COUNTY OF SONOMA

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

2023-2024 RETIREE BENEFITS GUIDE

Welcome…

The County of Sonoma offers health benefits designed to meet the needs of our retirees.

This Benefits Guide is designed to help you make informed decisions regarding your health benefit elections as a newly eligible retiree, 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 61 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/benefits.

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

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.

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ANNUAL ENROLLMENT

Annual Enrollment is **March 13th - April 3rd, 2023**. Annual Enrollment is your opportunity to add or drop coverage for your dependents and to ensure that our records accurately reflect your benefit elections. You can enroll and make changes to your plans by completing the Retiree Enrollment/Change form. For more information regarding Annual Enrollment, visit our website at http://sonomacounty.ca.gov/annual-enrollment.

DURING ANNUAL ENROLLMENT

You may:

Medical

- Change insurance provider or plan (only if currently enrolled)

Dental

- Change plans
- Elect or cancel coverage
- Add or drop your eligible dependents

You may NOT:

- Add dependents to your medical plan

Information to prepare and update:

Dependent data:

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

Beneficiary designations:

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

Personal information:

If you've moved or changed your contact information, be sure to complete an Address Change form or note the new address on the Retiree Enrollment/Change form when making plan changes. It's important to keep your personal information up-to-date at all times to ensure we are able to contact you regarding your health benefits.

Ready to enroll or make changes?

Complete a retiree enrollment/change form and return it to the HR Benefits Unit by April 3, 2023.

WAIVING COVERAGE (WHEN COVERED BY OTHER GROUP INSURANCE)

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

PERMANENTLY CANCEL ALL COVERAGE

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

MEDICARE ENROLLMENT REQUIREMENTS

Medicare eligible retirees and/or Medicare eligible dependents must complete and sign enrollment paperwork the month prior to the effective date of the Medicare eligibility and provide a copy of their Medicare card(s) demonstrating enrollment in Medicare Parts A and B. See page 45 for more information.

DEPENDENT ELIGIBILITY

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

- Your lawfully married spouse
- Your California state registered domestic partner
- Your or your spouse/domestic partner's dependent children under age 26 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 Qualified Medical Child Support Order (QMCSO)
- Eligible dependent children may continue eligibility after age 26 if permanently and totally disabled and enrolled in the plan prior to attaining the limiting age

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 SSN, you can go to the Social Security Administrations website to complete a form to request a SSN: https://www.ssa.gov/forms/ss-5.pdf. Applying for a social security number is FREE. If you have not yet provided the SSN (or other TIN) for each of your dependents that you have enrolled in the health plan, please provide the SSN to the Human Resources Benefits Unit.

DEPENDENT VERIFICATION

All dependents added to 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	Documents Required
Spouse	Marriage Certificate
Registered Domestic Partner	Declaration of Domestic Partnership filed with the California Secretary of State
Natural Children	Birth Certificate
Step Child(ren)	Marriage Certificate **and** Birth Certificate showing Spouse as Parent
Children Legally Adopted/Wards	Court documentation (Must include presiding Judge Signature & Court Seal)
Children of Domestic Partners	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).

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, except as provided in Split Enrollment Plans on the following page.
- Premium and out-of-pocket costs vary significantly between plans;
    - EPO (Exclusive Provider Organization)
    - PPO (Preferred Provider Organization)
    - Traditional HMO (Health Maintenance Organization)
    - Hospital Services DHMO (Deductible HMO Plan)
    - Deductible First HDHP (High Deductible Health Plan)

MEDICARE PLANS

The following plans are available to participants (Retiree and Eligible Dependents) when enrolled in Medicare Parts A & B:

UnitedHealthcare

- AARP® Medicare Supplement Insurance Plan with MedicareRx Prescription Drug

County Health Plan

- EPO (Exclusive Provider Organization)
- PPO (Preferred Provider Organization)

Kaiser Permanente

- Senior Advantage

Western Health Advantage

- Medicare Advantage MyCare 10/0

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

NON-MEDICARE PLANS

These plans are available to participants (Retiree and Eligible Dependent) not eligible for Medicare:

County Health Plan

- EPO (Exclusive Provider Organization)
- PPO (Preferred Provider Organization)

Kaiser Permanente

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP
- Northwest (OR/WA) Traditional HMO
- Hawaii Traditional HMO

Sutter Health Plus

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

Western Health Advantage

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

Please note: To be eligible for Kaiser Permanente, Sutter Health Plus or Western Health Advantage, you must live in a qualified coverage area. Contact the HR Benefits Unit to confirm eligibility before moving to a new location. If you move outside a qualified coverage area, you will be required to choose a new plan that meets coverage area eligibility.

SPLIT ENROLLMENT PLANS

A split enrollment allows a retiree and their dependents to be enrolled in a combination of Medicare and non-Medicare plans. The following plans allow split enrollments:

County Health Plan

- EPO (Exclusive Provider Organization)
- PPO (Preferred Provider Organization)

Kaiser Permanente

- Senior Advantage

Western Health Advantage

- Medicare Advantage MyCare 10/0

When enrolled with Kaiser Permanente or Western Health Advantage, Medicare eligible retirees or dependents will be enrolled in the Senior Advantage or Medicare Advantage plan. Non-Medicare retirees or dependents will choose between the Traditional HMO, Hospital Services DHMO or Deductible First HDHP Plans.

MEDICAL PLAN PREMIUMS

The total monthly medical plan premium for County sponsored retiree medical plans vary based on the medical plan and coverage level you select. As is the case with most employers, the County typically expects an increase in the medical premium from year-to-year.

COUNTY CONTRIBUTION FOR MEDICAL COVERAGE

HIRED BEFORE JANUARY 1, 2009

Retirees and the County of Sonoma, if applicable, share in the amount of monthly premiums for medical coverage. The County makes a contribution toward the cost of the plan you choose. You are responsible for the difference between the total premium cost and the County's contribution.

DSA and DSLEM Retirees hired before January 1, 2009 and retired on or after August 28, 2018 will receive a $500 per month County contribution into the DSA Retiree Medical Trust. The trust is administered by Vimly Benefit Solutions. For more information regarding the DSA Retiree Medical Trust contact DSA and DSLEM union representatives or email Vimly at redwood@vimly.com.

SCLEA, SCLEMA and SCPDIA Retirees hired before January 1, 2009 and retired on or after November 14, 2018 will receive a $500 per month County contribution into a Health Reimbursement Account (HRA). The HRA is administered by the P&A Group. Account information is available 24 hours a day, seven days a week online at www.padmin.com. If you need assistance with your HRA, contact the P&A Group at (800) 688-2611, Monday through Friday from 5:30 a.m. to 7:00 p.m. PST.

Not all Retirees hired prior to January 1, 2009 will be eligible for a County contribution. Eligibility for a County contribution towards Retiree medical insurance is determined by Memorandum of Understanding or Salary Resolution, as applicable.

HIRED ON OR AFTER JANUARY 1, 2009

Retirees are responsible for the full Medical Plan Premium. A Retirement Health Reimbursement Account (HRA) was set up for you and funded by the County of Sonoma. The available funds can be used to reimburse you for the Medical Plan Premiums, co-pays, deductibles and other eligible expenses.

The Retirement HRA is administered by the P&A Group. Account information is available 24 hours a day, seven days a week online at www.padmin.com. If you need assistance with your HRA, contact the P&A Group at (800) 688-2611, Monday through Friday from 5:30 a.m. to 7:00 p.m. PST.

OTHER HEALTH REIMBURSEMENT ACCOUNTS

Your Memorandum of Understanding (MOU) may have included a separate Health Reimbursement Account (HRA) in addition, or in lieu of, the County contributions to the Medical Premiums or Retirement Health Reimbursement Account. Review your MOU to determine your eligibility.

The HRA program is administered by the P&A Group. Account information is available 24 hours a day, seven days a week online at www.padmin.com. Online access allows you to view your account information, enroll in direct deposit, upload claims, and request a new HRA benefits card. If you need assistance with your HRA, contact the P&A Group at (800) 688-2611, Monday through Friday from 5:30 a.m. to 7:00 p.m. PST.

AARP MEDICARE PREMIUM RATES

Total premiums for the AARP Medicare Supplement Insurance and AARP MedicareRx plans vary based on your location and other factors. To request a monthly premium quote, contact UnitedHealthcare customer service at (877) 558-4759.

UnitedHealthcare customer service representatives are available 7 days a week from 8:00 a.m. to 8:00 p.m. PST.

It's important to understand UnitedHealthcare will provide you with a premium quote for the total cost of your medical and prescription coverage but may not have knowledge of the County's contribution to the total cost of your coverage until after you are enrolled. Because AARP Medicare Supplement Plans, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), offer many plan options and rates vary by region and other factors, we cannot publish the actual costs for each plan in this booklet.

To arrive at your cost, obtain a quote from UnitedHealthcare for both a medical plan and a prescription plan. If you receive a County contribution, subtract the contribution amount from that total to arrive at your cost. In many cases, this will cover the majority of the cost. You will be billed directly by UnitedHealthcare if you have a share of cost.

DETERMINING YOUR BENEFIT COSTS

The Medical Plan Premium Charts on the following pages provide the total monthly premium for each medical benefit. If you receive a County Contribution, you will need to deduct the contribution amount from the Total Monthly Premium amount listed in the charts to determine your contribution.

Examples:

CHP EPO - Self Coverage

Total Monthly Premium	$1,089.96
County Contribution	- $500.00
Retiree Contribution	$589.96

2023-2024 MEDICAL PLAN PREMIUM CHARTS

County Health Plans EPO & PPO

	Total Monthly Premium	
	EPO	PPO
Retiree and All Dependents - Non-Medicare		
Retiree	$1,068.24	$1,294.28
Retiree + 1	$2,086.76	$2,544.16
Retiree + 2 or more	$2,910.72	$3,555.32
Retiree and All Dependents - Medicare		
Retiree	$533.63	$646.52
Retiree + 1	$1,067.26	$1,293.04
Retiree + 2 or more	$1,600.89	$1,939.56
Retiree and Dependents - Split Enrollment in Medicare and Non-Medicare		
1 Medicare + 1 Non-Medicare	$1,610.87	$1,940.80
1 Medicare + 2 or more Non-Medicare	$2,620.39	$3,190.68
2 Medicare + 1 Non-Medicare	$2,135.50	$2,587.32
2 Medicare + 2 or more Non-Medicare	$3,154.02	$3,837.20

Traditional HMO

	Total Monthly Premium		
	Kaiser Permanente - California	Sutter Health Plus	Western Health Advantage
Retiree and All Dependents - Non-Medicare			
Retiree	$954.34	$760.40	$757.12
Retiree + 1	$1,908.68	$1,520.80	$1,514.26
Retiree + 2 or more	$2,700.78	$2,152.10	$2,142.68
Retiree and All Dependents - Medicare (Senior Advantage HMO)			
Retiree	$285.14	N/A	$378.50
Retiree + 1	$570.28	N/A	$757.00
Retiree + 2 or more	$855.42	N/A	$1,135.50
Retiree and Dependents - Split Enrollment in Medicare and Non-Medicare			
1 Medicare + 1 Non-Medicare	$1,239.48	N/A	$1,135.50
1 Medicare + 2 or more Non-Medicare	$2,031.58	N/A	$1,765.06
2 Medicare + 1 or more Non-Medicare	$1,362.38	N/A	$1,385.42
Retiree and Child Medicare + Spouse Non-Medicare	$1,524.62	N/A	$1,385.42

Hospital Services DHMO

	Total Monthly Premium		
	Kaiser Permanente - California	Sutter Health Plus	Western Health Advantage
Retiree and All Dependents - Non-Medicare			
Retiree	$768.42	$652.50	$627.62
Retiree + 1	$1,536.84	$1,305.00	$1,255.30
Retiree + 2 or more	$2,174.64	$1,846.70	$1,776.26
Retiree and All Dependents - Medicare (Senior Advantage HMO)			
Retiree	$285.14	N/A	$378.50
Retiree + 1	$570.28	N/A	$757.00
Retiree + 2 or more	$855.42	N/A	$1,135.50
Retiree and Dependents - Split Enrollment in Medicare and Non-Medicare			
1 Medicare + 1 Non-Medicare	$1,053.56	N/A	$1,006.12
1 Medicare + 2 or more Non-Medicare	$1,691.36	N/A	$1,527.14
2 Medicare + 1 or more Non-Medicare	$1,208.08	N/A	$1,277.96
Retiree and Child Medicare + Spouse Non-Medicare	$1,338.70	N/A	$1,277.96

Deductible First HDHP

	Total Monthly Premium		
	Kaiser Permanente - California	Sutter Health Plus	Western Health Advantage
Retiree and All Dependents - Non-Medicare			
Retiree	$706.22	$606.10	$569.20
Retiree + 1	$1,412.44	$1,212.20	$1,138.42
Retiree + 2 or more	$1,988.60	$1,715.30	$1,610.86
Retiree and All Dependents - Medicare (Senior Advantage HMO)			
Retiree	$285.14	N/A	$378.50
Retiree + 1	$570.28	N/A	$757.00
Retiree + 2 or more	$855.42	N/A	$1,135.50
Retiree and Dependents - Split Enrollment in Medicare and Non-Medicare			
1 Medicare + 1 Non-Medicare	$991.36	N/A	$947.70
1 Medicare + 2 or more Non-Medicare	$1,577.52	N/A	$1,420.16
2 Medicare + 1 or more Non-Medicare	$1,156.44	N/A	$1,229.44
Retiree and Child Medicare + Spouse Non-Medicare	$1,276.50	N/A	$1,229.44

PLANS OFFERED BY: COUNTY HEALTH PLAN

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

The County Health Plan EPO is an exclusive provider organizations (EPO). The EPO is a network of Hospitals, Physicians, medical laboratories, and other Health Care Providers who are located within a Service Area and who have agreed to provide Medically Necessary services and supplies for favorable negotiated discount fees applicable only to EPO Plan participants.

- Under the EPO Plan there is coverage ONLY when you use an EPO provider.
- All care in the County Health Plan EPO must be obtained within the plan network, except if you have an authorized referral from a network provider or if you have an emergency.

The EPO Plan offers you affordable out-of-pocket costs, with access to the doctors and hospitals you trust. You are free to visit any doctor or hospital in the EPO network where you pay an affordable copay or deductible, without the hassle of filling out claim forms. Covered services must be provided by EPO network providers. Most doctor and specialist office visits are available at a $50 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 80% after the deductible ($500 per individual or $1,500 per family) is met.

PREFERRED PROVIDER ORGANIZATION (PPO)

The County Health Plan PPO is a preferred provider organizations (PPO). A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. Under a PPO plan, you may choose the level of benefits you receive based on the providers you use when you receive care. Most in-network doctor and specialist office visits are available at a $20 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 90% after the deductible ($300 per individual or $900 per family) is met.

Retirees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit medical, dental and vision out-of-pocket expenses, including copays and coinsurance for reimbursement.

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 annual 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 physician (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, without 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 preventive 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 retiree) 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). 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. If you or your dependents are Medicare eligible, you are not allowed to contribute to an HSA, per IRS rules.

COUNTY HEALTH PLANS

The PPO and EPO medical plan options are self-funded, meaning the contributions from the County of Sonoma and eligible retirees are used to pay plan benefits, including services provided to the members and claims administration. Anthem Blue Cross is the network provider and medical plan claims administrator for both the EPO and PPO plans. Plan members have access to more than 60,800 doctors and specialists that make up a strong local California network. Anthem Blue Cross has contracted with more than 90% of hospitals in California, including 400 acute care hospitals. If you reside within California, services are provided through the Prudent Buyer Plan network and if you reside outside of California, services are provided through BlueCard network. More than 96% of hospitals and more than 91% of physicians across the country contract with Anthem Blue Cross through the BlueCard® program.

To find a network provider, visit Anthem Blue Cross online or call (877) 800-7339.

CVS/CAREMARK PRESCRIPTION COVERAGE

For both the County EPO and the County PPO medical plan options, outpatient retail and mail order drugs are available through CVS/Caremark.

You are encouraged to select a generic drug when possible. If a generic drug is not available, you will pay the brand-name copay. If a generic is available but a brand-name drug is medically necessary, as prescribed by your doctor, your doctor must request an exception to the plans' mandatory generic policy through CVS/Caremark prior to getting the prescription filled. If approved, you will be charged the brand-name copay. However, if you choose the brand-name drug, or the exception is not approved, the drug will be a covered expense, but you will be responsible for the brand copay along with the difference between the brand and generic cost.

If you are taking a maintenance drug, it can be filled at any retail pharmacy twice. After the second fill, it must be filled at a CVS pharmacy or by mail order through CVS/Caremark. Direct all prescription benefit appeals to CVS/Caremark Customer Service (800) 966-5772.

LIVEHEALTH ONLINE

When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious, or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere. **See a board-certified doctor 24/7, a licensed therapist in four days or less or a board-certified psychiatrist within two weeks.**

KAISER PERMANENTE PLANS

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/cost estimates 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 infertility 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 specialty 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 ML69 HMO
- Deductible First HDHP – Vista HD20 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 PLANS

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.

UHC AARP® MEDICARE SUPPLEMENT PLANS

Medicare participants may elect to purchase AARP® Medicare Supplement Insurance, insured by UnitedHealthcare Insurance Company (UnitedHealthcare), if the retiree and eligible dependents are all at least age 65 and currently enrolled in both Medicare Parts A and B. A Medicare supplement insurance plan (also known as a "Medigap" plan) is designed to supplement some or all of the health care costs not covered by Medicare Part A and Part B.

The County offers a range of Medicare supplement insurance plans to our Medicare-eligible retirees to help pay for some or all of the retiree's out-of-pocket costs. AARP Medicare Supplement Insurance Plans offer Medicare-eligible retirees an opportunity to choose from a variety of standardized Medigap plans (e.g. Plans A-N). Each plan offers a different level of benefits, and monthly premiums vary

Because there are so many plans and variables, we could not present all available plans in this guide. Instead, you must contact UnitedHealthcare for details. The most popular plans are shown in this booklet for illustrative purposes only.

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

To learn more about the AARP Medicare Supplement Insurance Plans and to request a monthly premium quote, contact UnitedHealthcare's Customer Service at (877) 558-4759. If you should choose to enroll by phone, please be aware that this process takes some time. Set aside at least 1 hour to sign up with a Customer Service representative. The group numbers and an enrollment checklist are provided on page 49. Customer Service representatives are available 7 days a week from 8:00 a.m. to 8:00 p.m. PST. Additional information is available on the following website: http://www.aarpmedsuppretirees.com.

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

IMPORTANT NOTE

Unlike some other plans where the medical and prescription benefits are part of the same coverage, Medicare supplement insurance plans do not include prescription drug benefits. As a result, the AARP Medicare Supplement Plans and the AARP® MedicareRx Prescription Drug Plan require separate enrollment. County retirees who enroll in the Medicare supplement plan must also enroll in an AARP MedicareRx Plan. The AARP MedicareRx Plans are available to retirees across the U.S. and in the five U.S. territories. All enrollees in these plans (i.e. retiree and their dependents) must be enrolled in both Medicare Part A and Part B and be at least age 65 in order to elect the coverage.

If you enroll in ANY Medicare Advantage plan or Part D Prescription Drug plan other than those offered to County of Sonoma retirees as explained in this guide, you may be dis-enrolled from your County-offered coverage.

AARP® MEDICARERX PRESCRIPTION DRUG PLANS (PDP)

AARP® MedicareRx Preferred and Saver Plus PDP offer a national pharmacy network with access to more than 68,000 pharmacies. The AARP® MedicareRX Walgreen's PDP includes a preferred pharmacy network of over 8,100 Walgreen's retail pharmacies (Including Duane Reade pharmacies). In addition, the plan's drug list includes thousands of brand-name and generic drugs. To assist in your decision, you can contact UnitedHealthcare at (877) 558-4759 with a list of medications and a representative will complete a needs assessment to find a plan that best fits your needs.

PART D DRUG BENEFITS

AARP MedicareRx Plans are Medicare Part D prescription drug plans (PDP). As a Medicare PDP, they are subject to changes implemented by the Patient Protection and Affordable Care Act (PPACA). The ACA requires Medicare Part D plans to gradually close the prescription drug coverage gap, known as the "donut hole." In 2022, retirees covered by a Medicare PDP, such as an AARP MedicareRx Plan, who reach the coverage gap, (when total costs you and your plan have spent reach $4,660) will pay no more than 25% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the coverage gap. You can expect additional savings in the coming years on your covered brand-name and generic drugs while in the coverage gap. Once your annual out-of-pocket drug costs exceed $7,400 in 2023, Part D Catastrophic Coverage begins and only a small coinsurance or copay is required. For more information, visit https://www.medicare.gov/drug-coverage-part-d or contact a UnitedHealthcare Customer Service representative at (877) 558-4759.

ENROLLING IN AARP® MEDICARE PLANS

UnitedHealthcare AARP Medicare plans are NOT administered by the County of Sonoma. The County of Sonoma coordinates the County contribution, where applicable. Any remaining premiums due will be payable to UnitedHealthcare and will not be deducted from your pension check.

To assist with enrollment in UnitedHealthcare's AARP Medicare Supplement and MedicareRx Plans, use the steps below. Each enrollee must complete ALL the following steps to enroll in the AARP Medicare Supplement and MedicareRx Plans:

1. Plan information and to enroll over the phone, contact UnitedHealthcare Customer Service at (877) 558-4759. Customer Service representatives are available Monday through Sunday from 8:00 a.m. to 8:00 p.m. PST:
   - AARP Medicare Supplement Insurance Plans Group # 1068
   - AARP MedicareRx PDP Group # 3803

2. Complete the County of Sonoma Retiree Benefits Enrollment/Change Form found in the back of this booklet. Keep a copy and send original form along with the following completed forms if plan enrollment was not completed over the phone:
   - Original AARP Medicare Supplement Insurance Plan enrollment form mailed to you by UnitedHealthCare, and
   - Original AARP MedicareRx Plan enrollment form mailed to you by UnitedHealthcare
   - Don't have these forms? If you did not receive the UnitedHealthcare enrollment form(s), immediately contact the Human Resources Benefits Unit and request the missing form(s) by calling or e-mailing:
     Phone: (707) 565-2900; or
     Email: benefits@sonoma-county.org

3. To enroll, send all original, completed, forms to:
   County of Sonoma
   Attn: HR Benefits Unit
   575 Administration Dr., Suite 116B
   Santa Rosa, CA 95403

THINGS TO KNOW…

Once you and/or your dependents reach age 65, you must enroll in **Medicare Parts A & B** and submit a copy of your and/or dependent's Medicare card to Human Resources Benefits Unit within 30 days to be eligible for County sponsored plan coverage.

UnitedHealthcare's AARP Medicare Supplement & MedicareRx Plans are individual plans with retirees paying their portion of the premium directly to UnitedHealthcare after the County contribution has been paid.

The AARP Medicare Supplement Plans may have premium increases around the first of the year. UnitedHealthcare will notify you if there is an increase.

Retirees who elect to enroll in UnitedHealthcare must enroll in both the AARP Medicare Supplement Insurance Plan and AARP MedicareRx Plan with the **same effective date** to be eligible for a County contribution.

- If you are **enrolling in AARP Medicare Supplement Plan through UnitedHealthcare for the first time or making a change to your current UnitedHealthcare plan**, please let the Customer Service agent know that you want a June 1, 2023 effective date.
- Phone enrollment is encouraged due to ease-of-use by contacting UnitedHealthcare Customer Service at (877) 558-4759.
- During AARP MedicareRx Plan phone enrollment, request the **"payment coupon book"** as your payment method to ensure you will receive the County Contribution toward your prescription drug plan enrollment. **Do not sign-up for the ACH debit from your Social Security check.**
- Keep your UnitedHealthcare phone enrollment Member ID and confirmation numbers for both the AARP Medicare Supplement Insurance Plan and the AARP MedicareRx Plan, as you will need to print these numbers on your required County of Sonoma Retiree Benefits Enrollment/Change Form.

MEDICAL PLAN COMPARISON CHART - COUNTY HEALTH PLANS		
Plan Information	County Health Plan EPO Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered** CVS/Caremark Group #3439-1004	County Health Plan PPO Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare) CVS/Caremark Group #3439-1002
GENERAL INFORMATION		
Health Plan Availability	Nationwide	Nationwide
Select A Primary Care Physician (PCP)	Does not require you to select a PCP	Does not require you to select a PCP
Seeing a Specialist	Allows you access to many types of services without receiving a referral or advance approval	Allows you access to many types of services without receiving a referral or advance approval
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child under age 26 Disabled: No age limit
Plan Year (June 1 - May 31) Medical Deductible	Individual: $500 Family: $1,500	Individual: $300 Family: $900
Plan Year Out-of-Pocket Maximum (including Deductibles, Copays & Coinsurance)	Medical/Prescription Drug Individual: $5,500/$1,100 Family: $11,500/$1,700	Medical/Prescription Drug Individual: $2,300/$1,100 Family: $4,900/$1,700
OFFICE VISITS AND PROFESSIONAL SERVICES		
Physician & Specialist Office Visits	In-Network: $50 copay, no deductible Out-of-Network: Not Covered	In-Network: $20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible
LiveHealth Online	$10 copay	$10 copay
Preventive Care Birth to Age 18	In-Network: No charge, no deductible Out-of-Network: Not Covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Preventive Care Adult Routine Care	In-Network: No charge, no deductible Out-of-Network: Not Covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Preventive Care Adult Routine OB/GYN	In-Network: No charge, no deductible Out-of-Network: Not Covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Diagnostic Imaging, Lab and X-ray	In-Network: 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible

MEDICAL PLAN COMPARISON CHART - COUNTY HEALTH PLANS		
Plan Information	County Health Plan EPO Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered** CVS/Caremark Group #3439-1004	County Health Plan PPO Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare) CVS/Caremark Group #3439-1002
OFFICE VISITS AND PROFESSIONAL SERVICES		
Physical Therapy (medical necessary treatment only)	In-Network: 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Chiropractic and Acupuncture	In-Network: 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Mental Health & Substance Use Disorder (outpatient)	In-Network: Office Visit: $50 copay, no deductible, Other Outpatient: 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: Office Visit: $20 copay, no deductible, Other Outpatient: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Family Planning Counseling and Consultation	In-Network: $50 copay, no deductible Out-of-Network: Not Covered	In-Network: $20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible
Routine Eye Exams with Plan Optometrist	In-Network: No charge, no deductible Out-of-Network: Not Covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Hearing Exam	In-Network: No charge, no deductible Out-of-Network: Not Covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Allergy Injections (serum included)	In-Network: $50 copay per visit, no deductible Out-of-Network: Not Covered	In-Network: $20 copay per visit, no deductible Out-of-Network: 40% coinsurance, after deductible
Infertility Services	Evaluation (diagnosis) and surgical repair only In-Network: $50 copay, no deductible Out-of-Network: Not Covered	Evaluation (diagnosis) and surgical repair only In-Network: $20 copay, no deductible Out-of-Network:40% coinsurance, after deductible
SURGICAL AND HOSPITAL SERVICES		
Hospitalization and Physician/Surgeon Services	In-Network: $500 copay plus 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: $125 per admission copay plus 10% coinsurance after deductible Out-of-Network: $125 per admission copay plus 40% coinsurance after deductible
Outpatient Surgery	In-Network: $500 copay plus 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - COUNTY HEALTH PLANS		
Plan Information	County Health Plan EPO Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered** CVS/Caremark Group #3439-1004	County Health Plan PPO Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare) CVS/Caremark Group #3439-1002
SURGICAL AND HOSPITAL SERVICES		
Maternity	In-Network: $250 copay plus 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: $125 per admission copay plus 10% coinsurance after deductible Out-of-Network: $125 per admission copay plus 40% coinsurance after deductible
Emergency Room	In-Network: $150 copay plus 20% coinsurance after deductible; Not Covered if non-emergency Out-of-Network: $150 copay plus 20% coinsurance after deductible; Not Covered if non-emergency (copays waived if admitted)	In-Network: $100 copay plus 10% coinsurance after deductible; If an emergency Out-of-Network: $100 copay plus 10% coinsurance after deductible; If an emergency (copays waived if admitted)
Ambulance	In-Network: 20% coinsurance after deductible Out-of-Network: 20% coinsurance after deductible if emergency; otherwise not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 10% coinsurance after deductible if emergency otherwise not covered
Mental Health & Substance Use Disorder (inpatient)	In-Network: $500 copay plus 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: $125 per admission copay plus 10% coinsurance after deductible Out-of-Network: $125 per admission copay plus 40% coinsurance after deductible
Skilled Nursing Facility	In-Network: Not Covered Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible; up to 100 days per plan year Out-of-Network: 40% coinsurance after deductible; up to 100 days per plan year
Home Health	In-Network: Not Covered Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible; up to 100 visits per plan year Out-of-Network: 40% coinsurance after deductible; up to 100 visits per plan year
Urgent Care	In-Network: $50 copay, no deductible Out-of-Network: Not Covered	In-Network: $20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible
Hearing Aids	One per ear every 36 months	One per ear every 36 months
Durable Medical Equipment	In-Network: 20% coinsurance after deductible Out-of-Network: Not Covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance after deductible

MEDICAL PLAN COMPARISON CHART - COUNTY HEALTH PLANS		
Plan Information	County Health Plan EPO Group # 175130M102 (CA Non-Medicare) Group # 175130M103 (CA Medicare) Group # 175130M106 (Out-of-State Non-Medicare) Group # 175130M107 (Out-of-State Medicare) **Out-of-Network Services Not Covered** CVS/Caremark Group #3439-1004	County Health Plan PPO Group # 175130M053 (CA Non-Medicare) Group # 175130M054 (CA Medicare) Group # 175130M059 (Out-of-State Non-Medicare) Group # 175130M060 (Out-of-State Medicare) CVS/Caremark Group #3439-1002
PRESCRIPTION MEDICATION		
Generic or Tier 1	$10 copay Up to 34 day supply	$5 copay Up to 34 day supply
Formulary Brand or Tier 2	$35 copay Up to 34 day supply	$20 copay Up to 34 day supply
Non-Formulary Brand or Tier 3	$70 copay Up to 34 day supply	$40 copay Up to 34 day supply
Mail Order Benefit Generic or Tier 1	$20 copay Up to 90 day supply	$10 copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	$70 copay Up to 90 day supply	$40 copay Up to 90 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	$140 copay Up to 90 day supply	$80 copay Up to 90 day supply
Mandatory Mail Order	Yes, through CVS Pharmacy Benefit	Yes, through CVS Pharmacy Benefit
Mandatory Generic Program	Yes	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at: https://sonomacounty.ca.gov/benefit-forms-and-plan-documents.

MEDICAL PLAN COMPARISON CHART - TRADITIONAL HMO			
Plan Information	Kaiser Permanente Traditional HMO Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	Sutter Health Plus Traditional HMO Group # 131802-000003 (Non-Medicare)	Western Health Advantage Traditional HMO Group # 950201-A001 (Non-Medicare)
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 Telehealth: $5 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 # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	Sutter Health Plus Traditional HMO Group # 131802-000003 (Non-Medicare)	Western Health Advantage Traditional HMO Group # 950201-A001 (Non-Medicare)
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 Telehealth: $5 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	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 # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	Sutter Health Plus Traditional HMO Group # 131802-000003 (Non-Medicare)	Western Health Advantage Traditional HMO Group # 950201-A001 (Non-Medicare)
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 # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	Sutter Health Plus Traditional HMO Group # 131802-000003 (Non-Medicare)	Western Health Advantage Traditional HMO Group # 950201-A001 (Non-Medicare)
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: https://sonomacounty.ca.gov/benefit-forms-and-plan-documents.

MEDICAL PLAN COMPARISON CHART - HOSPITAL SERVICES DHMO			
Plan Information	Kaiser Permanente Hospital Services DHMO Group # 9072-0006 (Non-Medicare)	Sutter Health Plus Hospital Services DHMO Group # 131802-000007 (Non-Medicare)	Western Health Advantage Hospital Services DHMO Group # 950201 (Non-Medicare)
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live or work in 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 Telehealth: $10 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 # 9072-0006 (Non-Medicare)	Sutter Health Plus Hospital Services DHMO Group # 131802-000007 (Non-Medicare)	Western Health Advantage Hospital Services DHMO Group # 950201 (Non-Medicare)
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 deductable, 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 # 9072-0006 (Non-Medicare)	Sutter Health Plus Hospital Services DHMO Group # 131802-000007 (Non-Medicare)	Western Health Advantage Hospital Services DHMO Group # 950201 (Non-Medicare)
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: https://sonomacounty.ca.gov/benefit-forms-and-plan-documents.

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE FIRST HDHP			
Plan Information	Kaiser Permanente Deductible First HDHP Group # 9072-0009 (Non-Medicare)	Sutter Health Plus Deductible First HDHP Group # 131802-000011 (Non-Medicare)	Western Health Advantage Deductible First HDHP Group # 950201 (Non-Medicare)
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live or work in 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**: $1,500 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $3,000	**Individual**: $1,500 **Any One Member in a family of two or more**: $3,000 **Family of two or more**: $3,000	**Individual**: $1,500 **Any One Member in a family of two or more**: $3,000 **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 Telehealth: $10 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 # 9072-0009 (Non-Medicare)	Sutter Health Plus Deductible First HDHP Group # 131802-000011 (Non-Medicare)	Western Health Advantage Deductible First HDHP Group # 950201 (Non-Medicare)
OFFICE VISITS AND PROFESSIONAL SERVICES			
Diagnostic Imaging, Lab and X-ray	**Diagnostic Lab**: $10 copay per encounter after deductible **Diagnostic X-ray**: $10 copay per encounter 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; Telehealth: $10 copay 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 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 maximums

MEDICAL PLAN COMPARISON CHART - DEDUCTIBLE FIRST HDHP			
Plan Information	Kaiser Permanente Deductible First HDHP Group # 9072-0009 (Non-Medicare)	Sutter Health Plus Deductible First HDHP Group # 131802-000011 (Non-Medicare)	Western Health Advantage Deductible First HDHP Group # 950201 (Non-Medicare)
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	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
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 # 9072-0009 (Non-Medicare)	Sutter Health Plus Deductible First HDHP Group # 131802-000011 (Non-Medicare)	Western Health Advantage Deductible First HDHP Group # 950201 (Non-Medicare)
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:
https://sonomacounty.ca.gov/benefit-forms-and-plan-documents.

MEDICAL PLAN COMPARISON CHART - MEDICARE PLANS			
Plan Information	Kaiser Permanente Senior Advantage Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare Plans A-N available; Plan G and Pre-ferred Plan for Part D used for example (Coverage varies by Plan selected)	Western Health Advantage Medicare Advantage MyCare 10/0 Group #950201-A001 (Non-Medicare) Group #950201-A001 (Medicare)
GENERAL INFORMATION			
Health Plan Availability	Based on residential zip code. Must live in service area within California, Hawaii, and the Northwest (Oregon/ Washington); rates vary by state	All states and select US territories	Based on residential zip code. Must live within WHA Service Area.
Select A Primary Care Physician (PCP)	Requires you to select a PCP who will work with you to manage your health care needs	Does not require you to select a PCP	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	Allows you access any specialist, as long as they accept Medicare, without receiving a referral or advance approval	PCP will refer to specialist providers and will obtain authorization from medical group. Members can be referred to any specialist participating in our Advantage Referral Program, which includes all medical groups.
Dependent Children Eligibility	Dependent child under age 26 Disabled: No age limit	Dependent child must have Medicare	Dependent child under age 26 Disabled: No age limit
Calendar Year Deductible	**None**	None (Plan G Example pays Part A Medicare deductibles for Medicare covered services. You are responsible for paying the Medicare Part B deductible of $226 in 2023)	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	No out-of-pocket maximums	$1500 per member
OFFICE VISITS AND PROFESSIONAL SERVICES			
Physician & Specialist Office Visits	$10 copay after deductible	No charge after the Part B deductible is paid	$10 per visit
Preventive Care Birth to Age 18	No charge, no deductible	N/A	No charge
Preventive Care Adult Routine Care	No charge, no deductible	No charge for Medicare-covered services	No charge

MEDICAL PLAN COMPARISON CHART - MEDICARE PLANS			
Plan Information	Kaiser Permanente Senior Advantage Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare Plans A-N available; Plan G and Pre-ferred Plan for Part D used for example (Coverage varies by Plan selected)	Western Health Advantage Medicare Advantage MyCare 10/0 Group #950201-A001 (Non-Medicare) Group #950201-A001 (Medicare)
OFFICE VISITS AND PROFESSIONAL SERVICES			
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge for Medicare-covered services	No charge
Diagnostic Imaging, Lab and X-ray	No Charge	No charge	No charge
Physical Therapy (medical necessary treatment only)	$10 Copay	No charge	$10 per visit
Chiropractic and Acupuncture	Discounted rates through Kaiser Choose Healthy (California Only)	No charge for Medicare-covered services	$20 per visit, up to 20 visits combined
Mental Health & Substance Use Disorder (outpatient)	**Individual**: $10 copay **Group**: $5 copay	No charge after deductible	$10 per visit
SURGICAL AND HOSPITAL SERVICES			
Hospitalization and Physician/Surgeon Services	Facility Fee: No charge Physician/Surgeon Fee: No charge	No charge, up to Medicare maximum days allowed	Facility Fee: No charge Physician/Surgeon Fee: No charge
Outpatient Surgery	$10 Copay	No charge for Medicare-covered services	$10 per visit
Maternity	No charge	No charge, up to Medicare maximum days allowed	No charge
Emergency Room	$50 Copay (waived if admitted)	No charge	$50 Copay (waived if admitted)
Ambulance	$50 per trip	No charge	$50 per trip
Mental Health & Substance Use Disorder (inpatient)	No charge	Not a covered benefit	No charge
Skilled Nursing Facility	No Charge - Up to 100 days per benefit period	No charge, up to Medicare maximum days allowed	No charge - Up to 100 days per benefit period
Home Health	No Charge Up to 100 visits per year	No charge, up to Medicare maximum days allowed	No charge
Hearing Aids	Not Covered	Hearing discounts available	$699 copay per aid Advanced, $999 copay per aid Prermium

MEDICAL PLAN COMPARISON CHART - MEDICARE PLANS			
Plan Information	Kaiser Permanente Senior Advantage Group # 9072-0000 (Non-Medicare) Group # 9072-0000 (Medicare)	AARP® Medicare Supplement Insurance Plans, insured by UnitedHealthcare Plans A-N available; Plan G and Pre-ferred Plan for Part D used for example (Coverage varies by Plan selected)	Western Health Advantage Medicare Advantage MyCare 10/0 Group #950201-A001 (Non-Medicare) Group #950201-A001 (Medicare)
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: $45 Copay Up to 30 day supply Tier 4: Non-preferred Drugs 40% coinsurance Specialty Drug Tier 5: 33% coinsurance Up to a 30 day supply	Tier 3: $10 Copay Up to 30 day supply Specialty Drug: 20% Coinsurance Up to 30 day supply
Mail Order Benefit Generic or Tier 1	$5 Copay Up to 100 day supply	$0 Copay Up to 90 day supply	$10 Copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	$10 Copay Up to 100 day supply	$0 Copay Up to 90 day supply	$20 Copay Up to 90 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	$10 Copay Up to 100 day supply	$120 Copay Up to 90 day supply **Non-Preferred Drugs Tier 4:** 40% coinsurance Up to 90 day supply **Specialty Drugs Tier 5:** 33% coinsurance 30 day supply	Tier 3: $20 Copay Up to 90 day supply Specialty Drug: 20% Coinsurance Up to 30 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	N/A

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:
https://sonomacounty.ca.gov/benefit-forms-and-plan-documents.

UNDERSTANDING MEDICARE BENEFITS

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

IMPORTANT

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

If you have questions about your eligibility for and enrollment in Medicare, contact the Social Security Administration at (800) 772-1213 at least 90 days prior to your 65th birthday. If you are enrolled in a plan for Non-Medicare-eligible retirees (not including Sutter Health Plus or Western Health Advantage), when you become Medicare-eligible you may elect to remain covered with your current medical carrier or choose a different medical plan. More information is available at: https://www.medicare.gov/medicare-and-you

Once you are enrolled in Medicare Parts A & B, coverage is provided as follows:

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

The County of Sonoma provides eligible retirees with reimbursement for the Medicare Part B premium (Effective June 1, 2009, frozen at $96.40 per month) beginning the month your Medicare Part B is effective. If you are eligible, this reimbursement is included in your monthly pension check. This benefit is limited to retirees hired before January 1, 2009 only and is not available to survivors of deceased retirees, retirees hired on or after January 1, 2009, or full cost retirees.

MEDICARE AND COUNTY BENEFITS

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

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

COUNTY HEALTH PLANS

If you choose to participate in one of the County Health Plans EPO or PPO, the benefits paid as you receive care are coordinated with your Medicare Parts A and B coverage. When you incur covered expenses under one of the County Health Plans, the cost will first be submitted to Medicare for payment. Under the County Health Plan EPO, Medicare retirees and/or Medicare dependents do not receive an additional payment other than Medicare on most services. Medicare usually pays 80% on services, which is the equivalent payment through the County Health Plan EPO plan. Then, the County Health Plan will pay an amount, based on the benefit provided for that type of expense (e.g., for an in-network doctor's office visit). Refer to the County Health Plan's Summary Plan Description for more information and examples of how County Health Plan benefits are coordinated with Medicare.

Under the County Health Plan EPO, Medicare retirees and/or Medicare dependents must use a provider that is both a preferred provider and a Medicare provider to receive benefits under the plan. Under the County Health Plans you are required to meet a deductible and pay applicable copays and coinsurance for services. You must use a Medicare provider to receive benefits under the County Health Plans. Under the County Health Plan PPO, you will receive a higher level of coverage when you use providers within the Anthem Blue Cross network based on your place of residence.

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

IMPORTANT NOTE REGARDING PRESCRIPTION DRUG COVERAGE… County Health Plan EPO and County Health Plan PPO include credible prescription coverage through CVS/Caremark. If you enroll in either County Health Plan EPO or PPO plans you cannot also enroll in Medicare Part D coverage or you risk being permanently dropped from your medical plan coverage.

KAISER PERMANENTE SENIOR ADVANTAGE HMO PLAN AND WESTERN HEALTH ADVANTAGE MEDICARE ADVANTAGE MYCARE 10/0 PLAN

These plans are approved as a "Medicare Advantage" plan by Medicare. When you choose to participate in these plans, you agree to allow Kaiser Permanente or Western Health Advantage to provide your Medicare Parts A and B benefits. In doing so, you authorize Medicare to pay

your benefits directly to Kaiser Permanente or Western Health Advantage. Under the Medicare Advantage plans you pay a set copay for most services you use. You must use Kaiser Permanente or Western Health Advantage contracted providers for your care, except in an emergency.

COORDINATION OF BENEFITS (COB) WITH COUNTY HEALTH PLAN

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

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

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

PRIMARY INSURANCE EXPLANATION OF BENEFITS

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

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

"LESSER OF" RULE

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

CARVE-OUT METHOD

Also please note the Plan uses the "carve-out" method of COB. Carve-out guarantees that you receive the same benefit you would receive in the absence of the other plan or Medicare. Carve-out also means you do not receive 100 percent of the total covered charge unless you satisfy this plan's annual deductible and annual out-of-pocket maximum. With carve-out, if this plan's (as the secondary plan) normal benefit is greater than the primary plan's payment, then this plan will pay the difference between its normal plan benefit and the primary plan's payment. If this plan's normal benefit is equal to or less than the primary plan's payment, then no payment will be made by this plan.

EXAMPLES OF COORDINATION OF BENEFITS (COB) BETWEEN MEDICARE AND THE COUNTY HEALTH PLAN (CHP)

With the Coordination Of Benefits (COB) between CHP and Medicare, CHP pays the difference between the two plans, if the amount it pays is higher than what Medicare pays. The examples below are for educational purposes only and are not a guarantee of allowances.

Example 1: Inpatient Hospital (In-Network):

Medicare Only:

	CHP - EPO	CHP - PPO
COB Allowance	$8,800	$8,800
Medicare Payment	-$7,540	-$7,540
Balance	$1,260	$1,260

County Health Plan and Medicare Coordination:

	CHP - EPO	CHP - PPO
COB Allowance	$8,800	$8,800
Deductible	-$500	-$300
Per Admission Co-Pay	-$500	-$125
Balance	$7,800	$8,375
Co-Insurance	80%	90%
Available CHP Benefit	$6,240	$7,538

In this example, the COB Allowance for Inpatient Hospital services is $8,800. Medicare alone would have paid $7,540 and you would be responsible for $1,260.

In both the EPO and PPO examples, the Available CHP Benefit is less than the Medicare Payment, so the CHP plan does not pay in this scenario. The member would be responsible for paying the balance of $1,260.

Example 2: Outpatient Surgery (In-Network):

Medicare Only:

	CHP - EPO	CHP - PPO
COB Allowance	$2,600	$2,600
Deductible	-$147	-$147
Balance	$2,453	$2,453
Co-Insurance	80%	80%
Medicare Payment	$1,962	$1,962

County Health Plan and Medicare Coordination:

	CHP - EPO	CHP - PPO
COB Allowance	$2,600	$2,600
Deductible	-$500	-$300
Co-Pay	-$500	-0
Balance	$1,600	$2,300
Co-Insurance	80%	90%
Available CHP Benefit	$1,280	$2,070

In this example, the COB allowance for Outpatient Surgery services is $2,600. Medicare alone would have paid $1,962 and you would be responsible for the deductible and the coinsurance totaling $2,109.

The EPO plan has an Available CHP Benefit amount of $1,280 which is less than the Medicare Payment of $1,962. The CHP plan would not pay in this scenario.

The PPO plan has an Available CHP Benefit amount of $2,070 which is more than the Medicare Payment of $1,962. The CHP plan would have paid the difference of $108 in this scenario. The member would be responsible for the remaining balance of $530, the difference between the COB allowed amount of $2,600 and the total amount of $2,070 paid by both plans.

Example 3: Physician Office Visit (In-Network):

Medicare Only:

	CHP - EPO	CHP - PPO
COB Allowance	$100	$100
Medicare Payment	-$80	-$80
Balance	$20	$20

County Health Plan and Medicare Coordination:

	CHP - EPO	CHP - PPO
COB Allowance	$100	$100
Co-Pay	-$50	-$20
Available CHP Benefit	$50	$80

In this example, the COB Allowance for Physician Office Visit is $100. Medicare alone would have paid $80 and you would be responsible for $20.

The EPO plan has an Available CHP Benefit amount of $50 which is less than the Medicare Payment of $80. The CHP plan would not pay in this scenario. The member would be responsible for the remaining balance of $20.

The PPO plan has an Available CHP Benefit amount of $80 is the same as the Medicare Payment of $80. The CHP plan would not pay in this scenario. The member would be responsible for the remaining balance of $20.

DENTAL BENEFITS

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

Take note… Dentistry has changed in recent years and continues to change on a regular basis. Much of this change is due to new materials, new technology, and new scientific discoveries, as well as changes in the way dentists run their practices. It's the dentist's responsibility to inform the patient about all of the reasonable and appropriate services that are available, regardless of the patient's dental coverage. It's the patient's responsibility to ask the right questions about these options and treatment.

Always request that your dentist submit a pre-treatment estimate to Delta Dental before having major dental work done. Don't be afraid to ask questions! Do not agree to any treatment unless you fully understand what condition is being treated, why it is being treated, and the costs of that treatment. When in doubt, contact Delta Dental.

To learn more about Delta Dental, visit us at www.DeltaDentalIns.com or call (888) 335-8227 for the Delta Dental PPO™ plan or (800) 422-4234 for DeltaCare® USA (DHMO) plan.

HOW THE DENTAL PLAN WORKS

The information in this benefits guide is only a summary of the plan benefits. For more detailed information, refer to the plan's evidence of coverage booklets, available through the County of Sonoma web site at: https://sonomacounty.ca.gov/benefit-forms-and-plan-documents.

Take note… The benefit plan year is June 1-May 31. The deductible is on a calendar year basis, from January 1 through December 31. This means your deductible and plan maximum benefit levels accumulate over the calendar year and start over as of January 1 each year.

Delta Dental PPO™ is underwritten by Delta Dental of California in CA.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

2023 - 2024 DENTAL PREMIUMS

You pay the full cost for dental coverage. If you enroll in retiree dental coverage during the Annual Enrollment Period, your coverage is effective June 1, 2023.

Monthly Dental Plan Premiums Effective June 1, 2023		
	Delta Care® USA (DHMO)	Delta Dental PPO™
Employee	$28.84	$47.06
Employee + 1	$49.05	$89.88
Employee + 2 or more	$72.59	$149.15

If you are interested in enrolling in a retiree dental plan, complete the Retiree Benefits Enrollment/Change Form and return to the County of Sonoma Human Resources Benefits Unit within 31 days of eligibility.

DELTA DENTAL PLANS COMPARISON CHART

Plan Feature	DeltaCare® USA (DHMO) Group #70247-0001	Delta Dental PPO™ Group #03136-0001
Who Can Enroll?	California residents only	No residency restrictions
Dental Provider Choice	DeltaCare® USA In-Network Providers only	In-Network and Out-of-Network Providers
Diagnostic & Preventive	Plan pays 100% for most services	Plan pays 100% for most services, no deductible
Basic Dental Services	You pay set co-payments ranging from $0 to $250 for most services	Plan pays 80% of allowable charges
Crowns & Cast Restorations	You pay set co-payments ranging from $0 to $90 for most services	Plan pays 50% of allowable charges
Prosthodontics	You pay set co-payments ranging from $0 to $175 for most services	Plan pays 50% of allowable charges; coverage for implants is included under the plan.
Orthodontics	$1,600 per child to age 19 and $1,800 per person age 19+ for 24 months of treatment. $75 per month per member co-payment for treatment after 24 months. Additional start-up fees may apply.	Not covered
Deductible	$0	$50 per individual
Annual Maximum Dental Benefits	None	$1,500 per individual

Delta Dental PPO™ - Using Out-of-Network Providers - If you visit a non-Delta Dental PPO™ provider, the plan will reimburse you at contracted rates only. You will need to file a claim with Delta Dental for reimbursement. To obtain a form and instructions for submitting your claim, visit the Delta Dental website at www.deltadentalins.com.

VISION AND LIFE INSURANCE BENEFITS

UNITEDHEALTHCARE LIFE INSURANCE

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

Coverage Amount	Monthly Premium
$10,000	$9.85

Retirees enrolled in the $2,000 life insurance policy will continue their enrollment at a cost of $1.97 per month.

VISION SERVICE PLAN (VSP) RETIREE SAVINGS PASS PROGRAM

County of Sonoma retirees and their dependents have access to discounts on vision care through the Vision Service Plan (VSP) Retiree Savings Pass Program. There is no cost to the retiree for this program. This program is only available through a VSP network doctor and has been enhanced to provide even more value when receiving an exam and materials.

Get the best in eye care and eyewear with COUNTY OF SONOMA and VSP® Vision Care.

At VSP, we invest in the things you value most—the best care at the lowest out of pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP…

Value and Savings. You'll enjoy more value and the lowest out-of-pocket costs.

High Quality Vision Care. You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.

Choice of Providers. The decision is yours to make—choose a VSP provider or any out of network provider.

Great Eyewear. It's easy to find the perfect frame at a price that fits your budget.

VSP RETIREE SAVINGS PASS HIGHLIGHTS

VSP Retiree Savings Pass Program	
Benefit	Group #3001 2860
WellVision Exam	•$50 with purchase of a complete pair of prescription glasses •20% off without purchase •Once every calendar year
Retinal Screening	Guaranteed pricing with WellVision Exam, not to exceed $39
Lenses	When a complete pair of prescription glasses are purchased - •Single vision: $40 •Lined Bifocals: $60 •Lined Trifocals: $75 •Polycarbonate for Children: $0
Lens Enhancements	Average savings of 20-25% on lens enhancements; such as, progressive, scratch-resistant, and anti-reflective coatings when a complete pair of prescription glasses are purchased
Frame	25% savings when a complete pair of prescription glasses are purchased
Additional Pairs	Same savings as first pair
Sunglasses	20% savings
Contact Lenses	15% savings on contact lens fitting and evaluation
Contact Lens Rebates	Exclusive rebates on eligible contact lenses
Laser Vision Correction	Average 15% savings on the regular price or 5% on the promotional price

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

Take note. . . The VSP Savings Pass Program is available at no cost to retirees. However, you must use a VSP network provider to receive the applicable discounts for services. You can find a VSP provider through the VSP web site at www.vsp.com or by calling the plan's customer service at (800) 877-7195.

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

AFTER YOU ENROLL, WHEN ARE CHANGES ALLOWED?

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 Registered Domestic Partnership (RDP)	• Enroll in or waive health coverage for your new spouse/RDP and other newly eligible dependents[1] • Waive health coverage for newly eligible dependents if your coverage is also waived[1] • Change health plans	• Waive health coverage for yourself and previously eligible children[1] • Enroll if not already enrolled
Divorce, Legal Separation, or Termination of Registered Domestic Partnership	• Cancel health coverage for your spouse/RDP • Enroll yourself and your dependent children in health coverage if you or they were previously enrolled in your spouse/RDP's health plan and only if a signed waiver is on file • Cancel health coverage for dependent children[2]	Change Health Plans
Gain a child due to birth or adoption	• Enroll in or waive health coverage for the newly eligible dependent[1] • Adoption placement papers are required • Change health plans	
Previously ineligible child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	• Add child named on QMCSO to your health coverage (enroll yourself, if eligible and waiver is on file) • Drop child named on QMCSO if required by QMCSO • Change health plans, when options are available, to accommodate the child named on the QMCSO	Make any other changes except as required by the QMCSO
Loss of a child's eligibility (e.g. child reaches the maximum age for coverage)	• Drop the child who lost eligibility from your health coverage	Change health plans
Death of a Dependent (Spouse/RDP or Child)	• Drop the deceased dependent from your health coverage • Enroll in health coverage if lost eligibility under spouse's/RDP's plan and waiver is on file • Change health plans	
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 or dental HMO and move out of their service area	
Death of retiree	• Eligible dependents may enroll at the time of the event or continue to waive if previously waived prior to retirees death until Medicare eligibility	Surviving dependents must enroll or continue to waive

MEDICARE/MEDICAID/MEDI-CAL/SCHIP 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
Retiree has become entitled to Medicare	• Change medical plans • Last opportunity to enroll yourself and dependent children in a medical plan, if previously waived. Spouse can continue to waive until they reach their own Medicare eligibility. • Eligibility for coverage will be permanently canceled if no enrollment within 60 days of Medicare eligibility	

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

You will be required to provide proof of mid-year event for all changes
Changes must be consistent with the event type.

AFTER YOU ENROLL, WHEN ARE CHANGES ALLOWED?

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

MEDICARE/MEDICAID/MEDI-CAL/SCHIP 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 Medicaid, Medi-Cal, or SCHIP[1]	• 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[1]	• 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 retire, transferring from active benefits to retiree benefits	• Change medical plans • Enroll in a retiree dental plan • Waive health coverage for yourself and/or dependents. Spouse/ RDP has independent waiver rights. • Enroll eligible dependents	• You may not be enrolled in an employee or other retiree benefits
Spouse/RDP obtains medical or dental benefits in another group health plan or public exchange	• Permanently cancel medical coverage for spouse/RDP • Waive dental coverage for spouse/RDP	• Change health plans • Waive health coverage[1]
Spouse/RDP loses coverage for medical and dental benefits in another group medical or dental plan (Proof of loss of other coverage is required)	• Enroll yourself and/or spouse/RDP in a health plan, if eligible and previously waived • Add dependent child(ren) to a medical plan if eligible and previously waived, only if waived along with retiree and retiree is also re-enrolled • Change health plans[1]	Enroll dependent children in a medical plan unless the retiree is enrolling[1]

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

[1]Waiving retiree medical is a one-time only option at the time of retirement or within 31 days of the event date for newly eligible dependents (e.g. marriage, adoption, birth). Per the Salary Resolution, eligible dependent children not enrolled in retiree medical at the time retiree is initially enrolled are not eligible for re-enrollment in retiree medical at any time in the future, including upon the loss of other group coverage.

Moving out of the service area?

To be eligible for an HMO, you must live in a qualified coverage area. Contact the HR Benefits Unit to confirm eligibility before moving to a new location.

If you move outside a qualified coverage area, you will be required to choose a new plan that meets coverage area eligibility, or drop County-sponsored coverage.

MID-YEAR PLAN CHANGES

EFFECTIVE DATES OF COVERAGE

Canceling Coverage:

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

Examples -

- A voluntary cancelation without other group coverage ends the last day of the month following the date we receive the submitted Enrollment/Change form.
- Spouse obtains other group coverage on the 1st of the month. Coverage for spouse ends on the last day of the prior month.

Adding newly eligible dependent:

Effective date of change is generally the **first of the month** following or coinciding with the event that allowed the change.

Examples -

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

New Retirees:

Effective on the **first of the month** following or coinciding with the date of retirement.

Examples -

- Retired July 1st. Employee coverage ends June 30th. Employee is offered the choice of COBRA or the County's Retiree coverage. If County's Retiree coverage is elected then the Retiree coverage is effective on July 1st.
- Retired July 9th. Employee coverage ends July 31st. Employee is offered the choice of COBRA or the County's Retiree coverage. If County's Retiree coverage is elected then the Retiree coverage is effective on August 1st.

Birth/Adoption:

Effective on the **first of the month** following date of birth/adoption. Medical plans will cover a newborn under the subscriber's coverage from date of birth through the end of the birth month. Request for enrollment must be made within 31 days from the date of birth to ensure continued medical coverage for the child.

APPEALS PROCESS

GENERAL INFORMATION

In the event a retiree believes that a request for health benefits 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.

TIMEFRAMES

Any retiree or dependent 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.

CONTACT INFORMATION AND RESOURCES

At the County of Sonoma, we're committed to helping our 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 retirees and their family members who are enrolled in County sponsored medical, dental and/or vision 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 health plans (medical, dental, etc.)
- 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 secure 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: https://sonomacounty.ca.gov/benefits

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
County Health Plans (PPO & EPO) Administered by Anthem Blue Cross	(800) 759-3030	www.anthem.com/ca
CVS/Caremark County Health Plans' Rx drug provider	(800) 966-5772	www.caremark.com
Kaiser Permanente - California	(800) 464-4000	www.my.kp.org/sonomacounty www.kp.org
Kaiser Permanente - Hawaii	(800) 805-2739	www.kp.org
Kaiser Permanente - Northwest	(877) 221-8221	www.kp.org
Sutter Health Plus	(855) 315-5800	www.sutterhealthplus.org/sonoma-county
UnitedHealthcare Plans AARP® Medicare Supplement Insurance and Rx Plans	(800) 54501797 TTY (877) 730-4192 (888) 867-5575	www.aarphealthcare.com www.aarpmedicarerx.com
Western Health Advantage	(888) 563-2250	www.westernhealth.com/mywha/welcome-to-wha/county-of-sonoma
Delta Dental	(800) 765-6003	www.deltadentalins.com
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
UnitedHealthcare (Life Insurance)		
Health Insurance Counseling and Advocacy Program (HICAP) Free and objective information and counseling about Medicare	(800) 434-0222	www.cahealthadvocates.org/HICAP/
The P&A Group COBRA and HRA	(800) 688-2611	www.padmin.com
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: https://sonomacounty.ca.gov/benefit-forms-and-plan-documents

REQUIRED NOTICES

NOTICE OF GRANDFATHER STATUS

Some of the medical plan options sponsored by the County are considered grandfathered medical plans in accordance with the Affordable Care Act. The following notice is required by law.

This group health plan (sponsored by the County) believes that the **Kaiser Hawaii and Kaiser Northwest HMO medical plan options are considered to be "grandfathered health plans"** under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the above noted plan options may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the HR Benefits Unit at (707) 565-2900.

You may also contact the U.S. Department of Health and Human Services at https://www.hhs.gov/.

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, 2023
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 waiving 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.

IRS FORM 1095

Under the Affordable Care Act, starting in early 2016, employers (and in some cases insurance companies) are required to provide retirees enrolled in self-insured plans, with IRS Form 1095C. If you were enrolled in the County Health Plan, administered by Anthem Blue Cross, you can expect to receive a 1095C form. It will be provided to you on or by March 2, 2023.

For each month of 2022 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

(not applicable to Kaiser Hawaii and Kaiser NW HMOs)

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 59.

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 59.

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.

COBRA COVERAGE REMINDER

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

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

Qualifying events for dependents enrolled in Retiree coverage typically include death of the retiree, divorce/legal separation from the retiree, or a child ceasing to be an eligible dependent child.

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

The maximum period of COBRA coverage is 36 months.

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

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

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.

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, 2023. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ 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: http://www.kancare.ks.gov Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
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.mymaineconnection.gov/benefits/s/?language=e n_US 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 TTY: (617) 886-8102
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 Email: HHSHIPPProgram@mt.gov	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/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**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 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/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, 2023, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

23020500
COUNTY OF SONOMA
HUMAN RESOURCES DEPARTMENT - BENEFITS UNIT
575 ADMINISTRATION DRIVE, SUITE 116B
SANTA ROSA, CA 95403

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