County of Sonoma

2015-2016 Annual Enrollment Retiree Benefits Guide

Annual Enrollment is March 23 through April 10, 2015

This is your once a year opportunity to make changes to your current benefit elections. Complete a County of Sonoma Retiree Benefits Enrollment/Change Form, included in the back of this booklet.

No action is necessary if you are NOT making any changes.

Your current benefit elections will automatically roll over to the new plan year if you do not complete a County of Sonoma Retiree Benefits Enrollment/Change Form.

We strongly encourage you to review this booklet carefully to ensure that you are making the best benefit decisions for yourself and your family for the 2015-2016 Plan Year (June 1, 2015 – May 31, 2016).

The County of Sonoma offers retired employees and their eligible dependents access to comprehensive health care benefits, which are designed to help meet our retirees' diverse health care needs.

The purpose of this booklet is to help you make informed decisions about your benefits during the 2015 Annual Enrollment Period. It highlights your options and key program features to consider when you enroll. It also includes your premium costs for the 2015/2016 plan year. Additional information and resources can be found listed at the back of this booklet.

The information provided in this enrollment booklet provides a summary of your benefits under the County-offered health plans. For more detailed information along with notices of your legal rights, review each plan's Summary Plan Description (SPD) or Evidence of Coverage (EOC). In the case of conflict between the information presented in this booklet and the plan's SPD/EOC booklets, the plan's SPD/EOC booklet determines the coverage. The booklets are available through the County's web site at:

http://hr.sonoma-county.org/for_retirees

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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 DHMO plans contain deductibles which must be met before some plan benefits will be paid. Each plan is structured differently. Retirees, depending on their specific medical needs, may find one plan more attractive than another.

These new plans are available to all retirees. In the case where a retiree selects one of these new plans and has Medicare and/or has one or more family members with Medicare, the member(s) with Medicare will receive the Kaiser Advantage Senior Advantage plan and all other non-Medicare members will receive the benefits of the DHMO plan selected.

See pages 10, 12, 13 and the Medical Plan Comparison Charts for more information on the Kaiser Permanente Hospital Services DHMO and Deductible First DHMO.

To help retirees understand these two new plan options, Kaiser Permanente representatives will give a presentations at the Retiree Annual Enrollment meetings. Kaiser representatives will explain the Kaiser plans and answer questions. See page 6 for the Annual Enrollment 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.

Benefit Changes for Legislative Compliance

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 towards the Kaiser Permanente medical calendar year out-of-pocket maximum in compliance with the Affordable Care Act.

Premium Changes Reflected on Pension Checks

The total cost of benefits changes annually. All cost changes will be reflected on your May 2015 pension check for coverage effective June 1, 2015.

Health Care Reform and Preventive Care Benefits

Take care of your health by taking advantage of free preventive screenings like blood pressure and cholesterol tests, mammograms, colonoscopies, and more. This includes coverage for vaccines and new preventive services for women. Prevention and early detection save lives and lower costs. More wellness information is available on the health plan's website.

Health Care Reform and Part-D Drug Benefits

The prescription drug plans available to you through AARP MedicareRx are Medicare Part-D plans. As Part-D plans, they are subject to changes implemented by the Patient Protection and Affordable Care Act (PPACA). The ACA requires Part-D prescription plans to gradually close the prescription drug coverage gap, known as the "donut hole." In 2015, retirees covered by a Medicare Part-D plan, such as an AARP MedicareRx prescription plan, who reach the coverage gap, (when total costs reach $2,960 or donut hole) will pay 45% of the plan's cost for covered brand-name drugs and 65% for covered generic drugs. Additionally, the discount on generic drugs has increased from 28% to 35%. You can expect additional savings in the coming years on your covered brand-name and generic drugs while in the coverage gap, until the gap is closed in 2020. Once your out-of-pocket drug costs exceed $4,700, Part-D Catastrophic Coverage begins and only a small coinsurance or co-payment is required. For more information, visit http://www.medicare.gov/part-d/index.html or contact a UnitedHealthcare(UHC)-AARP customer service representative at 888-867-5575.

CareCounsel can answer County plan questions and guide you through the benefit option decision process.

See page 47 for a list of all CareCounsel services

Call 1-888-227-3334

Annual Enrollment Meeting Schedule

Would you like more information about your benefit plan options? Take advantage of the opportunity to meet with representatives from AARP (UnitedHealthcare), Kaiser Permanente, Delta Dental and the County's Human Resources Benefit Unit. This year there will be a meeting for retirees with Medicare and a separate meeting for retirees without Medicare. Please make sure you attend the meeting most appropriate for your personal situation.

County of Sonoma Board Chambers 575 Administration Dr. Santa Rosa, CA	
Retirees <u>With</u> Medicare	**Retirees <u>Without</u> Medicare**
Thursday, March 26 9:00 – 11:30 a.m.	Thursday, March 26 1:00 p.m. – 3:30 p.m.
Friday, March 27 9:00 – 11:30 a.m.	Friday, March 27 1:00 p.m. – 3:30 p.m.

Annual Enrollment Forms Completion Help Sessions

Human Resources Benefits Unit staff will be available to assist you with completing Annual Enrollment election forms. Since active employees have the same Annual Enrollment Period as retirees, you will be best served if you drop-in during the times listed below:

One-on-One Help Sessions		
Date	**Time**	**Location**
Thursday, March 26	11:30 a.m. – 1:00 p.m. 3:30 p.m. – 5:00 p.m.	County of Sonoma Board Chambers 575 Administration Dr. Santa Rosa, CA
Friday, March 27	11:30 a.m. – 1:00 p.m. 3:30 p.m. – 5:00 p.m.	County of Sonoma Board Chambers 575 Administration Dr. Santa Rosa, CA
Monday, March 30	9:00 a.m. – 11:00 a.m. 2:00 p.m. – 4:00 p.m.	Human Resources Benefits Unit 575 Administration Dr., Suite 117C Santa Rosa, CA
Friday, April 3	9:00 a.m. – 11:00 a.m. 2:00 p.m. – 4:00 p.m.	Human Resources Benefits Unit 575 Administration Dr., Suite 117C Santa Rosa, CA
Monday, April 6	9:00 a.m. – 11:00 a.m. 2:00 p.m. – 4:00 p.m.	Human Resources Benefits Unit 575 Administration Dr., Suite 117C Santa Rosa, CA
Thursday, April 9	1:00 p.m. – 4:00 p.m.	Human Resources Benefits Unit 575 Administration Dr., Suite 117C Santa Rosa, CA
Friday, April 10	8:00 a.m. – 5:00 p.m.	Human Resources Benefits Unit 575 Administration Dr., Suite 117C Santa Rosa, CA

Enrolling in Benefits

Annual Enrollment Period – March 23 through April 10, 2015

Annual Enrollment is your **once-a-year opportunity** to make changes to your current benefit elections for the upcoming plan year, which begins on June 1, 2015 and continues through May 31, 2016.

During Annual Enrollment you may:

- Change your medical or dental plan election(s)
- Enroll in one of the retiree dental plans
- Drop coverage for dependents

You only need to take action during Annual Enrollment if you are making one or more of the changes noted above. Be sure to complete and submit the required form(s) to the County of Sonoma, Human Resources Benefits Unit by **5:00 p.m., Friday, April 10, 2015**.

If you simply want to continue your current elections in the coming benefit year and all of your dependents continue to meet the plans' eligibility criteria, no action is necessary — your current benefits will continue effective June 1, 2015

Items to Consider During Annual Enrollment

Dependent data:

Names, birthdates, Social Security numbers, full-time student status information are required to maintain enrollment.

Beneficiary designations:

There are no set deadlines for updating your beneficiary designations, but Annual Enrollment is a great time to update them if needed.

Personal information:

If you've moved or changed your name or contact information, be sure to notify the HR Benefits Unit at (707) 565-2900. It's important to keep your personal information updated at all times.

Kaiser Senior Advantage Enrollment Form

If you are making an election/change to enroll in or drop coverage in **Kaiser Senior Advantage**, you MUST contact Human Resources Benefits Unit Customer Service at (707) 565-2900 to request an additional form.

AARP Forms and Enrollment Check List

To assist with enrollment in the AARP Medicare Supplement Insurance Plans, use the checklist below. Complete ALL the following steps to enroll in AARP:

- ☐ **To inquire about enrollment and ask questions, contact both numbers listed below:**
  - ☐ **AARP® Medicare Supplement Insurance Plans** 800-545-1797 for Group # 1068
  - ☐ **AARP® MedicareRx Plans** 888-867-5575 for Group # 3803

  Customer service representatives are available Monday through Friday from 7:00 a.m. to 11:00 p.m. PST, and Saturday from 9:00 a.m. to 5:00 p.m. PST.

☐ **Complete** the **County of Sonoma Retiree Benefits Enrollment/Change Form** found in the back of this booklet. Keep a copy and **send original form** along with the following completed forms:

A. **Original** AARP® Medicare Supplement Insurance Plan enrollment form mailed to you by UHC, and

B. **Original** AARP® MedicareRx Plan enrollment form mailed to you by UHC

C. **Don't have these forms?** If you did not receive the AARP form(s), immediately contact the Human Resources, Benefits Unit and request the missing form(s) by calling or emailing:

Phone: 707-565-2900; or
Email: benefits@sonoma-county.org

☐ To enroll, send all original, completed, forms to:

County of Sonoma
Attn: HR Benefits Unit
575 Administration Dr., Suite 116C
Santa Rosa, CA 95403

Mail or drop off all three required forms by 5pm, Friday, April 10, 2015. If AARP forms are not available by deadline, return the County form by April 10, 2015 to be considered for enrollment. The absolute last day to submit the AARP additional forms is April 30, 2015.

Medical Plan Eligibility

Plan eligibility and plan benefits are based on an enrolled member's eligibility for Medicare. Use the information below to determine which plans are available to you and what plan benefits will be provided.

Non-Medicare Plans. These plans are available to retirees who are NOT eligible for Medicare and whose dependents are NOT eligible for Medicare.

- **County Health Plan EPO (CHP EPO)** – an Exclusive Provider Organization plan
- **County Health Plan PPO (CHP PPO)** – a Preferred Provider Organization
- **Kaiser Permanente HMO** – a Health Maintenance Organization, available to retirees residing in a Kaiser Permanente service region located in California, Hawaii, and the Northwest (Oregon/Washington); rates vary by state
- **Kaiser Permanente Hospital Services DHMO** (Deductible HMO Plan)
- **Kaiser Permanente Deductible First DHMO** (Deductible HMO Plan)

Medicare Plans. These plans are available to retirees who are themselves eligible for Medicare and/or one or more eligible spouse/dependent is eligible for Medicare. Plan benefits will be different for the member(s) with Medicare.

- **County Health Plan EPO** (CHP EPO) – an Exclusive Provider Organization. Medicare will be the primary coverage for members with Medicare.
- **County Health Plan PPO** (CHP PPO) – a Preferred Provider Organization. Medicare will be the primary coverage for members with Medicare.
- **Kaiser Permanente HMO** – a Health Maintenance Organization, available to retirees residing in a Kaiser Permanente service region located in California, Hawaii, and the Northwest (Oregon/Washington); rates vary by state. Enrolled member(s) without Medicare will receive the benefits of Kaiser Permanente HMO; enrolled member(s) with Medicare must assign their Medicare benefits to Kaiser Permanente Senior Advantage and will receive the benefits of the Kaiser Senior Advantage plan.
- **Kaiser Permanente Hospital Services DHMO** (Deductible HMO Plan)*. Enrolled member(s) without Medicare will receive the benefits of Kaiser Permanente Hospital Services DHMO; member(s) with Medicare must assign their Medicare benefits to Kaiser Permanente Senior Advantage and will receive the benefits of the Kaiser Senior Advantage plan.
- **Kaiser Permanente Deductible First DHMO*** (Deductible DHMO Plan). Enrolled member(s) without Medicare will receive the benefits of Kaiser Permanente Deductible First DHMO; enrolled member(s) with Medicare must assign their Medicare benefits to Kaiser Permanente Senior Advantage and will receive the benefits of the Kaiser Senior Advantage plan.

Medicare ONLY Plans. These plans require Medicare to have the benefits of the plan.

- **Kaiser Permanente Senior Advantage** – available to retirees residing in a Kaiser Permanente service region located in California, Northwest (Oregon/Washington) or Hawaii
- **AARP® Medicare Supplement Insurance Plan with MedicareRx Prescription Drug Plans**

As you consider which plan is right for you, it's important to understand how Medicare and your County-offered medical plan benefits work together to provide your health care benefits.

Brief Description of Medical Plans

The following provides a brief description of how each plan works.

County Health Plans (CHP EPO & CHP PPO)

CHP EPO (Exclusive Provider Organization). The plan includes a network of preferred providers, including doctors, hospitals and other health care facilities, which participate in the Anthem Blue Cross Prudent Buyer PPO Plan network. Prescription drug coverage is provided through CVS/Caremark. The plans' network providers agree in advance to provide their services at a negotiated, discounted rate. All care in the CHP EPO must be obtained within the plan network, except when you need emergency care.

CHP PPO (Preferred Provider Organization) The plan includes a network of preferred providers, including doctors, hospitals and other health care facilities, which participate in the Anthem Blue Cross Prudent Buyer PPO Plan network. Prescription drug coverage is provided through CVS/Caremark. The plans' network providers agree in advance to provide their services at a negotiated, discounted rate. You may seek care from providers outside the network, but you will pay less out of your own pocket when you use a network provider.

- **Deductibles and Coinsurance** Services under the County Health Plans are subject to an annual deductible. As you incur medical expenses, you first pay the deductible out of your own pocket. Then, after meeting the deductible, you pay your share of your covered expenses (known as "copayment or coinsurance"), up to the plan's annual out-of-pocket maximum.

- **Out-of-Pocket Maximum** When you meet the annual out-of-pocket maximum, the plan will pay the full cost of ***covered expenses*** for the remainder of the benefit year. Covered expenses (e.g. coinsurance amounts) apply towards the out-of-pocket maximum. Out-of-pocket costs incurred for non-covered services or supplies in excess of the plan's covered expenses (e.g. expenses incurred for out-of-network services that exceed the reasonable and customary charges allowed by the plan) **are not** applied toward the out-of-pocket maximum; these non-covered charges are the plan participant's financial responsibility. ***Be sure you understand the amount you will be required to pay out of your own pocket if you seek care out-of-network.***

County Health Plan Prescription Coverage. If a generic drug is not available, you will pay the brand-name co-pay. If a brand-name drug is medically necessary, as prescribed by your doctor, your doctor must request an exception to the plans mandatory generic policy through CVS/Caremark *prior* to getting the prescription filled. If approved, you will be charged the brand-name co-pay. However, if *you* choose the brand-name drug, or the exception is not approved, the drug will be a covered expense and you will be responsible for the brand copay along with the difference between the brand and generic cost. **If you are taking a maintenance drug, it can be filled at any retail pharmacy twice. After the second fill, it must be filled at a CVS pharmacy or by mail order through CVS/Caremark.**

Kaiser Permanente Plans (HMO & DHMO)

Kaiser Permanente HMO Plan. The HMO plan requires you to live within the plan's respective service area and to receive care from Kaiser Permanente providers. This means you have access to Kaiser Permanente providers only, except when you need emergency care. You share in the cost of your care through copayments, and, in some cases, coinsurance.

Kaiser Permanente Hospital Services DHMO Plan. The Hospital Services DHMO plan requires you to live within the plan's respective California service area and to receive care from Kaiser Permanente providers. This means you have access to Kaiser Permanente providers only, except when you need emergency care. You share in the cost of your care through copayments, coinsurance and deductibles.

- Most preventative services, such as routine physicals, mammograms, and routine preventative screenings are covered at no cost and are not subject to the calendar year deductible.
- Most doctor's 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.
- Hospitalizations, in-patient, and out-patient surgeries are subject to 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 for more information about the benefits, deductibles, and out-of-pocket maximums.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account) through COBRA or another employer, may submit Kaiser out-of-pocket expenses for reimbursement.

Members can use Kaiser Permanente's online Cost Estimate Tool to obtain a personalized estimate of medical care costs for common tests and procedures at www.kp.org/memberestimates.

Kaiser Permanente Deductible First DHMO Plan. The Deductible First DHMO plan requires you to live within the plan's California respective service area and to receive care from Kaiser Permanente providers. This means you have access to Kaiser Permanente providers only, except when you need emergency care. You share in the cost of your care through co-payments, coinsurance and deductibles.

- Most preventative services, such as routine physicals, mammograms, and routine preventative screenings are covered at no cost and are not subject to the calendar year deductible.
- For any service other than preventative services, a member must meet the calendar year deductible FIRST before ANY plan benefits will be paid. A member 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 satisfied, 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 scheduled surgery) 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 for more information deductibles, out-of-pocket maximums and plan benefits.

Members can use Kaiser Permanente's online Cost Estimate Tool to obtain a personalized estimate of medical care costs for common tests and procedures at www.kp.org/memberestimates.

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

Note: If you (the retiree) elect to enroll in this plan, which qualifies as a qualified high deductible health plan, and you have a Flexible Spending Arrangement 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 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.

Medical Plan Comparison Chart – County Health Plans

Plan Information	**County Health Plan EPO** Group # 175130M100 – Non-Medicare Group # 175130M103 - Medicare *Out-of-Network Providers Not Covered* **Member Pays**	**County Health Plan PPO** Group # 175130M051 – Non-Medicare Group # 175130M054 - Medicare **Member Pays**
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 (Member Pays)	20%	In-Network: 10% Out-of-Network: 40%
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: 40%, after deductible
Preventive Care Birth to Age 18	No charge, no deductible	In-Network: No charge, no deductible Out-of-Network: 40%, 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: 40%, after deductible
Diagnostic Lab and X-ray	20% after deductible	In-Network: 10% after deductible Out-of-Network: 40% after deductible
Physical Therapy	20% after deductible	In-Network: 10% after deductible Out-of-Network: 40% after deductible
Chiropractic	20% after deductible	In-Network: 10% after deductible Out-of-Network: 40% after deductible
Mental Health & Substance Abuse (Out-patient)	20% after deductible	In-Network: 10% after deductible Out-of-Network: 40% after deductible
Surgical and Hospital Services		
Inpatient Hospital and Physician Services	$500 co-pay + 20% after deductible	$125 per admission co-pay + In-Network: 10% after deductible Out-of-Network: 40% after deductible
Outpatient Surgery	$500 co-pay + 20% after deductible	In-Network: 10% after deductible Out-of-Network: 40% after deductible
Maternity	$250 co-pay + 20% after deductible	$125 per admission co-pay + In-Network: 10% after deductible Out-of-Network: 40% after deductible

Medical Plan Comparison Chart – County Health Plans

Plan Information	**County Health Plan EPO** Group # 175130M100 Group # 175130M103 - Medicare *Out-of-Network Providers Not Covered* **Member Pays**	**County Health Plan PPO** Group # 175130M051 Group # 175130M054 **Member Pays**
Emergency Room	$150 co-pay + 20% after deductible	$100 per visit co-pay + In-Network: 10% after deductible Out-of-Network: 40% (10% if emergency) after deductible
Ambulance	20% after deductible	In-Network: 10% after deductible Out-of-Network: 40% (10% if emergency) after deductible
Mental Health & Substance Abuse (Inpatient)	$500 co-pay + 20% after deductible	$125 per admission co-pay + In-Network: 10% after deductible Out-of-Network: 40% after deductible
Skilled Nursing Facility	Not Covered	In-Network: 10% after deductible Out-of-Network: 40% 100 days per plan year after deductible
Home Health	Not Covered	In-Network: 10% after deductible Out-of-Network: 40% after deductible
Hearing Aids	One per ear every 36 months	One per ear every 36 months
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 Chart – Kaiser Permanente Plans

Plan Information	**Kaiser Permanente HMO** Group # 9072-0000 **Member Pays**	**Kaiser Permanente Hospital Services Deductible HMO** Group # 9072-0006 **Member Pays**	**Kaiser Permanente Deductible First DHMO** Group # 9072-0009 **Member Pays**
Calendar Year Deductible	None	$1,500 Individual $3,000 Family	$1,300 Individual $2,600 Family
Plan Year Out of Pocket Maximum (Including Deductibles, Copays, and Coinsurance)	$1,500 Individual $3,000 Family	$4,000 Individual $8,000 Family	$3,000 Individual $6,000 Family
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	$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, 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

Medical Plan Comparison Chart – Kaiser Permanente Plans

Plan Information	**Kaiser Permanente HMO** Group # 9072-0000 **Member Pays**	**Kaiser Permanente Hospital Services Deductible HMO** Group # 9072-0006 **Member Pays**	**Kaiser Permanente Deductible First DHMO** Group # 9072-0009 **Member Pays**
Emergency Room	$50 co-pay	20% Coinsurance after deductible	$100 co-pay after deductible
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 period	$250 co-pay per admission after deductible Up to 100 days per benefit period
Home Health	No charge 100 days per year	No charge, no deductible 100 days per year	No charge after deductible 100 days per year
Hearing Aids	Not Covered	Not Covered	Not Covered
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

Medical Plan Comparison Chart – Medicare Only Plans

Plan Information	**UnitedHealthcare AARP Medicare Supplement** Group #1068 Sample Plan F – Coverage Varies by Plan Selected **Member Pays**	**Kaiser Permanente Senior Advantage** Group # 9072-0000 **Member Pays**
Calendar Year Deductible	$0 (Plan F Example pays Part A and Part B Medicare deductibles in full)	None
Plan Year Out of Pocket Maximum (Including Deductibles, Copays, and Coinsurance)	$0	$1,500 individual $3,000 family
Coinsurance (the Plan pays)	N/A	None
Lifetime Maximum	Unlimited (Medicare has limits on some services)	None
Dependent Children Eligibility	Contact the AARP customer service at 1-800-392-7537 to verify you or your dependent's eligibility	Any Dependent child under age 26 provided he/she is not eligible for own group coverage Disabled: No age limit, details in EOC
Office Visits and Professional Services		
Physician & Specialist	$0	$10 co-pay
Preventive Care Birth to Age 18	N/A	N/A
Preventive Care Adult Routine Care	$0 for Medicare-covered services	No charge
Preventive Care Adult Routine OB/GYN	$0 for Medicare-covered services	No charge
Diagnostic Lab and X-ray	$0 for Medicare-covered services	$0
Physical Therapy	$0 for Medicare-covered services	$10 co-pay
Chiropractic	$0 for Medicare-covered services	Discounted rates through Kaiser; Choose Healthy program in CA only
Mental Health & Substance Abuse (Outpatient)	$0	$10 co-pay individual $5 co-pay group
Surgical and Hospital Services		
Inpatient Hospital and Physician Services	$0, up to Medicare maximum days allowed	$0
Outpatient Surgery	$0, up to Medicare maximum days allowed	$10 per procedure
Maternity	$0, up to Medicare maximum days allowed	$0
Emergency Room	$0	$50 co-pay

Medical Plan Comparison Chart – Medicare Only Plans

Plan Information	**UnitedHealthcare AARP Medicare Supplement** Group #1068 Sample Plan F – Coverage Varies by Plan Selected **Member Pays**	**Kaiser Permanente Senior Advantage** Group # 9072-0000 **Member Pays**
Ambulance	$0	$50 per trip
Mental Health & Substance Abuse (Inpatient)	$0, 190 days lifetime maximum	$0
Skilled Nursing Facility	$0, up to Medicare maximum days allowed	$0, 100 days per benefit period
Home Health	$0, up to Medicare maximum days allowed	$0 (part-time, intermittent)
Hearing Aids	Not Covered AARP membership discounts may apply	Not Covered
Prescription Drugs		
Deductible	$0.00 - $320.00	$0.00
Preferred Generic or Tier 1	$1 - $4 co-pay 30 day supply	$5 co-pay 100 day supply
Non-Preferred Generic or Tier 2	$2 - $8 co-pay 30 day supply	$10 co-pay 100 day supply
Preferred Brand or Tier 3	$20 - $45 co-pay 30 day supply	$10 co-pay 100 day supply
Non-Preferred Brand or Tier 4	$35 - $9 co-pay 30 day supply	
Specialty or Tier 5	25% - 33% co-insurance	
Mail Order Benefit	Included with $15 discount in most areas	Same as retail
Mandatory Mail Order	No	N/A
Mandatory Generic Program	No	N/A

AARP Medicare Supplement Plans A through L offered in most states. Plan codes and plan benefits vary in WI, MA, and MN.

How Medicare Works

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with end-stage renal disease. In general, those eligible to receive Social Security are automatically enrolled in Medicare Part A at age 65; if eligible, you should receive your Medicare card in the mail three months prior to your 65th birthday. Send Sonoma County Human Resources-Benefits a copy as soon as you do.

Take note…If you have questions about your eligibility for and enrollment in Medicare, contact the Social Security Administration at 1-800-772-1213 at least 90 days prior to your 65th birthday. If you are enrolled in a plan for Non-Medicare-eligible retirees, when you become Medicare-eligible you may elect to remain covered with your current medical carrier or choose a different medical plan. More information is available at: http://www.medicare.gov/pubs/pdf/10050.pdf

Once you are enrolled in Medicare, coverage is provided as follows:

- ***Medicare Part A* provides hospital insurance.** It helps pay for Medicare-approved hospital stays, care in skilled nursing facilities, hospice care and hospital care from qualified Medicare providers. You typically do not pay a premium for Part A coverage if you paid Medicare taxes while you were working.
- ***Medicare Part B* provides medical insurance.** It helps pay for Medicare-approved doctor services, out-patient care, certain preventive care services, diagnostic tests and some other services and supplies that Medicare Part A does not cover. In most cases, the Medicare Part B premium is deducted from your Social Security benefits. If you do not receive a Social Security check, you will be billed quarterly for the Part B premium by the Social Security Administration.

The County of Sonoma provides eligible retirees with reimbursement for the Medicare Part B premium (Effective 6/1/09, frozen at $96.40 per month) beginning the month your Medicare Part B is effective. If you are eligible, this reimbursement is included in your monthly pension check. This benefit is limited to retirees only and is not available to survivors of deceased retirees.

How the County-Offered Medical Plans Work with Medicare

Eligible retirees who are enrolled in Medicare Parts A and B, can participate in a County-offered retiree medical plan, which, depending on the plan you elect, the plan provides, coordinates with, or supplements your Medicare Parts A and B coverage. Participation in one of the County-offered plans generally enhances the coverage you receive through Medicare Parts A and B. You pay a monthly premium *in addition to* your Medicare Part B premium for this coverage.

Following is a summary by plan of how Medicare and the County-offered plans work together to provide your benefits. Payments are generally based on the Medicare approved amount.

- **County Health Plans:** If you choose to participate in one of the County Health Plans EPO or PPO, the benefits paid as you receive care are ***coordinated with your Medicare Parts A and B coverage***. When you incur expenses under one of the County Health Plans, the cost will first be submitted to Medicare for payment. Then, the plan will pay an amount, based on the benefit

provided for that type of expense (e.g., for an in-network doctor's office visit). Refer to the plan's Summary Plan Description for more information and examples of how County Health Plan benefits are coordinated with Medicare.

Under the County Health Plans you are required to meet a deductible and pay applicable copayments and coinsurance for services. You must use a Medicare provider to receive benefits under the County Health Plans. You will receive a higher level of coverage when you use providers within the Anthem Blue Cross network.

Note: Coinsurance in the Medical Plan Comparison chart reflects the member's share of costs only. County health plans exclude "Private Contracts." If a member goes to a provider that doesn't accept Medicare, the claim is also not covered by the County health plans.

Take Note: *Medicare eligible retirees and/or their Medicare eligible dependents need to provide proof of enrollment in Medicare to enroll in a County-offered retiree medical plan. You must provide a copy of your and your eligible dependent's Medicare card(s) to Human Resources Benefits Unit and complete the appropriate enrollment forms.* ***If you do not complete the forms in the timeframe requested, your County-offered coverage is subject to cancellation.***

- **Kaiser Permanente Senior Advantage HMO Plan:** This plan is approved as a "Medicare Advantage" plan by Medicare. When you choose to participate in this plan, you agree to allow Kaiser Permanente to ***provide your Medicare Parts A and B benefits***. In doing so, you authorize Medicare to pay your benefits directly to Kaiser Permanente. Under the HMO plan you pay a set co-payment for most services you use. You must use Kaiser Permanente contracted providers for your care, *except* in an emergency.

For more detailed information regarding the County-offered plans, visit the County of Sonoma web site: http://hr.sonoma-county.org/for_retirees

Coordination of Benefits (COB) Examples for the CHP Plans

Some *members* may have health benefits coverage from more than one source, such as Medicare. In these instances, benefit coverage is coordinated between primary and secondary payers.

Participating providers should obtain information from *members* as to whether the *member* has health benefits coverage from more than one source, and if so provide this information to Anthem.

Coordination of benefits amongst different sources of coverage (payers) is governed by the terms of the *member's* benefit plan and applicable state and/or federal laws, rules and/or regulations. To the extent not otherwise required by applicable laws or regulations, ***participating providers*** **agree that in no event will payment from primary and secondary payers for *covered services* rendered to *members* exceed the rate specified in the provider agreement.**

Participating providers must submit a copy of the EOB that includes the primary payer's determination when submitting claims to Anthem. The services included in the claim submitted to Anthem should match the services included in the primary payer EOB. *Authorization*, *certification* or *notification* requirements under the *member's* benefit plan still apply in coordination of benefits situations.

Note : Some benefit plans require that the *member* update at designated time periods (e.g., annually) other health benefit coverage. Claims may be denied in the event the *member* fails to provide the required other coverage updates.

Based on the above, the 'Lesser Of' rule would apply to both Medicare and any other insurance coverage when benefits are coordinated when determining the allowed amount. Because of this language, it is important to note the provider may not bill the patient for the difference between what the Plan allows and Medicare's allowance (which is usually lower).

Also please note the Plan uses the "carveout" method of COB. Carveout guarantees that you receive the same benefit you would receive in the absence of the other plan or Medicare. Carveout also means you do not receive 100 percent of the total covered charge unless you satisfy this plan's annual deductible and annual out-of-pocket maximum. With carveout, if this plan's (as the secondary plan) normal benefit is greater than the primary plan's payment, then

this plan will pay the difference between its normal plan benefit and the primary plan's payment. If this plan's normal benefit is equal to or less than the primary plan's payment, then no payment will be made by this plan.

The following examples of County Health Plans' Coordination of Benefits (COB) with Medicare are for illustrative purposes only:

EXAMPLE 1: CHP PPO – Inpatient Hospital (In-Network):

$8,800	Medicare allowance
- $7,540	Medicare payment
$1,260	Balance Owed After Medicare (Medicare's 2015 hospital deductible)

The CHP PPO Plan available benefit is then determined:

$8,800	Allowed Amount
- $ 300	Deductible
- $ 125	Per admission copay
$8,375	Balance
x 90%	Coinsurance
$7,538	Available CHP PPO benefit

The next step is to determine the amounts paid by the CHP PPO plan and amount owed by the member. The Medicare allowed amount is $8,800. Medicare has paid $7,540. If Medicare did not exist, the CHP PPO plan would have paid $7537.50. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed amount ($8,800) and the total amount paid ($7,540) of $1,260 would be the total amount owed by the member.

EXAMPLE 2: CHP EPO - Inpatient Hospital (In-Network):

$8,800	Medicare allowance
- $7,540	Medicare payment
$1,260	Balance Owed after Medicare (Medicare's 2015 hospital deductible)

The CHP EPO Plan available benefit is then determined:

$8,800	Allowed Amount
- $ 500	Deductible
- $ 500	Per admission copay
$7,800	Balance
x 80%	Coinsurance
$6,240	Available CHP EPO benefit

The COB Allowed Amount in this example is $8,800. Medicare has paid $7,540. If Medicare did not exist, the CHP EPO plan would have paid $6,240. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed

amount ($8,800) and the total amount paid ($7,540) of $1,260 would be the total amount owed by the member.

EXAMPLE 3: CHP PPO – Outpatient Hospital (In-Network):

$2,600	Medicare allowance
- $ 147	Deductible
$2,453	Balance
x 80%	Coinsurance
$1,962	Medicare payment

The CHP PPO Plan available benefit is then determined:

$2,600	Allowed Amount
- $ 300	Deductible
$2,300	Balance
x 90%	Coinsurance
$2,070	Available PPO CHP benefit

The COB Allowed Amount in this example is $2,600. Medicare has paid $1,962.40. If Medicare did not exist, the CHP PPO plan would have paid $2,070 so the difference of $107.60 would be paid by the CHP plan. The remaining balance between the COB allowed amount ($2,600) and the total amount paid by both plans ($2,070) of $530 would be the total amount owed by the member.

EXAMPLE 4: CHP EPO - Outpatient Hospital (In-Network):

$2,600	Medicare allowance
- $ 147	Deductible
$2,453	Balance
x 80%	Coinsurance
$1,962	Medicare payment

The CHP EPO Plan available benefit is then determined:

$2,600	Allowed Amount
- $ 500	Deductible
- $ 500	Per admission copay
$1,600	Balance
x 80%	Coinsurance
$1,280	Available EPO CHP benefit

The COB Allowed Amount in this example is $2,600. Medicare has paid $1,962.40. If Medicare did not exist, the CHP EPO plan would have paid $1,280. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed amount ($2,600) and the total amount paid ($1,962.40) of $637.60 would be the total amount owed by the member.

EXAMPLE 5: CHP PPO – Professional (In-Network):

$100	Medicare allowance
- $ 55	Medicare payment
$ 45	Balance

$100	Allowed Amount
- $ 20	Copayment
$ 80	Available CHP PPO benefit

The COB Allowed Amount in this example is $100. Medicare has paid $55. If Medicare did not exist, the CHP PPO plan would have paid $80 so the difference of $25 would be paid by the CHP plan. The remaining balance between the COB allowed amount ($100) and the total amount paid by both plans ($80) of **$20 would be the total amount owed by the member**.

EXAMPLE 6: CHP EPO - Professional (In-Network):

$100	Medicare allowance
- $ 55	Medicare payment
$ 45	Balance

$100	Allowed Amount
- $ 50	Copayment
$ 50	Available CHP EPO benefit

The COB Allowed Amount in this example is $100. Medicare has paid $55. If Medicare did not exist, the CHP EPO plan would have paid $50. Because that is less than what Medicare paid, the plan does not pay in this scenario. The remaining balance between the COB allowed amount ($100) and the total amount paid ($55) of **$45 would be the total amount owed by the member**. The provider would owe the member a $5 refund if the member paid the $50 copay at the time of service.

Coordinating benefits with other insurance coverage (OIC), other than Medicare, follows the same methodology as well.

AARP® Medicare Supplement Insurance Plans:

Medicare participants may opt to purchase AARP® Medicare Supplement Insurance, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), if the retiree and eligible dependents are currently enrolled in both Medicare Parts A and B. A Medicare supplement insurance plan (also known as a “Medigap” plan) is designed to supplement some or all of the health care costs not covered through Medicare Part A and Part B.

The County offers a range of Medicare supplement insurance plans to our Medicare-eligible retirees to help pay for some or all of the retiree's out-of-pocket costs. AARP® Medicare Supplement Insurance Plans offer Medicare-eligible retirees an opportunity to choose from a variety of standardized plans (e.g. Plans A-N). Each plan offers a different level of benefits, and monthly premiums vary accordingly. Because there are so many plans and variables, we could not present all available plans in this booklet. Instead, you must contact UnitedHealthcare for details. The most popular plans are shown in this booklet for illustrative purposes only.

> ***Please note*: Unlike most other plans where the medical and prescription benefits are a part of a package, UHCs medical and prescription plans require separate enrollment. To enroll in a UHC-AARP plan, select and enroll in one of their Medicare Supplement plans as well as one of their Prescription Drug (Rx) plans.** *You must enroll in* ***both*** *plans. All enrollees in these plans (i.e. retiree and their dependents) must be enrolled in both Medicare Part A and Part B AND be at least age 65 in order to elect the AARP® plans.*

Membership in AARP is required for the AARP® Medicare Supplement Insurance Plans. If you are not a current member of AARP but wish to enroll in an AARP Medicare Supplement Plan, UnitedHealthcare will pay for your first year of membership (this is not available to residents of New York); otherwise, you will be billed directly by AARP for the annual membership fee, currently $16.00 per household.

To learn more about the AARP® Medicare Supplement Insurance Plans and to request a monthly premium quote, contact the plan's customer service at 1-800- 392-7537. If you should you choose to enroll by phone, please be aware that this process takes some time. Set aside at least 1 hour to sign up with a customer service representative. The group numbers and an enrollment checklist are provided on page 8. Customer service representatives are available Monday through Friday from 7:00 a.m. to 11:00 p.m. PST, and Saturday from 9:00 a.m. to 5:00 p.m. PST. Additional information is available on the following website:

http://www.aarpmedsuppretirees.comhttp://www.aarphealthcare.com/home.html

These plans are underwritten by UnitedHealthcare Insurance Company. Unlike the County Health Plans and Kaiser Senior Advantage, AARP Medicare Supplement Plans may require medical underwriting if you are outside of the guaranteed issue period when coverage may be subject to approval. If you are switching from a County medical plan, you are eligible for guaranteed issue. In cases where coverage is denied, you and any enrolled dependent will remain in the coverage in place prior to the application to the Medicare Supplement Plan or have the option to change to another plan provided you do so before Annual Enrollment ends.

Prescription Drug Coverage for Medicare-Eligible Retirees

Medicare Parts A and B provide coverage for eligible hospital and medical care expenses. Under Medicare, if you want prescription drug benefits as well, you may choose to enroll in a Medicare Part D prescription drug plan. The only time you need to enroll in a separate prescription drug plan is if you enroll in one of the UHC-AARP medical plans. Their Medicare Part-D prescription plans require separate enrollment. **All other County-offered medical plans include prescription drug coverage that is comparable to Medicare Part D coverage. Do not also enroll in Medicare Part D coverage when solicited by other agencies.** It is not necessary and conflicts with your enrollment in a County-sponsored plan. *Sometime in the fall, you likely will receive offers to enroll in Medicare Part D plans that have no connection to the county sponsored plans or you may have an opportunity to enroll in a Medicare Advantage plan through a spouse or through another avenue.*

If you enroll in ANY Medicare Advantage plan or Part D Prescription Drug plan other than those offered to County of Sonoma retirees as explained in this booklet, you may be dis-enrolled from your County-offered coverage. County retirees who enroll in an AARP medical plan must also enroll in an AARP® MedicareRx Plan. The AARP® MedicareRx Plans are available to retirees across the U.S. and in the five U.S. territories. ***You cannot enroll in a stand-alone Medicare Part D plan, such as the AARP® Medicare Rx Plans, without also enrolling in their medical plan.*** They offer a national pharmacy network with access to more than 65,000 pharmacies. In addition, the plan's drug list includes thousands of brand-name and generic drugs. To assist in your decision, you can give AARP a list of medications and ask for advice about costs and coverage.

To learn more about the AARP® MedicareRx Plan options and request a monthly premium quote, contact the plan's customer service at 888-867-5575. The group numbers and an enrollment checklist are provided on page 8 of this booklet for your convenience. You can also visit the Plan's web site at www.aarpmedicareplans.com.

Comparison Chart AARP MedicareRx Plans*

Sample of pricing in California. (Varies by State)

AARP MedicareRx Plans	Monthly Premium	Annual Deductible	Tier 1 Preferred Generic	Tier 2 Non- Preferred Generic	Tier 3 Preferred Brand	Tier 4 Non- Preferred Brand	Tier 5 Specialty Tier
Saver Plus	$26.00	$320	$1.00	$2.00	$20.00	$35.00	25%
Preferred	$57.90	$0	$4.00	$8.00	$45.00	$95.00	33%

*****Only available when paired with an AARP® Medicare Supplement Insurance Plan. Not all drugs are covered on all plans. Evaluate each carefully before selecting.

Remember*. . .** *You are eligible to enroll in a County-offered AARP MedicareRx Plan* ***ONLY *if you also enroll in the County-offered AARP Medicare Supplement Insurance Plan. These are separate elections but must be paired together. Contact AARP customer service at the number listed above for more information about these plans.*

Medical Plan Premiums

The total monthly medical plan premium costs for County-offered retiree medical plans vary based on the medical plan and coverage level you select.

County Contribution for Medical Coverage

Retirees and the County of Sonoma share in the cost of monthly premiums for medical coverage. The County makes a contribution toward the cost of the plan you choose. You are responsible for the difference between the total premium cost and the County's contribution. This amount is displayed as the Retiree cost in the Medical Plan Premium Comparison Chart.

Each eligible retiree who was hired before 1/1/2009 and enrolls as the subscriber in a County sponsored medical plan will receive a County contribution toward their medical plan premiums of up to $500 per month, regardless your date of hire, years of service, or your choice of medical plan and coverage level. There is a small retiree population whose County contribution was frozen at the March 2007 contribution rate by Board Resolutions 07-0269 and 08-0713. These retirees were individually notified of the frozen contribution benefit. A second Medical Plan Premium Comparison Chart is included in this booklet for retirees receiving the "frozen contribution."

2015/2016 Medical Plan Premium Cost Changes

As is the case with most employers, the County typically expects an increase in the total medical premium costs from year-to-year. And because retirees pay the difference between the total premium cost and the County's contribution, the premium increases have a direct effect on your contribution cost.

Requesting AARP Premium Rates for Annual Enrollment

Total premiums for the AARP Medicare Supplement Insurance and AARP MedicareRx plans vary based on your location and other factors. To request a monthly premium quote, contact the plan's customer service at:

UnitedHealthcare AARP® Plans AARP® Medicare Supplement Insurance Plans AARP® MedicareRx Plans	800-545-1797 TTY: 877-730-4192 888-867-5575	www.aarphealthcare.com www.aarpmedicarerx.com

UnitedHealthcare customer service representatives are available Monday through Friday from 7:00 a.m. to 11:00 p.m. PST, and Saturday from 9:00 a.m. to 5:00 p.m. PST.

It's important to understand UnitedHealthcare will provide you with a premium quote for the total cost of your medical and prescription coverage but may not have knowledge of the County's contribution to the total cost of your coverage until after you are enrolled. The County contributes up to $500 per month toward the cost of your family's premiums1. Because AARP Medicare Supplement Plans, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), offer many plan options and rates vary by region and other factors, we cannot publish the actual costs for each plan in this booklet. To arrive at your cost, obtain a quote from UnitedHealthcare for both a medical plan and a prescription plan. Subtract the county contribution from that total to arrive at your cost. If you have a share of cost, you will be billed directly by UnitedHealthcare. For most people, the county contribution covers the majority of the cost.

Medical Plan Premiums Chart (Up to $500 Contribution)

All Retirees[1]	County Health Plans				Kaiser Permanente Plans			
	PPO		EPO		Traditional/Senior Adv.		Hospital Services	
	Retiree	County	Retiree	County	Retiree	County	Retiree	County
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare								
Retiree without Medicare	$580.16	$500	$389.49	$500	$168.70	$500	$38.41	$500
Retiree and one dependent, No Medicare	$1,623.27	$500	$1,237.56	$500	$837.40	$500	$576.82	$500
Retiree and two or more dependents, No Medicare	$2,467.15	$500	$1,923.67	$500	$1,392.42	$500	$1,023.71	$500
Retiree Medicare Only Plans: All enrollees have Medicare								
Retiree with Medicare	$81.11	$500	$0.00	$478.55	$0.00	$337.34	$0.00	$337.34
Retiree and one dependent; All with Medicare	$662.22	$500	$457.10	$500	$174.68	$500	$174.68	$500
Retiree and two or more dependents; All with Medicare	$1,243.33	$500	$935.65	$500	$512.02	$500	$512.02	$500
Retiree Medicare Plans: Some enrollees have Medicare								
Retiree without Medicare and one dependent with Medicare	$1,161.27	$500	$868.04	$500	$506.04	$500	$375.75	$500
Retiree with Medicare and one dependent without Medicare	$1,161.27	$500	$868.04	$500	$506.04	$500	$375.75	$500
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$1,742.38	$500	$1,346.59	$500	$729.70	$500	$621.57	$500
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$1,742.38	$500	$1,346.59	$500	$843.38	$500	$713.09	$500
Retiree with Medicare and two or more dependents without Medicare	$2,204.38	$500	$1,716.11	$500	$1,061.06	$500	$822.64	$500
Retiree and one dependent without Medicare and one dependent with Medicare	$2,204.38	$500	$1,716.11	$500	$1,061.06	$500	$822.64	$500

[1] These rates apply to all retirees except those retirees whose county contribution was frozen at the March 2007 rate by Board Resolutions 07-0269 and 08-0713 and those hired after 1/1/2009.

[2] UHC AARP plans are priced individually based on plan selected; costs will vary between members. Dependents under 65 who are covered by Medicare will be coved only in specific circumstances. (Contact AARP for details.) County will contribute up to $500 towards the plan cost when coordinated through the County of Sonoma Human Resources Benefits Unit.

Medical Plan Premiums Chart (Up to $500 Contribution)

All Retirees[1]	Kaiser Permanente Plans						UHC AARP[2]	
	Deductible First DHMO		Hawaii		Northwest (OR/WA)			
	Retiree	County	Retiree	County	Retiree	County	Retiree	County
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare								
Retiree without Medicare	$0.00	$499.62	$212.42	$500	$284.32	$500	Not available as all members must have Medicare	
Retiree and one dependent, No Medicare	$499.24	$500	$924.84	$500	$1,068.64	$500		
Retiree and two or more dependents, No Medicare	$913.93	$500	$1,637.26	$500	$1,852.96	$500		
Retiree Medicare Only Plans: All enrollees have Medicare								
Retiree with Medicare	$0.00	$337.34	$0.00	$346.40	$0.00	$268.60	Varies[2]	
Retiree and one dependent, All with Medicare	$174.68	$500	$192.80	$500	$37.20	$500		
Retiree and two or more dependents, All with Medicare	$512.02	$500	$498.25	$500	$305.80	$500		
Retiree Medicare Plans: Some enrollees have Medicare								
Retiree without Medicare and one dependent with Medicare	$336.96	$500	$558.82	$500	$552.92	$500	Not available as all members must have Medicare	
Retiree with Medicare and one dependent without Medicare	$336.96	$500	$558.82	$500	$552.92	$500		
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$589.37	$500	$905.22	$500	$821.52	$500		
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$674.30	$500	N/A	N/A	N/A	N/A		
Retiree with Medicare and two or more dependents without Medicare	$751.65	$500	$1,271.24	$500	$1,337.24	$500		
Retiree and one dependent without Medicare and one dependent with Medicare	$751.65	$500	$1,271.24	$500	$1,337.24	$500		

Medical Plan Premiums Chart (Frozen Contribution)

All Retirees[1]	County Health Plans				Kaiser Permanente Plans			
	PPO		EPO		Traditional/Senior Adv.		Hospital Services	
	Retiree	County	Retiree	County	Retiree	County	Retiree	County
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare								
Retiree without Medicare	$580.16	$500	$389.49	$500	$318.79	$349.91	$188.50	$349.91
Retiree and one dependent, No Medicare	$1,623.27	$500	$1,237.56	$500	$987.49	$349.91	$726.91	$349.91
Retiree and two or more dependents, No Medicare	$2,467.15	$500	$1,923.67	$500	$1,542.51	$349.91	$1,173.80	$349.91
Retiree Medicare Only Plans: All enrollees have Medicare								
Retiree with Medicare	$260.26	$320.85	$157.70	$320.85	$83.48	$253.86	$83.48	$253.86
Retiree and one dependent; All with Medicare	$841.37	$320.85	$636.25	$320.85	$420.82	$253.86	$420.82	$253.86
Retiree and two or more dependents; All with Medicare	$1,422.48	$320.85	$1,114.80	$320.85	$758.16	$253.86	$758.16	$253.86
Retiree Medicare Plans: Some enrollees have Medicare								
Retiree without Medicare and one dependent with Medicare	$1,161.27	$500	$868.04	$500	$656.13	$349.91	$525.84	$349.91
Retiree with Medicare and one dependent without Medicare	$1,340.42	$320.85	$1,047.19	$320.85	$752.18	$253.86	$621.89	$253.86
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$1,921.53	$320.85	$1,525.74	$320.85	$975.84	$253.86	$867.71	$253.86
Retiree with Medicare, Spouse without Medicare and one dependent with Medicare	$1921.53	$320.85	$1,525.74	$320.85	$1,089.52	$253.86	$959.23	$253.86
Retiree with Medicare and two or more dependents without Medicare	$2,383.53	$320.85	$1,895.26	$320.85	$1,307.20	$253.86	$1,068.78	$253.86
Retiree and one dependent without Medicare and one dependent with Medicare	$2,204.38	$500.00	$1,716.11	$500	$1,211.15	$349.91	$972.73	$349.912

[1] These rates apply to those retirees whose county contribution was frozen at the March 2007 rate by Board Resolutions 07-0269 and 08-0713.

[2] UHC AARP plans are priced individually based on plan selected; costs will vary between members. Dependents under 65 who are covered by Medicare will be coved only in specific circumstances. (Contact AARP for details.) County will contribute up to $500 towards the plan cost when coordinated through the County of Sonoma Human Resources Benefits Unit.

Medical Plan Premiums Chart (Frozen Contribution)

All Retirees[1]	Kaiser Permanente Plans						UHC AARP[2]	
	Deductible First DHMO		Hawaii		Northwest (OR/WA)			
	Retiree	County	Retiree	County	Retiree	County	Retiree	County
Retiree Non-Medicare Plans: Retiree and all enrolled family members do NOT have Medicare								
Retiree without Medicare	$149.71	$349.91	$362.51	$349.91	$434.41	$349.91	Not available as all members must have Medicare	
Retiree and one dependent, no Medicare	$649.33	$349.91	$1,074.93	$349.91	$1,218.73	$349.91		
Retiree and two or more dependents, No Medicare	$1,064.02	$349.91	$1,787.35	$349.91	$2,003.05	$349.91		
Retiree Medicare Only Plans: All enrollees have Medicare								
Retiree with Medicare	$83.48	$253.86	$92.54	$253.86	$14.74	$253.86	Varies[2]	
Retiree and one dependent, All with Medicare	$420.82	$253.86	$438.94	$253.86	$283.34	$253.86		
Retiree and two or more dependents, All with Medicare	$758.16	$253.86	$785.34	$253.86	$551.94	$253.86		
Retiree Medicare Plans: Some enrollees have Medicare								
Retiree without Medicare and one dependent with Medicare	$487.05	$349.91	$708.91	$349.91	$703.01	$349.91	Not available as all members must have Medicare	
Retiree with Medicare and one dependent without Medicare	$583.10	$253.86	$804.96	$253.86	$799.06	$253.86		
Retiree with Medicare, Spouse with Medicare and one or more dependents without Medicare	$835.51	$253.86	$1,151.36	$253.86	$1,067.66	$253.86		
Retiree with Medicare, Spouse without Medicare and dependent with Medicare	$920.44	$253.86	N/A	N/A	N/A	N/A		
Retiree with Medicare and two or more dependents without Medicare	$997.79	$253.86	$1,517.38	$253.86	$1,583.38	$253.86		
Retiree and one dependent without Medicare and one dependent with Medicare	$901.74	$349.91	$1,421.33	$349.91	$1,487.33	$349.91		

About Your Dental Plan Options and Premiums

You can choose one of two retiree dental plans, offered through Delta Dental of California. The DeltaCare USA plan is for **California residents only**; the DeltaPreferred Option plan provides worldwide coverage.

How the Dental Plans Work

A summary of plan benefits is provided below. For more detailed information, refer to the plan's evidence of coverage booklets, available through the County of Sonoma web site at: http://hr.sonoma-county.org/for_retirees

You can also visit the Delta Dental web site at www.deltadentalins.com.

> ***Take note…****The County administers dental plan benefits on a calendar year basis, from January 1 through December 31. This means your deductibles and plan maximum benefit levels accumulate over the calendar year and start over as of January 1 each year.*

	DeltaCare USA Group #00247-0001	**DeltaPreferred Option Group #3136-0001**
Who Can Enroll?	California residents only	No residency restrictions
Dental Provider Choice	You must use a DeltaCare USA contracted dentist	Use any dentist, but pay lower out-of-pocket costs when using a DeltaPreferred Option contracted dentist. Note: If you visit a non-Delta Preferred Option provider, the plan will reimburse you at contracted rates only, and you will need to file a claim with Delta Dental for reimbursement. To obtain a form and instructions for submitting your claim, visit the Delta Dental web site at www.deltadentalins.com .
Diagnostic & Preventive	Plan pays 100% for most services, no deductible	Plan pays 100% for most services, no deductible
Basic	Plan pays 100% for most services	Plan pays 80% of allowable charges; most benefits available after 12 months of continuous enrollment in the plan
Crowns, Jackets & Cast Restorations	You pay set co-payments ranging from $0 to $90 for most services	Plan pays 50% of allowable charges; benefits available after 12 months of continuous enrollment in the plan
Prosthodontics	You pay set co-payments ranging from $10 to $175 for most services	Plan pays 50% of allowable charges; benefits available after 12 months of continuous enrollment in the plan**;** coverage for implants is included under the plan
Orthodontics	You pay first $1,600 per child and $1,800 per adult for 24- month treatment. Plan pays 100% thereafter. $75 per month member co-payment for treatment after 24 months. Additional start-up fees may apply.	Not covered
Deductible	$0	$50 per individual
Benefit Year Maximum Benefit	None	$1,000 per individual

Dental Plan Premiums

You pay the full cost for dental coverage. If you enroll in retiree dental coverage during Annual Enrollment Period, your coverage is effective June 1, 2015.

Monthly Dental Plan Premiums Effective June 1, 2015			
DeltaCare USA (DHMO)		**DeltaPreferred Option (PPO)**	
Retiree only	$29.87	Retiree only	$42.42
Retiree + 1	$49.25	Retiree + 1	$81.03
Retiree + 2 or more	$72.88	Retiree + 2 or more	$134.47

If you are interested in enrolling in a retiree dental plan, complete the Retiree Benefits Enrollment/Change Form and return to the County of Sonoma Human Resources Benefits Unit by **5:00 p.m., April 10, 2015**.

County of Sonoma
Attn: Human Resources Benefits Unit
575 Administration Dr., Suite 117C
Santa Rosa, CA 95403

Vision and Life Insurance Benefits and Premiums

Vision Service Plan - Retiree Access Plan

Group #: 300128600002

County of Sonoma retirees and their dependents have access to discounts on vision care through the Vision Service Plan (VSP) Retiree Access Plan. **There is no cost to the retiree for this program**. Through this plan, you will receive the following discounts from VSP network doctors only:

- Eye exam: 20% discount on VSP network doctors' fees
- Eyeglasses: 20% discount on prescription and non-prescription glasses, including sunglasses
- Contact lens exam: 15% off VSP network doctors' contact lens exam fees
- Contact lenses: Not covered.
- Laser vision correction: Discounts averaging 15% off of contracted laser centers' prices for laser vision correction surgery or an additional 5% off the center's promotional price

Discounts for eyeglasses are available from any VSP doctor within 12 months of your last covered eye exam.

VSP does not issue plan ID cards; simply provide your name, social security number, group number (listed above), and identify yourself as a County of Sonoma retiree when scheduling an appointment with a VSP doctor.

> ***Take note…****The VSP Retiree Access Plan is available at no cost to retirees. However, you must use a VSP network provider to receive the applicable discounts for services. You can find a VSP provider through the VSP web site at www.vsp.com or by calling the plan's customer service at 1-800-877-7195.*

Other VSP insurance plans may be available to you for purchase but are not offered through the County of Sonoma. Contact VSP for more information.

The Hartford Life Insurance

Group #: GL-673199

Retirees are offered a one-time opportunity at the time of retirement to enroll in life insurance. There is no opportunity to enroll or change coverage amount during the Annual Enrollment Period. The policy available is:

Coverage Amount	Monthly Premium
$10,000	$10.50

Retirees enrolled in the $2,000 life insurance policy will continue their enrollment at a cost of $2.10 per month.

Dependent Eligibility

Dependent Eligibility Criteria-Medical Plans

- Your lawfully married spouse or domestic partner
- Your and/or your domestic partner's dependents under age 26 including:
- Your son, daughter, stepson, stepdaughter, legally adopted child, a child placed with you for adoption, or child for whom you are the legally appointed guardian
- Child under a QMCSO
- Eligible dependents may be any age if permanently and totally disabled and enrolled in the plan prior to attaining the age criteria.

Dependent Eligibility Criteria-Dental Plans

In general, the following individuals may be eligible for enrollment in your dental insurance coverage. Refer to the table below for the plans' respective dependent age limitations.

- Your lawfully married spouse or your domestic partner
- Your and/or your domestic partner's dependents including:
- Your unmarried 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.

Dependents must:

- Be under age 19 at the end of the calendar year, (b) within each plan's full-time student age limit criteria (c) any age if permanently and totally disabled and enrolled in the plan prior to attaining the limiting age.
- Share the same principal residence as you for more than 50% of the calendar year, excluding temporary absences such as attending school, and receive more than 50% of his/her support from you during the calendar year. Special circumstances apply for a child whose parents are divorced or legally separated. For details, contact each plan's respective customer service department;
- Be a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico; special circumstances apply for an adopted child that does not meet these criteria. For details, contact each plan's respective customer service department.

The *Dependent Age Limits* chart below provides eligible dependent age limitations for enrollment in dental. When reaching the age limit, coverage is effective through the end of the dependent's birth month. ***You may be held financially responsible for expenses incurred by an ineligible dependent if you neglect to drop that dependent from coverage.***

Dependent Age Limits – Delta Dental	
DeltaCare USA	**DeltaPreferred Option**
An unmarried child between age 19 and 23 is eligible provided he/she is a full-time student. An unmarried child over the limiting age described above is eligible if incapable of supporting themselves due to mental or physical handicap incurred prior to reaching the limiting age, who is chiefly dependent upon the subscriber for support.	An unmarried child between age 19 and 23 is eligible provided he/she is a full-time student. An unmarried child over the limiting age described above is eligible if incapable of supporting themselves due to mental or physical handicap incurred prior to reaching the limiting age, who is chiefly dependent upon the subscriber for support.

After You Enroll, When Are Changes Allowed?

A Summary of the most Common Change of Status Events and the Mid-Year Enrollment Changes Allowed for Retirees Under a Health (Medical or Dental) Plan

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)* 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 in or waive health coverage for your new spouse/DP and other newly eligible dependents[1] • Waive health coverage for newly eligible dependents if your coverage is also waived[1] • Change health plans	• Waive health coverage for yourself and previously eligible children[1] • Enroll if not already enrolled
Divorce, Legal Separation, or Termination of Domestic Partnership (DP)	• Cancel health coverage for your spouse/DP • Enroll yourself and your dependent children in health coverage if you or they were previously enrolled in your spouse/DP's health plan and only if a signed waiver is on file • Cancel health coverage for dependent children[2]	• Change health plans
Gain a child due to birth or adoption	• Enroll in or waive health coverage for the newly eligible dependent[1] o Adoption placement papers are required as proof • Change health plans	
Previously ineligible child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if eligible and waiver is on file) • Change health plans, when options are available if necessary 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)	• Drop the child who lost eligibility from your health coverage	• Change health plans
Death of a dependent (spouse or child)	• Drop the dependent from your health coverage • Enroll in health coverage if the event resulted in the loss of other group coverage and if a waiver is in place • Change health plans	
Retiree has become entitled to Medicare	• Change medical plans • Last opportunity to enroll yourself, your spouse, and dependent children in a medical plan, if previously waived. Eligibility for coverage will be permanently canceled if no enrollment within 60 days of Medicare eligibility	
Spouse or Dependent has become entitled to Medicaid or Medicare	• Cancel medical coverage for the person who became entitled to Medicare or Medicaid[2]	• Change health plans
Spouse or Dependent lost entitlement to Medicare or Medicaid, or SCHIP	• Add the spouse who lost Medicare/Medicaid entitlement to your health plan, if eligible and previously waived • Add dependent child who lost Medicare/Medicaid entitlement to your health plan, if eligible and previously waived, only if waived along with retiree and retiree if also re-enrolling[2]	• Change health plans
Change of home address outside of plan service area	• Change health plans if you are enrolled in a medical or dental HMO and move out of their service area	
Death of retiree	• Eligible dependents must enroll at the time of the event or permanently lose eligibility[2]	• Surviving dependents must enroll or will be permanently canceled[2]
Employment Status Events		
You retire, transferring from active benefits to retiree benefits	• Change medical plans • Enroll in a retiree dental plan • Waive health coverage for yourself and/or dependents covered on your plan at the time of retirement provided they have other group coverage (one time option) [1] [2] • Enroll dependents who are currently enrolled or listed as waived on your active employee medical coverage	• Add dependents to retiree medical plan not already enrolled in or waived from your active employee medical plan[1] [2]
Spouse obtains medical or dental benefits in another group plan or public exchange	• Permanently cancel medical coverage for spouse[1] • Waive dental coverage for spouse	• Change health plans • Waive health coverage[1]
Spouse loses coverage for medical or dental benefits in another group medical or dental plan (Proof of loss of other coverage is required)	• Enroll yourself and/or spouse in a health plan, if eligible and previously waived • Add dependent child(ren) to a medical plan if eligible and previously waived, only if waived along with retiree and retiree is also re-enrolling • Change health plans [1] [2]	• Enroll dependent children in a medical plan unless the retiree is enrolling[2]

Effective Dates of Coverage for Mid-Plan Year Changes

The benefit election changes from the previous table are effective as follows:

Canceling Coverage: Effective date of change is generally the **last day of the month after the event** that allowed the change.

E.g. Spouse obtains other group coverage on the 1st of the month. Coverage for spouse ends on the last day of the prior month.

Adding newly eligible dependent: Effective date of change is generally the **first of the month following or coinciding with the event** that allowed the change.

E.g. Married on 1st of the month. Coverage for new spouse is effective on the 1st of the same month.
Married on the 2nd of the month. Coverage for new spouse is effective on the 1st of the following month.

New Retirees: Effective on the **1st of the month following or coinciding with the date of retirement**.

E.g. Retired July 1st. Employee coverage ends June 30th, retiree coverage is effective on July 1st.
Retired July 9th. Employee coverage ends July 31st, retiree coverage is effective August 1st.

Exception:

Birth/Adoption: Effective on the **1st of the month following date of birth/adoption**. Medical plans will cover a newborn under the subscriber's coverage from date of birth through the end of the birth month. Submit paperwork to Human Resources early and no later than 31 days from the date of birth to ensure medical coverage for the child.

All rules above apply equally to IRS qualified and non-qualified dependents for consistency and ease of administration.

[1]Waiving retiree medical is a one-time only option at the time of retirement or within 31 days of the event date for newly eligible dependents (e.g. marriage, adoption, birth).

[2] Per the Salary Resolution, eligible dependent children not enrolled in retiree medical when the retiree is enrolled are not eligible for re-enrollment in retiree medical at any time in the future, not even upon the loss of other group coverage.

Dropping Eligible Dependents:

Dependents dropped from coverage have limited or no re-enrollment rights. Review Section 15 of the County of Sonoma's Salary Resolution carefully before dropping coverage for eligible spouse and/or dependents.

Waiving Coverage (when covered by other group insurance):

Medical coverage can be waived only at the time of retirement or within 31 days of initial eligibility for newly eligible dependents. Re-enrollment is very limited. Read Section 15 of the County of Sonoma's Salary Resolution and the waiver language on the Retiree Benefits Enrollment and Change Form carefully before waiving coverage. Also, see footnotes above on this page.

Medicare Enrollment Requirements:

Medicare eligible retirees and/or Medicare eligible dependents must complete and sign enrollment paperwork the month prior to the effective date of the Medicare eligibility and provide a copy of their Medicare card(s) demonstrating enrollment in Medicare Part A and B.

Permanently Cancel All Coverage:

You may permanently cancel medical coverage at any time. However, you will give up all future re-enrollment rights. Read Section 15 of the County of Sonoma's Salary Resolution carefully before cancelling medical coverage.

Contact Information and Resources

CareCounsel

CareCounsel is a health care advocacy program available at no cost to County of Sonoma retirees and active employees. Contact CareCounsel for the following:

- Questions about health plan benefits including understanding Medicare
- 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
- Tips for how to make a successful transition from one plan to another

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.

For additional assistance in making a medical benefit election, consider visiting your current plan's website or calling their customer service number for information such as your own prescription drug history including costs. You can then use this in conversation with any new carrier you are considering to help determine your out-of-pocket costs and coverage.

County of Sonoma Human Resources Benefits Unit

Contact the Human Resources Benefits Unit with questions related to benefit eligibility and coverage, the Annual Enrollment process, and to request additional forms.

E-mail: benefits@sonoma-county.org

Phone: 707-565-2900

Internet: http://hr.sonoma-county.org/for_retirees

Opportunity. Diversity. Service.
COUNTY OF SONOMA
HUMAN RESOURCES DEPARTMENT

County-Offered Health Plan Contact Information

Contact your health plan carriers with questions related to your benefits coverage, to find network providers, to pre-authorize care as required, or to confirm that your residence is within the plans' service area.

Plan	Phone	Web
County Health Plans *Administered by Anthem Blue Cross*	800-759-3030	www.anthem.com/ca
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 California	800-464-4000	www.kp.org
Kaiser Permanente Hawaii	800-805-2739	www.kp.org
Kaiser Permanente Northwest	877-221-8221	www.kp.org
UnitedHealthcare AARP® Plans UnitedHealthcare AARP® Medicare Supplement Insurance Plans AARP® MedicareRx Plans	800-545-1797 TTY:877-730-4192 888-867-5575	www.aarphealthcare.com www.aarpmedicarerx.com
Health Insurance Counseling and Advocacy Program (HICAP) Free and objective information and counseling about Medicare	800-434-0222	www.cahealthadvocates.org/HICAP/
Delta Dental Plans DeltaPreferred Option DeltaCare USA Annual Notices from Delta: HIPAA Notice of Availability, Grievance process, Tissue and Organ Donations, Language Assistance Program	800-765-6003 800-422-4234	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	thehartford.com
County Wellness Program	707-565-2900	healthyhabits.sonoma-county.org
Sonoma County HIPAA Privacy Practices	707-565-4999	sonoma-county.org/health/publications/privacy.aspsonoma- county.org/privacy/privacy.htm

Important Legal Notices from the County of Sonoma

The following notices are provided to participants in the County's health and welfare programs in compliance with state and federal regulations.

Important Reminder to Provide the Plan with the Social Security Number (SSN) of Each Enrollee in a Health Plan

Employers are required by law to collect the social security number (SSN) of each medical plan participant and provide that SSN on future reports that will be provided to you and also to the IRS each year. Employers are required to make at least two consecutive attempts each year to gather missing 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 card is free.

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

Medicare Notice of Credible Coverage Reminder

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the Plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

The prescription drug coverage under the plan options offered by the County are creditable and this is discussed in more detail in the Plan's Medicare Part D Notice of Creditable Coverage which is available from the Human Resources Benefits Unit.

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 Privacy Officer at 707-565-439 or by email at joann.borri@sonoma- county.org for a copy of the current notice or visit the Plan's website at http://www.sonoma- county.org/privacy/privacy.htm.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2014. You should contact your State for further information on eligibility –

To see if any more States have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/ebsa	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA – Medicaid**
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
IDAHO – Medicaid	**MONTANA – Medicaid**
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA – Medicaid**
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
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	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**

Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website:http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice Reminder

You or your dependents 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.

Plan limits, deductibles, co-payments, and coinsurance apply to these benefits. For more information on WHCRA benefits, contact CareCounsel at 888-227-3334 or County Human Resources Benefits Unit at benefits@sonoma-county.org or call 707-565-2900, or http://hr.sonoma-county.org/

Availability of Summary Health Information: the Summary of Benefit and Coverage (SBC) Document(s)

The health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

As required by law, across the US, insurance companies and group health plans like ours are providing plan participants with a consumer-friendly SBC as a way to help understand and compare medical plan benefits. Choosing a health coverage option is an important decision. To help you make an informed choice, the Summary of Benefits and Coverage (SBC), summarizes and compares important information in a standard format.

Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC.

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan had to follow about how the SBCs look, how many pages the SBC should be (maximum 4-pages, 2-sided), the font size, the colors used when printing the SBC and even which words were to be bold and underlined.

The SBC for each medical plan option is available by contacting the Human Resources Benefits Unit at benefits@sonoma-county.org or call 707-565-2900, or on-line at http://hr.sonoma-county.org/

COBRA Coverage Reminder

In compliance with a federal law referred to as COBRA Continuation Coverage, this plan offers its eligible members and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events).

Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include death of the retiree, divorce/legal separation, or a child ceasing to be an eligible dependent child.

In addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may want to look for coverage through the Health Care Marketplace. See https://www.healthcare.gov/. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

The maximum period of COBRA coverage is generally either 18 months or 36 months, depending on which qualifying event occurred.

In order to have the chance to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan, **you and/or a family member must inform the plan in writing of that event no later than 60 days after that event occurs**. That notice should be sent to Human Resources Benefits Unit via first class mail and is to include the retiree's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents).

If you have questions about COBRA contact the Human Resources Benefits Unit at benefits@sonoma- county.org or call 707-565-2900 or on-line at http://hr.sonoma-county.org/content.aspx?sid=1024&id=1589

County of Sonoma
Human Resources Benefits Unit
575 Administration Dr., 116C
Santa Rosa, CA 95403

Patient Protection Rights of The Affordable Care Act

Designation of a Primary Care Provider (PCP):

Generally, the medical plans offered by the County 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. However, **the Kaiser medical plan generally requires the designation of a primary care provider (PCP)**. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser at https://healthy.kaiserpermanente.org.

Direct Access to OB/GYN Providers:

You do not need prior authorization (pre-approval) from the medical plan or the County or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network 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 the insurance carrier directly on the number on your medical card. Additional assistance is available from CareCounsel, Healthcare Advocates at 888-227-3334, or Sonoma County Human Resources Benefits Unit at benefits@sonoma-county.org or call 707-565-2900, or on-line at http://hr.sonoma-county.org/

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 24, 2014
Name of Entity/Sender:	County of Sonoma:
Contact—Position/Office:	County of Sonoma, Human Resources Benefits Unit
Address:	575 Administration Dr., Suite 116C, 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.