COUNTY OF SONOMA

Human Resources Benefits Unit • (707) 565-2900 • Benefits@sonoma-county.org

2022 - 2023 EXTRA HELP BENEFITS GUIDE

Welcome...

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

This Benefits Guide is designed to help you make informed decisions regarding your health benefit elections as a newly eligible employee, during the Annual Enrollment period, and for any potential mid-year changes you may experience throughout the year.

Within this guide, you'll find overviews for each of the health benefit providers, medical plan comparison charts, plan premiums and information to help you determine if you are eligible for a mid-year plan change and when those changes need to be made.

We encourage you to use this Benefits Guide as a reference throughout the plan year. If you have questions, contact the Human Resources Benefits Unit or the plan providers directly. Plan phone numbers and web sites are listed on page 38 of this Benefits Guide.

This Benefits Guide is intended as an overview of your medical benefits including eligibility, plan options, rates, how to enroll, and other important information. More detailed information is available in the official plan documents. For information about your other County benefits, please go to http://sonomacounty.ca.gov/HR/Benefits/.

Your benefit eligibility is determined by the terms of your applicable Memorandum of Understanding (MOU), Employee Contract, or Salary Resolution.

This Benefits Guide is not a promise of continued or future benefits. The information provided is current and applicable as of the printing of this guide. In the case of conflict between the information presented in this Benefits Guide and the official plan document, the plan document determines the coverage.

ANNUAL ENROLLMENT

Annual Enrollment is **March 7, 2022 through March 25, 2022**. Annual Enrollment Period is your opportunity to add, drop, or waive coverage for you or your dependents, and to ensure that our records accurately reflect your benefit elections. You can enroll and make changes to your plans online in Employee Self Service (ESS). For more information regarding Annual Enrollment, visit our website at http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/.

During Annual Enrollment, you may:

- Enroll in coverage
- Change your medical plan
- Add/Drop/Waive dependents from your coverage
- Decline medical coverage
- Waive medical coverage (if enrolled in other Group Coverage or Covered CA)

Information to prepare and update:

Dependent data

- Names
- Birthdates
- Social Security Numbers
- Dependent Verification Documentation

Personal information:

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

Ready to enroll or make changes?

To update dependents, make plan changes, and enroll or waive coverage for you and your family, login to Employee Self Service at
https://ngssprod.sonomacounty.ca.gov:7012/selfServiceADF/faces/ssLogin

If an eligible dependent is not listed in Employee Self Service in your medical benefit plan, that dependent will not be covered and will not be able to access benefits from the County when seeking services. Dependents who are no longer eligible must be removed from coverage and failure to do so in a timely manner may result in your liability to repay the Plan if any benefits are paid to or on behalf of an ineligible person.

BENEFIT ELIGIBILITY

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

To be initially eligible for medical benefits listed in this Benefits Guide, you must meet the following criteria before payroll deductions begin:

1. Must generally be scheduled to work at least forty (40) hours per pay period, and
2. Worked at least eighty (80) hours in the previous two (2) pay periods.

CONTINUE COVERAGE AND CONDITIONS FOR REGAINING ELIGIBILITY

Once enrolled in a medical plan, an Extra Help employee who fails to work at least twenty (20) hours in any pay period in which a premium deduction was due, will continue to be eligible for medical plan coverage by paying the full amount of the premiums by payroll deduction. If the employee's pay check is insufficient to fully cover the deduction, the employee must make arrangements to pay the premium directly to ACTTC's Payroll Office. Premiums are due in the ACTTC's Payroll Office by the last day of the pay period in which there were insufficient hours worked. Failure to pay premiums will result in loss of coverage.

Please reference your Sonoma County Salary Resolution or applicable Bargaining Unit Memorandum of Understanding for additional information about Extra Help benefits and stipulations to continue medical plan coverage.

DEPENDENT ELIGIBILITY

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

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

Dependent coverage will end the last day of the month in which the dependent turns age 26. See your Memorandum of Understanding or Salary Resolution to verify dependent eligibility. An exception is available for an unmarried dependent child over the plan's age limit, who is chiefly dependent upon the subscriber for support, and is incapable of supporting one's self due to mental or physical disability incurred prior to reaching the limiting age.

*ESC, SCDPDAA and SEIU - County Affidavit is acceptable

SOCIAL SECURITY NUMBERS ARE REQUIRED

You are required to provide a Social Security number (SSN) or a Federal Tax Identification number (TIN) for your dependent(s) when you enroll them in a County sponsored medical plan. The County needs this information to comply with IRS reporting and the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173). If a dependent does not yet have a social security number, you can go to the Social Security Administrations website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE. If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please provide the Social Security number to the Human Resources Benefits Unit.

DEPENDENT VERIFICATION

All dependents currently enrolled and newly enrolling in County sponsored medical plans will be required to show proof of dependency. Please use the chart below to determine what documentation to provide to the HR Benefits Unit for each dependent you are enrolling in medical coverage.

Dependent	Age	Documents Required
Spouse	N/A	Marriage Certificate
Domestic Partner	N/A	**ESC/SCDPDAA/SEIU:** County Affidavit or Declaration of Domestic Partnership filed with the California Secretary of State **ALL OTHERS/SAL RES:** Declaration of Domestic Partnership filed with the California Secretary of State
Natural Children	Under Age 26	Birth Certificate
Step Child(ren)	Under Age 26	Marriage Certificate **and** Birth Certificate showing Spouse as Parent
Children Legally Adopted/Wards	Under Age 26	Court documentation (Must include presiding Judge Signature & Court Seal)
Children of Domestic Partners	Under Age 26	**ESC/SCDPDAA/SEIU:** County Affidavit or Declaration of Partnership filed with the California Secretary of State -and-Birth Certificate showing Domestic Partner as Parent **ALL OTHERS/SAL RES:** Declaration of Domestic Partnership filed with the California Secretary of State-and-Birth Certificate showing parent as Domestic Partner

DUAL COVERAGE NOT ALLOWED

An eligible employee/retiree and his/her eligible dependent(s) may be enrolled in a County sponsored medical plan, but are allowed only to enroll either as a subscriber in a County sponsored 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 sponsored health plan).

COUNTY CONTRIBUTION FOR MEDICAL COVERAGE

There is no change to the County Contribution for medical coverage for Extra Help employees. The maximum County contribution amount per month is $400 ($200 semi-monthly). The County's contribution is pro-rated based on the hours worked in a pay period:

- If you work 40 hours or more in a pay period, you receive the full semi-monthly pay period County contribution of $200.
- If you work 20 hours or more, but less than 40 hours in a pay period, you receive a pro-rated County contribution based on the hours you work.
- If you work less than 20 hours in a pay period, no County contribution will be paid.

MEDICAL PLAN PREMIUM COLLECTION

Provided you have met initial eligibility, premium deductions for coverage elected during Annual Enrollment begin May 11, 2022 for coverage effective June 1, 2022. Premiums are collected in the month prior to coverage. Premiums for the plan will be paid in advance on the first two pay dates of the month prior to the coverage effective date and on the first two pay dates of every month thereafter. When there is a third pay check in a month, no premiums will be collected from that third pay check. When payment has been made in full, coverage will take effect on the first of the month following payment and shall end on the last day of the same month. Coverage will be month to month and is dependent on full payment of premiums and subject to continued eligibility.

The employee premiums shall be paid through pre-tax payroll deduction as allowed by IRS Code Section 125.

PRE-TAX INSURANCE BENEFITS

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

IS MY DEPENDENT IRS-QUALIFIED?

In accordance with the law, the County's benefits coverage can be provided on a tax-free basis to any eligible spouse, or eligible child of the employee until the end of the month in which the child becomes ineligible for County health plans. If your eligible dependent is your own natural child, your step child, adopted child, child lawfully placed for adoption, or eligible foster child, you may indicate each as IRS Qualified regardless of the child's marital or student status or whether or not the child is claimed as a dependent on your taxes.

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

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

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

KEY ITEMS TO CONSIDER IN CHOOSING A MEDICAL PLAN

- Compare benefit coverage levels and premium costs carefully to see which option best fits your needs.
- Review the “Service Areas” of the medical plan you are interested in to ensure you are eligible for enrollment based on where you live.
- Dependents must be enrolled in the same plan as yourself.
- Premium and out-of-pocket costs vary significantly between the HMO, Hospital Services and Deductible First plans. You and the County share the cost of the premiums. Your share of the premium cost will be processed through payroll deductions. Out-of-pocket costs, such as deductibles, copays, and coinsurance, are your responsibility and may be incurred at the time of service.

MEDICAL BENEFITS

The County of Sonoma cares about your health and well-being and is pleased to offer you a choice of medical plan options. You are eligible to choose from the following medical plans:

Kaiser Permanente

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

Sutter Health Plus

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

Western Health Advantage

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

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:

- Employee
- Employee + 1
- Employee + 2 or more

If you want dependents to be covered, your eligible dependents must be enrolled in the same medical plan as you select.

SUMMARY OF BENEFITS AND COVERAGE

You may view the Summary of Benefits and Coverage (SBC) information for each of the County's medical plans online at:
http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/.

2022-2023 MEDICAL PLAN PREMIUM CHART

SEMI-MONTHLY RATES FOR ALL BARGAINING UNITS

Traditional HMO			
Plan	**Employee Contribution**	County Contribution (Maximum)	Total Premium Cost
Kaiser Permanente			
Employee	$269.45	$200.00	$469.45
Employee + 1	$738.90	$200.00	$938.90
Employee + 2 or more	$1,128.55	$200.00	$1,328.55
Sutter Health Plus			
Employee	$160.35	$200.00	$360.35
Employee + 1	$520.75	$200.00	$720.75
Employee + 2 or more	$820.00	$200.00	$1,020.00
Western Health Advantage			
Employee	$163.04	$200.00	$363.04
Employee + 1	$526.09	$200.00	$726.09
Employee + 2 or more	$827.42	$200.00	$1,027.42

Hospital Services DHMO			
Plan	**Employee Contribution**	County Contribution	Total Premium Cost
Kaiser Permanente			
Employee	$178.00	$200.00	$378.00
Employee + 1	$556.00	$200.00	$756.00
Employee + 2 or more	$869.74	$200.00	$1,069.74
Sutter Health Plus			
Employee	$109.15	$200.00	$309.15
Employee + 1	$418.35	$200.00	$618.35
Employee + 2 or more	$675.00	$200.00	$875.00
Western Health Advantage			
Employee	$100.95	$200.00	$300.95
Employee + 1	$401.92	$200.00	$601.92
Employee + 2 or more	$651.72	$200.00	$851.72

2022-2023 MEDICAL PLAN PREMIUM CHART

SEMI-MONTHLY RATES FOR ALL BARGAINING UNITS

Deductible First HDHP			
Plan	**Employee Contribution**	County Contribution	Total Premium Cost
Kaiser Permanente			
Employee	$150.75	$200.00	$350.75
Employee + 1	$501.50	$200.00	$701.50
Employee + 2 or more	$792.62	$200.00	$992.62
Sutter Health Plus			
Employee	$87.20	$200.00	$287.20
Employee + 1	$374.40	$200.00	$574.40
Employee + 2 or more	$612.80	$200.00	$812.80
Western Health Advantage			
Employee	$72.93	$200.00	$272.93
Employee + 1	$345.87	$200.00	$545.87
Employee + 2 or more	$572.41	$200.00	$772.41

County contributions listed in this guide are current as of February 1, 2022. County contributions are determined by a MOU or Salary Resolution. Changes to the County contributions made on or after February 2, 2022 can be found on the County of Sonoma website at:
http://sonomacounty.ca.gov/_templates_portal/Service.aspx?id=2147521431.

PLANS OFFERED BY: KAISER PERMANENTE, SUTTER HEALTH PLUS AND WESTERN HEALTH ADVANTAGE

TRADITIONAL HMO

The Traditional HMO plans have a higher monthly premium with no deductible, low copays, and a lower out of pocket annual maximum, making your total annyal expenses more predictable. Hospitalization, radiology, lab tests and most preventive services are also covered at no cost. Generally, specialist services require a referral from your primary care phsician (PCP) and you must use the provider's network unless you have an out-of-area urgent or emergency situation or an approved referral.

HOSPITAL SERVICES DHMO

The Hospital Services DHMO plans offer a lower monthly premium with deductibles only on hospital related services, including emergency room visits, inpatient stays, and outpatient surgery. You pay the full cost of these services up to the deductible then a 20% coinsurance until you reach your out-of-pocket maximum. The out-of-pocket maximum includes the calendar year deductible, copays, and coinsurance. Physician and specialist visits, radiology, lab tests, and prescriptions have a flat copay, wihtout having to meet the deductible. Preventative services are covered at no cost.

DEDUCTIBLE FIRST HDHP

The Deductible First HDHP plans offer the lowest monthly premium and requires a member to meet the calendar year deductible FIRST before ANY plan benefits will be paid, except covered preventative services. Members will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations, etc., until the calendar year deductible is met. Once the deductible is met, covered medical, hospital, and prescription benefits will be provided for a copay or coinsurance amount. The calendar year out-of-pocket maximum includes calendar year deductibles, copays, and coinsurance.

Take Note: If you (the employee) elect to enroll in the Deductible First HDHP, which qualifies as a HSA qualified high deductible health plan, and you have a Flexible Spending Account (FSA) and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Beacause FSA and HRA accounts can be used to reimburse your out-of-pocket medical expenses, the IRS does not allow you to also contribute to a HSA at the same time, as it is considered prohibited health coverage. While the County does not offer an HSA, this rule applies to all enrolled dependents in this plan. Dependents will not be able to contribute to an HSA through their employer if enrolled in a Deductible First HDHP plan.

KAISER PERMANENTE

Easy Access: With Kaiser Permanente it's simple to find the care you need. Along with primary care, urgent care, emergency care, and labor and delivery, members have convenient access to a wide choice of specialty services with facilities in Sonoma County, Marin County, and access to Kaiser Permanente throughout California.

Personalized care: Whether you come into a Kaiser Permanente facility for a routine visit, urgent care, or emergency care, your doctors, nurses, and specialists have access to your electronic medical record. You have expanded opportunities to interact with care team the way you want: in person, physician email, 24-hour advice nurse line, linked to your medical record, telephone appointments and video visits are possible. To learn more about Kaiser Permanente, visit us at www.my.KP.org/sonomacounty or call (800) 464-4000.

Visit kp.org/costestimates for an estimate of what you'll pay for common services. Estimates are based on your plan benefits and whether you've reached your deductible— so you get personalized information every time. You can also call 1-800-390-3507, weekdays from 7 a.m. to 5 p.m. Visit kp.org/paymedicalbills anytime to track services you received, what you paid, what your health plan paid, the amount you owe and how close you are to reaching your deductible.

SUTTER HEALTH PLUS

Affordability. Access. Quality. Sutter Health Plus is a local not-for-profit HMO that gives members affordable access to a network of high-quality providers, spanning 16 counties located in Northern California. The health plan's network in Sonoma County includes Sutter Santa Rosa Regional Hospital and Novato Community Hospital (serving southern Sonoma County), Sutter Pacific Medical Foundation, Sutter Medical Group of the Redwoods, Sutter Santa Rosa Same Day Care (previously "Urgent Care"), and a Sutter Walk-In Care facility located in both Petaluma and Santa Rosa.

Features and Benefits

Take a moment to learn about Sutter Health Plus:

- Comprehensive benefits and coverage for hospitalization, urgent care, primary care, specialty care, X-ray, laboratory, prescription drug coverage, and some plans offer chiropractic services and infertitily coverage
- Coverage for a variety of no-cost preventive care services to help prevent or detect health problems early on
- Easy to use online tools, such as:
  - A Member Portal that gives members access to important plan documents; eligibility, benefits and copay information; forms and resources; change primary care physician (PCP); request or print member identification cards
  - My Health Online (not offered by all providers) to schedule appointments, email doctors, view test results, and access records
- Many Sutter Health Plus providers use an electronic health record
- Sutter Health Plus partners with CVS Caremark as the Pharmacy Benefits Manager for your retail, mail order and speciality prescription services
- Coverage for emergency and urgent care anywhere in the world
- A year-round 24/7 nurse advice line
- Health Coaching Program to help with healthy weight, tobacco cessation, and stress management—all at no additional out-of-pocket costs

Plan Offerings

Sutter Health Plus has three plan offerings available for county of Sonoma employees, to meet a variety of needs.

- Traditional HMO – Traditional ML42 HMO
- Hospital Services DHMO – Peak ML21 HMO
- Deductible First HDHP – Vista HD08 HDHP HMO

For more information about Sutter Health Plus or to view the plan comparisons, visit www.sutterhealthplus.org/sonoma-county or call Member Services (855) 315-5800.

WESTERN HEALTH ADVANTAGE

Headquartered in Sacramento, Western Health Advantage (WHA) is a non-profit HMO health plan founded in 1996. We believe decisions on health care should be made in hospitals not corporate offices. Which is why at WHA we trust doctors to decide the best health care path for patients. And because we're based locally, not in another state, approvals and decisions are made quickly without delays. It's what happens when a health plan is founded by doctors not accountants.

The WHA provider network includes major hospitals and medical centers and thousands of local, trusted doctors and specialists from reputable medical groups including, Hill Physicians, Meritage Medical Network, Providence St. Joseph Health Medical Network, Mercy Medical Group, Woodland Clinic Medical Group, and NorthBay Healthcare. With WHA, members have choices for specialist referrals beyond their PCP's medical group. Visit mywha.org/referral for additional information.

Enjoy the peace-of-mind that comes with 13 major hospitals and medical centers in Northern California, including four in Sonoma County (Healdsburg District Hospital, Petaluma Valley Hospital, Santa Rosa Memorial Hospital, and Sonoma Valley Hospital). You will also find conveniently located full-service care centers that offer a wide array of services under one roof — providing access to quality care in a neighborhood near you.

In addition to your traditional medical benefits, your membership with WHA provides you with these value added benefits:

- Nurse24, around the clock nurse advice
- Assist America, worldwide travel assistance
- Fitness center discounts
- Complementary Alternative Medicine: acupuncture and chiropractic services
- Mental health and substance abuse services
- MyWHA Wellness, online health and wellness tools, and condition management services.

To learn more about Western Health Advantage, visit us at chooseWHA.com/Sonoma-County or call (888) 563-2250.

MEDICAL PLAN COMPARISON CHART - TRADITIONAL HMO			
Plan Information	Kaiser Permanente Traditional HMO Group #602483-003	Sutter Health Plus Traditional HMO Group #131802-000001	Western Health Advantage Traditional HMO Group #950201-A000
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live or work in the service area within California	Based on residential zip code. Must live or work in the service area within Northern California	Based on residential zip code. Must live in the service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	None	None	None
Calendar Year Out-of-Pocket Maximum (including Deductibles, Copays & Coinsurance)	**Individual**: $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more**: $3,000	**Individual**: $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more**: $3,000	**Individual**: $1,500 **Any One Member in a family of two or more:** $1,500 **Family of two or more**: $3,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$10 Copay	$10 Copay	$10 Copay
Preventive Care Birth to Age 18	No Charge	No Charge	No Charge
Preventive Care Adult Routine Care	No Charge	No Charge	No Charge
Preventive Care Adult Routine OB/GYN	No Charge	No Charge	No Charge

MEDICAL PLAN COMPARISON CHART - TRADITIONAL HMO			
Plan Information	Kaiser Permanente Traditional HMO Group #602483-003	Sutter Health Plus Traditional HMO Group #131802-000001	Western Health Advantage Traditional HMO Group #950201-A000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-ray	No Charge	No Charge	No Charge
Physical Therapy (medical necessary treatment only)	$10 Copay	$10 Copay	$10 Copay
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic**: $10 Copay Up to 20 visits per year (Chiropractic services do not apply to out-of-pocket maximum) **Acupuncture**: PCP referral $10 copay LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	**Chiropractic**: $15 Copay Up to 20 visits per year - Copays do not contribute to Out-Of-Pocket maximum **Acupuncture**: $15 Copay Up to 20 visits per year
Mental Health & Substance Use Disorder (outpatient)	**Individual**: $10 copay **Group**: $5 copay	**Individual**: $10 copay **Group**: $5 copay	**$10 copay** per office or virtual visit No copay for Outpatient services
Family Planning Counseling and Consultation	No Charge	No Charge	No Charge
Routine Eye Exams with Plan Optometrist	No Charge	No charge for annual refractive eye exam	No Charge
Hearing Exam	No Charge	No Charge	No Charge
Allergy Injections (serum included)	$3 Copay	$10 Copay with a PCP or Specialist (Visits where only an injection is received without seeing a PCP or Specialist are no charge)	$3 Copay

MEDICAL PLAN COMPARISON CHART - TRADITIONAL HMO			
Plan Information	Kaiser Permanente Traditional HMO Group #602483-003	Sutter Health Plus Traditional HMO Group #131802-000001	Western Health Advantage Traditional HMO Group #950201-A000
Infertility Services	$10 Copay	50% Coinsurance (Infertility services do not apply to out-of-pocket maximum)	$10 Copay Copays do not contribute to Out-Of-Pocket maximum
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/Surgeon Services	Facility Fee: No charge Physician/Surgeon Fee: No charge	Facility Fee: No charge Physician/Surgeon Fee: No charge	Facility Fee: No charge Physician/Surgeon Fee: No charge
Outpatient Surgery	$10 Copay	$10 Copay	$10 Copay
Maternity	No charge	No charge	No charge
Emergency Room	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)	$50 Copay (waived if admitted)
Ambulance	$50 per trip	$50 per trip	$50 per trip
Mental Health & Substance Use Disorder (inpatient)	No charge	No charge	No charge
Skilled Nursing Facility	No Charge - Up to 100 days per benefit period	No Charge - Up to 100 days per benefit period	No Charge - Up to 100 days per benefit period
Home Health	No Charge Up to 100 visits per year	No Charge Up to 100 visits per year	No Charge - Up to 100 visits per year
Urgent Care	$10 Copay	$10 Copay	$10 Copay
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	20% coinsurance in accordance with formulary	No charge	20% coinsurance - based on WHA's contracted rates with providers

MEDICAL PLAN COMPARISON CHART - TRADITIONAL HMO			
Plan Information	Kaiser Permanente Traditional HMO Group #602483-003	Sutter Health Plus Traditional HMO Group #131802-000001	Western Health Advantage Traditional HMO Group #950201-A000
PRESCRIPTION MEDICATION			
Generic or Tier 1	$5 Copay Up to 100 day supply	$5 Copay Up to 30 day supply	$5 Copay Up to 30 day supply
Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$10 Copay Up to 30 day supply	$10 Copay Up to 30 day supply
Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	Tier 3 - $20 Copay Up to 30 day supply Tier 4 (Specialty Drug) - $20 Copay Up to a 30 day supply only	$20 Copay Up to 30 day supply
Mail Order Benefit Generic or Tier 1	$5 Copay Up to 100 day supply	$10 Copay Up to 100 day supply	$5 Copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$20 Copay Up to 100 day supply	$10 Copay Up to 90 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	$40 Copay Up to 100 day supply	$20 Copay Up to 90 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at: http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/.

MEDICAL PLAN COMPARISON CHART - HOSPITAL SERVICES DHMO			
Plan Information	Kaiser Permanente Hospital Services DHMO Group #602484-0006	Sutter Health Plus Hospital Services DHMO Group #131802-000005	Western Health Advantage Hospital Services DHMO Group #950201
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live or work in the service area within California	Based on residential zip code. Must live or work in the service area within Northern California	Based on residential zip code. Must live in the service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**Individual**: $1,000 **Any One Member in a family of two or more**: $1,000 **Family of two or more**: $2,000	**Individual**: $1,000 **Any One Member in a family of two or more**: $1,000 **Family of two or more**: $2,000	**Individual**: $1,000 **Any One Member in a family of two or more**: $1,000 **Family of two or more**: $2,000
Calendar Year Out-of-Pocket Maximum (including Deductibles, Copays & Coinsurance)	**Individual**: $3,000 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $6,000	**Individual**: $3,000 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $6,000	**Individual**: $3,000 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $6,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible

MEDICAL PLAN COMPARISON CHART - HOSPITAL SERVICES DHMO			
Plan Information	Kaiser Permanente Hospital Services DHMO Group #602484-0006	Sutter Health Plus Hospital Services DHMO Group #131802-000005	Western Health Advantage Hospital Services DHMO Group #950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-ray	**Diagnostic Lab**: $10 copay per encounter, no deductible **Diagnostic X-ray**: $10 copay per encounter, no deductible **CT/PET Scans & MRI**: $50 per procedure, no deductible	**Diagnostic Lab**: $20 copay, no deductible **Diagnostic X-ray**: $10 copay per procedure, no deductible **CT/PET Scans & MRI**: $50 copay per procedure, no deductible	**Diagnostic Lab**: no charge, no deductible **Diagnostic X-ray**: no charge, no deductible
Physical Therapy (medical necessary treatment only)	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic**: $20 Copay, no deductible up to 20 visits per year (Chiropractic services do not apply to out-of-pocket maximum) **Acupuncture**: PCP referral $20 copay, no deductible, LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	**Chiropractic**: $15 Copay, no deductible. Up to 20 visits per year - Copays do not contribute to Out-Of-Pocket maximum **Acupuncture**: $15 Copay, no deductible. Up to 20 visits per year
Mental Health & Substance Use Disorder (outpatient)	**MH/SUD individual**, $20 copay, no deductible **MH group**, $10 copay, no deductible **SUD group**, $5 copay, no deductible	**MH/SUD individual**, $20 copay, no deductible **MH/SUD group**, $10 copay, no deductible	**$20 copay, no deductible,** per office or virtual visit No copay, no deductible, for Outpatient services
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	$20 copay, no deductible
Routine Eye Exams with Plan Optometrist	No charge, no deductible	No charge, no deductible	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	No charge, no deductible	$20 Copay, no deductible with a PCP or Specialist (Visits where only an injection is received without seeing a PCP or Specialist are no charge, no deductible)	No charge, no deductible
Infertility Services	50% coinsurance, no deductible	50% coinsurance, no deductible (Infertility services do not apply to out-of-pocket maximum)	50% coinsurance, no deductible Copays do not contribute to out-of-pocket maximum

MEDICAL PLAN COMPARISON CHART - HOSPITAL SERVICES DHMO			
Plan Information	Kaiser Permanente Hospital Services DHMO Group #602484-0006	Sutter Health Plus Hospital Services DHMO Group #131802-000005	Western Health Advantage Hospital Services DHMO Group #950201
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/Surgeon Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance after deductible	$20 copay per visit, no deductible, performed in office setting 20% coinsurance, after deductible, performed in facility
Maternity	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance	$150 per trip, no deductible	No charge after deductible	$150 per trip, no deductible
Mental Health & Substance Use Disorder (inpatient)	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	20% coinsurance, no deductible Up to 100 days per benefit period	20% coinsurance, after deductible Up to 100 days per benefit period	20% coinsurance, no deductible Up to 100 days per benefit period
Home Health	No Charge, No Deductible Up to 100 visits per year	No Charge, No Deductible Up to 100 visits per calendar year	No Charge, No Deductible Up to 100 visits per year
Urgent Care	$20 Copay, no deductible	$20 Copay, no deductible	$20 Copay, no deductible
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	20% coinsurance in accordance with formulary, no deductible	20% coinsurance after deductible	20% coinsurance, no deductible

MEDICAL PLAN COMPARISON CHART - HOSPITAL SERVICES PLANS			
Plan Information	Kaiser Permanente Hospital Services DHMO Group #602484-0006	Sutter Health Plus Hospital Services DHMO Group #131802-000005	Western Health Advantage Hospital Services DHMO Group #950201
PRESCRIPTION MEDICATION			
Generic or Tier 1	$10 copay up to 30 day supply, no deductible	$10 copay up to 30 day supply, no deductible	$10 copay up to 30 day supply, no deductible
Formulary Brand or Tier 2	$30 copay up to 30 day supply, no deductible	$30 copay up to 30 day supply, no deductible	$30 copay up to 30 day supply, no deductible
Non-Formulary Brand or Tier 3	$30 copay up to 30 day supply, no deductible (Must be deemed medically necessary under the treatment of the Kaiser physician)	Tier 3 - $60 copay up to 30 day supply, no deductible Tier 4 (Specialty Drug) - 20% coinsurance up to a maximum of $100 per prescription up to 30 day supply, no deductible	$50 copay up to 30 day supply, no deductible
Mail Order Benefit Generic or Tier 1	$20 copay up to 100 day supply, no deductible	$20 copay up to 100 day supply, no deductible	$20 copay up to 90 day supply, no deductible
Mail Order Benefit Formulary Brand or Tier 2	$60 copay up to 100 day supply, no deductible	$60 copay up to 100 day supply, no deductible	$60 copay up to 90 day supply, no deductible
Mail Order Benefit Non-Formulary Brand or Tier 3	$60 copay up to 100 day supply, no deductible	$120 copay up to 100 day supply, no deductible	$100 copay up to 90 day supply, no deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at: http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/.

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE FIRST HDHP			
Plan Information	Kaiser Permanente Deductible First HDHP Group #602484-0009	Sutter Health Plus Deductible First HDHP Group #131802-000009	Western Health Advantage Deductible First HDHP Group #950201
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live or work in the service area within California	Based on residential zip code. Must live or work in the service area within Northern California	Based on residential zip code. Must live or work in the service area within Northern California
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs	Requires you to select a PCP who will work with you to manage your health care needs
Seeing a Specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**Individual**: $1,400 **Any One Member in a family of two or more**: $2,800 **Family of two or more**: $2,800	**Individual**: $1,500 **Any One Member in a family of two or more**: $2,800 **Family of two or more**: $3,000	**Individual**: $1,400 **Any One Member in a family of two or more**: $2,800 **Family of two or more**: $2,800
Calendar Year Out-of-Pocket Maximum (including Deductibles, Copays & Coinsurance)	**Individual**: $3,000 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $6,000	**Individual**: $3,000 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $6,000	**Individual**: $3,000 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $6,000
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE FIRST HDHP			
Plan Information	Kaiser Permanente Deductible First HDHP Group #602484-0009	Sutter Health Plus Deductible First HDHP Group #131802-000009	Western Health Advantage Deductible First HDHP Group #950201
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-ray	**Diagnostic Lab**: $10 copay after deductible **Diagnostic X-ray**: $10 copay per procedure after deductible **CT/PET Scans & MRI**: $50 copay per procedure after deductible	**Diagnostic Lab**: $20 copay after deductible **Diagnostic X-ray**: $10 copay per procedure after deductible **CT/PET Scans & MRI**: $50 copay per procedure after deductible	No charge after deductible
Physical Therapy (medical necessary treatment only)	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy	**Chiropractic**: Not covered **Acupuncture**: PCP referral $20 copay after deductible LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	No charge after deductible Up to 20 visits per year
Mental Health & Substance Use Disorder (outpatient)	MH/SUD individual, $20 copay after deductible MH group, $10 copay after deductible SUD group, $5 copay after deductible	MH/SUD individual, $20 copay per visit, after deductible MH/SUD group, $10 copay per visit, after deductible	**$20 copay after deductible** per office or virtual visit No copay, after deductible, for Outpatient services
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	$20 copay after deductible
Routine Eye Exams with Plan Optometrist	$20 copay, no deductible	No charge, no deductible	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	$5 copay after deductible	$20 Copay, after deductible with a PCP or Specialist (Visits where only an injection is received without seeing a PCP or Specialist are no charge, after deductible)	$5 copay after deductible
Infertility Services	Not covered	Not covered	50% coinsurance, no deductible Copays do not contribute to out-of-pocket maximum

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE FIRST HDHP			
Plan Information	Kaiser Permanente Deductible First HDHP Group #602484-0009	Sutter Health Plus Deductible First HDHP Group #131802-000009	Western Health Advantage Deductible First HDHP Group #950201
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/Surgeon Services	$250 copay per admission after deductible	**Hospitalization Facility Fee**: $250 copay per day, up to 5 days after deductible **Inpatient Physician Services**: No charge after deductible	$250 copay per admission after deductible
Outpatient Surgery	$150 copay per procedure after deductible	$20 copay per visit after deductible	$150 copay per procedure after deductible
Maternity	$250 copay per admission after deductible Inpatient Physician Services: No charge after deductible	Hospitalization Facility Fee: $250 copay per day, up to 5 days after deductible Inpatient Physician Services: No charge after deductible	$250 copay per admission after deductible Inpatient Physician Services: No charge after deductible
Emergency Room	$100 copay after deductible	$100 copay after deductible	$100 copay after deductible
Ambulance	$100 copay per trip, after deductible	$100 copay per trip, after deductible	$100 copay per trip, after deductible
Mental Health & Substance Use Disorder (inpatient)	$250 copay per admission after deductible	MH/SUD Inpatient Facility: $250 copay per day, up to 5 days after deductible MH/SUD Inpatient Physician Services: No charge after deductible	$250 copay per admission after deductible
Skilled Nursing Facility	$250 copay per admission after deductible Up to 100 days per benefit period	$100 copay per day up to 5 days after deductible Up to 100 days per benefit period	$250 copay per admission after deductible Up to 100 days per benefit period
Home Health	No charge after deductible Up to 100 visits per year	No charge after deductible Up to 100 visits per calendar year	No charge after deductible Up to 100 visits per year
Urgent Care	$20 copay after deductible	$20 copay after deductible	$20 copay after deductible
Hearing Aids	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	20% co-insurance in accordance with formulary after deductible	20% coinsurance after deductible	20% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE FIRST HDHP			
Plan Information	Kaiser Permanente Deductible First HDHP Group #602484-0009	Sutter Health Plus Deductible First HDHP Group #131802-000009	Western Health Advantage Deductible First HDHP Group #950201
PRESCRIPTION MEDICATION			
Generic or Tier 1	$10 copay up to 30 day supply after deductible	$10 copay up to 30 day supply after deductible	$10 copay up to 30 day supply after deductible
Formulary Brand or Tier 2	$30 copay up to 30 day supply after deductible	$30 copay up to 30 day supply after deductible	$30 copay up to 30 day supply after deductible
Non-Formulary Brand or Tier 3	$30 copay up to 30 day supply after deductible (Must be deemed medically necessary under the treatment of the Kaiser physician)	**Tier 3** - $60 copay up to 30 day supply after deductible **Tier 4 (Specialty Drug)** - 20% coinsurance ($100 per prescription maximum) up to 30 day supply after deductible	$50 copay up to 30 day supply after deductible
Mail Order Benefit Generic or Tier 1	$20 copay up to 100 day supply after deductible	$20 copay up to 100 day supply after deductible	$20 copay up to 90 day supply after deductible
Mail Order Benefit Formulary Brand or Tier 2	$60 copay up to 100 day supply after deductible	$60 copay up to 100 day supply after deductible	$60 copay up to 90 day supply after deductible
Mail Order Benefit Non-Formulary Brand or Tier 3	$60 copay up to 100 day supply after deductible	$120 copay up to 100 day supply after deductible	$100 copay up to 90 day supply after deductible
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at: http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/.

MID YEAR CHANGES

Elections shall be effective prospectively. Generally, elections that add or change coverage will be effective on the first day of the month following or coinciding with the date the completed Extra Help Enrollment/Change Form and applicable supporting documentation is received by the Human Resources Benefits Unit. (The exception is that when enrollment is requested for a newborn, newly adopted child or child placed for adoption, coverage is effective on the date of birth or adoption or placement for adoption). For newly eligible Extra Help Employees, elections are effective on the first day of the month following the date of eligibility, including those hired on the first day of the month.

Elections that cancel or drop coverage will be effective on the last day of the month following or coinciding with the date the completed Extra Help Enrollment/Change Form and applicable supporting documentation is received by the Human Resources Benefits Unit.

If your coverage was terminated or lapsed while on leave, you will need to complete a new Extra Help Enrollment/Change Form within 31 calendar days from your return to work date. Your coverage will start on the first of the month following the full payment of premiums. For example, premiums collected in May pay for June coverage. If you are returning from a Military leave of absence, your coverage will be effective on the date you return from leave.

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

NEWBORN CHILDREN

Newborn children must be enrolled in County plan coverage, including medical, to receive benefits under the plan. Failure to request enrollment for your newborn in a County plan within 31 days of the date of birth will result in your newborn not having coverage from date and time of birth forward for most plans. You will be liable for any services and/or expenses incurred for that newborn who is not timely and properly enrolled.

To enroll your newborn, submit a completed Extra Help Election/Change Form to the Human Resources Benefits Unit. If enrollment is requested timely, coverage must be retroactively effective to the date of birth, adoption or placement for adoption. You are encouraged to request newborn enrollment and submit enrollment paperwork as soon as possible (and no later than 31 days after the date of birth) to avoid non-coverage for your newborn child.

When properly enrolled, the newborn will be assigned under the medical group to which the parent is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

Mid year changes must be submitted within 31 days of the event date!

You will be required to provide proof of the mid-year event for all changes

Per IRS regulations, changes must be consistent with the event type. See Change of Status and Mid-Year Changes chart to determine what changes you are eligible for.

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

LIFE/FAMILY EVENTS

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**
Marriage or Commencement of Domestic Partnership (DP)	• Enroll yourself, if applicable • Enroll your new spouse/DP and other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans	Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	• Drop your spouse/DP from your health coverage • Drop dependent child(ren) if show proof of other coverage under spouse's plan • Children of a Domestic Partner MUST be dropped (regardless of whether they enroll in other coverage) as they are no longer eligible dependents • Enroll yourself and your dependent children if you or at least one dependent child was previously enrolled in your spouse/DP's plan and lost eligibility • Change health plans	Drop health coverage for yourself
Gain a child due to birth or adoption	• Enroll yourself, if applicable • Enroll the eligible child and any other eligible dependents • Change health plans * Adoption placement papers are required	• Drop health coverage for yourself or any other covered individuals without proof of enrollment in spouse/DP's plan
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Drop child named on QMCSO if required by QMCSO • Change health plans, when options are available, to accommodate the child named on the QMCSO	• Drop health coverage for yourself • Make any other changes except as required by the QMCSO
Loss of a child's eligibility (e.g. child reaches the maximum age for coverage) or death of a dependent child	• Drop the child who lost eligibility from your health coverage • Change health plans to accommodate newly removed dependent(s) and remaining covered individuals	• Drop health coverage for yourself or any other covered individuals
Death of a spouse/DP	• Drop the deceased dependent from your health coverage • Enroll yourself and/or any eligible children if lost eligibility under spouse's/DP's plan • Change health plans	• Drop health coverage for yourself or any other covered individuals
Change of home address outside of plan service area that causes a loss of eligibility for coverage	• Change health plans if you are enrolled in a medical HMO and move out of their service area	• Cannot add eligible dependents

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

MEDICARE/SCHIP/MEDICAID/CHIP EVENTS

If you experience the following event...	**You may make the following change(s) within 60 days of the event…**	**YOU MAY NOT make these types of Changes**
Covered person has become entitled to Medicare	• Drop coverage for the Dependent who became entitled to Medicare, with proof of Medicare enrollment • If Employee becomes entitled to Medicare, may drop all coverage (self and dependents) * Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person has lost entitlement to Medicare	• Add coverage for the Dependent who lost entitlement to Medicare, with proof of Medicare disenrollment	• Change Plans
Covered person has become entitled to Medicaid, Medi-Cal, or SCHIP	• Drop coverage for the Dependent who became entitled to Medicaid, Medi-Cal, or SCHIP with proof of Medicaid/Medi-Cal or SCHIP enrollment • Drop coverage for yourself with proof of your own Medicaid/ Medi-Cal/SCHIP enrollment • If you or an eligible dependent is gaining eligibility for premium assistance, may enroll those gaining eligibility for premium assistance only if not already enrolled in County coverage * Documentation required	• Drop health coverage for yourself or any other covered individuals who are not newly Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person lost entitlement to Medicaid, Medi-Cal or SCHIP	• Add the person who lost entitlement to Medicaid, Medi-Cal, or SCHIP	• Drop coverage for yourself or any enrolled dependents • Change plans

EMPLOYMENT STATUS EVENTS

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**
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	• 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 if they enroll in spouse's or DP's coverage • Drop coverage for yourself if you enroll in your spouse's/DP's coverage * Proof of coverage in the other health plan required	• Change health plans. • Add any eligible dependents to your health coverage. • Enroll yourself if you are not currently enrolled

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage or eligibility for health benefits in another group, individual, or exchange health plan. You or your dependents exhaust COBRA coverage under other group health plan.	• Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans * Proof of loss of other coverage is required	• Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	• You must drop coverage for yourself and any enrolled Dependents because you are no longer eligible for coverage	• Add any Dependents

EMPLOYMENT STATUS EVENTS

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**
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase	• Drop coverage for yourself (only if there is a significant cost change and there is no other similar health plan option available) • Change health plans to a less expensive plan	• No change is allowed unless there is a significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.
You experience an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution	• You may suspend coverage for yourself and dependents while on leave and reinstate coverage upon return to work if you are still eligible then	• Add or Drop any dependents, change plans, or enroll if not currently enrolled
You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution	• Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans	• No change is allowed unless a significant change in the employer subsidy for health (not FSA) coverage
You return from Military leave	• Prior elections at beginning of leave are reinstated unless another Change Event has occurred which permits the change	
You, your spouse, or dependents enroll in a Qualified Health Plan through a Public health Insurance Marketplace	• Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself * Proof of enrollment in Marketplace Coverage is required	• Add any dependents,change plans, or enroll yourself if not currently enrolled

CONTACT INFORMATION AND RESOURCES

At the County of Sonoma, we're committed to helping our employees, retirees, and their families enjoy optimal health. That's why we've teamed up with community wellness partners to bring you a range of useful programs and wellness tools.

CARECOUNSEL

Advocating for You and With You. Navigating the complex world of health benefits can be a challenge, leaving you questioning if you have made the right choices for you and your family's best health. CareCounsel's health advocacy program is a confidential health advocacy benefit sponsored by the County that can help you understand and effectively navigate your health benefits. This service is available to County employees, retirees and their family members who are enrolled in County sponsored medical plans.

CareCounsel offers high touch and customized service backed by experience and depth. Here are just a few of the things CareCounsel can help you with:

- Compare health plan options and the differences between plan coverage
- Benefits education and assistance for all types of medical plans
- Getting the most of your healthcare dollars
- Locate network doctors, hospitals and ancillary services
- Obtaining second opinions
- Troubleshooting medical claims/bills
- Provide support for grievances and appeals
- Navigating Medicare (when you turn 65 and ongoing)
- Helping you become a more proactive health consumer
- Access to the Stanford Health Library
- Stanford educational webinars and community education sessions
- Connecting you with expert healthcare resources

You can reach CareCounsel at (888) 227-3334 or via Live Chat or email contact form at www.carecounsel.com or email staff@carecounsel.com. Member Care Specialists are available 6:30 a.m. to 5:00 p.m. PST Monday - Friday. CareCounsel is a wholly owned subsidiary of Stanford Health Care.

Keep CareCounsel at your fingertips; scan the QR code and save their contact information:

1. Focus smart phone camera on QR code
2. Select "Add 'CareCounsel'" to contacts from the banner at the top of the screen
3. Select "Save" in the upper, right-hand corner of the contact information
4. Call, email, visit web page or share the contact with your dependents via contact info

CUSTOMER SERVICE SUPPORT

Visit the insurance company websites for additional resources. Contact the Human Resources Benefits Unit with questions related to your eligibility, coverage, and Annual Enrollment Period.

E-mail: benefits@Sonoma-County.org
Phone: (707) 565-2900
Internet: http://sonomacounty.ca.gov/HR/Benefits/Annual-Enrollment/

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

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	Website
Kaiser Permanente	(800) 464-4000	www.my.kp.org/sonomacounty www.kp.org
Sutter Health Plus	(855) 315-5800	www.sutterhealthplus.org/sonomacounty
Western Health Advantage	(888) 563-2250	www.westernhealth.com/mywha/welcome-to-wha/county-ofsonoma
Sonoma County HIPAA Privacy Practices	(707) 565-5703	https://sonomacounty.ca.gov/Health/Notice-of-Privacy-Practices-for-County-of-Sonoma-Health-Plan-Members/

For more information regarding medical plan coverages, please review the Summary of Benefits and Coverage (SBC). The SBC's be found on the County website at:
http://sonomacounty.ca.gov/HR/Benefits/Benefit-Forms-and-Plan-Documents/

APPEALS PROCESS

GENERAL INFORMATION

In the event an employee believes that a request for health benefit eligibility or enrollment has been improperly denied by the County of Sonoma Human Resources Benefits Unit, he or she may appeal the decision within the parameters set forth in the following procedure.

TIME FRAMES

Any employee whose request for benefits is denied has the right to request a review by filing an appeal in writing directly with the HR Benefits Unit. Appeals must be submitted within 30 calendar days of the notice of denial or adverse decision. The appeal should include the basis for the appeal, as well as any supporting documentation.

If the appeal does not contain sufficient information to make a decision, the appellant will be notified in writing of the extension which will specifically describe the required information.

NOTIFICATION

Upon timely delivery of the requested information, and within 30 calendar days, the HR Benefits Unit will report its findings. Should the requested information not be received by the HR Benefits Unit within the time specified, the HR Benefits Unit will make a decision without it, in which case, the decision is final and is not eligible for a second appeal.

If the appellant disagrees with the HR Benefits Unit's decision and there is additional information that was not included in the first appeal which supports the position, a second appeal can be made to the attention of the HR Benefits Manager, whose decision will be final. Such appeals must be received within 15 calendar days of the first appeal decision notice.

Please contact the HR Benefits Unit with questions or concerns about the appeals process by calling (707) 565-2900 or email benefits@sonoma-county.org.

REQUIRED NOTICES

Medicare Notice of Creditable 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 County-sponsored medical plans is or is not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the County are or are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage below.

IMPORTANT NOTICE FROM THE COUNTY OF SONOMA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE - YOUR MEDICARE PART D NOTICE

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 sponsored medical 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?
As an employee, if you decide to join a Medicare drug plan, your current active employee County of Sonoma coverage will not be affected. As a retiree, if you decide to join a Medicare drug plan, your current retiree County of Sonoma coverage will 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 will 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…
See contact information 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 (800) MEDICARE ((800) 633-4227). TTY users should call (877) 486-2048.

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

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

Date:	March 1, 2022
Name of Entity/Sender:	County of Sonoma
Contact—Position/Office:	Human Resources Benefits Unit
Address:	575 Administration Dr., Suite 116B, 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: (888) 227-3334

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because the group health plans offered by the County provide coverage for mastectomies, WHCRA applies to your plan. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

This coverage will be subject to the same annual deductible, coinsurance and/or copay provisions otherwise applicable to medical and surgical services under the policy/plan.

If you have questions about this Notice, contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT NOTICE

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

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

SPECIAL ENROLLMENT EVENT NOTICE

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

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

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

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

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

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 a health Plan. You can get another copy of this Notice from the County of Sonoma Privacy Officer at (707) 565-5703 or https://sonomacounty.ca.gov/Health/Notice-of-Privacy-Practices/.

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

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

Note that if you are a resident certain states including California you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state's minimum coverage requirements. Consult with your own state's insurance department for information on whether your state has adopted or will be adopting a state Individual Mandate penalty.

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

KEEP THE COUNTY NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly furnish to the County's HR Benefits Unit information regarding change of name, address, marriage, divorce or legal separation, change in Domestic Partnership status, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give the County a timely notice of the above noted events may:

- Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
- Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
- Cause claims to not be able to be considered for payment until eligibility issues have been resolved,
- Result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future [medical, dental, and/or vision] benefits.

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact HR Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

IRS FORM 1095C

Under the Affordable Care Act, starting in early 2016, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095C. It will be provided to you on or by March 2, 2022.

For each month of 2020 that you were enrolled in a medical plan, this 1095C form documents that you (and any enrolled family members) met the federal requirement to have "minimum essential coverage or MEC," meaning group medical plan coverage.

If you receive a 1095C form, you do not need to attach the form to your personal income tax return or wait to receive the form before filling your tax return. If you receive a form this year, you should keep it in a safe place with your other tax records because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095C will also be provided to the IRS.)

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP): The Kaiser, Sutter, and Western Health Advantage 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. Until you make this designation, the health insurance company designates one for you. 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 the health insurance company at the number provided on page 38.

Direct Access to OB/GYN Providers: You do not need prior authorization (pre-approval) from Kaiser, Sutter, Western Health Advantage, Anthem 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 health plan carrier at the phone number or website address provided on page 38.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:

  – Cover emergency services without requiring you to get approval for services in advance (prior authorization).

  – Cover emergency services by out-of-network providers.

  – Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.

  – Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact CMS No Surprises Helpdesk at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

FAMILY CARE & MEDICAL LEAVE & PREGNANCY DISABILITY LEAVE

DFEH

THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING

THE MISSION OF THE DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING IS TO PROTECT THE PEOPLE OF CALIFORNIA FROM UNLAWFUL DISCRIMINATION IN EMPLOYMENT, HOUSING, BUSINESS ESTABLISHMENTS, AND STATE-FUNDED PROGRAMS AND ACTIVITIES, AND FROM HATE VIOLENCE AND HUMAN TRAFFICKING.

Under California law, you may have the right to take job-protected leave to care for your own serious health condition or a family member with a serious health condition, or to bond with a new child (via birth, adoption, or foster care). California law also requires employers to provide job-protected leave and accommodations to employees who are disabled by pregnancy, childbirth, or a related medical condition.

Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, and if we employ five or more employees, you may have a right to a family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent, parent-in-law, grandparent, sibling, spouse, or domestic partner. While the law provides only unpaid leave, employees may choose or employers may require use of accrued paid leave while taking CFRA leave under certain circumstances.

Even if you are not eligible for CFRA leave, if you are disabled by pregnancy, childbirth or a related medical condition, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement-for pregnancy disability it is to the same position and for CFRA it is to the same or a comparable position-at the end of the leave, subject to any defense allowed under the law.

If possible, you must provide at least 30 days' advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events that are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave. Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

We may require certification from your health care provider before allowing you a leave for pregnancy disability or for your own serious health condition. We also may require certification from the health care provider of your family member who has a serious health condition, before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or reduced work schedule.

If you are taking a leave for the birth, adoption, or foster care placement of a child, the basic minimum duration of the leave is two weeks, and you must conclude the leave within one year of the birth or placement for adoption or foster care.

Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact your employer.

If you have been subjected to discrimination, harassment, or retaliation at work, or have been improperly denied PDL or CFRA leave, file a complaint with DFEH.

TO FILE A COMPLAINT

Department of Fair Employment and Housing
dfeh.ca.gov
Toll Free: 800.884.1684
TTY: 800.700.2320

If you have a disability that requires a reasonable accommodation, DFEH can assist you with your complaint. Contact us through any method above or, for individuals who are deaf or hard of hearing or have speech disabilities, through the California Relay Service (711).

DFEH-100-21ENG / January 2022

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

EMPLOYER NOTICE ABOUT THE HEALTH INSURANCE MARKETPLACE

As your employer, the County should distribute a notice to new employees when they are first hired. The notice is at least two pages long. To help you recognize the notice, here is a snapshot of the first page of the Notice:

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact County of Sonoma Human Resources Benefits Unit • (707) 565-2900 • Benefits@Sonoma-County.org

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA –Medicaid	**ALASKA –Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO –Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1 -800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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