Yammer Page with Collaborative Videos, Photo Collages, and Recipes
- ✓ Employee Interest Groups
- ✓ Babies & You Program
- ✓ Blood Drives
- ✓ Peer Support Groups

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

PREVENTIONCLOUD WELLNESS PORTAL QUICK START GUIDE

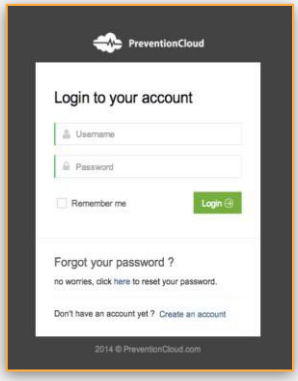
WELLNESS PORTAL REGISTRATION

Okta Access

Using your computer or mobile device, go to
https://preventioncloud.com/oauth/okta (Okta access)

Library & Courts Employees:
Using your computer or mobile device, go to https://www.preventioncloud.com

- **Employee Username**
  County email address (Jdoe@smcgov.org)
- **Password**
  Birthdate (MMDDYYYY) - ***Once logged in, you will be prompted to change your password***



Library & Courts Employees

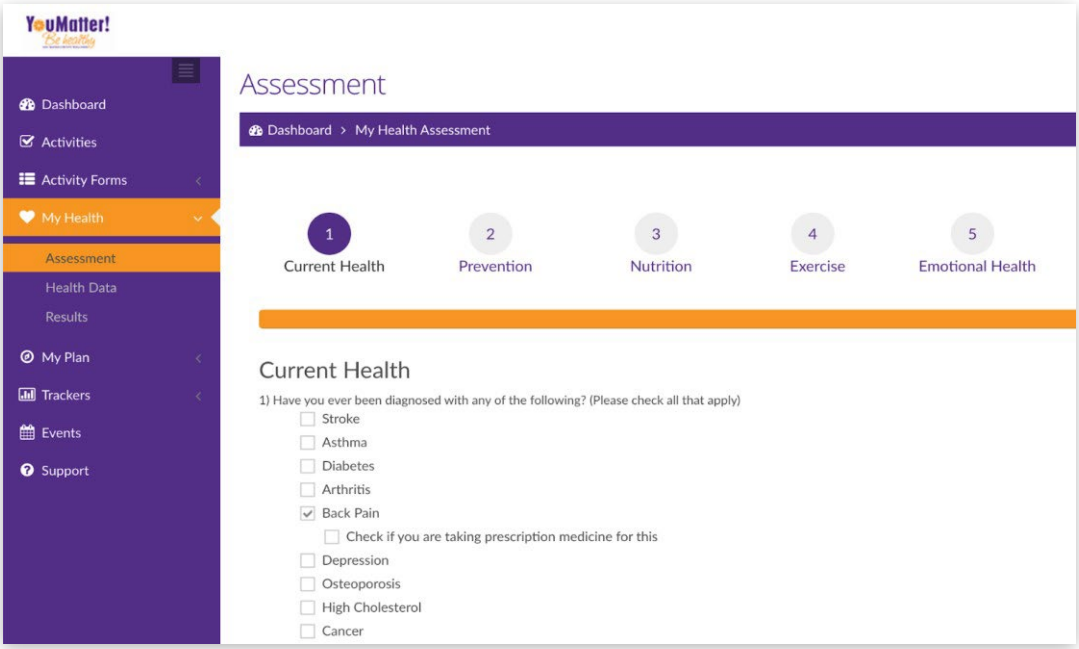
Spouses / Partners *(must be listed in Workday)*:
Using your computer or mobile device, go to https://www.preventioncloud.com

- **Spouse/Partner Username**
  FIRST NAME + LAST NAME + Year of birth (JOHNDOE1968)
- **Password**
  Birthdate (MMDDYYYY) - ***Once logged in, you will be prompted to change your password***

Spouses / Partners

COMPLETE YOUR ONLINE HEALTH ASSESSMENT

1. Log into your PreventionCloud Wellness Portal.
2. Select '**Online Health Assessment**' located below your homepage.
3. Answer all questions to the best of your knowledge and click **'Continue'** after you complete each page until you see your results.



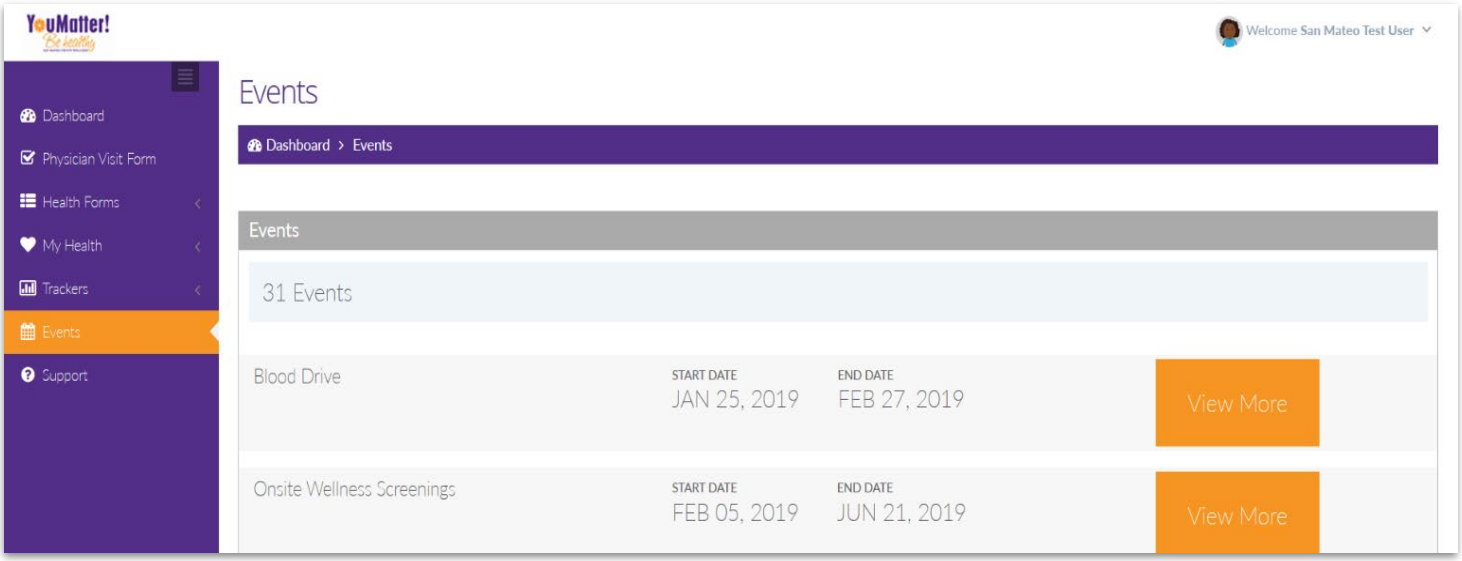
PREVENTIONCLOUD TIP

It is optional for you to complete the 'Biometrics' section. When you attend a Wellness Screening (onsite, physician, or lab), your results will be entered into that section. However, you can still complete this section if you choose.

YouMatter! Be healthy
SAN MATEO COUNTY WELLNESS

REGISTRATION FOR YOUR WELLNESS ACTIVITIES

1. Select **'All Event Registration'** located below your wellness banner.
2. Find the activity of your choice and select the **'Join'** or **'View More'** button.
3. Choose the date you'd like to participate and confirm your registration.



PREVENTIONCLOUD TIP

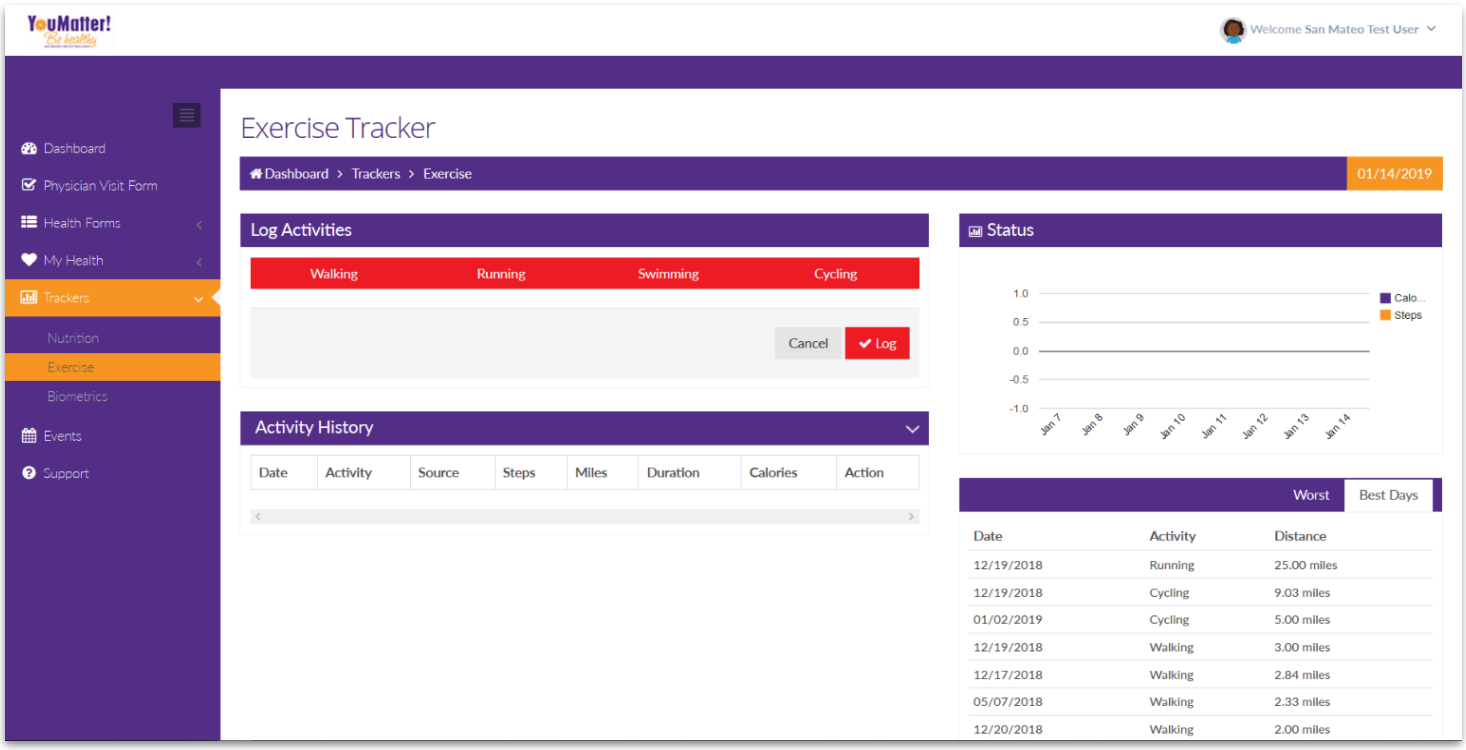
The PreventionCloud Wellness Portal is available to employees and their spouses who are enrolled in / waived a San Mateo County medical plan. All other employee groups have access to LMS Wellness.

TRACKERS – NUTRITION, EXERCISE & BIOMETRICS

1. Select **'Trackers'** on the left menu.
2. Choose either **'Exercise', 'Nutrition', or 'Biometrics'**.
3. Log your physical activity, food / water intake, or screening results.

PREVENTIONCLOUD TIP

You can log previous data by selecting the date in the top right corner and enter the information for that date.



If you have any questions, please contact the Wellness Team at wellness@smcgov.org.

Employee Assistance Program

ADMINISTERED BY CLAREMONT, POWERED BY UPRISE HEALTH

You and your eligible family members are covered by an Employee Assistance Program (EAP) provided by the County. This program is entirely voluntary and confidential.

OVERVIEW OF THE EMPLOYEE ASSISTANCE PROGRAM

The County's EAP Program is an essential component of the County's work-life benefit, offering work-life assistance to our employees and family members. Personalized consultations, resources and referrals are available at no cost for a wide range of needs that include:

Counseling visits - The EAP offers 8 free counseling visits per incident, per rolling 12 months for almost any personal issue. Claremont EAP will work with you to find the most appropriate counselor to meet your needs.

- Marital/Relationship issues
- Parenting/Family issues
- Work concerns
- Depression
- Anxiety

Work/Life referrals - consultants can provide you with referrals and information for services such as: child care, elder care, pet care, adoption assistance, school/College assistance, health and wellness, convenience referrals, stress, substance abuse, and other issues impacting your quality of life.

Legal consultation - EAP offers up to 30 minutes of free consultation with an attorney per issue to answer your legal questions, either in-person or over the phone. On-going services, if required, are offered at a 25% discount. EAP can assist with legal issues such as: divorce, child custody, real estate, personal injury, criminal law, and free simple will kits.

Financial consultation - Financial professionals and licensed CPAs will provide up to 30 minutes of telephonic coaching per issue on a range of financial issues such as: budgeting, debt management, tax planning, retirement planning, home buying strategies, college planning, and credit repot coaching.

Call toll-free, 24 hours a day, seven days a week: 800-834-3773

Or you can visit www.claremonteap.com and enter **County of San Mateo** as the organization name

Employee Assistance Program

	SELF-REFERRAL	SUPERVISOR REFERRAL
Service Overview	Free, short-term counseling to employees and members of their families who wish to address personal or work issues	Provides an employee with support and assistance in solving their work performance problem
Referral Source	Self-referral Available for immediate family members including: • Your spouse/domestic partner • Your children • Spouse/domestic partner's children • Young adult dependents up to age 26	Initiated by supervisor, manager or Human Resources Department Not a mandatory referral Offered as part of a performance improvement plan
Available Sessions	Up to 5 face-to-face counseling sessions	Up to 10 face-to-face counseling sessions
How to Get Started	Call 800-834-3773 Group/Employer: County of San Mateo Representatives are available 24 hours a day, 7 days a week	Manager/Supervisor/HR calls 800-834-3773 for a clinical consultation Supervisor Referral Form is completed, shared with Claremont and with the employee The employee calls 800-834-3773 Representatives are available 24 hours a day, 7 days a week
Eligibility	All San Mateo County & Court employees are eligible.	

Short Term Disability Insurance

The County offers Basic Short-Term Disability (STD) insurance for those Extra Help employees with a designation of .75FTE or more.

STD insurance, administered by Standard Life Insurance, is designed to pay a weekly benefit in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, which can help you meet your financial commitments in a time of need.

BASIC STD

Eligibility	Employees who are not enrolled in CA SDI
Benefit Amount	$95 per week (not to exceed 70% of pre-disability earnings) reduced by Deductible income
Benefit Cost	$1.95 semi-monthly
Benefit Duration	18 weeks
Benefit waiting period (sickness or accident)	14 days

Contact Numbers

Kaiser Permanente		
Group #7056	www.kp.org	800-464-4000
BCC (Health Savings Account)		
BCCCSM	www.mywealthcareonline.com/bccsmartcare/	800-685-6100
The Standard (Short Term Disability)		
Group #645866	www.standard.com	(t) 800-368-2859 (f) 800-378-6053
Claremont Employee Assistance Program (EAP)		
County of San Mateo	www.claremonteap.com	800-834-3773

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

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, deductibles and coinsurance apply. 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.

Notice of Choice Providers

The County of San Mateo 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, 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 benefits division at 650-363-1919 or benefits@smcgov.org.

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 benefits division at 650-363-1919 or benefits@smcgov.org.

HIPAA Notice of Special Enrollment Rights

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

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

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

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 8.39% in 2024 of your modified adjusted household income.

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 atwellness@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.

Notice Regarding Wellness Program

County of San Mateo 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 choose to participate in the wellness 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.

However, employees who choose to participate in the wellness program will receive a cash incentive for completing a Health Risk Assessment, one MyPlan, and one Personal Wellness Plan on PreventionCloud. Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will receive $500 - $750.

Wellness Basket prizes may be available for employees who participate in certain health-related activities such as physical activity challenges, completing surveys, attending 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 the County of San Mateo may use aggregate information it collects to design a program based on identified health risks in the workplace, the County of San Mateo 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.

Medicare Part D Notice

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

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

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

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

2.County of San Mateo has determined that the prescription drug coverage offered by Kaiser Permanente, 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 County of San Mateo are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2024
Name of Entity: County of San Mateo
Contact: Human Resources- Benefits Division
Address: 455 County Center, 5th Floor Redwood City, CA 94063
Phone: (650) 363-1919

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

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

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

WHO ARE THE QUALIFIED BENEFICIARIES?
Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

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

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

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

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

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

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

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

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

For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/ebsa/publications/cobraemployee.html.

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

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

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

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

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

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

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

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if

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

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

CAN I ENROLL IN ANOTHER GROUP HEALTH PLAN?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

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

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?
When considering your options for health coverage, you may want to think about:

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

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

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

IMPORTANT INFORMATION ABOUT PAYMENT

FIRST PAYMENT FOR CONTINUATION COVERAGE

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

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

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

GRACE PERIODS FOR PERIODIC PAYMENTS

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 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: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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.

New Health Insurance Marketplace Coverage Optionsand 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 valuestandard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered By Your Employer

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

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

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

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

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

Revised 9.26.23