2019

Retiree Benefits Overview

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 16 for more details.

Your Next Wave Of Benefits Is Here.

At San Benito County, we value our retirees. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason San Benito County offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

January 1, 2019 - December 31, 2019

2019 BENEFIT CHANGES

Plan	Benefit Changes
Anthem Choice PPO for Non-Medicare Retirees	Increased emergency room copay and calendar year deductible, see page 8
Anthem HDHP for Non-Medicare Retirees	- Increased calendar year deductible, see page 9 - NEW ID cards will be mailed - NEW Group and Bin Number (see page 21)
Anthem Safe PPO for Non-Medicare Retirees	Increased emergency room copay and calendar year deductible, see page 10

Who Can You Cover?

WHO IS ELIGIBLE?

A qualified retiree of the County, who is aged 50 years or older and is currently covered under the County medical plan.

You can enroll the following family members in our retiree medical plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by San Benito County are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis. Contact your tax advisor about your domestic partner's tax dependent status and advise San Benito County if your domestic partner is a tax dependent.
- Your children (including your Domestic Partner's Child):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHEN CAN I ENROLL?

Coverage for new retirees begins on the **First of The Month Following The End of Your Active Employment.**

Open enrollment is generally held in October. Open enrollment is the one time each year that retirees can make changes to their benefit elections without a qualifying life event.

Retirees who waive medical coverage may only rejoin the County plan if proof of loss of other non-individual coverage is shown.

You have 31 days to make your change

Cost of Medical

NON-MEDICARE RETIREES

Plan by Tier	Monthly Premium	County Contribution	Employee Monthly Cost	Employee Bi-Weekly Cost
Kaiser HMO				
Single	$794.00	$550.00	$244.00	$122.00
Two Party	$1,572.00	$1,050.00	$522.00	$261.00
Family	$2,040.00	$1,315.00	$725.00	$362.50
Anthem Safety PPO				
Single	$732.00	$550.00	$182.00	$91.00
Two Party	$1,465.00	$1,050.00	$415.00	$207.50
Family	$1,872.00	$1,315.00	$557.00	$278.50
Anthem Choice PPO				
Single	$837.00	$550.00	$287.00	$143.50
Two Party	$1,674.00	$1,050.00	$624.00	$312.00
Family	$2,176.00	$1,315.00	$861.00	$460.50
Anthem HDHP				
Single	$776.00	$550.00	$226.00	$113.00
Two Party	$1,551.00	$1,050.00	$501.00	$250.50
Family	$2,017.00	$1,315.00	$702.00	$351.00

MEDICARE RETIREES

Plan by Tier	Monthly Premium	County Contribution	Retiree Monthly Cost	Retiree Bi-Weekly Cost
Kaiser KPSA HMO				
Single	$334.00	$334.00	$0.00	$0.00
Two Party	$651.00	$51.00	$0.00	$0.00
Family	N/A	N/A	N/A	N/A
Anthem Choice PPO Supp (EGWP)				
Single	$439.00	$385.00	$54.00	$27.00
Two Party	$878.00	$735.00	$143.00	$71.50
Family	$1,316.00	$920.50	$395.50	$197.75

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Kaiser Permanente Plan Participants

- Call Kaiser's 24/7 NurseLine at 800-464-4000
- Find an urgent care center by visiting kp.org
- Use Kaiser Video Visit (My Doctor Online) or schedule a telephone appointment

Anthem Medical Plan Participants

- Call Anthem's 24/7 NurseLine at 800-977-0027
- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

GET A VIDEO HOUSE CALL

Kaiser and Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment.

Kaiser's video visit is a secure and easy way to visit your doctor. It saves travel time and expense. All you need is a computer with a high-speed internet connection and a webcam or a smartphone mobile device. Visit kp.org/mydoctor/videovisits for more information.

Anthem's LiveHealth Online provides 24/7 access to U.S. board-certified physicians, copay is the same as your plan's office visit copay. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit livehealthonline.com.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

Carrum Health For Non-Medicare Retirees

San Benito County has partnered with Carrum Health to provide eligible health plan members access to an **enhanced surgery benefit** program with top-quality hospitals and surgeons. Carrum Health is a special surgery benefit that provides exclusive access to Scripps Hospital, Stanford Health Care, Providence Saint John's Health Center (Santa Monica), and The Hoag Orthopedic Institute's Outpatient Center (Orange County).

Eligible members include active employees and their dependents who are enrolled in the Anthem PPO or High Deductible Health Plans. Eligible procedures include: hip and knee replacement, spinal fusion surgery, 80 orthopedic procedures (shoulder, elbow, wrist, hand, hip, knee, ankle, foot and spine), multiple spine procedures, coronary bypass (CABG), bariatric (weight loss) surgery. Please contact Carrum Health to learn if your desired procedure is available.

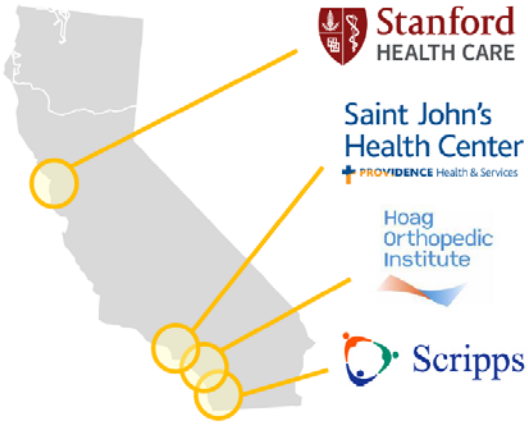
Use of this benefit is optional. This benefit is separate from and in addition to the benefits already provided under Anthem. This benefit is not administered by **Anthem**. This benefit must be accessed through Carrum Health.

Under the Carrum Health surgery benefit program, your personally assigned Carrum "Care Concierge" will:

- Help complete forms
- Gather and transfer medical records
- Assist in the selection of a surgeon
- Schedule the surgery
- Make travel arrangements (if necessary)
- Coordinate post-discharge recovery care

carrum health

You will have special access to "Centers of Excellence" which are hospitals and surgeons that have been vetted for providing top-quality care and achieving better outcome!



Location	Procedures
SF Bay Area, CA	Hip and Knee Replacement Spinal Fusion Surgery
Santa Monica, CA	Hip and Knee Replacement
Orange County, CA	80 Orthopedic Procedures (Shoulder, Elbow, Wrist, Hand, Hip, Knee, Ankle, Foot and Spine)
San Diego, CA	Hip and Knee Replacement Multiple Spine Procedures Coronary Bypass (CABG) Bariatric (Weight Loss) Surgery

There are no medical bills! Co-insurance and deductibles will be waived!*
*Due to IRS regulations, on HDHP plans the deductible applies but the co-insurance is waived.

Travel expenses (if applicable) will be covered for the patient and an adult companion!

To learn more or get started with the program, contact Carrum Health
Toll Free: 1-888-855-7806
Online: carrum.me/EIAHEALTH

Medical Plans For Non-Medicare Retirees

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

San Benito County gives you a choice of medical plans through Kaiser Permanente and Anthem Blue Cross.

	Kaiser Permanente Traditional HMO Plan
	In-Network
Calendar Year Deductible	
Individual	$0
Family	$0
Annual Out-of-Pocket Max	
Individual	$1,500
Family	$3,000
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$15 per visit
Specialist	$15 per visit
Preventive Services	No Charge
Lab and X-ray	
CT, MRI, PET scans	No Charge
Other lab and x-ray tests	
Hospitalization	
Inpatient	No Charge
Outpatient	$15 per surgery
Emergency Room	$50 per visit (copay waived if admitted)
Chiropractic and Acupuncture (20 visits combined per calendar year)	$15 per visit
PRESCRIPTION DRUG	**Generic I Brand**
Rx Copay Out of Pocket Max	Combined with Medical
Retail – 30 day supply	$5 I $20
Mail Order – Up to100 day supply	$10 I $40

Specific details and plan limitations are provided in the Summary Plan Description (SPD), which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this summary differs from the Plan Documents, the Plan Documents will prevail.

Medical Plans For Non-Medicare Retirees

	Anthem Choice PPO	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$750	
Family	$1,500	
Annual Out-of-Pocket Max		
Individual	$3,000	N/A
Family	$6,000	N/A
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	$20 per visit	40%
Specialist	$20 per visit	40%
Preventive Services	No Charge	40%
Lab and X-ray		
CT, MRI, PET scans	20%	40%
Other lab and x-ray tests	20%	40%
Hospitalization		
Inpatient	20%	40%
Outpatient	20%	40%
Emergency Room	$100 copay + 20% (copay waived if admitted)	
Outpatient Surgery	20%	40%, up to $350 per visit
Chiropractic and Acupuncture (20 visits combined per calendar year)	$15 per visit	40%
PRESCRIPTION DRUG		
Rx Copay Out-Of-Pocket Max	$2,000 (individual) | $4,000 (family)	
	Retail	**Mail Order**
Generic	$5	$10
Preferred	$20	$40
Non-Preferred	$50	$100
Supply	31 days	90 days

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Medical Plans For Non-Medicare Retirees

	Anthem High Deductible Health Plan[1]	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$1,600	$2,850
Family	$3,200	$8,550
Annual Out-of-Pocket Max		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	$25 per visit[2]	30%[2]
Specialist	$25 per visit[2]	30%[2]
Preventive Services	No Charge	30%[2]
Lab and X-ray		
CT, MRI, PET scans	$25 per visit[2]	30%[2]
Other lab and x-ray tests	$25 per visit[2]	30%[2]
Hospitalization		
Inpatient	$250 per day (3 day Max)[2]	30%[2]
Outpatient	$250 per day (3 day Max)[2]	30%[2]
Emergency Room	10%[2]	
Outpatient Surgery	$250 / admission	30%, up to $350 per visit
Chiropractic & Acupuncture Care (20 visits combined per calendar year)	10%[2]	30%[2]
PRESCRIPTION DRUG Rx Copay Out-Of-Pocket Max	Combined with medical	
	Retail	**Mail Order**
Generic	$15 [2]	$30 [2]
Preferred	$25 [2]	$50 [2]
Non-Preferred	$35 [2]	$70 [2]
Supply	30 days	90 days

[1]HSA Compatible
[2]Benefit after plan deductible

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Medical Pans For Non-Medicare Retirees

	Anthem Safety PPO	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$550	$850
Family	$1,650	$2,550
Annual Out-of-Pocket Max		
Individual	$4.500	$4,500
Family	$9,000	$9,000
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	$20 per visit	10%
Specialist	$20 per visit	10%
Preventive Services	No Charge	No charge
Lab and X-ray		
CT, MRI, PET scans	10%	10%
Other lab and x-ray tests	10%	10%
Hospitalization		
Inpatient	10%	10%
Outpatient	10%	10%
Emergency Room	$50 + 10% (copay waived if admitted)	
Outpatient Surgery	10%	10%, up to $350 per visit
Chiropractic Care (20 visits per calendar year)	$20 per visit	10%
Acupuncture Care	$20 per visit	10%
PRESCRIPTION DRUG Rx Copay Out-Of-Pocket Max	$2,650 (individual) | $5,300 (family)	
	Retail	**Mail Order**
Generic	$10	$20
Preferred	$25	$40
Non-Preferred	$45	$75
Supply	30 days	90 days

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Medical Plans For Medicare Retirees

	Kaiser Permanente Senior Advantage (KPSA)
	In-Network
Calendar Year Deductible	
Individual	$0
Family	$0
Annual Out-of-Pocket Max	
Individual	$1,500
Family	$3,000
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$10 per visit
Specialist	$10 per visit
Preventive Services	No Charge
Lab and X-ray	
CT, MRI, PET scans	No Charge
Other lab and x-ray tests	
Hospitalization	
Inpatient	No Charge
Outpatient	$10 per surgery
Emergency Room	$50 per visit (copay waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year)	$10 per visit
PRESCRIPTION DRUG	**Generic I Brand**
Rx Copay Out of Pocket Max	Combined with Medical
Retail – 30 day supply	$5 I $20
Mail Order – Up to 100 day supply	$10 I $40

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Medical Plans For Medicare Retirees

	Anthem CHOICE PPO Supp (EGWP)	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	None	
Family	None	
Annual Out-of-Pocket Max		
Individual	None	
Family	None	
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	No Charge	No Charge
Specialist	No Charge	No Charge
Preventive Services	No Charge	No Charge
Lab and X-ray		
CT, MRI, PET scans	No Charge	No Charge
Other lab and x-ray tests	No Charge	No Charge
Hospitalization		
Inpatient	No Charge	No Charge
Outpatient	No Charge	No Charge
Emergency Room	No Charge	
Chiropractic & Acupuncture Care	$15 per visit (20 visits combined per calendar year)	
PRESCRIPTION DRUG		
Rx Copay Out-Of-Pocket Max	$2,000 (individual) I $4,000 (family)	
	Retail	**Mail Order**
Generic	$5	$10
Preferred	$20	$40
Non-Preferred	$50	$100
Supply	31 days	90 days

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For Assistance

I If you need to reach our plan providers, here is their contact information:

Carrier	Group No./ID	Phone Number	Website
Kaiser Permanente	605299	(800) 464-4000	www.kp.org
Anthem Blue Cross	**Non-Medicare:** Choice: 175075M752 Safety: 175075M756 **HDHP:** 175075M760, BIN: 020099 **Medicare:** Medicare Supplemental: 175075M761	(800) 967-3015	www.anthem.com/ca
Express Scripts	**Non-Medicare:** Choice: 175075M752 Safety: 175075M756 **Medicare:** Medicare Supplemental: EIAEGWPBSCSTD	(800) 282-2881	www.express-scripts.com

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services. In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

Medicare Part D Notice

Important Notice from County of San Benito about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with County of San Benito 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 San Benito has determined that the prescription drug coverage offered by the Kaiser Permanente & Anthem Blue Cross are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your County of San Benito coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under Kaiser and Anthem are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your County of San Benito prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 County of San Benito and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information. [NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of San Benito 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 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 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:	January 1, 2019
Name of Entity/Sender:	County of San Benito
Contact-Position/Office:	Steve Coffee, Human Resources Analyst
Address:	481 Fourth Street, Hollister, CA 95023
Phone Number:	(831) 636-4000 extension 15

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Human Resources.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call Human Resources.

NOTICE OF CHOICE OF PROVIDERS

The HMO plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, HMO plans designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the carriers directly.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical carrier directly.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment County's plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the County's plans without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.
- If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption.

For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the County's medical plans if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

MICHELLE'S LAW

The County plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required. If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Human Resources in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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 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 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 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, 2018. Contact your State for more information on eligibility —

ALABAMA – Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
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: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.gethipptexas.com/

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, 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)
OMB Control Number 1210-0137

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.