HUMAN RESOURCES
— Work Here Thrive Here —

2024 BENEFITS

MAKE THE MOST OF YOUR BENEFITS

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

Your Next Wave Of Benefits Is Here.

At San Benito County, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason San Benito County offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

January 1, 2024 - December 31, 2024

WHO CAN YOU COVER?

Who is Eligible?

Employees in **regular, full-time positions and those appointed to a regular position at a time base of 50% or higher** are eligible for the benefits outlined in this overview.

In order to comply with the Affordable Care Act (ACA), San Benito County determines your eligibility for medical coverage based on the number of hours you work each month.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your registered domestic partner is eligible for coverage if you have completed a Declaration of Domestic Partnership. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by San Benito County are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis. Contact your tax advisor about your domestic partner's tax dependent status and advise San Benito County if your domestic partner is a tax dependent.
- Your children (including your Domestic Partner's Child):
    - Under the age of 26 (23 for dental and vision) are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are a certified disabled dependent
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
    - Another person's child under age 26 may be eligible for coverage if a parent-child relationship exists. An Affidavit of Parent-Child Relationship (PDF) must be filed prior to enrollment and be updated upon request.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO CAN YOU COVER? (CONT.)

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 San Benito County cannot also be covered as a dependent.
- Employees who work less than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.
- New employees with an appointment expected to last 6 months or less.

When Can I Enroll?

Coverage for new employees begins on the **First of The Month Following Receipt of Your Enrollment Forms**. New employees are given 30 days from their hire date to enroll in benefits and to ensure timely processing and payroll deductions.

Open enrollment 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 notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events 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 30 days to make your change.

COST OF MEDICAL, DENTAL AND VISION

Plan by Tier		Monthly Medical Contributions *(Pending Negotiations)*			Biweekly Cost (24 Pay Period)
Active	**Tier**	**Carrier Rates**	**Total County Contribution** *2024 PEMHCA included	**Employee Share**	**Employee Share**
Kaiser Permanente HMO	Employee	$1,021.41	$550	$471.41	$235.71
	Employee+ 1	$2,042.82	$1,050	$992.82	$496.41
	Family	$2,655.67	$1,315	$1,340.67	$670.34
Anthem Blue Cross Select HMO	Employee	$1,138.86	$550	$588.86	$294.43
	Employee+ 1	$2,277.72	$1,050	$1,227.72	$613.86
	Family	$2,961.04	$1,315	$1,646.04	$823.02
Anthem Blue Cross Traditional HMO (Available in San Benito County)	Employee	$1,339.70	$550	$789.70	$394.85
	Employee+ 1	$2,679.40	$1,050	$1,629.40	$814.70
	Family	$3,483.22	$1,315	$2,168.22	$1,084.11
Blue Shield Access+ HMO/EPO	Employee	$1,076.84	$550	$526.84	$263.42
	Employee+ 1	$2,153.68	$1,050	$1,103.68	$551.84
	Family	$2,799.78	$1,315	$1,484.78	$742.39
United Healthcare HMO	Employee	$1,091.13	$550	$541.13	$270.57
	Employee+ 1	$2,182.26	$1,050	$1,132.26	$566.13
	Family	$2,836.94	$1,315	$1,521.94	$760.97
PERS Platinum PPO (Available in San Benito County)	Employee	$1,314.27	$550	$764.27	$382.14
	Employee+ 1	$2,628.54	$1,050	$1,578.54	$789.27
	Family	$3,417.10	$1,315	$2,102.10	$1,051.05
PERS Gold PPO *Limited Provider Network (Available in San Benito County)	Employee	$914.82	$550	$364.82	$182.41
	Employee+ 1	$1,829.64	$1,050	$779.64	$389.82
	Family	$2,378.53	$1,315	$1,063.53	$531.77
PORAC PPO (Safety Members Only) (Available in San Benito County)	Employee	$931.00	$550	$381.00	$190.50
	Employee+ 1	$2,117.00	$1,050	$1,067.00	$533.50
	Family	$2,651.00	$1,315	$1,336.00	$668.00

Note :The County offers an insurance stipend of $69.23 per pay period in lieu of medical coverage.

Ancillary Contributions *(pending negotiations)*					Biweekly Cost (24 Pay Period)
Active	**Tier**	**Carrier Rates**	**County Contribution**	**Employee Share**	**Employee Share**
Delta Dental (PRISM) PPO	Employee	$46.90	$30.00	$16.90	$8.45
	Employee+ 1	$80.50	$30.00	$50.50	$25.25
	Family	$131.40	$30.00	$101.40	$50.70
EyeMed Vision (PRISM)	Employee	$5.35	$5.35	$0.00	$0.00
	Employee+ 1	$10.70	$5.35	$5.35	$2.68
	Family	$13.80	$5.35	$8.45	$4.23

GETTING CARE WHEN YOU NEED IT NOW

When to Use the ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

When to Use Urgent Care

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

When You Need Care Now

What do you do when you need care right away, but it’s not an emergency?

Kaiser Permanente Plan Participants

- Call Kaiser's 24/7 NurseLine at 800-464-4000
- Find an urgent care center by visiting kp.org
- Use Kaiser Video Visit (My Doctor Online) or schedule a telephone appointment

Anthem Medical Plan Participants

- Call Anthem's 24/7 NurseLine at 800-977-0027
- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

GETTING CARE WHEN YOU NEED IT NOW

Get a Video House Call

Kaiser and Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment.

Kaiser's video visit is a secure and easy way to visit your doctor. It saves travel time and expense. All you need is a computer with a high-speed internet connection and a webcam or a smartphone mobile device. Visit kp.org/mydoctor/videovisits for more information.

Anthem's LiveHealth Online provides 24/7 access to U.S. board-certified physicians, copay is the same as your plan's office visit copay. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit livehealthonline.com.

Preventive or Diagnostic?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

MEDICAL

It is the County's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The County offers a choice of medical plans through CalPERS Medical. When making a selection for a health plan, please keep in mind that the County aligns its contribution rates with the CalPERS Kaiser Region 1 premium.

Click here to view your CalPERS Health Benefit Summary!

Health Maintenance Organization (HMO)

Under HMO plans, most services and medicines are covered with a small copayment. Most HMOs require you to select a Primary Care Physician (PCP) to coordinate your care and require advance approval for some services, such as treatment by a specialist.

Care must generally be obtained from in-network providers, or you may be required to pay out of pocket for the cost of services (except in the event of emergency or urgent care services). Not all HMO plans are available in all California counties. To see if these plans are available in your zip code, visit the CalPERS website at www.calpers.ca.gov and use the zip code finder search engine.

Preferred Provider Organization (PPO)

PPO plans are designed to provide choice, flexibility and value. A PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with your insurer to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral.

For most services, there is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. Non-network providers are typically covered at a lower benefit level requiring you to pay a higher percentage of the bill.

Please note that PPO networks are subject to change at any time during the year.

CalPERS SEARCH TOOLS

CalPERS Health Plan Search by Zip Code

To find CalPERS health plans available in your area, search by zip code at www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/zip-search.

Why Would I Choose the PPO Plan?	Why Would I Not Choose the PPO Plan?
• You have a doctor you like and you would like to keep this doctor. • You want to see specialists and other providers without having to first get a referral and/or pre-approval. • You want the freedom to see providers who are not in the network. • You are confident that you can manage your own care. • You do not want a primary care doctor.	• You don't want the extra responsibility of managing your own care. • PPOs are not as closely regulated by the government as HMOs. • You do not want to pay the higher costs of a PPO. • You do not want to get bills from providers.

Explore Your Benefits with myCalPERS

Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at https://my.calpers.ca.gov.

2024 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To view the SBCs and glossary online, visit www.calpers.ca.gov and select View Health Plan Rates to access the Plans & Rates page, or visit any of the health plan websites below. To request a free paper copy of the SBC and glossary, contact each health plan directly.

Anthem Blue Cross HMO & EPO
(855) 839-4524
www.anthem.com/ca/calpers

Blue Shield of California
(800) 334-5847
www.blueshieldca.com/calpers

California Association of Highway Patrolmen[1]
(800) 734-2247
www.thecahp.org

California Correctional Peace Officers Association[1]
(800) 257-6213
www.ccpoabtf.org

Health Net of California
(888) 926-4921
www.healthnet.com/calpers

Kaiser Permanente
(800) 464-4000
www.kp.org/calpers

Peace Officers Research Association of California[1]
(800) 288-6928
http://ibt.porac.org

PERS Gold & PERS Platinum
(877) 737-7776
www.anthem.com/ca/calpers

Sharp Health Plan
(855) 995-5004
www.sharphealthplan.com/calpers

UnitedHealthcare
(877) 359-3714
www.uhc.com/calpers

Western Health Advantage
(888) 942-7377
www.westernhealth.com/calpers

[1] To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

DENTAL

The County of San Benito provides you with a comprehensive coverage through Delta Dental.

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

	Delta Dental PPO	
	In-Network	**Out-of-Network**
Calendar Year Maximum	$1,500	
Calendar Year Deductible Individual / Family	None	$50 per individual
Deductible Waived for D&P?	N/A	Yes
Diagnostic & Preventive Oral Exam X-Rays Teeth Cleaning	100%	100%
Basic Services Fillings Oral Surgery Periodontics (Gum Disease) Endodontics (Root Canals) Simple Tooth Extractions	80%	80%
Major Services Crowns Inlays/Onlays Cast Restorations	50%	50%
Orthodontia Adults Children (up to age 19)	60%	50%
Ortho Lifetime Max	$1,500	$1,500

Specific details and plan limitations are provided in the Summary Plan Description (SPD), which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this summary differs from the Plan Documents, the Plan Documents will prevail.

VISION

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

EyeMed has absorbed MES Vision effective January 1st, 2024. Vision plan through EyeMed is available to full-time employees only. Register at www.eyemed.com after January 1st and obtain access to the portal for value add services and to find a provider.

	EyeMed Vision Plan	
	In-Network	**Out-of-Network**
Copays Exam Materials	$10 $25	$40 See schedule below
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens	$0 after copay $0 after copay $0 after copay	Up to $30 Up to $50 Up to $70
Frames	$150 Allowance + 20% off on balance over	Up to $105
Contacts (Elective – in lieu of glasses)	$150 Allowance + 15% off on balance over	Up to $105
Frequency of Services Exam Lenses Frames Contact Lenses (in lieu of frames)	12 Months 12 Months 24 Months 12 Months	

Specific details and plan limitations are provided in the Summary Plan Description (SPD), which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this summary differs from the Plan Documents, the Plan Documents will prevail.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

General, Confidential and Management groups participate in the State Disability Insurance.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

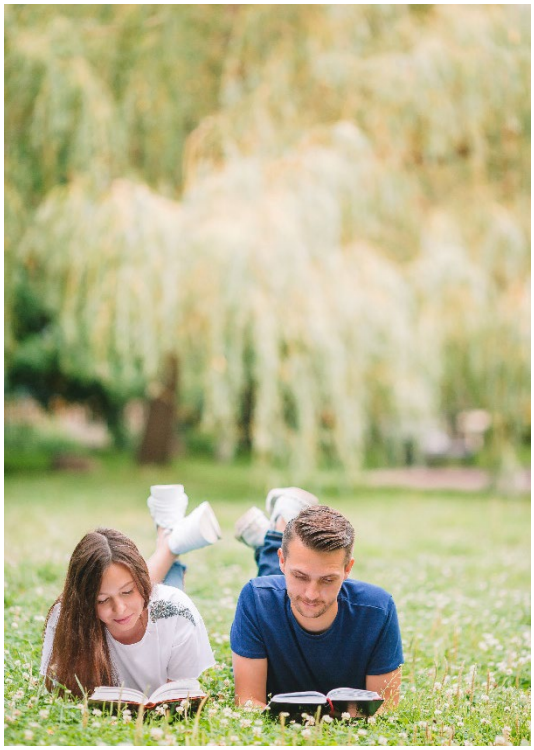
Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by VOYA and premiums are paid in full by County of San Benito.

VOYA Basic Life and AD&D

County pays for a $20,000 basic life insurance and AD&D policy for each employee.

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

VOLUNTARY LIFE AND AD&D INSURANCE



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting Those You Leave Behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by VOYA and available for your spouse and/or child(ren). All full-time employees working a minimum of 20 hours per week are eligible.

VOYA Voluntary Life

Employee

- Coverage Amount: Increments of $10,000
- Minimum Amount: $20,000
- Maximum Amount: $500,000, not to exceed 7x annual earnings
- Guaranteed Issue: $250,000, not to exceed 2x annual earnings

Spouse

- Coverage Amount: Increments of $5,000
- Minimum Amount: $10,000
- Maximum Amount: $250,000, not to exceed 50% of employee benefit
- Guaranteed Issue: $50,000

Child(ren)

- Coverage Amount: $2,500, $5,000, $7,500 or $10,000

Note: Benefit amount reduces to 65% at age 65.

In the Event of a Serious or Fatal Accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by VOYA and available for your spouse and/or child(ren). All full-time employees working a minimum of 20 hours per week are eligible.

Benefit amount is equal to the amount you elect for Voluntary Life Insurance.

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 30 days after the date you become eligible), you must complete and submit EOI.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

EAP Provided by Trindel

The Employee Assistance Program (EAP) is a FREE service to all County employees. Trindel Insurance Fund provides confidential professional counseling to help employees and their family members resolve issues that affect their personal lives and/or work performance. How to start:

- Choose an EAP Provider from the EAP Provider List on Trindel's website: (trindel.org) under programs menu.
- Make an appointment with an EAP Provider of your choice from the list. Take a copy of your most recent paystub or County badge to your first visit.
- Contact Trindel Insurance Fund or Human Resources if you have any questions.
- You will receive up to three (3) sessions within any six (6) month period that may be used for yourself, your spouse and your dependent minor children as defined by the IRS.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
877.533.2363
TDD: 800.697.0353

Website
www.guidanceresources.com

Mobile App:
GuidanceResources® Now

Web ID:
My5848i

Log on today to connect

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through ComPsych® GuidanceResources® can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

Confidential Emotional Support Provided by VOYA

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them. Contact ComPsych for no-cost, confidential solutions to life's challenges. With ComPsych, you'll receive:

Our highly trained clinicians will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

GuidanceResources® Online is your 24/7 link to vital information, tools and support.

Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

24/7 Support, Resources, and Information

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultantSM, who will answer your questions and, if needed, refer you to a counselor or other resources.

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools. ComPsych GuidanceResources is a no cost benefit that's provided by Voya Life and Disability.

MASA MTS

Protect your family from ground and air ambulance out of pocket costs with MASA MTS. Most people are not aware that on average, group health insurance does NOT cover 100% of emergency ground and air ambulance costs until it is too late. MASA Medical Transport Solutions (MTS) is the leading membership program with over 40 years of experience providing medical transportation benefits covering all emergency ground and air ambulance providers in the U.S. and Canada.

When is Your Next Medical Emergency Planned?

Unfortunately, emergencies happen, and they can become a substantial financial burden for you and your family.

Here are some interesting facts to think about when considering adding MASA MTS to your benefits plan:

- A ground ambulance can cost up to $5,000.
- Emergency air flights can cost anywhere between $36,400 and $40,600.
- 530,000 families turn to bankruptcy each year because of medical bills.
- 97% of employees worry about having enough money to cover out-of-pocket expenses.

A MASA Membership prepares you for the unexpected and gives you the peace of mind to access vital emergency medical transportation no matter where you live, for a minimal monthly fee.

- One low fee for the entire family
- NO deductibles
- NO health questions
- Easy claim process

For more information, please contact Human Resources.

Benefit and Costs:

Emergent Plus and Platinum
Both Emergent Plus ($14) and Platinum ($39) premiums are Family Rates and provide coverage for Employee, Employee Spouse/Domestic Partner, and Dependents up to the age of 26.

Emergent Plus Membership

- Emergency Air Ambulance Coverage
- Emergency Ground Ambulance Coverage
- Hospital to Hospital Ambulance Coverage
- Repatriation to Hospital Near Home Coverage

MASA MTS (CONT.)

Platinum Membership Benefits

- Emergency Air Ambulance Coverage
- Emergency Ground Ambulance Coverage
- Hospital to Hospital Ambulance Coverage
- Repatriation to Hospital Near Home Coverage
- Patient Return Transportation Coverage
- Companion Transportation Coverage
- Hospital Visitor Transportation Coverage
- Hospital Visitor Transportation Coverage
- Minor Return Transportation Coverage
- Vehicle & RV Return Coverage
- Pet Return Transportation Coverage
- Organ Retrieval & Organ Recipient Transportation Coverage
- Mortal Remains Transportation Coverage

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- HealthEquity FSA website
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

DO YOU PAY FOR DEPENDENT CARE?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through Health Equity (formerly Wageworks).

How the Healthcare FSA Works

- This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars.
- Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents.
- You may access your entire annual election from the first day of the plan year and you can set aside up to $3,050 this year.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

IMPORTANT: Unused FSA money up to $610.00 will be carried over to the next plan year. Anything over $610 will be forfeited.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered through Health Equity (formerly Wageworks).

Here's How the Dependent Care FSA Works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

VOLUNTARY HEALTH-RELATED PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

The following voluntary insurance policies are available to San Benito County employees through Aflac:

Accident Insurance

- Emergency Treatment Benefit
- Specific-Sum Injuries Benefit
- Accidental-Death Benefit
- Initial Hospitalization Benefit
- Hospital Confinement Benefit

Cancer/Specified-Disease

- Initial Diagnosis Benefit
- Hospital Confinement Benefit
- Radiation and Chemotherapy Benefits
- Surgical/Anesthesia Benefit
- Benefits paid directly to the insured, unless otherwise assigned
- Benefits paid regardless of any other insurance
- Ambulance, Transportation, and Lodging Benefits
- Cancer Wellness Benefit

Critical Care and Recovery (Specified Health Event)

Pays a First-Occurrence Benefit, as well as Hospital Confinement and Continuing Care Benefits for heart attack, stroke, sudden cardiac arrest, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, coma, or paralysis.

Short-Term Disability

In the case of illness or injury, it helps you maintain your standard of living and helps you pay your bills.

AFLAC Agent

For more information about policy benefits, limitations, and exclusions, please call our Aflac insurance agent.

Chris Nester

- **Phone:** (831) 663-1900
- **Email:** chris_nester@us.aflac.com

OTHER BENEFITS

Deferred Compensation

Employees may participate in tax-deferred retirement savings. Two 457 plans available. Employees may rollover funds from prior 401k or 457 accounts. IRS limits apply.

Retirement

Regular employees will be enrolled into the CalPERS retirement system in accordance with the Public Employees' Retirement Law. Employee contributions vary according to bargaining unit.

Employee Group	Contribution for Classic Employees	Contribution for PEPRA Employees
Miscellaneous (Non-safety) *(Participates in Social Security in addition to CalPERS)*	2% at 55	2% at 62
Safety *(Does not participate in Social Security)*	3% at 55	2.7% at 57

Payday

Employees are bi-weekly. The insurance and benefits deductions will take place bi-monthly – normally the first two pay periods of the previous month. Bank/Credit union and 457 Retirement Deferrals deductions will take place bi-weekly.

Vacation

Based on continued years of service. Maximum accruals apply.

< 4 years of service = 10 days per year
5 to 9 years of service = 15 days per year
10 to 14 years of service = 18 days per year
15 + years of service = 20 days per year

Administrative Leave

Management employees receive 80 hours of administrative leave per calendar year. Forty (40) unused hours can be paid out at the end of the calendar year.

Holidays

13.5 holidays (including 3 floating) for most employees. Safety officers and dispatchers receive approximately 5% holiday pay in addition to their base pay in lieu of paid holidays off.

Sick Leave

15 days per year. Maximum accruals apply.

Tuition Reimbursement Program

Employees may be eligible for tuition reimbursement per fiscal year amount is dependent on your bargaining unit.

OTHER BENEFITS (CONT.)

COUNTY FEDERAL
SANTA CLARA COUNTY FEDERAL CREDIT UNION

Membership

County Federal Credit Union is a progressive, innovative, yet traditional financial institution. We are federally chartered credit union serving County and City employees, we are not open to the general public. With assets in excess of $650 million and over 46,000 members, County Federal offers state-of-the-art delivery channels, multiple branch locations, Saturday hours and a wide selection of convenience-oriented products and services. Highlights of our features and benefits include:

- ✓ Our FREE Rewards Checking account with no monthly service charge, no minimum balance requirement and no direct deposit requirement. Bill pay is also FREE.
- ✓ FREE 24-hour account access through services line Direct Connect 24, Online Banking, Mobile Banking and CO-OP ATM Network.CO-OP provides you with FREE access to over 30,000 ATM locations, including select 7-Eleven, Walgreens and Costco stores.
- ✓ Lower rates on consumer, credit card and mortgage loans. Second mortgage programs are also available.
- ✓ FREE access to our Car Connection Consultant who will take the hassle out of buying your next new or used vehicle, get you the best price possible and an APR discount on your next auto loan.
- ✓ FREE financial education and counseling through BALANCE, a division of Consumer Credit Counseling that works exclusively with credit unions.
- ✓ FREE seminars designed to help you plan for retirement, buy your first home, build a better budget and much more.
- ✓ The ability to sponsor your immediate family members for membership.
- ✓ Our M3 Money Club for children up to age 12 and Get Started Account for teens, ages 13-19. Financial Education and Scholarship opportunities are available to them as well.
- ✓ Membership for life! Once a member, you'll always be a member regardless of where you work or live in the future.
- ✓ Members can purchase U.S. Postage Stamps. Discount AMC and Cinemark movie tickets, discounted Disneyland and other amusement park tickets and See's candy gift certificates.

To establish your membership, simply visit one of their convenient branch locations and you may be able to have the $5 one-time membership waived!

NCUA www.sccfcu.org COUNTY FEDERAL ...It's About Building Relationships for Life

FOR ASSISTANCE

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

Plan Type	Group No./ID	Provider	Phone Number	Website
CalPERS Medical	See ID	Medical & Retirement	(888) 225-7377	www.calpers.ca.gov
		Anthem	(855) 839-4524	www.anthem.com/ca/calpers/hmo
		Blue Shield	(800) 334-5847	www.blueshieldca.com/calpers
		Kaiser	(800) 464-4000	my.kp.org/calpers/
		Western Health	(888) 942-7377	www.westernhealth.com/calpers
		UnitedHealthcare	(877) 359-3714	www.uhc.com/calpers
		PORAC	(800) 288-6928	www.porac.org
		PERS PPO	(877) 737-7776	www.anthem.com/ca/calpers
Dental	1508-5555	Delta Dental	(800) 765-6003	www.deltadentalins.com
Vision	1036726	EyeMed Vision	(866) 804.0982	www.eyemed.com
Life and Disability	316407-189	Voya	(800) 955-7736	www.voya.com
MASA Medical Transport		David Dye	(913) 912-9008	ddye@masamts.com
Flexible Spending Account (FSA)		Wageworks	(877) 924-3967	www.wageworks.com
Employee Assistance Program (EAP)		Trindel Insurance Fund	(530) 623-2322	www.trindel.org
		Voya/ComPsych	(877) 533-2363	www.guidanceresources.com
Credit Union		Santa Clara County Federal Credit Union	(408) 282-0700 (800) 282-6212	www.sccfcu.org
Aflac		Chris Nester	(831) 663-1900	chris_nester@us.aflac.com
Nationwide Financial		Justin Bryant	(831) 200-5501	justin.bryant@nationwide.com
Empower Retirement		Rick Luerra	(303) 737-5910	Richard.luerra@empower.com

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

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Medicare Part D Notice

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your County of San Benito 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 Kaiser and Anthem 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 Benito 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 Benito and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. [NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of San Benito 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/Sender:	County of San Benito
Contact-Position/Office:	Elvia Barocio, Human Resources Analyst
Address:	481 Fourth Street, Hollister, CA 95023
Phone Number:	(831) 636-4000 extension 14

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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. If you would like more information on WHCRA benefits, call your Human Resources.

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 Human Resources.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment County's 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's plans 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 plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.
- If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption after the loss of other coverage.
- Gain a new dependent as a result of marriage, 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's medical plans 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.

Notice of Choice of Providers

The HMO plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, 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 carriers directly.

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

You do not need prior authorization from the plans 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 your medical carrier directly.

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, 2024. 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.

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 9.12% in 2023 of your modified adjusted household income.

Continuation Coverage Rights Under COBRA Initial Notice

Note: this notice describes how your group health coverage may be continued following the occurrence of certain qualifying events. Please review it carefully. This letter is to advise you of your rights, only. This is not a letter of termination. No action is necessary on your part.

Introduction

It is important that all covered individuals (employee, spouse, and dependent children) take the time to read this notice carefully and be familiar with its contents.

You are receiving this notice because you have recently become covered under your employer's group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to Businessolver, Inc. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Employer Informed of Address Changes

In order to protect your family's rights, you should keep informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send.

Plan Contact Information

If you do not understand any part of this summary notice or have questions regarding the information or your obligations, please contact us by phone at 844-427-5554 or submit a written request to:

CSAC EIA (c/o Businessolver, Inc) ATTN: COBRA Administration
P.O. Box 310512
Des Moines, IA 50331-0512 844-427-5554

SAN BENITO COUNTY

HUMAN RESOURCES

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