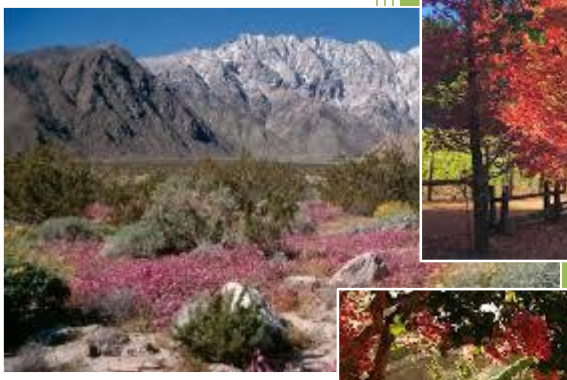
County of Sonoma

2015-2016 Annual Enrollment Employee Benefits Guide



CONTENTS

ANNUAL ENROLLMENT

Is March 23 through April 10, 2015!

Tips

- ✓ Review What's New For 2015-2016 for important changes that may be of interest to you (page 4)
- ✓ Check important dates and Annual Enrollment meeting locations (page 9 & 10)
- ✓ Contact CareCounsel at 888-227-3334 if you have any questions on health plan benefits or need help choosing a plan
- ✓ Enroll or make changes using Employee Self-Service at http://ep-internal.win.root.sonoma.gov/selfService_HRPROD/action.login Step-by-step instructions begin on page 11
- ✓ Select the right coverage level. Review the medical plan comparison charts (pages 19-22), dental and vision benefits (pages 26-27), and life insurance information (pages 27-29)
- ✓ You need to take action during the Annual Enrollment Period only if you need to make a change; otherwise your current elections will roll over for the new plan year
- ✓ Don't delay — enroll or make your changes on or before April 10, 2015
- ✓ Submit any additional required documentation to HR Benefits Unit by Friday, April 24, 2015
- ✓ Detailed benefit plan information and more can be found in this Guide or online at: **http://hr.sonoma-county.org/content.aspx?sid=1024&id=1223**

This guide gives you an overview of your benefits including eligibility, plan options, rates, how to enroll, and other important information. More detailed information is available in the official plan documents. For information about your other County benefits, please go to http://hr.sonoma-county.org/content.aspx?sid=1024&id=1203. In the left blue bar, select For Employees. Then select Health and Welfare Benefits.

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

AS YOU ENROLL

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

This guide is designed to help you make informed decisions about your benefit elections during the 2015 Annual Enrollment Period. It highlights your options and key program features to consider when you enroll. Your benefit eligibility is determined by the terms of your applicable Memorandum of Understanding, employee contract, or Salary Resolution. You will also find in this benefits guide, comparison charts for convenient at-a-glance referencing, enrollment instructions, and plan contact information. Please read your materials carefully, and choose the plans that best meet your needs.

The benefits and premium costs contained in this guide are effective June 1, 2015 through May 31, 2016.

We encourage you to use this Guide as a reference throughout the year. If you have questions, contact the HR Benefits Unit or the plan providers directly. Plan phone numbers and web sites are listed in the Contact Information section on page 28 of this Guide.

WHAT'S NEW FOR 2015 - 2016

The following is a quick summary of significant changes.

TWO NEW, LOWER PREMIUM COST, KAISER PERMANENTE PLAN OPTIONS

The County is pleased to offer two, new lower cost Kaiser Permanente Plan options; the Hospital Services DHMO (Deductible HMO) and the Deductible First DHMO (Deductible HMO). These new, lower cost Kaiser Permanente plans have deductibles which must be met before some plan benefits will be paid. Each plan is structured differently. Employees, depending on their specific medical needs, may find one plan more attractive than another. Employees are encouraged to evaluate these two new plans in comparison to the current Kaiser Permanente Traditional $10 copayment plan.

Kaiser Permanente representatives will be giving presentations to explain the Kaiser plans and to answer employee questions at the Annual Enrollment meetings scheduled throughout the

Items to Consider During Annual Enrollment Period

Dependent data:

Gather this information before proceeding with enrollment: Names, birthdates, Social Security numbers, and proof of full-time student status are required to complete your enrollment process.

Beneficiary designations:

There are no set deadlines for updating your beneficiary designations, but the Annual Enrollment Period is a great time for you to update them to ensure they are current.

Personal information:

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

County. See page 10 for the meeting schedule. If you are unable to attend an Annual Enrollment meeting and have plan questions after reviewing the information in this booklet carefully, please call CareCounsel, your personal, confidential, healthcare advocate service, at 888-227-3334. CareCounsel can assist you in evaluating the new plans related to your specific medical needs.

KAISER PERMANENTE HOSPITAL SERVICES DHMO (DEDUCTIBLE HMO) PLAN

The Hospital Services DHMO plan provides a 17% savings compared to the current Kaiser Permanente $10 copay plan. Most doctors office visits, radiology services, lab tests, and prescriptions are available for a copay or coinsurance amount, even before you have reached the calendar year deductible. Most preventative services, such as well baby/child visits (up to 23 months), immunizations, routine physicals, mammograms, and routine preventative screenings are covered at no cost and are not subject to the calendar year deductible. However, if you have services that *are subject* to the deductible, such as hospitalizations and in- and out-patient surgeries, you will be required to meet the calendar year deductible *before* plan benefits will be paid. This plan has a calendar year out-of-pocket maximum, capping the cost paid by the member. The out-of-pocket maximum includes the calendar year deductible, copayments, and coinsurance. See the Medical Plan Comparison Chart on page 20 for more information about the deductibles, out-of-pocket maximums, and plan benefits.

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

KAISER PERMANENTE DEDUCTIBLE FIRST DHMO (DEDUCTIBLE HMO) PLAN

The Deductible First DHMO plan provides a 21% savings compared to the current Kaiser Permanente Plan. This plan requires a member to meet the calendar year deductible FIRST before ANY plan benefits will be paid. Members will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations, etc., until the calendar year deductible is met. Once the deductible is met, covered medical, hospital, and prescription benefits will be provided for a copayment or coinsurance amount. While this plan does require a member to meet the deductible first, members who anticipate a hospital stay (such as a surgery or the birth of a child), may find this plan offers a lower total out-of-pocket cost than the new Hospital Services DHMO plan. The calendar year out-of-pocket maximum includes; calendar year deductibles, copayments, and coinsurance. See the Medical Plan Comparison Chart on page 20 for more information about deductibles, out-of-pocket maximums and plan benefits.

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

Note: If you (the employee) elect to enroll in this plan, which qualifies as a qualified high deductible health plan, and you have a Flexible Spending Account and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are **NOT allowed to establish a Health Savings Account (HSA).** Because the County's FSA and HRA accounts can be used to reimburse your out of pocket medical

expenses, the IRS does not allow you to also have a Health Savings Account at the same time as it is considered prohibited health coverage.

MANDATORY BENEFIT CHANGES

The Affordable Care Act (ACA) requires that all medical and prescription drug plans comply with an established annual limit on participant cost-sharing for plan years beginning in 2015. The limitation on annual out-of-pocket maximums for medical and prescription costs in the 2015-2016 Plan Year are now limited to $6,600 for individual and $13,200 for family coverage.

The County Health Plan PPO prescription maximum out-of-pocket is being reduced from $6,350 to $1,100 for an individual and from $12,700 to $1,700 for a family. The benefit enhancements are effective June 1, 2015.

The County Health Plan EPO prescription maximum out-of-pocket is being reduced from $6,350 to $1,100 for an individual and from $12,700 to $1,700 for a family. The benefit enhancements are effective June 1, 2015.

Starting in 2015, for the Kaiser Permanente plans, outpatient drugs provided by Kaiser Permanente pharmacy services will accumulate toward the Kaiser Permanente medical calendar year out-of-pocket maximum in compliance with the Affordable Care Act.

GOING GREEN

The Human Resources Benefits Unit is going green this year! The Annual Enrollment Employee Benefits Guide will be sent electronically to employees who have an e-mail address on file with the County. The Annual Enrollment Employee Benefits Guide will be mailed to County employees who do not have an e-mail address on file with the County and will be available upon request. Help us reduce our global footprint. If you don't have a work e-mail, enter your personal e-mail address in Employee Self-Service and next year you'll receive your annual enrollment information electronically.

SOCIAL SECURITY NUMBERS FOR YOUR DEPENDENTS ARE REQUIRED!

You will be required to provide a Social Security number or a Federal Tax Identification number for your dependent(s) when you enroll them in a County-sponsored medical plan. The County needs this information to comply with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173). This law requires group health plan insurers, third-party administrators, and group health plan administrators to report information that the Department of Health and Human Services requires for purposes of coordination of benefits. Further information about the mandatory reporting requirements under this law is available at http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html

This Annual Enrollment Period is your opportunity to add and/or drop dependents and to ensure that our records accurately reflect your benefit elections. **If an eligible dependent is not listed in Employee Self-Service in each of your benefit plans (i.e. medical, dental, vision, and dependent life insurance), your dependents will not be covered and will not be able to access benefits when seeking services.**

STUDENT STATUS VERIFICATION REQUIRED FOR DENTAL AND VISION PLANS

The annual student status verification process is being conducted during the Annual Enrollment Period this year. Employees with dependents ages 19 through 22 enrolled in a dental or vision plan, must provide proof of their dependent's full-time student status during the Annual Enrollment Period. The proof of student status must indicate that the student is enrolled in the current semester and must include the name of the school, the student's name and that the student is enrolled in 12.0 or more units. Dependents in this age group without evidence of full-time student status will be dropped from dental and/or vision plans effective June 1, 2015. (Note: No evidence of student status is required for the medical plans. Eligible

dependents can be covered up to age 26 regardless of student status under the Kaiser Permanente and County Health Plans.)

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Are you in a Bargaining Unit eligible for an HRA contribution? Out-of-pocket health care expenses or medical premiums paid with post-tax dollars may be reimbursed from the HRA. During the Annual Enrollment Period, you may elect to pay some or all of your health plan premiums with post-tax dollars.

If you elect to pay some or all of your premiums on a post-tax basis, your election will result in the loss of annual tax savings.

This booklet provides a simple overview of the HRA plan.

Use the following link http://hr.sonoma-county.org/documents/Premium-Conversion-Election-Form.pdf to obtain the form necessary for the election of post-tax health plan premium payments. Additional HRA information:

http://hr.sonoma-county.org/content.aspx?sid=1024&id=3013

SUMMARY OF BENEFITS AND COVERAGE

You may view Summary of Benefits and Coverage (SBC) information for the County's medical plans online at: http://hr.sonoma-county.org/content.aspx?sid=1024&id=1224. Select For Employees in the blue bar on the left side of the screen, then select Health and Welfare Benefits and click on Annual Enrollment.

2015 ANNUAL ENROLLMENT MASTER SCHEDULE

March 23	Monday	**Annual Enrollment begins!** Informational meetings are scheduled throughout the County. Check the meeting schedule included in this Guide for locations, dates and times. During Annual Enrollment, if you are eligible, you may: • Enroll in a medical or dental plan • Change medical plans • Add dependents to or remove them from your medical, dental, and/or vision plans • Waive or Decline County-sponsored medical plan and/or dental plan coverage • Enroll in Supplemental Life insurance • Change your Benefit Plan Premium Conversion Option elections • Add/change your life insurance beneficiary information If you need help navigating Employee Self-Service you may attend one of the hands-on help sessions listed on page 34. Computer access is also available at these locations. You may attend these help sessions on County time with your supervisor's approval.
April 10	Friday	**Annual Enrollment ends at midnight!** This is the deadline to submit your 2015 Benefit Elections using Employee Self-Service. (Paper forms are due by 5:00 p.m.)
April 24	Friday	Deadline to submit proof of Full-time Student Status for over-age dependents on the dental or vision plans. Failure to provide documentation will result in denial of enrollment.
April 28	Tuesday	2015-16 benefit elections will be available for viewing using Employee Self-Service.
May 20	Wednesday	Pay warrants reflect annual enrollment rate changes.
June 1	Monday	Effective date of coverage for changes made to medical, dental, vision, and life insurance plans.

2015 ANNUAL ENROLLMENT MEETING SCHEDULE

Benefits are an important part of your total compensation package. Take advantage of this opportunity to review your benefit plan options. **Please allow up to 1½ hours per session.***

* *You may attend these meetings on County-paid time with supervisory approval.*

MARCH 23	DEPT/LOCATION	STREET ADDRESS	ROOM
10:30 A.M. – 12:00 P.M.	Department of Transportation And Public Works (TPW)	2300 County Center Dr., Suite B100 Santa Rosa	Main Conference Room
MARCH 24	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
8:00 A.M. – 9:30 A.M.	Sonoma County Water Agency	404 Aviation Blvd., Santa Rosa	Redwood Room
10:00 A.M. – 11:30 A.M.	Community Development Commission (CDC)	1440 Guerneville Rd., Santa Rosa	Hearing Room
2:30 P.M. – 4:00 P.M.	Permit & Resource Management Dept. (PRMD)	2550 Ventura Ave., Santa Rosa	PRMD Hearing Room
MARCH 25	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
10:00 A.M. – 11:30 A.M.	Human Resources & County Administration	575 Administration Dr., Suite 113A Santa Rosa	CAO Community Government Affairs Room
2:30 P.M. – 4:00 P.M.	Open Space District (OSD)	747 Mendocino Ave., Santa Rosa	Large Conference Room
MARCH 26	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
8:00 A.M. – 9:30 A.M.	Department of Transportation And Public Works (TPW)	2175 Airport Blvd., Santa Rosa Road Maintenance Meeting La Plaza	Conference Room
MARCH 31	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
2:00 P.M. – 3:30 P.M.	Human Resources & County Administration	575 Administration Dr., Suite 113A Santa Rosa	CAO Community Government Affairs Room
APRIL 1	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
8:00 A.M. – 9:30 A.M.	Sonoma County Sheriff's Office	2796 Ventura Ave., Santa Rosa	Sheriff Main Office, Training Room
10:30 A.M. – 12:00 P.M.	Human Services Department (HSD)	2227 Capricorn, Suite 100, Santa Rosa	Santa Rosa Conference Room
2:00 P.M. – 3:30 P.M.	Sonoma County Sheriff's Office	2796 Ventura Ave., Santa Rosa	Sheriff Main Office, Training Room
APRIL 2	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
10:00 A.M. – 11:30 A.M.	Sonoma County Fairgrounds	1350 Bennett Valley Rd., Santa Rosa	Showcase Room
1:30 P.M. – 3:00 P.M.	Juvenile Justice Center	7425 Rancho Los Guilicos Rd., Santa Rosa	Lobby Conference Room
APRIL 7	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
9:00 A.M. – 10:30 A.M.	Human Services Department (HSD)	3600 Westwind Blvd., Santa Rosa	Wright Brothers Conference Room
10:30 A.M. – 12:00 P.M.	Economic Development Board (EDB)	141 Stony Cir., Suite 110 Santa Rosa	Large Conference Room (Board Room)
2:00 P.M. – 3:30 P.M.	Department of Child Support Services (DCSS)	3725 Westwind Blvd., Suite 200, Santa Rosa	Conference Room C
APRIL 8	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
8:30 A.M. – 10:00 A.M.	Department of Health Services (DHS)	3313 Chanate Rd., Santa Rosa	Rotunda Room
10:30 A.M. – 12:00 P.M.	Permit & Resource Management Dept. (PRMD)	2550 Ventura Ave., Santa Rosa	PRMD Hearing Room
2:30 P.M. – 4:00 P.M.	SCERA	433 Aviation Blvd., Suite 100 Santa Rosa	Board Room
APRIL 9	**DEPT/LOCATION**	**STREET ADDRESS**	**ROOM**
9:00 A.M. – 10:30 A.M.	FY&C	1202 Apollo Way, Santa Rosa	Annadel Room (Badges Required)
1:30 P.M. – 3:00 P.M.	Juvenile Justice Center	7425 Rancho Los Guilicos Rd., Santa Rosa	Lobby Conference Room

ANNUAL ENROLLMENT PERIOD – MARCH 23 THROUGH APRIL 10, 2015

Annual Enrollment Period is your once-a-year opportunity to make changes to your current benefit elections for the coming plan year, June 1, 2015 through May 31, 2016.

WHAT CAN I DO DURING ANNUAL ENROLLMENT PERIOD?

- ✓ Enroll, waive coverage (due to enrollment in other group coverage) or decline coverage.
- ✓ Change your medical election and/or dental plan coverage level.
- ✓ Add, waive (due to enrollment in other group coverage) or drop medical and/or dental coverage for your eligible dependents.
- ✓ Apply for supplemental and/or dependent life insurance. Note: Supplemental life insurance takes effect only after approval from The Hartford.
- ✓ Enroll in basic life insurance if you are a part-time DSA, SCLEA, or ESC represented employee. (Basic life insurance and Basic Accidental Death & Dismemberment (AD&D) enrollment is automatic for all other eligible employees.)
- ✓ Change your pre-tax/post-tax payroll deductions for medical premiums.

You need to take action during Annual Enrollment Period only if you need to make a change; otherwise your current elections will roll over for the new plan year.

SUBMITTING ANNUAL ENROLLMENT PERIOD ELECTIONS AND DEADLINE

Benefit elections and/or changes to your existing benefits are made online through the County's Employee Self-Service (ESS) system. A link will be e-mailed to you on the first day of the Annual Enrollment Period. Save the e-mail until you are ready to make your benefit elections.

ESS is also accessible via the link 

on the County of Sonoma Intranet (located under the "What's New" column on the right side of the Intranet home page) or under Employee Resources on the County's internet home page (located on the bottom of the page in the blue bar.) From the Employee Resources Internet page, select HRMS Employee Self-Service on the left sidebar menu.

Log into the Employee Self-Service (ESS) system using your ESS password. Forgot your password? Manage your password using the link on the bottom of the ESS page.

To begin the benefit enrollment/changes process, select Annual Enrollment Period located under Benefits on the lower left side of the Employee Self-Service home page (after logging in). All ESS Benefit elections and changes must be submitted to the Human Resources Benefits Unit by midnight on Friday, April 10, 2015.

If you are unable to access eP Employee Self-Service, a paper form is available online. However, please make every effort to utilize the online system. Support is available. ESS hands-on workshop dates and times will be sent to you via email. If you must use paper, the County of Sonoma Employee Benefits Enrollment/Change Form is located on the County of Sonoma Human Resources website http://hr.sonoma-county.org/foremployees.htm. Paper forms are due by 5:00 p.m., Friday, April 10, 2015, in the Human Resources Benefits Unit office.

WHAT IF I WANT TO CONTINUE MY CURRENT ELECTION?

Need Assistance? Please refer to the Contact Information and Resources insert at the back of this booklet for available help during the Annual Enrollment Period.

Your current benefits will continue effective June 1, 2015 through May 31, 2016. Be aware, that making no change is considered an election to retain the benefits currently in place for the upcoming plan year. At a minimum, verify and confirm your dependents on each plan. Ensure that only your eligible dependents are covered.

WHAT IF I WANT TO MAKE A CHANGE MID-YEAR?

Plan elections are irrevocable for the plan year, unless a qualifying mid-year Change-in-Status event is experienced. Mid-year benefit plan changes must:

1. Be consistent with the qualifying event

2. Meet the guidelines of County contracts/agreements, plan documents and IRC Section 125

3. Be received by the HR Benefits Unit within 31 days of the qualifying event

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

EFFECTIVE DATE OF MID-YEAR CHANGES

Elections shall be effective prospectively. Generally, elections that add or change coverage will be effective the first day of the month following or coinciding with the event that allowed the change. New Hires are effective the first day of the month following the date of hire, including those hired on the first day of the month.

Elections that cancel or drop coverage will be the last day of the month following or coinciding with the event that allowed the change.

If you were terminated from County plan coverage while on leave, upon return from your leave, you will need to complete new enrollment forms. Your coverage will be effective the first day of the month following your return from leave. If you are returning from a Military leave of absence, your coverage will be effective on the date you return from leave.

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

FOR NEWBORN CHILDREN

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

To enroll your newborn, submit completed mid-year election change paperwork to Human Resources Benefits Unit within 31 days of the newborn's date of birth. Please note pursuant to IRS Regulations and the County's plan document, newborn coverage is made effective the first day of the month following the newborn's date of birth. You are encouraged to submit paperwork as soon as possible to avoid incurring multiple premiums being owed as a result of retroactive coverage.

The newborn will be assigned under the medical group to which the mother (parent) is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

REVIEW YOUR BENEFITS

PRE-TAX HEALTH INSURANCE BENEFITS

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

IS MY DEPENDENT IRS-QUALIFIED?

An Internal Revenue Code provision, enacted March 30, 2010, permits group health plans, like the County's, to provide medical coverage on a tax-free basis to any eligible child of the plan participant until the end of the month after a child turns 26. Therefore, if your eligible dependent is your spouse, your own child, your stepchild, adopted child, child lawfully placed for adoption, or eligible foster child, you may indicate each as IRS Qualified regardless of the child's marital or student status or whether or not the child is claimed as a dependent on your taxes (up to age 26).

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

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

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

MID-YEAR STATUS CHANGES

County of Sonoma - Human Resources Department

Change of Status Events and Mid-Year Enrollment Changes

Allowed for Employees Under a Health Plan

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code[1].

This chart is only a summary of some of the permitted health plan changes and is **not** all inclusive.

If you experience the following Event...	You may make the following change(s) [2] within 31 days of the Event…	YOU MAY NOT make these types of changes
Life / Family Events		
Marriage or Commencement of Domestic Partnership (DP)	• Enroll yourself, if applicable • Enroll your new spouse/DP and other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans	• Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	• Drop your spouse/DP from your health coverage • Enroll yourself and your dependent children if you or they were previously enrolled in your spouse/DP's plan	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents ○ Adoption placement papers are required • Change health plans	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Make any other changes, except as required by the QMCSO
Loss of a child's eligibility (*e.g.* child reaches the maximum age for coverage or is no longer a full-time student (dental and/or vision coverage)	• Drop the child who lost eligibility from your health coverage • Child will be offered COBRA	• Change health plans • Drop health coverage for yourself or any other covered individuals
Regain eligibility (e.g. full-time student (dental and/or vision coverage)	• Add child who regained eligibility to your dental and/or vision coverage ○ Documentation of full-time student status is required	• Add any additional eligible dependents to your dental or vision coverage
Death of a dependent (spouse/DP or child)	• Drop the dependent from your health coverage • Change health plans	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicare, Medicaid, Medi-Cal, or SCHIP [2]	• Drop coverage for the person who became entitled to Medicare, Medicaid, Medi-Cal, or SCHIP • Add the person who lost entitlement to Medicare, Medicaid, Medi-Cal, or SCHIP ○ Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible
Change of home address outside of plan service area that causes a loss of coverage	• If you are enrolled in an HMO and move out of their service area, then you can elect new coverage	• Does not apply to County Health Plan, dental or vision coverage
Employment Status Events		
You become newly eligible for benefits due to change in employment status or bargaining group	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents • Drop health coverage • Drop your spouse/DP and other eligible dependents • Change health plans	• Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits

County of Sonoma - Human Resources Department

Change of Status Events and Mid-Year Enrollment Changes

Allowed for Employees Under a Health Plan

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code[1].

This chart is only a summary of some of the permitted health plan changes and is **not** all inclusive.

If you experience the following Event...	You may make the following change(s)[2] within 31 days of the Event…	YOU MAY NOT make these types of changes
Spouse/DP obtains health benefits in another group health plan	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself ○ Proof of coverage in the other health plan required	• Change health plans. • Add any eligible dependents to your health coverage.
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage for health benefits in another group health plan. You or your dependents exhaust COBRA coverage under other group health plan.	• Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your spouse/DP's plan, if available ○ Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered dependents)	
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase or an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution.	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself • Change health plans to a less expensive plan	• No change is allowed unless the reduction in hours causes a loss of eligibility or a loss or significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.
You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution	• Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans	• No change is allowed unless the increase in hours results in new eligibility or a significant change in the employer subsidy for medical (not FSA) coverage
You return from Military leave	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents • Change health plans	
You, your spouse, or dependents enroll in a Qualified Health Plan through a Public health Insurance Marketplace	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself	

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

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

BENEFIT ELIGIBILITY

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

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

DEPENDENT ELIGIBILITY

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

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

Dependent coverage will end the last day of the month in which the dependent no longer meets the eligibility requirements listed in the table below. An exception is available for an unmarried dependent child over the plan's age limit, who is chiefly dependent upon the subscriber for support, and is incapable of supporting one's self due to mental or physical disability incurred prior to reaching the limiting age, described in the following table.

	County Health Plan PPO & EPO	All Kaiser Permanente Plans	Delta Dental	Vision Service Plan	Dependent Life Insurance
Non-Student	Up to age 26	Up to age 26	Up to age 19	Up to age 19	Up to age 26
Full-Time Student*	Up to age 26	Up to age 26	Up to age 23	Up to age 23	Up to age 26

* Full-time: Enrolled in 12 units or equivalent at an accredited school, college, or university. Proof must be provided within 31 days of the event.

MEDICAL BENEFITS

You are eligible to choose from the following medical plans:

- County Health Plan EPO (Exclusive Provider Organization)
- County Health Plan PPO (Preferred Provider Organization)
- Kaiser Permanente HMO (Health Maintenance Organization)
- Kaiser Permanente Hospital Services DHMO (Deductible Health Maintenance Organization)
- Kaiser Permanente Deductible First DHMO (Deductible Health Maintenance Organization)

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

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

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

KEY ITEMS TO CONSIDER

Compare benefit coverage levels and premium costs carefully to see which option best fits your needs.

- In the CHP PPO, you may obtain services from either In-Network (preferred) or Out-of-Network (non-preferred) providers, but you will pay less out of your own pocket when you use an In-Network provider.
- In the CHP EPO, (Exclusive Provider Organization) all services must be obtained from within the plan network; there are no Out-of-Network benefits, except in an emergency.
- The two Kaiser Permanente deductible plans have significant differences in out-of-pocket costs.
- Dependents must be enrolled in the same plan as yourself. Review the "Service Areas - Medical Plans" chart below to ensure you are eligible for enrollment based on where you live.
- Medical plan costs vary based on the plan and coverage you select. You and the County share the costs. You pay your share of the premium through payroll deductions for the premiums, and when you use services such as when you pay the cost for deductibles, co-pays and the coinsurance.

Employee Assistance Plan (EAP)

In addition to your medical plan coverage, the County's EAP, offered at no cost to you through Managed Health Network (MHN), can help County employees with consultations on a wide range of emotional health, family, and work issues. In addition, they feature services to help balance work and life with consultations in the following areas:

- Childcare and Eldercare Assistance
- Financial Services
- Legal Services
- Identity Theft Recovery Services
- Daily Living Services

MHN can be reached at 800-227-1060, 24 hours a day, seven days a week, or www.mhn.com

MEDICAL PLAN COMPARISON	**County Health Plan EPO** Group # 175130M100 *Out-of-Network Providers Not Covered*	**County Health Plan PPO** Group # 175130M051
Plan Year Deductible	$500 individual $1,500 family	$300 individual $900 family
Plan Year Out of Pocket Maximum (Including Deductibles, Copays, and Coinsurance)	Medical/Prescription Drug $5,500/$1,100 individual $11,500/$1,700 family	Medical/Prescription Drug $2,300/$1,100 individual $4,900/$1,700 family
Coinsurance (the Plan pays)	80%	In-Network: 90% Out-of-Network: 60%
Lifetime Maximum	None	None
Dependent Children Eligibility	Any Dependent child under age 26 Disabled: No age limit	Any Dependent child under age 26 Disabled: No age limit
Office Visits and Professional Services		
Physician & Specialist	$50 co-pay, no deductible	In-Network: $20 co-pay, no deductible Out-of-Network: 60%, after deductible
Preventive Care Birth to Age 18	No charge, no deductible	In-Network: No charge, no deductible Out-of-Network: 60%, after deductible
Preventive Care Adult Routine Care	No charge, no deductible, one exam every 12 months	No charge, In Network only, no deductible, one exam every 12 months
Preventive Care Adult Routine OB/GYN	No charge, no deductible	In-Network: No charge, no deductible Out-of-Network: 60%, after deductible
Diagnostic Lab and X-ray	80% after deductible	In-Network: 90% after deductible Out-of-Network: 60% after deductible
Physical Therapy	80% after deductible	In-Network: 90% after deductible Out-of-Network: 60% after deductible
Chiropractic	80% after deductible	In-Network: 90% after deductible Out-of-Network: 60% after deductible
Mental Health & Substance Abuse (Out-patient)	80% after deductible	In-Network: 90% after deductible Out-of-Network: 60% after deductible
Surgical and Hospital Services		
Inpatient Hospital and Physician Services	$500 co-pay + 80% after deductible	$125 per admission co-pay + In-Network: 90% after deductible Out-of-Network: 60% after deductible
Outpatient Surgery	$500 co-pay + 80% after deductible	In-Network: 90% after deductible Out-of-Network: 60% after deductible
Maternity	$250 co-pay + 80% after deductible	$125 per admission co-pay + In-Network: 90% after deductible Out-of-Network: 60% after deductible
Emergency Room	$150 co-pay + 80% after deductible	$100 per visit co-pay + In-Network: 90% after deductible Out-of-Network: 60% (90% if emergency) after deductible

MEDICAL PLAN COMPARISON – CONTINUED	**County Health Plan EPO** Group # 175130M100 ***Out-of-Network Providers Not Covered***	**County Health Plan PPO** Group # 175130M051
Ambulance	80% after deductible	In-Network: 90% after deductible Out-of-Network: 60% (90% if emergency) after deductible
Mental Health & Substance Abuse (Inpatient)	$500 co-pay + 80% after deductible	$125 per admission co-pay + In-Network: 90% after deductible Out-of-Network: 60% after deductible
Skilled Nursing Facility	Not Covered	In-Network: 90% after deductible Out-of-Network: 60% 100 days per plan year after deductible
Home Health	Not Covered	In-Network: 90% after deductible Out-of-Network: 60% after deductible
Prescription Drugs		
Generic or Tier 1	$10 co-pay 34 day supply	$5 co-pay 34 day supply
Formulary Brand or Tier 2	$35 co-pay 34 day supply	$15 co-pay 34 day supply
Non-Formulary Brand or Tier 3	$70 co-pay 34 day supply	$30 co-pay 34 day supply
Mail Order Benefit	3 mos. supply for 1 co-pay	3 mos. supply for 1 co-pay
Mandatory Mail Order	Yes	Yes
Mandatory Generic Program	Yes	Yes

MEDICAL PLAN COMPARISON-CONTINUED	**Kaiser Permanente HMO** Group # 602484-0003	**Kaiser Permanente Hospital Services DHMO** Group # 602484-0006	**Kaiser Permanente Deductible First DHMO** Group # 602484-0009
Calendar Year Deductible	None	$1,500 Self-Only Enrollment $1,500 Any one member in a family of two or more $3,000 Family of two or more	$1,300 Self-Only Enrollment $2,600 Any one member in a family of two or more $2,600 Family of two or more
Calendar Year Out of Pocket Maximum (Including Deductibles, Copays, and Coinsurance)	$1,500 Self-Only Enrollment $1,500 Any one member in a family of two or more $3,000 Family of two or more	$4,000 Self-Only Enrollment $4,000 Any one member in a family of two or more $8,000 Family of two or more	$3,000 Self-Only Enrollment $6,000 Any one member in a family of two or more $6,000 Family of two or more
Coinsurance (the Plan pays)	None	Varies	Varies
Lifetime Maximum	None	None	None
Dependent Children Eligibility	Any Dependent child under age 26 Disabled: No age limit	Any Dependent child under age 26 Disabled: No age limit	Any Dependent child under age 26 Disabled: No age limit
Office Visits and Professional Services			
Physician & Specialist	$10 co-pay	$20 co-pay, no deductible	$20 co-pay after deductible
Preventive Care Birth to Age 18	No charge	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge	No charge, no deductible	No charge, no deductible
Diagnostic Lab and X-ray	No Charge	$10 per encounter, no deductible	$10 per encounter after deductible
Physical Therapy (medically necessary treatment only)	$10 co-pay medically necessary treatment only	$20 co-pay, no deductible	$20 co-pay after deductible
Chiropractic	Discounted rates through Kaiser Choose Healthy	Discounted rates through Kaiser Choose Healthy	Discounted rates through Kaiser Choose Healthy
Mental Health & Substance Abuse (Outpatient)	$10 co-pay individual $5 co-pay group	$20 co-pay individual/$10 co-pay group; no deductible	$20 co-pay after deductible
Surgical and Hospital Services			
Inpatient Hospital and Physician Services	No charge	20% Coinsurance after deductible	$250 co-pay per admission after deductible
Outpatient Surgery	$10 co-pay	20% Coinsurance after deductible	$150 co-pay per procedure after deductible
Maternity	No charge	20% Coinsurance after deductible	$250 co-pay per admission after deductible
Emergency Room	$50 co-pay	20% Coinsurance after deductible	$100 co-pay after deductible

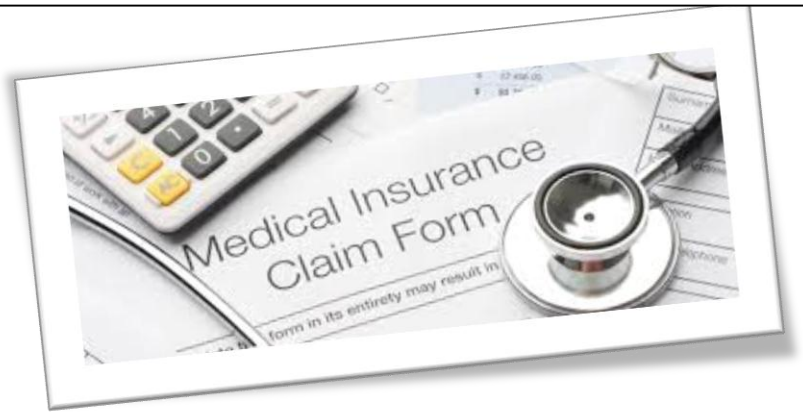
MEDICAL PLAN COMPARISON – CONTINUED	**Kaiser Permanente HMO** Group # 602484-0003	**Kaiser Permanente Hospital Services DHMO** Group # 602484-0006	**Kaiser Permanente Deductible First DHMO** Group # 602484-0009
Ambulance	$50 per trip	$150 per trip, no deductible	$100 co-pay per trip after deductible
Mental Health & Substance Abuse (Inpatient)	No charge	20% Coinsurance after deductible	$250 co-pay per admission after deductible
Skilled Nursing Facility	No charge Up to 100 days per benefit period	20% Coinsurance, no deductible Up to 100 days per benefit	$250 co-pay per admission after deductible
Home Health	No charge 100 days per year	No charge (deductible doesn't apply) 100 days per year	No charge after deductible 100 days per year
Prescription Drugs			
Generic or Tier 1	$5 co-pay 100 day supply	$10 co-pay 30 day supply, no deductible	$10 co-pay 30 day supply after deductible
Formulary Brand or Tier 2	$10 co-pay 100 day supply	$30 co-pay 30 day supply, no deductible	$30 co-pay 30 day supply after deductible
Mail Order Benefit Generic or Tier 1	Same as retail	$20 co-pay 100 day supply, no deductible	$20 co-pay 100 day supply after deductible
Mail Order Benefit Formulary Brand or Tier 2	Same as retail	$60 co-pay 100 day supply, no deductible	$60 co-pay 100 day supply after deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	N/A	N/A

COUNTY CONTRIBUTION FOR MEDICAL COVERAGE

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

The relationship between premiums and plan participant's use of the plans is important to understand – because plan utilization is a key driver of the premiums charged by our plan carriers. This means that your decisions as you use your plan benefits can make a difference. You can choose to use your benefits wisely; to be aware of the costs of the services you select; to use in- network providers; choose generic drugs; and commit to making healthy choices that reduce the need for medical solutions to lifestyle-driven health issues. Statistics have shown that 50% of medical costs are the result of behavioral choices. Making the choice to live healthier is one way you can help keep future costs down. Actively participate in the county's wellness program, Healthy Habits. Let your doctor know that cost is important to you. Talk to your doctor about the cost of care to see if there are affordable ways to achieve the desired outcome. Do not avoid necessary treatment due to cost. Preventive treatment is shown to save costs in the long run by identifying issues early. Visit http://healthyhabits.sonoma-county.org/ for more information on how to make healthy choices.

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



2015/2016 MEDICAL PLAN PREMIUM CHART

Bi-Weekly Premiums For Coverage Effective June 1, 2015 through May 31, 2016			
Plan	**Total Premium Cost**	**County Contribution**	**Employee Contribution**
County Health Plan EPO			
Self	$409.13	$229.98	$179.15
Self and 1 dependent	$799.21	$229.98	$569.23
Self and 2 or more dependents	$1,114.80	$229.98	$884.82
County Health Plan PPO			
Self	$496.83	$229.98	$266.85
Self and 1 dependent	$976.63	$229.98	$746.65
Self and 2 or more dependents	$1,364.78	$229.98	$1,134.80
Kaiser Permanente HMO			
Self	$307.58	$229.98	$77.60
Self and 1 dependent	$615.16	$229.98	$385.18
Self and 2 or more dependents	$870.45	$229.98	$640.47
Kaiser Permanente Hospital Services DHMO Plan			
Self	$247.65	$229.98	$17.67
Self and 1 dependent	$495.30	$229.98	$265.32
Self and 2 or more dependents	$700.85	$229.98	$470.87
Kaiser Permanente Deductible First DHMO Plan			
Self	$229.81	$229.98	$0.00
Self and 1 dependent	$459.61	$229.98	$229.63
Self and 2 or more dependents	$650.36	$229.98	$420.38

Part-time employees in allocated positions of thirty-two 32 hours or more bi-weekly, (.40 FTE minimum) are eligible to participate in the County's medical, dental, and vision plans and the County's contribution toward their premiums is pro-rated. The County's contribution is based on the number of qualifying hours compared to a full-time employee. Qualifying hours include hours worked and qualified leave hours. Contact your Payroll Clerk if you have questions regarding your eligibility for a pro-rated County contribution. More details can be found in the Health and Welfare benefits booklet at http://hr.sonoma-county.org/for_employees.htm.

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

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

PLANNING TO RETIRE IN THE COMING YEAR? If so, read the Retiree Health and Welfare benefits booklet on the Human Resources website and Section 15 of the Salary Resolution about dependent eligibility at retirement, as well as write to benefits@sonoma-county.org to determine your eligibility for retiree health coverage.

Service Area – Medical Plans	
County Health Plans (CHP)	**Kaiser Permanente Plans**
Within California An online provider listing can be found at www.anthem.com/ca by selecting Find A Doctor, and then searching under "Where are you looking?" The plan name is Blue Cross Prudent Buyer PPO Plan. Outside of California Log on to www.anthem.com/ca http://www.anthem.com/ca Select Find a Doctor, and then under "What insurance plan would you like to use?," select your state. Under Plan Type/Network select PPO and for Plan Name, select National PPO (BlueCard PPO).	Within California, Oregon, Washington and Hawaii Live or work in a geographical area within a 30-mile radius of any Kaiser Permanente Medical Facility.

Take note… The Medical Plan Comparison Chart is only a summary of the benefits covered. For detailed information, along with notices of your legal rights, review the Summary Plan Description (SPD) and Evidence of Coverage (EOC) for each plan, and the Employee Health and Welfare Benefits booklet available through the County of Sonoma web site: http://hr.sonoma-county.org/foremployees.htm.

In the event of conflict between the information presented in this summary and the plan's SPD/EOC booklets, the plan's SPD/EOC booklets determine the coverage.

DENTAL AND VISION BENEFITS

DELTA DENTAL PREMIER PLAN BENEFIT HIGHLIGHTS

Delta Premier Group #3126-0124	
Services	**All Bargaining Units**
Diagnostic & Preventive	Plan pays 80% of allowable charges; an extra annual cleaning is included during pregnancy
Basic	Plan pays 80% of allowable charges
Crowns, Jackets, & Cast Restorations	Plan pays 80% of allowable charges
Prosthodontics	Plan pays 80% of allowable charges; coverage for implants is now included under the plan
Orthodontics	Plan pays 50% of allowable charges, up to a lifetime maximum of $3,000
Deductible	$0
Calendar Year Maximum Benefit	$3,000 per person per calendar year

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

2015/2016 BI-WEEKLY DENTAL PREMIUMS

Bargaining Unit	Total Premium Cost	County Contribution	Employee Contribution
ESC, SCLEA, SCLEMA, SCPDIA, Local 39	$62.56	$50.56	$12.00
Board of Supervisors, SCDPDAA, DSA, DSLEM, Elected Officials/Department Heads, SCPA, SEIU, Unrepresented, Administrative Management, Confidential	$62.56	$49.56	$13.00
WCE	$62.56	$39.56	$23.00

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

VISION SERVICE PLAN (VSP) BENEFIT HIGHLIGHTS

VSP Group # 1243-7001-0002	
Services from VSP Providers	**All Bargaining Units**
Eye Exams	Covered in full every 12 months-following the date of your last exam
Prescription Glasses	Lenses: Covered in full every 12 months-following date of last lenses Frames: $115 allowance plus 20% of any out-of-pocket costs, provided every 24 months (following the date of your last frames)
Contact Lens Care In lieu of prescription glasses	$105 allowance for contacts and related exam every 12 months (following date of last contact lens exam and contacts)

2015/2016 BI-WEEKLY VISION PREMIUMS

Bargaining Unit	Total Premium Cost	County Contribution	Employee Contributions
All Bargaining Units: ESC, SCLEA, SCLEMA, SCPDIA, Local 39, Board of Supervisors, SCDPDAA, DSA, DSLEM, Elected Officials/Dept. Heads, SCPA, SEIU, WCE, Unrepresented, Admin Management, Confidential	$7.55	$7.55	$0.00

COUNTY BASIC LIFE AND SUPPLEMENTAL LIFE INSURANCE

- Basic Life Insurance, AD&D, and Supplemental Life Insurance are insured by The Hartford Life Ins. Co.
- All regular full-time employees and regular part-time employees, in an allocated position of 60 hours (.75 FTE) or more per pay period, receive a basic life insurance and AD&D benefits paid by the County.
- Part-time DSA, SCLEA, and ESC employees working less than 60 hours per pay period can purchase basic, supplemental, and dependent life insurance at their own expense. The rate is $0.90 bi-weekly under Basic Life Class 3 as shown in the following table.
- All regular full-time employees and regular part-time employees, in an allocated position of 60 hours (.75 FTE) or more per pay period, may also purchase Supplemental Life Insurance coverage.
- The maximum amount of Life Insurance, Basic Life and Supplemental Life combined, cannot exceed $500,000.

- The coverage level you elect is subject to approval by The Hartford. No payroll deductions will be taken until your application is approved by The Hartford.

ELIGIBILITY FOR BASIC LIFE INSURANCE AND SUPPLEMENTAL LIFE INSURANCE

The Hartford Group # GL-673199			
Bargaining Units	**Basic Life Class**	**Basic Life and AD&D Insurance 100% Paid by the County***	**Supplemental Life Employee Paid**
SEIU (01, 05, 10, 25, 80) Unrepresented (00)	1	$10,000	1, 2, 3 or 4 times your Basic Life Amount
Local 39 (85)	2	$20,000	1, 2, 3 or 4 times your Basic Life Amount
DSA (46,47) SCLEA (30,40,41,70)	3	$25,000	1, 2, 3 or 4 times your Basic Life Amount
Confidential (51)	4	1.5 times Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount
Board of Supervisors (49) DLSEM (43) SCLEMA (44) SCPA (45) SCDPDA (60) Administrative Management (50) Department/Agency Heads (52)	5	2 times Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount
SEIU Supervisory (95 only)	6	1 time Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount
WCE (21)	7	$25,000	1, 2, 3 or 4 times your Base Annual Salary
ESC (75)	8	$25,000	1, 2, 3, 4 or 5 times your Base Annual Salary
SMART	9	2 times Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount

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

SUPPLEMENTAL LIFE INSURANCE COST

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

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

2015/2016 Employee Supplemental Life Insurance Premiums per $10,000 of Coverage		
Age	Bi-Weekly Rate	Annual Rate
29 and under	$0.28	$7.20
30 – 34	$0.31	$8.17
35 – 39	$0.39	$10.20
40 – 44	$0.59	$15.37
45 – 49	$0.86	$22.44
50 – 54	$1.37	$35.77
55 – 59	$2.28	$59.40
60 – 64	$3.38	$88.08
65 – 69	$5.53	$144.35
70 – 74	$10.12	$264.13

DEPENDENT LIFE INSURANCE

You can also purchase dependent life insurance coverage for your spouse/domestic partner and any dependent child through the end of the month they turn age 26. The benefit provided for dependent coverage is $5,000 for each eligible family member. The premium is $0.223 bi-weekly; which covers all eligible members of your family.

KEY POINTS TO CONSIDER ABOUT LIFE INSURANCE

- You pay the full cost of supplemental and dependent coverage on a post-tax basis.
- If you are currently enrolled in Supplemental Life, and haven't yet reached your maximum guaranteed issue, you can elect a one-level increase with automatic approval, no evidence of good health required.
- Especially if you are the sole wage-earner in your family, think about whether or not you need more protection than the County-paid basic coverage provides.
- Consider whether you have enough money to cover funeral and/or legal expenses in the event of a death of a spouse, domestic partner, or children. Dependent life insurance may help with these expenses.
- The benefit provided for dependent coverage is a payment to the employee of $5,000 for each eligible family member.
- Be sure to designate a beneficiary (or beneficiaries) for your employee life insurance and keep them up-to-date (basic and supplemental). The Hartford Beneficiary Form is located in the main menu of Employee Self-Service.
- http://www.thehartford.com/employee-coverage/beneficiary-counseling
- http://www.thehartford.com/employee-coverage/funeral-planning

EMPLOYEE HEALTH REIMBURSEMENT ACCOUNTS (HRAS)

If you are enrolled in a County sponsored medical plan you may be eligible for a Health Reimbursement Account (HRA) depending on your Bargaining Unit's MOU. A listing of eligible Bargaining Units and HRA contribution amounts are outlined on the Health and Welfare Benefits website: http://hr.sonoma-county.org/for_employees.htm.

WHAT AN HRA CAN DO FOR EMPLOYEES

- Reimburse qualified medical expenses (pursuant to IRC Section 213(d)) and health insurance premiums paid with post-tax dollars. To designate a portion of your health premiums to be paid with post-tax dollars, you must submit an Annual Health Care Premium Conversion Plan Election Form during Annual Enrollment Period. This form is available online at http://hr.sonoma-county.org/documents/Premium-Conversion-Election-Form.pdf or from your payroll clerk. Instructions are contained on the Annual Health Care Premium Conversion Plan Election Form.
- Accumulate money to pay for both current and future health care expenses, COBRA and/or future retiree health care premiums and costs.

EXPENSES THAT CAN BE REIMBURSED FROM AN HRA

- Out-of-pocket medical, dental, and vision care expenses for the participating employee and their IRS eligible dependents (including spouses, children & step-children up to age 26, etc., but generally not domestic partners).
- Insurance co-pays, deductibles and other expenses not usually covered by the County-sponsored health plan such as acupuncture, laser eye surgery, etc.
- Premiums for long-term care insurance and COBRA continuation of coverage for participating employee and IRS eligible dependents.
- Health insurance premiums paid with post-tax dollars. Sonoma County employees' health benefit premiums are paid on a pre-tax basis. In order to qualify for HRA reimbursement you must elect a share of your premiums to be paid using post-tax dollars.
- Your final medical expenses (up to one year after death).

For more information about the Employee HRA please see the Health and Welfare Benefits Website: http://hr.sonoma-county.org/for_employees.htm and select the Employee HRA Accounts link to Employee HRA Information.

CONTACT INFORMATION AND RESOURCES

CARECOUNSEL

The County of Sonoma provides CareCounsel, a health care advocacy program available at no cost to active employees and retirees. CareCounsel will listen to your concerns, answer your questions, and help you navigate health plan benefits. Contact CareCounsel for the following:

- Questions about your health plan benefits
- Assistance with choosing a health plan and selecting and locating doctors and hospitals
- Troubleshooting claims problems and obtaining support with medical claims and appeals
- Addressing quality-of-care concerns
- Finding resources for a health condition
- Getting the most from your health care dollars

You can reach CareCounsel at 888-227-3334. Resources are also available through the CareCounsel web site at www.carecounsel.com. CareCounsel is an autonomous subsidiary of Stanford Hospital & Clinics.

CUSTOMER SERVICE SUPPORT

Visit the County's website and review the frequently asked questions (FAQs) and expanded information found in the Health and Welfare Benefits Booklet and other benefit website pages. Visit the insurance company websites for additional resources. Contact the Human Resources Benefits Unit with questions related to your eligibility, coverage, and Annual Enrollment Period.

E-mail: benefits@sonoma-county.org
Phone: 707-565-2900
Internet: http://hr.sonoma-county.org/for_employees.htm

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

COUNTY-OFFERED PLAN CONTACT INFORMATION

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

Plan	Phone	Web
County Health Plans (CHP PPO & CHP EPO) *Administered by Anthem Blue Cross* **Summary of Benefits and Coverage (SBC)**	800-759-3030	www.anthem.com/ca hr.sonoma-county.org/content.aspx?sid=1
CVS/Caremark *County Health Plans' prescription drug provider* Order Prescriptions, Obtain your Prescription History, Find Savings and Opportunities, Learn about Medications, Ask a Pharmacist	800-966-5772	www.caremark.com
Kaiser Permanente **Summary of Benefits and Coverage (SBC)**	800-464-4000	www.kp.org hr.sonoma-county.org/content.aspx?sid=1024&id=1224
Delta Dental Plan Annual Notices from Delta: HIPAA Notice, Grievance process, Tissue and Organ Donations, Language Assistance Program	800-765-6003	www.deltadentalins.com http://hr.sonoma-county.org/content.aspx?sid=1024&id=1228
Vision Service Plan	800-877-7195	www.vsp.com
The Hartford Life & Accident Insurance Company	888-563-1124	www.thehartford.com
Employee Assistance Program (EAP) *Administered through Managed Health Network(MHN)*	800-227-1060	www.members.mhn.com **Company code**: sonomacounty **Law Enforcement**: scle
HEALTHY HABITS County of Sonoma **County Wellness Program**	707-565-2900	http://healthyhabits.sonoma- county.org
Sonoma County HIPAA Privacy Practices	707-565-4999	http://www.sonoma-county.org/privacy/privacy.htm
Glossary of Health Coverage and Medical Terms related to the Summary of Benefits and Coverage (SBC)		dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

Please refer to the Employee Health and Welfare Benefits booklet, available electronically on our website at http://hr.sonoma-county.org/ for important legal notices.

EMPLOYEE SELF-SERVICE HELP SESSIONS

Need assistance with Employee Self-Service (ESS)?

Have questions related to submitting your annual enrollment elections online? Computers will be available for you to enter your Annual Enrollment elections electronically in Employee Self-Service.

LOCATION	DATE	DROP-IN HOURS
DCSS	Tuesday, March 24	10:30 a.m. - 2:30 p.m.
EOC Training Room	Monday, March 30	8:30 a.m. - 5:00 p.m.
FY&C	Tuesday, March 31	1:00 p.m. - 4:30 p.m.
FY&C	Wednesday, April 1	9:00 a.m. - 1:00 p.m.
EOC Training Room	Wednesday, April 1	3:00 p.m. - 5:00 p.m.
EOC Training Room	Thursday, April 2	8:30 a.m. - 12:00 p.m.
DCSS	Thursday, April 2	2:00 p.m. - 4:30 p.m.
EOC Training Room	Friday, April 3	8:30 a.m. - 5:00 p.m.
EOC Training Room	Tuesday, April 7	8:30 a.m. -5:00 p.m.
FY&C	Wednesday, April 8	1:00 p.m. - 4:30 p.m.
DCSS	Thursday, April 9	8:00 a.m. - 1:00 p.m.
EOC Training Room	Thursday, April 9	3:00 p.m. - 5:00 p.m.
EOC Training Room	Friday, April 10	12:30 p.m. - 4:30 p.m.

Locations:

EOC Training Room (across from the Adult Detention Center)
600 Administration Dr., Santa Rosa
(The EOC is the single story building with the large radio tower on top.)
Entrance is located on the North side of the building.

DCSS (Department of Child Support Services)
3725 Westwind Blvd., Suite 200 (upstairs), Santa Rosa
Important: Check-in at the reception desk. County I.D. required.

FY&C (Family, Youth and Children's Services)
1202 Apollo Way, Santa Rosa
Important: Check-in at the reception desk. County I.D. required.

REQUIRED NOTICES

IMPORTANT NOTICE FROM THE COUNTY OF SONOMA 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 the County of Sonoma and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. County of Sonoma has determined that the prescription drug coverage offered by the County offered plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

   Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current County coverage will not be affected. For further information on how your coverage will be affected, please contact your benefit office or CareCounsel at the number below.

If you do decide to join a Medicare drug plan and drop your current County of Sonoma coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

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 the County of Sonoma changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	March 23, 2015
Name of Entity/Sender:	County of Sonoma
Contact—Position/Office:	Human Resources Benefits Unit
Address:	575 Administration Dr., Suite 117C, Santa Rosa, CA 95403
Phone Number:	707-565-2900 or Benefits@sonoma-county.org

Health Insurance Counseling and Advocacy Program (HICAP): 800-434-0222
Healthcare Advocacy, CareCounsel: 1-888-227-3334

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 NOTICE

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA which amends ERISA, requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your group health plan offers coverage for mastectomies, WHCRA applies to your plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including Lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the policy/plan.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MONTANA – Medicaid	OREGON – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your plan provider to precertify the extended stay. If you have questions about this Notice, contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

SPECIAL ENROLLMENT EVENT:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or social security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the Plan. You can get another copy of this Notice from the County of Sonoma Privacy Officer at (707) 565-4999 or www.sonoma-county.org/privacy/privacy.html.

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

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

Americans without medical plan coverage could have to pay a penalty when they file their personal income taxes. Visit the Health Insurance Marketplace for detailed information on individual shared responsibility payment penalty.

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

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

The medical plans offered by this employer do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider; however, payment by the Plan may be less for the use of a non-network provider.

You also do not need prior authorization from the Plan 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 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 plan.