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

The purpose of this booklet is to help you make informed decisions about your benefits. It highlights your options and key program features to consider when you enroll. The benefits, premium costs, rules, and policies contained in this booklet are effective June 1, 2011 through May 31, 2012.

We encourage you to review this booklet carefully so that you can make the best choices possible for yourself and your family. You can also seek additional information from the resources listed at the back of this booklet.

The information in this booklet provides a summary of your benefits under the County-offered health plans. You should carefully review each plan's Summary Plan Description (SPD) or Evidence of Coverage (EOC) booklet for more details on these benefits. The booklets are available through the:

- County of Sonoma web site: **http://hr.sonoma-county.org/**

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

Benefits Enrollment and Changes

Annual Enrollment

The annual enrollment period **is your once-a-year opportunity to make changes to your current benefit elections for the coming benefit year, which begins on June 1, 2011 and continues through May 31, 2012.**

During annual enrollment you may:

- Change your medical plan election and add or drop medical insurance coverage for your eligible dependents
- Enroll yourself and your eligible dependents in medical insurance coverage if you previously declined or waived coverage
- Enroll in dental coverage and add or drop dental coverage for your eligible dependents
- Apply for supplemental life insurance (requires pre-approval from the insurance company)
- Apply for life insurance coverage for your eligible dependents
- Apply for life insurance coverage for yourself if you are a part-time employee in DSA, SCLEA, or ESC
- Drop coverage for yourself and/or your ineligible dependent(s)

You need to take action during annual enrollment **only** if you need to make one or more of the changes noted above. Be sure to complete and submit the required form(s) by the annual enrollment deadline. Forms are available online at http:hr.sonoma-county.org and from your department's Payroll Clerk or the Human Resources Benefits Unit.

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, and your current plan is still available, no action is necessary — your current benefits will continue.

Key Issues to Consider During Annual Enrollment

As long as you are thinking about benefits, annual enrollment is a great time to make sure that all of the following are correct and up-to-date:

Dependent data: Names, birthdates, Social Security numbers, full-time student status, etc. For example, don't forget to drop coverage for recent high school graduates who do not meet the full-time student eligibility criteria for coverage (dental and vision only). To update your dependent data, complete the *County of Sonoma Employee Benefits Enrollment/Change Form*, available through your Payroll Clerk.

Beneficiary designations: There are no set deadlines for updating your beneficiary designations, but annual enrollment is a great time to take a look at them. For example, if you got married or divorced in recent years, and you haven't yet updated your beneficiary designation for your life insurance benefit, now is a good time to do so. You can update your beneficiary(ies) using the *County of Sonoma Employee Benefits Enrollment/Change Form*, available online at http://hr.sonoma-county.org/, or by contacting the HR Benefits Unit at 707-565-2900 via-email at benefits@sonoma-county.org.

Personal information. If you've moved or changed your name or contact information, be sure to notify your Payroll Clerk. It's important to keep your personal information up-to-date at all times.

Enrolling as a Newly Eligible Employee

If you are a new employee or become newly eligible for benefits during the benefit year, you must actively enroll in medical, dental, employee supplemental life insurance, dependent life insurance and flexible spending accounts if you want to participate in these plans.

Your department's Payroll Clerk will provide you with the forms you need to make your benefit elections. You must make your elections by your enrollment deadline – within 31 days of your initial eligibility date. If you don't meet your enrollment deadline, you will not be allowed to enroll in benefits until the next annual enrollment period, unless you experience one of the events or changes noted below.

When Changes Are Allowed

County of Sonoma - Human Resources Department

Summary of some of the more Common

Change of Status Events and Mid-Year Enrollment Changes

Allowed for Employees Under a Health Plan (Medical, Dental and/or Vision)

Changes apply equally to IRS qualified and non-qualified dependents for legal compliance, consistency and ease of administration

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 yourself, if applicable • Enroll your new spouse/DP and other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans o Marriage Certificate or Domestic Partner Registration required	• Drop health coverage and not enroll in spouse/DP's plan.
Divorce or Termination of Domestic Partnership	• Drop your spouse/DP from your health coverage • Enroll yourself and your dependent children if you or they were previously enrolled in your spouse/DP's plan o Proof of Dissolution of Marriage/Revocation of Domestic Partnership required o Proof of loss of other coverage required	• Change health plans • Drop health coverage for yourself or any other covered individual
Gain a child due to birth or adoption (Effective date of birth or adoption placement)	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Change health plans o Adoption placement papers are required	• Drop health coverage for yourself or any other covered individuals
Child requires coverage due to a QMCSO	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Change health plans, when options are available, to accommodate the child named on the QMCSO o QMSCO paperwork required	• 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 • Child will be offered COBRA.	• Change health plans • Drop health coverage for yourself or any other covered individuals
Death of a dependent (spouse/DP or child)	• Drop the dependent from your health coverage • Change health plans	• Drop health coverage for yourself or any other covered individuals
Covered person has become entitled to (or lost entitlement to) Medicaid, Medicare, Medi-Cal or SCHIP [1]	• Drop coverage for the person who became entitled to Medicare, Medicaid, Medi-Cal or SCHIP. • Add the person who lost Medicare, Medicaid, Medi-Cal or SCHIP	• Drop health coverage for yourself or any other covered individuals

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

County of Sonoma - Human Resources Department
Summary of some of the more Common
Change of Status Events and Mid-Year Enrollment Changes
Allowed for Employees Under a Health Plan (Medical, Dental and/or Vision)

Changes apply equally to IRS qualified and non-qualified dependents for legal compliance, consistency and ease of administration
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...
	entitlement o Proof from SSA required	
Change of home address outside of plan service area	• If you are enrolled in an HMO and move out of their service area, then you can elect new coverage	• Does not apply to County Health Plan, dental or vision coverage
Employment Status Events		
You become newly eligible for benefits due to change in employment status or bargaining group	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents • Drop health coverage for yourself • Drop your spouse/DP and other eligible dependents • Change health plans	• Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse/DP obtains health benefits in another group health plan	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself o Proof of coverage in the other health plan required	• Change health plans • Add any eligible dependents to your health coverage
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage for health benefits in another group health plan, you or your dependents exhaust COBRA coverage under other group health plan	• Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans o Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• Enroll in your spouse/DP's plan, if available • Elect temporary COBRA coverage for the qualified beneficiaries (you and your covered dependents)	
You experience a reduction in hours that results in a significant cost increase or an unpaid leave not covered by FMLA, CFRA etc. where the County will no longer be making a contribution	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself • Change health plans to a less expensive plan	• No change is allowed unless the reduction in hours causes a loss of eligibility or a loss or significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.
You return from Military leave	• Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents • Change health plans	

Effective Dates: The above benefit election changes are effective as follows:
Canceling Coverage: Effective date of change is generally the **last day of the month after the event** that allowed/caused 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 new/changing coverage: 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 Hires: Effective on the **1st of the month following date of hire**. E.g., Hired June 1. Coverage is effective on July 1. Hired June. 9. Coverage is effective July. 1.
Exceptions:
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 your payroll clerk or Human Resources early and no later than 31 days from the date of birth to ensure medical coverage for the child.
Return from Military Leave: Effective on **the date you return to work**.

Take note… The circumstances under which you may change your benefit elections outside of the annual enrollment period are described in the plans' Summary Plan Description (SPD) or Evidence of Coverage (EOC) booklets. The chart above provides examples of common reasons; it is not an exhaustive list. Contact the Human Resources Benefits Unit with your specific questions.

Dependent Eligibility

The following are generally eligible for enrollment in County sponsored medical benefits:

- Your lawfully married spouse
- Your domestic partner
- You or your domestic partner's dependents including:
  - Your son, daughter, stepson, stepdaughter, legally adopted child, a child placed with you for adoption, eligible foster child, or child for whom you are the legally appointed guardian
- Eligible dependents must:
  - Be under each plan's age limit criteria, or
  - Be any age if permanently and totally disabled and enrolled in the plan prior to attaining the limiting age.

Note that the dependent eligibility rules for dental, vision, and life insurance differ from the medical eligibility rules. Read them carefully before making enrollment elections for your dependent(s).

Dependent Age Limits – Medical Plans	
County Health Plans	**Kaiser Permanente HMO**
Any dependent child through the end of the month they turn age 26 is eligible provided he/she is not eligible for his/her own group coverage. An unmarried dependent child over the limiting age described above is eligible if incapable of supporting self due to mental or physical disability incurred prior to reaching the limiting age, who is chiefly dependent upon the subscriber for support.	

Dependent eligibility criteria-Dental, Vision, and Life Insurance

In general, the following individuals may be eligible for enrollment in your dental, vision and dependent life insurance coverage. These are general guidelines for dependent eligibility only. Different criteria and age limits may apply by plan. Refer to the table on the following page for the plans' respective dependent age limitations.

- Your lawfully married spouse
- Your domestic partner
- Your 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

To enroll a dependent he or she must:

- Be (a) under age 19 at the end of the calendar year, (b) under each plan's age limit criteria, or (c) any age if permanently and totally disabled and enrolled in the plan prior to attaining limiting age.

- Share the same principal residence as you for more than 50% of the calendar year, excluding temporary absences such as attending school; special circumstances apply for a child whose parents are divorced or legally separated. For details, contact each plan's respective customer service department.

- 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 County-offered dental, vision, and life insurance plans. 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 delete that dependent from coverage.***

Dependent Age Limits – Delta Dental and Vision Service Plan
An unmarried child between age 19 and 23 is eligible provided he/she is a full-time student.[1] An unmarried child over the limiting age described above is eligible if incapable of supporting self due to mental or physical handicap incurred prior to reaching the limiting age, who is chiefly dependent upon the subscriber for support.
Dependent Age Limits – Life Insurance
An unmarried child between age 21 and 23 is eligible provided he/she is a full-time student.

[1]Proof of attendance at an accredited school, college or university must be submitted to the carrier, when requested. For Delta Dental, Vision Service Plan and life insurance, proof of attendance must be submitted to the Human Resources Benefits Unit.

Dependent Eligibility at Retirement

Only those dependents covered on your medical plan at the time of retirement may be eligible for coverage. If you are planning to retire from County service during the coming benefit year, be sure to add eligible dependents to your medical plan (if not already enrolled) during annual enrollment. The effective date of coverage must precede your retirement date.

Deleting Ineligible Dependents from Coverage

You must immediately cancel coverage for:

- Your divorced spouse or terminated domestic partnership
- Your dependents who no longer meet the plans' eligibility criteria (e.g., those who are over the plans' specified age limits for all the plans or married, or no longer full-time students for the dental, vision, and life insurance plans)

Are you struggling with problems at home or work?

The County's Employee Assistance Program (EAP), offered through Managed Health Network (MHN), can help County employees with referrals to a range of professional counselors, including psychologists, social workers, marriage and family counselors, financial advisors, child and elder care providers, retirement counselors and lawyers.

MHN can be reached at 800-227-1060,
24 hours a day, seven days a week.
Or online at www.members.mhn.com
Company Code:
Law Enforcement: SCLE
All Other County Employees: sonomacounty

Medical Coverage

Medical Plan Choices

You are eligible to choose from the following medical plans:

- County Health Plan PPO (CHP PPO)
- County Health Plan EPO (CHP EPO)
- Kaiser Permanente HMO

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

1. Self
2. Self and 1 dependent
3. Self and 2 or more dependents

Medical plan premiums, which vary based on the plan and coverage you select, are included later in this booklet.

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

How the Medical Plans Work

County Health Plan EPO

EPO stands for Exclusive Provider Organization, the plan uses a network of preferred providers, including doctors and hospitals, which participate in the Anthem Blue Cross provider network (Blue Cross Prudent Buyer PPO Plan) in California and within the Blue Cross/Blue Shield Bluecard program outside of California. Prescription drug coverage is provided through CVS/Caremark. These network providers agree in advance to provide their services at a negotiated, discounted rate. Unlike a PPO, you are required to use a network provider, except in an emergency, as there are no out-of-network benefits.

Services under the County Health Plan EPO are subject to co-payments and/or an annual deductible. As you incur medical expenses, you pay co-payments and the deductible out of your own pocket depending on the services received. Then, after meeting the deductible, you pay a portion of your covered expenses through coinsurance and continue to make co-payments. Refer to the following page for definitions of these key benefit terms.

County Health Plan PPO

PPO stands for Preferred Provider Organization, the plan uses a network of preferred providers, including doctors and hospitals, which participate in the Anthem Blue Cross provider network (Blue Cross Prudent Buyer PPO Plan) in California and within the Blue Cross/Blue Shield Bluecard program outside of California. Prescription drug coverage is provided through CVS/Caremark. These network providers agree in advance to provide their services at a negotiated, discounted rate. Unlike an EPO, you may seek care from any provider under these plans, but you will pay less out of your pocket when you use a network provider.

Services under the County Health Plan PPO are subject to co-payments and/or an annual deductible. As you incur medical expenses, you pay co-payments and the deductible out of your own pocket depending on the services received. Then, after meeting the deductible, you pay a portion of your covered expenses through coinsurance and continue to make co-payments. Refer to the following page for definitions of these key benefit terms.

Kaiser Permanente HMO Plan

A Health Maintenance Organization (HMO) plan requires you to receive care and services from specific medical providers within Kaiser facilities. This means you have access to Kaiser providers only, except when you need emergency care. You must select a Primary Care Physician (PCP) that coordinates your total health care, including arranging referrals to specialists, laboratory tests, x-rays, hospitalization, and medications.

As long as you use providers and services in the HMO network, a significant portion of your health care expenses is covered. You share in the cost of your health care through co-payments, and, in some cases, coinsurance.

The HMO plan requires you to live or work within the plan's service area.

Key Issues to Consider When Choosing Your Medical Plan

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

- Review the "Service Areas - Medical Plans" chart below to ensure you are eligible for enrollment.

- If you choose to cover your eligible dependents, they must be enrolled in the same option you elect for yourself. Consider dependent age limits of the plans.

- You and the County share the cost of medical coverage. Depending on the plan you elect, you pay your share through bi-weekly payroll deductions and in the form of co-pays and coinsurance as you seek care.

The plans are funded in part through the County's and your contributions toward plan premiums; costs are incurred as employees seek medical care and claims are paid for that care.

The relationship between premiums and employees' use of the plans is important to understand – because utilization is a key driver of the premiums charged by our plan carriers. This means your decisions as you use your plan benefits can make a difference. You can choose to use your benefits wisely; to be aware of the costs of the services you select; and commit to making healthy choices that reduce the need for medical solutions to lifestyle-driven health issues.

Service Areas – Medical Plans	
County Health Plans	**Kaiser**
Statewide Within the Prudent Buyer Plan network. For providers outside of California, log on to the above web site, select Find a Doctor, then click on BlueCard PPO	**Statewide** Live or work within a geographical area within a 30-mile radius of any Kaiser Permanente Medical Facility

Key Benefit Plan Terms

Understanding how our plans work is a critical first step in taking action to manage costs. Keep these key benefit terms in mind when comparing the plans and coverage available to you.

- **Deductible.** This is the amount you are required to pay each year before a plan begins to pay benefits. You begin accumulating expenses toward the satisfaction of your deductible at the beginning of each benefit year (June 1 for County Plans). *Example:* With each new benefit year, employees who elect self only coverage under the County Health Plan PPO pay the first $300 toward services subject to the plan's deductible. Employees who elect coverage for themselves and two or more dependents pay the first $300 per individual, up to a maximum of $900 per family, toward services subject to the plan's deductible.

- **Coinsurance.** This is the percentage of the cost you pay when you receive certain health care services. *Example:* For in-network services under the County Health Plan PPO, plan participants pay 10% and the County pays 90% of covered expenses for most services. The 10% share is the employee's coinsurance.

- **Co-payment** This is the flat-dollar amount you pay when you receive certain medical care services. Co-pays are typically due at the time you receive the service. *Example:* Enrollees in the Kaiser Permanente plan pay a $10 co-pay for each doctor's office visit; enrollees in the County Health Plan PPO pay a $20 co-pay for in-network doctor's office visits. Co-payment amounts do not count toward a plan's out-of-pocket maximum or deductible.

- **In-Network.** This is care or services provided by doctors, hospitals, labs or other facilities that participate in the network of providers assembled by the plan you elect. Generally, you pay less when you receive care in-network because the providers in the network agree to charge a pre-negotiated, lower fee. This reduces your out-of-pocket costs and the overall claims costs.

- **Out-of-Network.** This is care or services furnished by doctors, hospitals, labs or other facilities that **DO NOT** participate in the plan's provider network. Only the County Health Plan PPO may cover a portion of the expenses incurred through visits with out-of-network providers; however, the CHP EPO and Kaiser plans do not, except in emergencies. If you are enrolled in the County Health Plan PPO and use an out-of-network provider, your share of the cost is based on the "reasonable and customary" charges allowed by the plan. These charges may be substantially higher than the fees negotiated with and charged by in-network providers – ***so you should be sure you understand the amount you will be required to pay out of your own pocket if you seek care out-of-network***. Amounts charged over the "reasonable and customary" do not count towards annual deductibles and out of pocket maximums.

- **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. co-insurance amounts) apply towards the out-of-pocket maximum. Co-payments, deductibles, and prescription drug co-payments **are not** applied toward the out-of-pocket maximum. In addition, 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.***

Using Your Benefits Wisely

You can also take these simple actions to improve your health and manage your out-of-pocket costs.

- **Seek preventive care.** Be sure to complete your annual physical or health screenings — this is key to identifying possible health issues and appropriate treatments early, which in turn, may help to improve your health and keep costs down over the longer run.

- **Use the emergency room only in the event of a life-threatening emergency.** An emergency room visit may be required for life-threatening events such as chest pain, heart attack or stroke, severe burns, deep cuts, visibly broken bones, uncontrollable bleeding, loss of consciousness, shortness of breath, and life threatening allergic reactions. In non-emergency situations (e.g., for colds and flu, sprains and minor cuts), you should visit your physician or an urgent care clinic. Doing so can help to keep your out-of-pocket costs down and manage medical premium cost inflation from year-to-year. If you are unsure if you should visit your physician or an urgent care clinic, call the number on your medical insurance card for assistance and guidance.

- **Make healthy lifestyle choices.** Quitting smoking, regular exercise and good nutrition can help you to avoid costly lifestyle-driven health problems and in doing so, reduce your costs over time.

- **Actively manage a chronic health issue.** For example, if you have diabetes, asthma, chronic obstructive pulmonary disease (COPD) or lower back pain, work with your doctor to understand the care you need on an ongoing basis.

- **Watch for opportunities to save on prescription drug costs.** Prescription drugs make up a substantial portion of medical claims costs. You can impact this trend (and keep money in your pocket) by choosing generic drugs when available and appropriate. To do this, ask your doctor to specify that a generic substitution is authorized — or even ask if there is an over-the-counter equivalent for the drug being prescribed. Also, be sure to take advantage of your plan's mail order prescription drug program for your maintenance drugs, which may provide your supply of medication at a lower co-pay. In addition, you can save money by refilling or obtaining prescription drugs at a local, in-network pharmacy *before* traveling or taking vacations.

County Health Plan Participants Take Note… 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 not be a covered expense and you will be responsible for the full cost.

If you are taking a maintenance drug, it can be filled at any retail pharmacy twice. After that it must be filled at a CVS pharmacy, or by mail order through CVS/Caremark for a 90 day supply.

Take note… The **Medical Plan Comparison Chart** on the next pages is only a summary of the benefits covered under the County Health Plans and the Kaiser Permanente HMO Plan. For more detailed information along with notices of your legal rights, review the Summary Plan Description (SPD), Evidence of Coverage (EOC) for each plan available through the:

- County of Sonoma web site at:
  http://hr.sonoma-county.org/

You should carefully review each plan's SPD or EOC booklet for more details on these benefits. In the case of conflict between the information presented in this summary and the plan's SPD/EOC booklets, the plan's SPD/EOC booklets determine the coverage.

Medical Plan Comparison	County Health Plan EPO Group # 175130M100	County Health Plan PPO Group # 175130M051	Kaiser Permanente HMO Group # 602484-0003
Annual Deductible	$500 individual $1,500 family	$300 individual $900 family	None
Annual Out of Pocket Maximum	$5,000 individual $10,000 family	$2,000 individual $4,000 family	$1,500 individual $3,000 family
Co-insurance	80%	In-network: 90% Out of Network: 60%	None
Lifetime Maximum	**None**	**None**	None
Dependent Children Eligibility	**Any Dependent child under age 26 provided he/she is not eligible for own group coverage.** Disabled: No age limit	**Any Dependent child under age 26 provided he/she is not eligible for own group coverage.** Disabled: No age limit	**Any Dependent child under age 26 provided he/she is not eligible for own group coverage.** Disabled: No age limit
Office Visits and Professional Services			
Physician & Specialist	$50 co-pay, no deductible	In-network: $20 co-pay Out of Network: 60%	$10 co-pay
Preventive Care Birth to Age 18	**No charge, no deductible**	In-network: **No charge**, no deductible Out of Network: 60%, after deductible	**No charge**
Preventive Care Adult Routine Care	**No charge**, no deductible, one exam every 24 months	**No charge**, in network only, no deductible, one exam every 24 months	**No charge**
Preventive Care Adult Routine OB/GYN	**No charge**, no deductible	In-network: **No charge**, no deductible Out of Network: 60%, after deductible	**No charge**
Lab and X-ray	80%	In-network: 90% Out of Network: 60%	No charge
Physical Therapy	80%	In-network: 90% Out of Network: 60%	$10 co-pay medically necessary treatment only
Chiropractic	80%	In-network: 90% Out of Network: 60%	Discounted rates through Kaiser ChooseHealthy
Mental Health & Substance Abuse (Out-patient)	80%	In-network 90% Out of Network: **60**%	$10 co-pay individual $5 co-pay group
Surgical and Hospital Services			
Inpatient Hospital and Physician Services	$500 co-pay + 80%	$125 per admission co-pay + In-network: 90% Out of Network: 60%	No charge
Outpatient Surgery	$500 co-pay + 80%	In-network: 90% Out of Network: 60%	$10 co-pay
Maternity	$250 co-pay + 80%	In-network: 90%, Out of Network: 60%	No charge
Emergency Room	$150 co-pay + 80%	$100 per visit co-pay + In-network: 90% Out of Network: 60%	$50 co-pay
Ambulance	80%	In-network: 90% Out of Network: 60%	$50 per trip
Mental Health & Substance Abuse (In- patient)	$500 co-pay + 80%	$125 per admission co-pay + In-network: 90% Out of Network: **60%**	No charge
Skilled Nursing facility	Not Covered	In-network: 90%, Out of Network: 60% 100 days per year	No charge 100 days per year
Home Health	Not Covered	In-network: 90% Out of Network: 60%	No charge 100 days per year
Prescription Drugs			
Generic or Tier 1	$10 co-pay 34 day supply	$5 co-pay 34 day supply	$5 co-pay 100 day supply
Formulary Brand or Tier 2	$35 co-pay 34 day supply	$15 co-pay 34 day supply	$10 co-pay 100 day supply
Non-Formulary Brand or Tier 3	$75 co-pay 34 day supply	$30 co-pay 34 day supply	$10 co-pay 100 day supply
Mail Order Benefit	3 months supply for 1 co-pay	3 months supply for 1 co-pay	Same as retail
Mandatory Mail Order	Yes	Yes	No
Mandatory Generic Program	Yes	Yes	N/A

Medical Premiums

The total premium costs vary based on the medical plan and coverage level you select. Each year there are two important factors that will affect your medical plan premium:

1. The County contributes up to $500 per month toward your medical plan election ,), regardless of the plan and level of coverage.
2. Increase to the total premium costs passed on to the County and employees by our medical plan carriers.

Do you know your bargaining unit?

It's important to know the bargaining unit under which your position is covered. Your premium costs, and proration rules for part-time employees are all based on your unit.

If you don't know your bargaining unit name and number, contact your department's Payroll Clerk for clarification.

2011/2012 Medical Plan Premium Chart

Bi-Weekly Premiums For Coverage Effective June 1, 2011 through May 31, 2012			
Plan	**Total Premium Cost**	**County Contribution**	**Employee Contribution**
County Health Plan EPO			
Self	$308.87	$229.98	$78.89
Self and 1 dependent	$603.34	$229.98	$373.36
Self and 2 or more dependents	$841.59	$229.98	$611.61
County Health Plan PPO			
Self	$375.70	$229.98	$145.72
Self and 1 dependent	$738.51	$229.98	$508.53
Self and 2 or more dependents	$1,032.03	$229.98	$802.05
Kaiser Permanente HMO			
Self	$251.13	$229.98	$21.15
Self and 1 dependent	$502.25	$229.98	$272.27
Self and 2 or more dependents	$710.69	$229.98	$480.71

Premium Conversion

Employee-paid contributions for medical, dental and vision premiums are withheld through payroll deductions on a pre-tax basis for the employee and Federal tax-dependents. This means, depending on your tax bracket, your net pay is only reduced by approximately 75% of the amount of the actual employee cost because of the tax savings.

Prorated County Contribution for Part-Time Employees

Eligible part-time employees may receive a County contribution for medical, dental, and vision coverage. The contribution is based on the number of qualifying hours in each pay period as a ratio to the 80 used as the basis for full-time employees. Since the County contribution may be less than for a full-time employee, a part-time employee's contribution cost can be more.

Prorated County Contribution = (Qualifying Hours / 80 Hours) X $229.98
Employee Contribution = Total Premium Cost – Prorated County Contribution

EXAMPLE:
A part-time employee working 40 hours on a bi-weekly basis elects Self coverage under the County Health Plan PPO
Calculate Prorated County Contribution: (40/80) X $229.98 = $114.99
Calculate Employee Contribution: $375.70 - $114.99 = $260.71

The County contribution is prorated for eligible part-time employees, with the following exception: Employees in .75 FTE (60 hours or more bi-weekly) in SCPA (45), Board of Supervisors (49), Administrative Management (50), Confidential (51), Administrative Department/Agency Heads (52), SCPDIA (55), and SCDPDAA (60) are eligible to receive the full County contribution.

Take note… Qualifying hours include hours worked and qualified leave hours. Contact your Payroll Clerk if you have questions regarding your eligibility for a prorated County contribution.

Dental Coverage

Employee dental insurance is offered through Delta Dental Premier to eligible employees. This coverage is also extended to your eligible dependents if you enroll yourself. To elect or waive dental coverage, you must indicate your election(s) on the *County of Sonoma Employee Benefits Enrollment/Change Form*, available online and from your Payroll Clerk. To ensure coverage for your eligible dependents, be sure to list them on the form.

How the Dental Plan Works

- ***Dental Providers:*** You can visit any licensed dental provider under the plan. However, you will pay less out of your own pocket when you visit a Delta Dental Premier network provider. If you visit a non-Delta Dental Premier 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.

- ***Plan ID Cards:*** Delta Dental Premier does not provide members with an ID card for the plan. So, when you and your eligible dependents seek dental care, you will need to provide your Social Security Number and the plan's group number to your provider. Group number is listed in the table below. Note: If your un-enrolled or ineligible dependent(s) seek care through the County-offered plan, you may be held financially responsible for the expenses incurred.

- ***Plan Benefits:*** Coverage limits and co-payments apply for all procedures. The County administers this plan 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. A summary of plan benefits is provided below. Refer to the plan's evidence of coverage booklet, available through the County of Sonoma web site at http://hr.sonoma-county.org/.

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

Dental Premiums

Bi-weekly premiums for eligible full-time employees' dental coverage vary based on bargaining unit, as noted in the table below. The County contribution for dental coverage provided to eligible part-time employees is prorated using a similar formula as the medical insurance, as described elsewhere in this booklet. Simply take the total premium cost, calculate the county contribution using the formula, and then add the employee contribution from the table below.

Bi-Weekly Premiums for Dental Coverage			
Bargaining Unit	**Total Premium Cost**	**County Contribution**	**Employee Contribution**
ESC, SCLEA, SCLEMA, SCPDIA,	$62.56	$50.56	$12.00
Board of Supervisors, SCDPDAA, DSA, DSLEM, Elected Officials/Department Heads, SCPA, SEIU, Unrepresented, Administrative Management, Confidential	$62.56	$49.56	$13.00
WCE	$62.56	$39.56	$23.00
Local 39	$62.56	$38.56	$24.00

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

Vision Coverage

How the Vision Plan Works

- ***Vision Providers:*** To receive benefits through the plan, you must seek care from a VSP network provider. The VSP network has more than 18,000 participating providers nationwide, including ophthalmologists and optometrists. You can locate a VSP provider through VSP's web site at www.vsp.com or by calling their toll-free number at 1-800-877-7195.

- ***Plan ID Cards:*** VSP does not provide members with an ID card for the plan. So, when you and your eligible dependents seek vision care, you will need to provide your Social Security Number and the plan's group number to your provider. Group numbers are noted in the table below. Note: If you're un-enrolled or ineligible dependent(s) seek care through the County-offered plan, you may be held financially responsible for the expenses incurred.

Plan Benefits

A summary of plan benefits is included in the table below. This is a summary of covered vision care expenses only. For more details, refer to the plan's evidence of coverage booklet available through the County's web site at http://hr.sonoma-county.org/

Computer Vision Care (CVC) Benefit

This specialty plan allows you to get corrective eyewear designed to meet specific health and vision needs of computer users. Lenses and frames for these supplemental glasses are available at the same service frequency as your core plan. This benefit is not available to dependents. This benefit is completely administered by VSP. For details, contact VSP's customer service at 1-800-877-7195

Vision premiums are fully paid by the County for full-time employees. The County contribution for vision coverage provided to eligible part-time employees is prorated using the same formula as the medical insurance, as described elsewhere in this booklet.

Vision Service Plan Benefit Highlights – Group # 1243 7001 0002	
Services	**All Bargaining Units**
Eye Exams	Covered in full every 12 months, following the date of your last exam
Prescription Glasses	Lenses: Covered in full every 12 months (following the date of your last lenses) Frames: $115 allowance plus 20% of any out-of-pocket costs, provided every 24 months (following the date of your last frames)
Contact Lens Care *(in lieu of prescription glasses)*	$105 allowance for contacts and contact lens exam every 12 months (following the date of your last contact lens exam and contacts)
Bi-Weekly Vision Premiums	
All Bargaining Units	
$7.91	

Life Insurance

County-Paid Basic Life Insurance Coverage

All regular full-time employees or regular part-time employees, in an allocated position of 60 hours (.75 FTE) or more per pay period, receive a basic life insurance benefit paid by the County.

Part-time DSA, SCLEA and ESC employees working less than 60 hours per pay period can purchase basic life insurance at their own expense.

County-Paid Basic Life Insurance Coverage	
Benefit Level	**Bargaining Units**
Class 1 $10,000	SEIU, Unrepresented
Class 2 $20,000	Local 39
Class 3 $25,000	DSA, ESC, SCLEA, SCPDIA, WCE
Class 4 1.5 times annual salary, up to $200,000	Unrepresented Confidential
Class 5 2 times annual salary, up to $200,000	Board of Supervisors, DSLEM, Department/Agency Heads, SCLEMA, SCPA, SCDPDA, Unrepresented Administrative Management
Class 6 1 times annual salary, up to $100,000	SEIU Supervisory (95 only)

Employee Supplemental Life Insurance

You may also purchase supplemental life insurance for yourself in amounts equal 1, 2, 3, or 4 times your basic life insurance benefit, not to exceed $500,000 when combined with the basic life ins. benefit. The coverage level you elect is subject to approval by The Hartford. No payroll deductions will be taken until your application is approved by The Hartford.

The cost of supplemental coverage is based on your age and the amount of insurance you select. Current rates for each $10,000 in supplemental life insurance coverage are listed in the table to the right.

2010/2011 Employee Supplemental Life Insurance Premiums		
Age	**Bi-Weekly Rate**	**Annual Rate**
29 and under	$0.28	$7.20
30 – 34	$0.31	$8.17
35 – 39	$0.39	$10.20
40 – 44	$0.59	$15.37
45 – 49	$0.86	$22.44
50 – 54	$1.37	$35.77
55 – 59	$2.28	$59.40
60 – 64	$3.38	$88.08
65 – 69	$5.53	$144.35
70 – 74	$10.12	$264.13

Dependent Life Insurance

You can also purchase dependent life insurance coverage for your spouse/domestic partner and eligible unmarried dependent children up to the age of 21 (age 23 if a full-time student). The benefit provided for dependent coverage is $5,000 for each eligible family member. The premium is $0.23 bi-weekly and includes all eligible members of your family.

Key Issues to Consider About Life Insurance

- You pay the full cost of supplemental and dependent coverage on a post tax basis.
- Think about whether or not you need more protection than the County-paid coverage provides, especially if you are the sole wage-earner in your family.
- Consider whether you have enough money to cover funeral and/or legal expenses in the event of a death of a spouse, domestic partner, or children. Dependent life insurance may help with these expenses.
- Be sure to designate a beneficiary(ies) for your employee life insurance.

Frequently Asked Questions About Supplemental Life Insurance Coverage

What is the maximum amount of supplemental life insurance I can purchase?
The maximum amount you can purchase is four times your basic benefit, but ***cannot exceed $500,000*** when combined with your basic life insurance benefit.

Do I have to apply for supplemental coverage?
Supplemental life insurance coverage is optional. If you are interested in obtaining supplemental coverage, you will need to apply by completing an enrollment card which is available upon request from your department's Payroll Clerk. Complete and submit the card to the Human Resources Benefits Unit by the applicable deadline (by April 15, 2011, if electing coverage during annual enrollment; or, within 31 days of your eligibility date if enrolling as a newly eligible employee).

When is coverage effective?
Coverage becomes effective on the first of the month after The Hartford notifies you and the County of your acceptance. **Due to the large volume of applications, it can take three or four months for our insurance carrier, The Hartford, to process the applications**. No payroll deductions will be taken until your application is approved.

Important Mandatory Notices

Following are notices required by law to be communicated to plan participants.

Reconstructive Surgery Following Mastectomy

The County sponsored medical plans, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your medical plan for more information.

Notice of Prescription Drug Creditable Coverage

Federal law requires Medicare-eligible participants who enroll in employer-sponsored prescription drug coverage be provided with a "Notice of Creditable Coverage." This plan's notice states that under the County of Sonoma medical plans, prescription drug coverage is, on average, as generous as the standard Medicare Prescription Drug Coverage. You will be provided with the Notice prior to the effective date for coverage under the County's prescription drug plan and again each year. Please keep a copy in your records. A copy is also available upon request from the Human Resources Benefits Unit.

Private Health Information

A portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) addresses the protection of confidential health information. It applies to all health benefit plans. In short, the idea is to make sure that confidential health information that identifies (or could be used to identify) you is kept completely confidential. This individually identifiable health information is known as "protected health information" (PHI), and it will not be used or disclosed without your written authorization, except as described in the HIPAA Privacy Notice or as otherwise permitted by federal and state health information privacy laws.

The HIPAA Privacy Notice explains how the group health plans uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in the plan. You can get a copy of this Notice on the County of Sonoma web site at: **http://hr.sonoma-county.org/** , or by request from the Human Resources Benefits Unit.

Changes Allowed Under the Children's Health Insurance Program Reauthorization Act of 2009

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit those eligible for group health plan coverage to enroll in the plan if they:

- Lose eligibility for Medicaid or SCHIP coverage
  OR
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SCHIP or of the eligibility determination).

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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, 2011. You should contact your State for further information on eligibility –

<table>
<tr><th>ALABAMA – Medicaid</th><th>CALIFORNIA – Medicaid</th></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504</td><td>Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443</td></tr>
<tr><th>ALASKA – Medicaid</th><th>COLORADO – Medicaid and CHIP</th></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td rowspan="3">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943
CHIP Website: http:// www.CHPplus.org
CHIP Phone: 303-866-3243</td></tr>
<tr><th>ARIZONA – CHIP</th></tr>
<tr><td>Website: http://www.azahcccs.gov/applicants/default.aspx
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td></tr>
<tr><th>ARKANSAS – CHIP</th><th>FLORIDA – Medicaid</th></tr>
<tr><td>Website: http://www.arkidsfirst.com/
Phone: 1-888-474-8275</td><td>Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-877-357-3268</td></tr>
</table>

GEORGIA – Medicaid	**MISSOURI** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP 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: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
KANSAS – Medicaid	
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	
MASSACHUSETTS – Medicaid and CHIP	**NEW MEXICO –** Medicaid and CHIP
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	
NEW YORK – Medicaid	**TEXAS** – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493

NORTH CAROLINA – Medicaid	**UTAH** – Medicaid
Website: http://www.nc.gov Phone: 919-855-4100	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
NORTH DAKOTA – Medicaid	**VERMONT**– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	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
OREGON – Medicaid and CHIP	**WASHINGTON** – Medicaid
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
PENNSYLVANIA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
RHODE ISLAND – Medicaid	**WISCONSIN** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, 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
1-866-444-EBSA (3272)

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

OMB Control Number 1210-0137 (expires 09/30/2013)

Benefits Resources and Vendors

CareCounsel

CareCounsel is a health care advocacy program available to County of Sonoma retirees and active employees. Contact CareCounsel for the following:

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

You can reach CareCounsel at 888-227-3334. Resources are also available through the CareCounsel web site at www.carecounsel.com**.**

County of Sonoma Human Resources Benefits Unit

Contact the Human Resources Benefits Unit with questions related to your eligibility, coverage and annual enrollment.

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

County-Offered Health Plan Vendor Contact Information

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

Plan	Phone	Web
County Health Plans (CHP PPO and CHP EPO) *Administered by Anthem Blue Cross*	800-759-3030	**www.anthem.com/ca**
CVS/Caremark *County Health Plans' prescription drug provider*	800-966-5772	**www.caremark.com**
Kaiser Permanente	800-464-4000	**www.kp.org**
Delta Dental Plans Delta Dental Premier (employees)	800-765-6003	**www.deltadentalins.com**
Vision Service Plan	800-877-7195	**www.vsp.com**
Hartford Life & Accident Insurance Company	888-563-1124	**www.thehartfordatwork.com**
Employee Assistance Program Administered through Managed Health Network (MHN)	800-227-1060	**www.members.mhn.com** **Company code: sonomacounty** **Law Enforcement: scle**