HEALTH

LIFE AND FINANCIAL BENEFITS

RETIREMENT

MAKING YOUR DECISIONS

BENEFITS GUIDE

COUNTY OF SANTA CLARA EMPLOYEE SERVICES AGENCY

2024–2025 PLAN YEAR

BEGIN HERE

ABOUT YOUR COUNTY OF SANTA CLARA EMPLOYEE BENEFITS

The County of Santa Clara strives to provide you and your family with programs, tools, and resources to help you live a healthy life.

In this Benefits Guide, you'll find the information you need to make your benefit elections either during Open Enrollment or as a new hire. It's easy to navigate the Benefits Guide if you're viewing it online or on your mobile phone—use the icons along the top to jump to the section you want, and when you're in a section, click or touch the subtopics. You can also click the arrows next to the page numbers to go back or forward.

We encourage you to carefully review this Benefits Guide to understand the options available to you and to enroll in the plans that best fit the needs of you and your family. Also, throughout the year, the Guide can help you make informed health care decisions as you experience certain life events.

Rate Changes for the 2024–2025 Plan Year

This year, you'll see changes to the premium rates for medical coverage under the County's health plans for the 2024–2025 plan year.

Use MobileBenes on Your Smartphone!

Your benefits are right there—in the palm of your hand—when you have the MobileBenes website on your home screen. It's a great resource for benefits info on the go!

Using your browser, access **scc.mobilebenes.com**. Then, follow the simple instructions on how to add it to your mobile desktop.

IT'S OPEN ENROLLMENT—MAY 1–31, 2024

Instructions for enrolling are covered in the **Making Your Decisions** section. If you want to make benefit changes, be sure to submit the required paperwork by May 31, 2024, to your Employee Service Center. All election changes will go into effect on June 24, 2024. See **page 43** for details.

During the Open Enrollment period, we encourage you to review your benefit elections, your covered dependents, and make sure your decisions continue to meet your needs. Be sure to take a look at your current benefits available on your personalized Benefits Statement. To access your statement, go to the County's Connect website, click on **My Benefits** and then click on **My Benefits Statement**.

This guide highlights certain components of the benefit plans available to County of Santa Clara eligible employees, but it is only an overview. This guide does not take the place of the official plan documents, including any applicable insurance contracts or policies or related evidences or certificates of coverage, which are the final authority on plan provisions used to determine how, when, or whether benefits are paid or payable and control in the event of any conflict. This guide is a tool for you to use, but you should consult the plan documents for any benefits it describes—these documents are available on **esa.santaclaracounty.gov/open-enrollment**. The County of Santa Clara reserves the right to change, amend, suspend, withdraw, or terminate any or all of the plans, in whole or in part, at any time, subject to any applicable contractual requirements. Further, neither the plans nor this guide are an employment contract. They do not guarantee you the right to continued employment with the County of Santa Clara.

MEDICAL

The County of Santa Clara offers coded employees three medical plan options. You can choose from two Health Maintenance Organization (HMO) plans and a Point of Service (POS) plan. See the *Plans at a Glance* **comparison chart** on page 7 for highlights of key plan features and benefits.

About the HMO Plans

With an HMO plan, you choose a Primary Care Physician (PCP) from a network of local health care professionals who will refer you to in-network specialists or hospitals when necessary. All of your health care is coordinated through that PCP.

You may choose the Valley Health Plan or Kaiser Permanente Health Plan.

Valley Health Plan. With Valley Health Plan, you must be an employee of the County of Santa Clara. The VHP network expansion includes San Benito and Monterey Counties. With Valley Health Plan, all services and prescriptions are covered at 100% except chiropractic and acupuncture visits, which have $10 copays for full-time employees. Out-of-network services are not covered except under emergency conditions.

Kaiser. With Kaiser, you must live or work within a 30-mile radius of a Kaiser hospital. However, non-Medicare subscribers who live outside of the service area are eligible to enroll if you work in the service area at the time of initial enrollment. Dependent children may live anywhere inside or outside the service area. Other dependents such as your spouse may live anywhere, except they are not eligible to enroll, or to continue enrollment, if they live in or move to the service area of a region outside of California. With Kaiser, many services are covered at 100% with minimal or no office visit copayments.

About the Health Net POS Plan

The Health Net Point of Service Plan is a type of managed care health insurance plan that offers you a choice of different types of providers, separated into three tiers. The benefits paid by the plan—and what you'll pay out of your own pocket—will vary, based on your tier choice when you receive your care. The next page shows how it works.

Don't forget to take advantage of the ***free*** preventive care benefits that are offered through your County medical coverage.

KNOW BEFORE YOU GO

The benefits provided under the POS Plan's Tier One and Tier Two may be different than under Tier Three. For example, out-of-network well-woman visits are not covered. Make sure you understand what's covered—and what's not—before you visit a provider. Contact Health Net at **800-522-0088** for details.

MEDICAL COVERAGE FOR EXTRA HELP EMPLOYEES

Extra Help (non-coded) County employees may only enroll in certain medical plan options offered by the County:

- **Valley Health Plan (VHP) Preferred HMO Plan:** All Extra Help employees may enroll.
- **Valley Health Plan (VHP) Classic HMO Plan:** Eligibility for enrollment in this plan depends on your union agreement.

All other benefits do not apply.

HEALTH

Tier One: HMO Providers—*You may pay the lowest share of the cost.*

- Receive care from Health Net HMO providers located within a 30-mile radius of where you live or work.
- You select a Primary Care Physician (PCP), who coordinates your care and refers you to specialists and hospitals if needed.
- You pay a $15 office visit copayment, and the plan pays covered services at 100%.

Tier Two: Preferred Provider Organization (PPO) Providers—*You may pay more out of pocket.*

- Receive care from a provider in a selected network of Health Net medical doctors, hospitals, and other health care professionals (called a PPO network).
- Referrals for specialized care are not required.
- You pay a $20 office visit copay. Also, the plan pays 90% for many covered services; you pay the remaining 10%.

Tier Three: Out-of-Network—*You pay the most out of pocket.*

- You may seek care out of network from any licensed provider.
- You need to meet a deductible for out-of-network care before the plan begins paying benefits.
- Then, the plan pays 70% of the charges it considers usual, customary, and reasonable for the services you receive. (This is also known as the plan's maximum allowable amount.) You are responsible for the remaining balance.

For more information, or to ask questions, contact your **Department's Employee Service Center** (see page 46) or the plans directly:

Plan	Customer Service	Website
Valley Health Plan (Group C, Policy A)	888-421-8444	valleyhealthplan.org/scc
Kaiser Permanente Health Plan (Group 890)	800-464-4000	my.kp.org/santaclaracounty
Health Net (Group 40785A)	800-522-0088	healthnet.com/portal/member/content/iwc/mysites/sc/home.action

HEALTH

Telemedicine: Supporting Your Physical and Mental Health

Each of the County's medical plans offers telemedicine as part of their covered services for enrolled members and dependents. You can save time and money through virtual visits, where you can chat with a licensed doctor or therapist from anywhere, at any time. Appointments can be held on the web, phone, or mobile app.

Telemedicine is available by phone or video 24 hours a day, seven days a week. Doctors (including general practitioners and pediatricians) can diagnose your symptoms, prescribe medication, and send the prescription to your local pharmacy. Use their services as a cost-effective alternative to expensive emergency room or urgent care visits.

In addition, mental health support is available. Depending on the plan, you can talk to a psychiatrist to get a diagnosis and/or medication, or talk to a therapist to get help with ongoing concerns.

Before you run out to the ER, urgent care, your dermatologist's or therapist's office, consider whether a telemedicine visit makes more sense. It may be a good option when:

- It's not convenient for you to leave work or home.
- Your doctor or pediatrician is not available when you are.
- You have nonemergency health concerns, and it's after hours.
- You're traveling and need medical care.
- You have a health issue, such as the flu, allergies, a sinus infection, rash, sore throat, etc.
- You need treatment of ongoing or complex skin issues, such as psoriasis, eczema, acne, etc.
- You need after-hours support for anxiety, eating disorders, depression, or family issues.

Available Services

Following are brief descriptions of the telemedicine services available through the County's medical plans, with contact information available in the box to the right.

Valley Health Plan—MDLIVE / Physician-Based Telehealth Options

As a Valley Health Plan member, you have virtual access, 24/7, to doctors and therapists through VHP's telehealth benefit at no cost. Visit MDLIVE's special home page for the County, where you can activate your account and/or download their mobile app. Certain physicians and provider networks have their own telehealth networks. These are also covered under the Valley Health Plan.

All members can also call VHP's 24/7 Nurse Advice Line at no cost, to seek advice on the most appropriate care option for their condition or symptoms. The number is **866-682-9492**.

Kaiser Permanente—My Doctor Online

As a Kaiser member, you can connect with a Kaiser provider by phone, video, or email. Online visits known as e-visits are also available, where you answer some questions online and get advice or treatment from a clinician within two hours (available 7 a.m. to 7 p.m. daily).

Health Net—Teladoc

As a Health Net member, you may speak with a licensed doctor by phone or video within minutes, using Teladoc. Confidential mental health therapy is also available from Teladoc's behavioral health providers.

TELEMEDICINE SERVICES

Need to access a doctor 24/7 without leaving your home or office? Contact your health plan's telemedicine service:

Valley Health Plan—MDLIVE
888-467-4614
mdlive.com/VHP

866-682-9492
VHP 24/7 Nurse Advice Line

Kaiser Permanente
866-454-8855
mydoctor.kaiserpermanente.org/ncal/health-guide/mdo-app

Health Net—Teladoc
800-475-6168 (TTY: 711)
teladoc.com/hn

HEALTH

Medical Plans at a Glance

The chart below offers an overview of some of our medical plans' features. The official plan documents offer a detailed explanation of covered services, limitations, and exclusions.

	Valley Health Plan HMO	Kaiser Permanente HMO	Health Net POS Tier 1—HMO; Tier 2—PPO; Tier 3—Out of Network / POS
Type of Plan	HMO—Services provided through Valley Health Plan providers and facilities	HMO—Services provided through Kaiser providers and facilities	Members may use Health Net HMO or PPO network providers, or seek care out of network
Service Area	Open to employees of the County of Santa Clara	Live or work within 30-mile radius of a Kaiser hospital	To receive HMO-level benefits, live or work within a 30-mile radius of the doctor selected
Deductible	None	None	Tier 1—None Tier 2—None Tier 3—$200 per member / $600 per family per year
Annual Out-of-Pocket Maximum (Individual / Family)	$1,000 / $2,000	$1,500 / $3,000	**Medical:** Tier 1—$1,500 / $4,500 Tier 2—$2,000 / $6,000 Tier 3—$3,000 / $9,000 **Prescription drug:** In- and out-of-network—$2,000 / $4,000 **Medical and prescription drug annual out-of-pocket maximums are separate**
Office Visits	No copay	$10 copay	Tier 1—$15 copay Tier 2—$20 copay Tier 3—Plan pays 70% of the maximum allowable amount
Annual Routine Preventive Exam	No copay	No copay	Tiers 1 & 2—No copay Tier 3—Covered for individuals under age 18
Hospital Services	No copay with prior authorization	$100 copay per admission at Kaiser Permanente hospitals	Tier 1—No copay if referred by PCP Tier 2—Plan pays 90% with prior authorization Tier 3—Plan pays 70% of maximum allowable amount
Emergency Services	No copay. Services at out-of-network hospitals are covered if deemed medically necessary. Must notify VHP within 24–48 hours if you receive services out of network.	$35 copay at a Kaiser facility; waived if admitted. Services at a non-Kaiser facility are covered if deemed medically necessary. Must notify plan within 24–48 hours if you receive services from a non-Kaiser facility.	Tier 1—$50 copay at in-network hospital Tier 2*—$75 copay Tier 3*—Plan pays 70% of maximum allowable amount Copay is waived if admitted
Urgent Care	No copay	$10 copay at Kaiser facility	Tier 1—$35 copay Tier 2*—$50 copay Tier 3*—Plan pays 70% of maximum allowable amount

* PPO and out-of-network services are charged at the HMO level if deemed to be an emergency.

Continued on next page

Medical Plans at a Glance (continued)

	Valley Health Plan HMO	Kaiser HMO	Health Net POS Tier 1—HMO; Tier 2—PPO; Tier 3—Out of Network / POS
Prescriptions (Retail)	No copay	Generic—$5 copay for 30-day supply Brand—$10 copay for 30-day supply	Generic—$5 copay for 30-day supply Brand—$15 copay for 30-day supply Non-Formulary—$30 copay for 30-day supply
Prescriptions (Mail Order)	No copay; 61- to 90-day supply; mail order through Birdi for maintenance medications	Generic—$10 copay for 100-day supply Brand—$20 copay for 100-day supply	Generic—$10 for 90-day supply Brand—$30 for 90-day supply Non-Formulary—$60 for 90-day supply *(Maintenance medications can be obtained through mail-order service or at a contracted CVS pharmacy)*
Chiropractic Care	$10 copay per visit, up to 24 visits per calendar year when referred by PCP	Not covered	Tier 1—$5 copay; 20 visits per calendar year; plan providers contracted through American Specialty Health Plan (ASHP) Tier 2—Not covered Tier 3—Not covered
Acupuncture	$10 copay per visit, up to 24 visits per calendar year when referred by PCP	Not covered	Not covered
Covered Durable Medical Equipment	Plan pays 100% of covered equipment	Plan pays 100%*	Tier 1—Plan pays 100% Tier 2—Plan pays 50% Tier 3—Not covered
Mental Health (Outpatient)	No copay	$10 copay	Tiers 1 & 2—$15 copay Tier 3—Plan pays 70% of maximum allowable amount
Mental Health (Inpatient)	No copay	$100 copay per admission	Tiers 1 & 2—No copay Tier 3—Plan pays 70% of maximum allowable amount
Well-Woman Care	No copay	No copay	Tier 1—No copay per annual visit Tier 2—No copay per annual visit Tier 3—Not covered
Well-Baby Care	No copay	No copay	Tier 1—No copay per office visit Tier 2—No copay per office visit Tier 3—Plan pays 70% of maximum allowable amount

* For members who live outside of the service area, durable medical equipment for home use is generally not covered. However, the following base-covered items are covered for members who live out of the area, if the member picks them up at a Plan facility: standard curved-handle cane; standard crutches; blood glucose monitor and related supplies for diabetes blood testing; insulin pump and related supplies, except insulin or other drugs; nebulizer and related supplies to treat children with asthma; peak flow meter.

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Medical Plan Wellness Programs

Each of the County's medical plan providers offers several valuable wellness programs to employees and their family members who are enrolled in the plan. The links provided below will take you to the provider's website for more information.

Valley Health Plan (VHP)	
Fitness	Yoga, Total Body, Conditioning Virtual Fitness Classes
Mental Health	MDLive Telehealth
Weight Watchers	50% off Core and Premium Plans
Diabetes Prevention	YMCA: Four-month membership + In-person diabetes prevention workshops
Healthy Living	Healthy Living Self-Management Tools
Tobacco Cessation Program	Certified program to help you quit smoking

Kaiser	
Fitness	ClassPass: On-demand video workouts or in-person fitness classes; ChooseHealthy program: Discounts on fitness, health, and wellness products; Active&Fit Direct: Gym membership at participating fitness centers
Mental Health	Therapy, self-care resources, health classes Calm, Headspace, myStrength
Telephonic Health Coaching	One-on-one guidance and support from a dedicated wellness coach

Health Net	
Active&Fit Direct Programs	Lifestyle coaching, workout videos, and gym memberships
Mental Health	myStrength
Unwinding	Breathing exercises, meditations, sleep support, and more
Telephonic Health Coaching	Confidential, one-on-one health coaching sessions
Eat Right Now	Healthy eating program with videos, exercises, and on-demand tools
RealAge Test	Identify health risks and receive a personalized action plan
Maternity & Family Planning	Start Smart for Your Baby: Program for pregnant and new parents
Craving to Quit Tobacco	Program to help you quit your tobacco habit
Welvie	Surgery decision support program

HEALTH

Gender-Affirming Healthcare Information

The County of Santa Clara is deeply committed to the values of equality and inclusion for all employees, without regard to sexual orientation, gender identity, or expression. As part of our commitment to protect employees from discrimination in accessing health care, the County's health plan providers are prohibited from denying, canceling, limiting, or refusing coverage to employees based on gender identity, expression, or transgender status. Our health plan vendors have provided the following information to clarify their coverage for gender-affirming healthcare.

Valley Health Plan

At Valley Health Plan, we are committed to providing inclusive and comprehensive care for all members, including those who are transgender or gender diverse. We recognize the unique healthcare needs of transgender and gender diverse individuals and are dedicated to ensuring that our services are respectful, affirming, and tailored to meet these needs.

Our commitment to gender affirming care means that we support and cover a wide range of services, including hormone therapy, surgical procedures, mental health support, and other treatments that align with established standards of care. We work closely with knowledgeable and compassionate providers who understand the importance of affirming gender identity in the delivery of healthcare. Because Valley Health Plan is a County of Santa Clara-sponsored plan, we also collaborate with Valley Medical Center's Gender Health Center to support the needs of our members.

We believe that everyone deserves access to quality healthcare that respects their gender identity and expression. By offering gender affirming care, we aim to promote the health and well-being of our transgender and gender diverse members, empowering them to live authentically and confidently.

Kaiser Permanente

At Kaiser Permanente, we're committed to delivering the most culturally responsive, inclusive, and equitable care for our transgender and gender-diverse patients. Our dedicated clinicians provide medical, surgical, and mental health care to transgender and nonbinary patients in ways that work for you—wherever you receive care in Northern California.

HEALTH

Please visit our Gender-Affirming Care webpage at **https://select.kaiserpermanente.org/county-of-santa-clara#/specialty-care/transgender-services** to find more information about services and resources for transgender and nonbinary patients along with health resources for the LGBTQIA+ community.

Health Net

Health Net's LGBTQ+ Inclusive Healthcare benefits are designed to address some of our members most important healthcare needs. Health Net knows having a health plan that supports our members' needs matters. That's why we're proud to feature health plans that include benefits and resources available to our LGBTQ+ members.

Covered services include those which are medically necessary or meet the definition of reconstructive surgery. Gender-affirming procedures and services linked to some Health Net plans may include, but are not limited to:

- Mental health evaluation and treatment
- Genital surgery
- Hormone therapy
- Hair removal needed for reconstructive surgery
- Hysterectomy
- Tracheal (windpipe) shave
- Voice modification surgery
- Voice modification therapy

Please see your health plan coverage document for details or call the number on the back of your Member ID card.

HEALTH

COVID-Related Coverage

During the COVID-19 national health emergency, our health plans were required to put temporary benefit enhancements in place. The U.S. government declared an end to the public health emergencies effective May 11, 2023. In accordance with California state law, those enhancements ended and benefits coverage reverted to pre-pandemic provisions on November 11, 2023.

As part of our ongoing commitment to employee health, the County of Santa Clara maintains coverage for certain COVID-related services. Please note the following COVID-related coverage offered by our health plan providers.

Coverage/ expense	Valley Health Plan	Health Net	Kaiser Permanente
COVID-related vaccinations	No cost when received at any retail pharmacy in California (except Walmart and Rite Aid), or at any Valley Medical Center pharmacy.	No cost when received from a Tier 1 or Tier 2 in-network provider. Out-of-network vaccinations subject to the plan's Tier 3 out-of-network deductible and coinsurance.	No cost when received in-network. Out-of-network costs subject to cost sharing and member financial responsibility.
COVID-related testing	Free over-the-counter test kits from in-network pharmacies. Reimbursement of up to $12 per test kit (a maximum of 8 per month) when purchased out-of-network.	Free over-the-counter test kits from in-network pharmacies. Out-of-network testing subject to the plan's Tier 3 out-of-network deductible and coinsurance.	$0 copay PCR testing in-network; free over-the-counter test kits at Kaiser Permanente pharmacies or through **kp.com**. Out-of-network testing subject to cost sharing and member financial responsibility.
COVID-related physician's office visits	No cost when received in-network. Out-of-network costs subject to cost sharing and member financial responsibility.	No cost when visiting a Tier 1 or Tier 2 in-network provider. Out-of-network office visits subject to the plan's Tier 3 out-of-network deductible and coinsurance.	$10 per visit copay. Out-of-network costs subject to cost sharing and member financial responsibility.
COVID-related telemedicine	No cost when received in-network. Out-of-network costs subject to cost sharing and member financial responsibility.	No cost when visiting a Tier 1 or Tier 2 in-network provider. Out-of-network office visits subject to the plan's Tier 3 out-of-network deductible and coinsurance.	$0 copay
COVID-related prescription drugs	No cost when received in-network. Out-of-network costs subject to cost sharing and member financial responsibility.	Subject to the standard copays as all other covered prescriptions.	Subject to the standard copays as all other covered prescriptions.

If you have additional questions about coverage of COVID-related care, contact your health plan provider:

- Kaiser Permanente—**800-464-4000**; **my.kp.org/santaclaracounty**
- Valley Health Plan—**888-421-8444**; **valleyhealthplan.org/scc**
- Health Net—**800-522-0088**; **healthnet.com/portal/member/content/iwc/mysites/sc/home.action**

2024–2025 HEALTH PLAN PREMIUM RATES

Medical Plan Premium Rates

Your share of costs for medical coverage are based on the plan you choose and the family members you decide to cover, as follows:

- **For Valley Health and Kaiser HMO Plans,** a four-tiered rate structure applies—you may choose to cover yourself only, yourself and your spouse or registered domestic partner, yourself and your child(ren), or yourself and your family.
- **For the Point of Service Plan,** a two-tiered rate structure applies—you may choose to cover yourself only or yourself and your family.

For most full-time coded employees, the County pays the cost of employee-only coverage for all health plans and the majority of the cost for covering your family members. Contribution structures are based on bargaining unit agreements, and your contributions are deducted from your paycheck on a pre-tax basis. Contribution structures for part-time employees may be different. Rates are subject to change each fiscal year.

If you are a full-time employee and your spouse or registered domestic partner also works for the County, all family members must enroll under one employee (subscriber), and the County will pay 100% of the family rate regardless of the health plan you choose.

FIND THE 2024–2025 RATES

The medical plan rates, including the County's contributions and your required biweekly payroll deductions, are available through the **Employee Services Agency Open Enrollment website**, under "Employee Benefits."

Dental and Vision Plan Premium Rates

The County pays the full cost of the dental and vision insurance for full-time coded employees and their eligible dependents.

Part-Time Employees

Part-time employees share the cost of health, dental, vision, and basic life plans. These rates are prorated based on the number of regular hours an employee works each pay period. Your contribution is deducted from your paycheck on a pre-tax basis. For more information on prorated costs, contact your **Department's Employee Service Center** (see page 46).

Payroll Deductions

Employees are responsible for verifying that their payroll deductions are correct. If you experience a problem with your payroll deductions, contact your **Department's Employee Service Center** (see page 46) immediately.

DENTAL

The County offers two dental plans to its employees:

Delta Dental

With this plan, you may choose a Delta Preferred Provider Organization (PPO) dentist, a Delta Premier dentist, or a non-network dentist that is a member of the California Dental Association. When you visit a Delta Dental dentist, you'll pay a share of the contracted fee for most services. If you visit a non-network dentist, the plan pays its share of allowable charges for services provided, and you are responsible for any balance.

Your costs are usually lower when you choose a Delta PPO dentist. Some providers may require you to complete a claim form, although most dentists will file the claim electronically for you.

LIBERTY Dental

LIBERTY Dental is a Dental Health Maintenance Organization (DHMO). Similar to a medical HMO plan, you must live in the plan's service area and receive care from participating dental providers. Copayments apply for specific services; however, there are usually no annual benefit limits and no claim forms.

For more information or to ask questions about dental coverage, contact your **Department's Employee Service Center** (see page 46) or the plan directly:

Plan	Customer Service	Website
Delta Dental (Group 1766)	888-335-8227	deltadentalins.com
LIBERTY Dental Plan (Group 100232)	888-359-1088	client.libertydentalplan.com/scc

Dental Plans at a Glance

The chart below provides a brief summary of each plan's features. For additional information, covered services, limitations, and exclusions, you should consult each plan's certificate of benefits.

Services	Delta Dental	LIBERTY Dental
Diagnostic or Preventive	Plan pays 75%, you pay 25% and, if you visit a non-network dentist, any balance due*	You pay $0
Restorative	Plan pays 75%, you pay 25% and, if you visit a non-network dentist, any balance due	You pay $0
Crowns & Bridges	Plan pays 75%, you pay 25% and, if you visit a non-network dentist, any balance due	You pay $75 for most services
Prosthodontics (dentures)	Plan pays 75%, you pay 25% and, if you visit a non-network dentist, any balance due	You pay $100 per denture (upper or lower)
Annual Benefit Limits	$2,000 per calendar year per member	None
Orthodontic	Plan pays 60% up to $2,000 lifetime per member, you pay 40% and any balance due	Varies

* Diagnostic and preventive services do not count toward the annual maximum if seen by a Delta Dental PPO dentist.

VISION

The County offers vision benefits from Vision Service Plan (VSP). You may select a provider from their list of optometrists or go out of network. When you make your appointment, mention to your selected provider's office that you are a VSP member. The provider's office will contact VSP for you and verify your eligibility.

Vision in-network benefits cover an exam with a $20 copay and lenses every 12 months at no cost. The plan provides an in-network allowance of $120 for frames every 24 months. Any lens enhancements selected, such as special coatings or tints, would have discounted copays associated with them, which amount to approximately 20–25% off normal retail charge. Additional discounts apply to any frame allowance overage paid, as well as additional frames when received at an in-network location.

The plan also provides an in-network allowance of $120 for contact lenses every 12 months in lieu of glasses, including the exam.

Contact VSP at **800-877-7195**, or go to **sccgov.vspforme.com** to find a provider.

BENEFITS FOR 2024–2025

You can use the $120 in-network frame allowance at additional retailers, including Costco and Walmart locations. Visit **sccgov.vspforme.com** to view the in-network options for your area.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The robust employee assistance plan (EAP), offered through Concern, helps employees and their families (spouses, domestic partners, and children up to age 26) by providing timely access to mental health and well-being resources. Concern is a top-tier provider of mental health services and comprehensive crisis and organizational support.

Under the EAP, you and each family member can receive confidential counseling sessions for stress, anxiety, relationships, grief and loss, and more. In addition, Concern offers personal coaching, child or elder care resources, and much more.

For more information, call Concern at **800-344-4222**, 24/7, or visit **sccconnect.sharepoint.com/sites/esa/Benefits/SitePages/Employee-Assistance-Program.aspx** for details.

HEALTH CARE BONUS WAIVER

The Health Care Bonus Waiver program gives you the option to receive a taxable increase in gross wages by waiving the County's medical coverage.

Full-time employees who elect to waive medical coverage receive $74 per pay period in taxable wages. Part-time employees who participate in this program receive a prorated amount for this benefit.

If you elect to participate in this program, you must complete the necessary paperwork and provide written documentation annually showing proof of medical coverage with an insurance program other than that provided by the County (e.g., your spouse's employer's plan).

Written documentation may include:

- A letter from the insurance company
- A letter from your spouse's or registered domestic partner's employer
- An annual benefits statement from another employer or insurance company

All documentation must show current coverage for the plan year. Your health plan card is not sufficient proof of coverage.

Making Your Health Care Bonus Waiver Election

- You have the opportunity to elect the Health Care Bonus Waiver program during each year's Open Enrollment period. If you are currently participating and want to continue during the 2024–2025 plan year, you must reelect the program; otherwise, the County will discontinue your Health Care Bonus Waiver and automatically waive your medical coverage.
- As a new hire, you'll consider the waiver program when you make your medical plan election within 30 days of your hire date. You may elect a County-sponsored medical plan or waive coverage. If you do not make an election, the County will automatically waive your medical coverage.
- You cannot change your Health Care Bonus Waiver election during the year unless you have a qualifying event, such as the birth of a child, death, marriage, or divorce. If you do have a qualifying event, you may change your election within 30 days of the event. Otherwise, you must wait until the program's next Open Enrollment period to make a change.

HEALTH FLEXIBLE SPENDING ACCOUNT (HFSA)

This program allows you to set up a special account for paying out-of-pocket health expenses with tax-free dollars. You may contribute up to $3,200 per calendar year to this account.

Once established, here's how your account works:

- You may use your funds to pay eligible expenses for you, your spouse, and your qualified dependents, regardless of whether they are enrolled in the County's medical, dental, and vision plans.
- You have access to your full annual HFSA election at any time during the year.
- The plan runs on a calendar-year basis—so you may reimburse yourself for expenses incurred between January 1, 2024, and December 31, 2024.
- The plan also includes a grace period following the end of the calendar year. If you have funds left over, you can apply them for expenses incurred from January 1, 2025, through March 15, 2025.
- The HFSA is administered by P&A Group, which charges an $0.85-per-pay period service fee for your account. (Note that you are not double charged this fee if you enroll in the Dependent Care Assistance Program as well.) The HFSA comes with a debit card; you can use it to pay your providers directly for health care expenses. You can also set up an online account and submit claims online or through your mobile phone. Reimbursement payments are made via a check or direct deposit to your bank account.
- Finally, with a Flexible Spending Account, an IRS use-it-or-lose-it rule applies. ***Be sure to estimate the amount you want to contribute with care.*** If you have money remaining in your account at the end of the plan year's grace period, you forfeit those funds.

COMMON HFSA ELIGIBLE EXPENSES

The IRS determines which expenses are eligible for reimbursement. Some examples include:

- Prescription drugs
- Copays and coinsurance
- Deductibles
- Birth control
- Many over-the-counter medications, when prescribed by your doctor
- Dental work
- Orthodontia
- Glasses and contacts
- Chiropractic care
- Massage therapy

Refer to IRS Publication 502 for a complete list of eligible expenses.

H E A L T H

Making Your HFSA Contribution Election

- If you wish to participate in the HFSA, the IRS requires you to enroll and elect your contribution amount each year.
- As noted previously, the program runs on a calendar-year basis, from January 1 through December 31. Thus, during the fall of each year, you'll have an opportunity to enroll during the annual enrollment period for Flexible Spending Accounts (typically in November). Your annual election is deducted from your paycheck in equal increments.
- As a new hire, you may elect to participate in this program within 30 days of your date of hire.
- You cannot change your annual election amount during the year unless you have a qualifying event, such as the birth of a child, death, marriage, or divorce. If you do have a qualifying event, you may change your HFSA election within 30 days of the event. Otherwise, you must wait until the program's next enrollment period to make a change.

Contact P&A Group at **716-852-2611**, or go to **padmin.com** to learn more about this program.

DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

The DCAP program allows you to set up a special account for paying dependent care services, which are necessary for you to work, with tax-free dollars. It's a smart and convenient way to save on these expenses.

Through the program, you may reimburse yourself for expenses related to:

- The care for your dependent children under age 13.
- The care for another dependent who is physically or mentally incapable of caring for him- or herself; this includes elder day care.

You may contribute up to $5,000 per year to your account ($2,500 if you are married and filing separately). This limit is set by the IRS. Also note that if you participate in this program, you may not claim a federal income tax childcare expense credit on your tax return.

Your DCAP account works much like the Health Flexible Spending Account, as follows:

- The plan runs on a calendar-year basis—so you may reimburse yourself for expenses incurred between January 1, 2024, and December 31, 2024.
- The DCAP is administered by P&A Group, which charges an $0.85 service charge per pay period for your account. (Note that you are not double charged this fee if you enroll in the HFSA as well.) You can set up an online account and submit claims online or through your mobile phone. Reimbursement payments are made via a check or direct deposit to your bank account.
- Finally, with the DCAP, an IRS use-it-or-lose-it rule applies. ***Be sure to estimate the amount you want to contribute with care.*** If you have money remaining in your account at the end of the plan year's grace period, you forfeit those funds.

COMMON DCAP ELIGIBLE EXPENSES

The IRS determines which expenses are eligible for reimbursement. Some examples include:

- Summer camp
- Daycare
- After-school programs
- Nanny care
- Work-related babysitting (your sitter cannot be a tax dependent)
- Elder care

Refer to IRS Publication 503 for more details regarding eligible expenses and providers.

Making Your DCAP Contribution Election

- If you wish to participate in the DCAP, the IRS requires you to enroll and elect your contribution amount each year.
- As noted previously, the program runs on a calendar-year basis, from January 1 through December 31. Thus, during the fall of each year, you'll have an opportunity to enroll during the annual enrollment period for Flexible Spending Accounts (typically in November). Your annual election is deducted from your paycheck in equal increments.
- As a new hire, you may elect to participate in this program within 30 days of your date of hire.
- You cannot change your annual election amount during the year unless you have a qualifying event, such as:
  - The birth of a child, death, marriage, or divorce
  - A change in employment status
  - You move
  - A change in the cost of your provider's services
  - When your child turns age 13
  - If your qualifying relative regains his or her ability for self-care
- Your dependent care expenses may also qualify for a dependent care tax credit on your individual tax return. Consult your tax advisor to determine whether to participate in the DCAP or whether to take the credit; expenses generally may not be reimbursed by the DCAP if they are also claimed as a tax credit.

If you have a qualifying event, you may change your DCAP election within 30 days of the event. Otherwise, you must wait until the program's next enrollment period to make a change.

Contact P&A Group at **716-852-2611**, or go to **padmin.com** to learn more about this program.

Employee Childcare Assistance Program (ECAP)

In addition to the DCAP program on pages 20-21, the County of Santa Clara also offers the ECAP program, an employer-funded Dependent Care FSA that helps families offset the cost of childcare expenses. Under ECAP, the County contributes funds to eligible employees' Dependent Care accounts on a tax-free basis. You can then use those funds to reimburse yourself for expenses related to caring for your dependent children under age 13.

The ECAP is open to all active, full-time coded employees who have dependent child(ren) under age 13 and whose individual income is less than $119,999 annually. If you are married and both you and your partner work for the County, only one spouse is eligible to receive the benefit. Part-time coded employees, extra help, per diem and contractors are not eligible for the plan.

The amount the County contributes to your Dependent Care FSA is dependent upon your individual annual income, as shown below. In addition to the County's contributions, you have the option to contribute pre-tax funds to the account, up to the combined maximum threshold of $5,000, as permitted by IRS rules. The grid below illustrates the different benefit amounts based on your annual income and the maximum amount, if any, you may contribute to the account.

COMMON ECAP ELIGIBLE EXPENSES

The IRS determines which expenses are eligible for reimbursement. Some examples include:

- After-school programs
- Child care centers
- Eligible in-home providers
- Nursery schools
- Summer day camps

Annual Income Tier	Bi-Weekly Employer Contribution	Maximum Annual Employer Contribution	Maximum Annual Employee Contribution
Less than $60,000	$192.30	$5,000.00	$0
$60,000 - $79,999	$153.84	$4,000.00	$1,000.00
$80,000 - $99,999	$115.38	$3,000.00	$2,000.00
$100,000 - $119,999	$76.92	$2,000.00	$3,000.00

LIFE AND FINANCIAL BENEFITS

Applying for the ECAP

You can apply for the employer-funded Dependent Care FSA from September 1-September 30, 2024 for expenses incurred beginning January 1, 2025. You must complete the required eligibility paperwork from P&A Group in order to be considered for the plan. Once your eligibility is confirmed, you will be notified and provided instructions to set up a DCAP account. The County will then deposit funds directly into your Dependent Care FSA account on a bi-weekly basis.

You will need to apply for the ECAP and elect your contribution amount each year. If you are a new hire, you may apply to participate within 30 days of your date of hire.

Please note that if you elect to make your own contributions, you cannot change your annual election amount during the year unless you have a qualifying event, such as:

- The birth of a child, death, marriage, or divorce
- A change in employment status
- You move
- A change in the cost of your provider's services
- When your child turns age 13

If you have a qualifying event, you may change your DCAP election within 30 days of the event. Otherwise, you must wait until the program's next enrollment period to make a change.

Your dependent care expenses may also qualify for a dependent care tax credit on your individual tax return. Consult your tax advisor to determine whether to participate in the ECAP or whether to take the credit; expenses generally may not be reimbursed by the ECAP if they are also claimed as a tax credit.

Contact P&A Group at **716-852-2611**, or go to **padmin.com** to learn more about this program.

LIFE INSURANCE

Active hourly and salaried employees holding regular coded positions and working one-half time or more per week are eligible for County-sponsored life insurance.

Basic Life Insurance (Provided by Standard Insurance Company)

Employees in most bargaining units receive $25,000 of basic life insurance coverage. The County pays 100% of the cost for full-time coded employees. Part-time employees pay a prorated amount of the rate based on the number of regular hours worked in each pay period.

You may designate any beneficiary for your County-provided life insurance benefits. However, it's important to understand that California is a community property state. As such, you may want to consult with an attorney for legal advice regarding community property laws and how they apply to the distribution of your life insurance benefits.

LIFE AND FINANCIAL BENEFITS

Supplemental Life Insurance (Provided by Standard Insurance Company)

To add to your basic life insurance coverage, you may choose to purchase supplemental life insurance.

The amounts available for purchase are based on your biweekly salary, and you pay for the full premium cost for this coverage.

The chart below shows the different options and costs. For example:

- If your biweekly salary is $278.40 or less, you may elect Option 1 only, and your biweekly premium is $0.73 per pay period.
- If your biweekly salary falls between $576.81 and $773.60, you may elect Option 1, 2, 3, or 4, and you pay the applicable biweekly premium. Assuming you choose Option 3, you pay $2.09 per pay period.
- If your biweekly salary is above $3,855.94, you may elect one option from Options 1 through 13, and you pay the applicable biweekly premium. Assuming you choose Option 10, you pay $14.98 per pay period.

Supplemental Life Insurance Premium Rates			
Qualifying Biweekly Salary	**Option**	**Coverage Amount**	**Biweekly Premium Rate**
$278.40 or less	1	$31,000	$0.73
$278.41 to $382.40	2	$42,000	$1.20
$382.41 to $576.80	3	$63,000	$2.09
$576.81 to $773.60	4	$83,000	$2.76
$773.61 to $1,142.20	5	$125,000	$4.15
$1,142.21 to $1,538.45	6	$167,000	$6.40
$1,538.46 to $1,923.00	7	$209,000	$8.97
$1,923.01 to $2,307.69	8	$250,000	$10.73
$2,307.70 to $2,692.31	9	$299,000	$12.83
$2,692.32 to $3,076.92	10	$349,000	$14.98
$3,076.93 to $3,462.63	11	$399,000	$17.13
$3,462.64 to $3,855.93	12	$449,000	$21.55
$3,855.94 and above	13	$500,000	$30.92

Making Your Supplemental Life Insurance Election

- As noted above, your biweekly salary amount determines your eligibility for the different coverage options (Options 1–13).
- You have the option to elect an automatic increase formula or a fixed formula when choosing your benefit. If you elect the automatic increase formula, your coverage will be updated automatically as your base salary changes as a result of a pay increase. If you choose the fixed benefit option, your coverage option amount remains fixed and does not change when your salary changes.
- Your first opportunity to enroll occurs as a new hire—you may select any option you are eligible for and enroll within 30 days of your hire date. You are not required to provide evidence of insurability (defined in the plan's Summary Plan Description) if you enroll within your initial new hire window.
- As you continue employment with the County, you may enroll (or change your election) at any time. But if you missed your initial new hire window, you'll be required to provide evidence of insurability.

WHAT IS EVIDENCE OF INSURABILITY?

When you sign up for certain benefits, such as life insurance and long-term disability insurance, the insurer may require you to provide information about your health status—also called "evidence of insurability." This may include the release of your medical records and getting a physical exam.

Standard Insurance Company (our insurer) may ask you to complete the evidence of insurability process if:

- You do not enroll for supplemental life insurance or long-term disability insurance coverage within 30 days of your date of hire.
- If you request a change or increase to your coverage amount.
- If you take a leave of absence, do not pay for your premiums during the leave, and want to reinstate your coverage upon your return to work.

If required, Standard Insurance Company will provide you with instructions and the form(s) needed for completing this process. It may take up to three months for an approval or denial of coverage from Standard.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

(Provided by Standard Insurance Company)

To protect your family financially in the event of an accidental death or severe injury, you may choose to purchase accidental death and dismemberment insurance coverage for yourself and your spouse and children. You pay for the full premium cost for this coverage, and you may enroll or change your election at any time without restriction.

You may choose from the following coverage options:

AD&D Coverage Options	
Employee Coverage Options You select one…	**…PLUS decide whether you want to cover your spouse and/or children.**
$10,000	The plan pays you a percentage of the value of your benefit in the event of your spouse's and/or child's death or covered loss (e.g., loss of sight, loss of a hand or foot) as follows: • 60% for your spouse—if you have a spouse only • 20% per child—if you have children only • 50% for your spouse and 15% per child—if you have both a spouse and children A maximum benefit payout also applies: • $250,000 max for the loss of your spouse • $100,000 max for the loss of a child
$20,000	
$40,000	
$60,000	
$80,000	
$100,000	
$125,000	
$150,000	
$200,000	
$250,000	
$300,000	
$350,000	
$400,000	
$450,000	
$500,000	

LIFE AND FINANCIAL BENEFITS

Your premium cost depends on the option(s) you choose. The costs are the same for full-time and part-time employees. The biweekly premium cost for coverage is:

AD&D Insurance Premium Rates		
Benefit Amount	**Employee-Only Coverage**	**Coverage for Yourself and Your Spouse or Children**
$10,000	$0.08	$0.12
$20,000	$0.16	$0.24
$40,000	$0.32	$0.48
$60,000	$0.48	$0.72
$80,000	$0.64	$0.96
$100,000	$0.80	$1.20
$125,000	$1.00	$1.50
$150,000	$1.20	$1.80
$200,000	$1.60	$2.40
$250,000	$2.00	$3.00
$300,000	$2.40	$3.60
$350,000	$2.80	$4.20
$400,000	$3.20	$4.80
$450,000	$3.60	$5.40
$500,000	$4.00	$6.00

The plan pays benefits under the following circumstances:

- In the event of death resulting from an accident, the plan pays 100% of the coverage amount.
- For the loss of a hand, foot, or eye, the plan pays 50% of the benefit amount.
- For the loss of more than one hand, foot, and/or eye, the plan pays 100% of the benefit amount.

Additional benefits and exclusions apply—refer to the plan's certificate of benefits, available through the Employee Services Agency website, under **Accidental Death and Dismemberment Insurance**.

If you want to enroll or change your coverage, contact your **Department's Employee Service Center** (see page 46).

AD&D COVERAGE FOR DEPUTY SHERIFFS AND CORRECTIONAL OFFICERS

The County provides $20,000 of occupational AD&D coverage to all active Sheriffs and Correctional Officers. Contact your Department's Employee Service Center for more information. Also note, the plan's certificate of benefits is available through the Employee Services Agency website, under **Accidental Death and Dismemberment Insurance**.

TIME AWAY FROM WORK

Disability

If you have a non-work-related illness or injury and become unable to work for an extended period, the County offers disability benefits that partially replace your salary while you are away under certain circumstances.

Most employees have a deduction for SDI automatically deducted from their paychecks. This deduction appears on your paycheck as CA OASDI/EE.

California State Disability Insurance (SDI)

The State of California SDI program provides income replacement for eligible employees, due to their non-work-related illnesses or injuries, pregnancies, or childbirth.

The state disability insurance program pays weekly benefits ranging from $50 up to $1,620. The benefit paid is based on the highest wages you earn during one quarter in a 12-month base period, up to a maximum benefit amount. Your claim may begin when your doctor certifies that your disability prevents you from doing your regular or customary job duties. Depending on the type of disability claim, the benefit may be paid for up to 52 weeks. The State of California makes all benefits and eligibility determinations.

To learn more about eligibility and benefits covered through California SDI, go to **edd.ca.gov/Disability/About_DI.htm**.

There may be a seven-day waiting period for disability benefits to commence. You may use sick leave and/or vacation time during this period. Then, you may integrate state disability insurance with your remaining sick leave and vacation balances. One advantage of doing so is that you may be paid as close to or equal to your regular pay while you are away from work, depending on your salary. **However, integration is not automatic.** Before or within one week of your disability, you (or your designee) should notify your Department's Employee Service Center to discuss your options. Otherwise, you may be placed on an unpaid leave of absence, which affects your pay and your medical, dental, vision, and life insurance benefits.

LIFE AND FINANCIAL BENEFITS

TAKE NOTE

Pregnancy leave entitlements are governed by the California Pregnancy Disability Leave (PDL) Act and California Family Rights Act (CFRA).

Pregnancy disability benefits during leave for most employees are covered under California's SDI program. The typical disability leave under PDL for a normal pregnancy is up to four weeks before your expected delivery date and up to six weeks (for normal delivery) or eight weeks (for cesarean section) after the actual delivery. Following your pregnancy disability period, you may also be eligible to take an additional six weeks of leave through the CFRA. You may also be eligible for 12 weeks of income replacement at rates similar to SDI—for six of these weeks through the California Paid Family Leave program as noted below.

Paid Family Leave (PFL)

Paid Family Leave is a part of California's SDI program. PFL provides up to eight weeks of partial pay to employees who take time away from work to bond with a new child (including newly fostered and adopted children) or to care for a seriously ill family member.

The state pays a percentage of an employee's eligible salary. The minimum weekly benefit is $50; the maximum weekly benefit is $1,620.

To learn more about PFL, go to: **edd.ca.gov/en/disability/paid-family-leave**.

Long-Term Disability Insurance (Provided by Standard Insurance Company)

Most active hourly and salaried employees working one-half time or more per week are eligible for long-term disability coverage. This is a voluntary benefits plan—you pay the full premium cost for this coverage.*

You may choose from two types of benefits:

1. **Based-on-Salary Plan:** This covers 66 2/3% of your base salary. The maximum monthly salary amount considered for coverage is $22,500. The minimum monthly benefit is $216.67; the maximum monthly benefit is $15,000. Under the Base Plan, your benefit (and premium cost) automatically adjusts as your pay increases.

* The terms and conditions of this coverage are governed by the insurance company documents.

2. **Fixed Benefit Options:** You select a benefit amount that is lower than what your monthly base salary provides. This is a fixed benefit amount and a fixed premium. If your salary increases, your benefit amount and premium will not change. You have several options to choose from, as follows:

Long-Term Disability Plan—Fixed Benefit Options		
Option	**Benefit Amount**	**Minimum/Maximum Monthly Benefit**
2	66²/₃% of the first $2,275 of monthly base salary	$216.67 minimum / $1,516.67 max
3	66²/₃% of the first $2,600 of monthly base salary	$216.67 minimum / $1,733.33 max
4	66²/₃% of the first $2,925 of monthly base salary	$216.67 minimum / $1,950.00 max
5	66²/₃% of the first $3,250 of monthly base salary	$216.67 minimum / $2,166.67 max
6	66²/₃% of the first $3,574 of monthly base salary	$216.67 minimum / $2,383.33 max
7	66²/₃% of the first $3,900 of monthly base salary	$216.67 minimum / $2,600.00 max
8	66²/₃% of the first $4,225 of monthly base salary	$216.67 minimum / $2,816.67 max
9	66²/₃% of the first $4,875 of monthly base salary	$216.67 minimum / $3,250.00 max
10	66²/₃% of the first $5,850 of monthly base salary	$216.67 minimum / $3,900.00 max
11	66²/₃% of the first $6,500 of monthly base salary	$216.67 minimum / $4,333.33 max

The biweekly premium cost for coverage is:

If deductions are being taken from your paycheck toward California SDI	If deductions are NOT being taken from your paycheck toward California SDI
The premium cost is $0.721 per $100 of your covered biweekly base salary.	The premium cost is $0.926 per $100 of your covered biweekly base salary.

Contact the Employee Benefits Department to learn more about the premium cost for the coverage level you are interested in purchasing.

Here is how the plan pays benefits:

- Benefits begin following 60 days of disability.
- The plan provides income replacement up to age 65, or Social Security Normal Retirement Age, whichever is longer.
- An age-graded benefit schedule applies for disabilities beginning at age 60 or later.

Your long-term disability insurance benefit payment may be reduced by other forms of income (e.g., workers' compensation insurance and California State Disability Insurance payments).

The long-term disability insurance plan offered to County Executives, Physicians, and Dentists may vary from the benefits described in this Guide. For details, see the PDF attachments listed at the bottom of the Employee Services Agency's **Time Away From Work** page.

Making Your Long-Term Disability Insurance Election

- As noted above, you may choose the Base Plan or one of the Fixed Benefit options (Options 2–11).
- Your first opportunity to enroll occurs when you are a new hire—you may select any option and enroll within 30 days of your hire date. You are not required to provide evidence of insurability (defined in the plan's Summary Plan Description) if you enroll within the initial new hire window.
- As you continue employment with the County, you may enroll (or change your election) at any time. But if you missed your initial new hire window, you'll be required to provide evidence of insurability to become insured.

LIFE AND FINANCIAL BENEFITS

Vacation or Scheduled Time Off (STO)

Depending on your bargaining unit, employees earn vacation or scheduled time off (STO). Vacation or STO is accrued on an hourly basis, based on an eight-hour work day. Your accrued vacation or STO is based on your years of employment with the County and the maximum allowable balance. Refer to the memorandum of agreement for your bargaining unit to see how your benefit is calculated.

When planning and taking vacation or STO, you should talk with and secure approval from your manager.

Sick Leave

Most coded employees are eligible to accrue up to 96 hours of sick leave per year. Refer to the memorandum of agreement for your bargaining unit to see how your benefit is calculated.

Additional Types of Leaves

Several other types of leave may be available to employees:

- **Military leave**—governed by the State of California, for serving in the national or state military and in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
- **Bereavement leave**—in the event of the death of an immediate family member
- **Jury duty**—to serve on a jury without a loss of pay
- **Leave without pay**—may be granted to employees for up to one year

Contact your **Department's Employee Service Center** (see page 46) for more information.

LIFE AND FINANCIAL BENEFITS

Holidays

The County observes the following holidays:

- New Year's Day
- Martin Luther King Jr. Day (third Monday in January)
- Presidents' Day (third Monday in February)
- Cesar E. Chavez's Birthday (March 31)
- Memorial Day (last Monday in May)
- Juneteenth (June 19)
- Fourth of July
- Labor Day (first Monday in September)
- Columbus Day (second Monday in October)
- Veterans Day (November 11)
- Thanksgiving Day and Friday after
- Christmas Day

Contact your **Department's Employee Service Center** (see page 46) for more information.

ADDITIONAL BENEFITS

VTA SmartPass

The SmartPass Clipper card can be used for unlimited rides on the VTA bus or light rail systems (VTA express bus service is excluded). All eligible County employees are provided with a Clipper card. For questions or replacement cards, please send an email to **benefits@esa.sccgov.org**.

You will use the same Clipper card as long as you are part of the program. The County does not receive any information about how you use your card. When you retire or leave employment with the County, your card will be deactivated, but you can continue to use the card by loading personal funds to ride public transit. There is no need to return the card to the County.

The SmartPass Clipper card is not valid for free travel or discounts on any other transit system. However, additional fares from other agencies, including AC Transit, BART, Caltrain, Muni, and SamTrans, may be loaded on the same Clipper card. For questions about coordinating your card with other transit services, contact Clipper customer service at **custserv@clippercard.com** or **877-878-8883**.

P&A Group Commuter Benefits Program

The County's pre-tax commuter benefits program, administered by P&A Group, allows eligible employees to set aside tax-free dollars to pay for expenses related to commuting to work. You may elect up to $232.50 per month for transit expenses or up to $315.00 per month for parking expenses. Enrollment is open for a period of time each month, when you can place a one-time order or set it up as a monthly deduction.

Commuter Benefits is administered by P&A Group, which charges a $1.83 service charge for each monthly deduction. Your transportation or parking funds will be loaded onto your current Benefits Card (if you have one with a Flexible Spending Account) or a new one that will be sent to you. Your P&A Group balance will roll over from month to month as long as you're an active employee and remain eligible for this benefit. Contact P&A Group at **716-852-2611**, or go to **padmin.com**.

RETIREMENT

PUBLIC EMPLOYEES' RETIREMENT SYSTEM (CalPERS)

Eligible County employees participate in the CalPERS defined benefit (DB) pension plan. The plan provides employees with a lifetime pension benefit based on a formula, rather than contributions made to a savings or 457 plan.

CalPERS pension benefits are funded through a combination of employer and employee contributions toward the plan.

- For classic employees in most bargaining units, the County pays the majority of the contributions required to fund plan benefits. The amount varies and is determined by bargaining unit agreement.
- Non-classic employees are required to pay at least half of the normal cost to fund their pension plan benefit.

To calculate your benefit at retirement, CalPERS includes the following in its formula:

- For classic employees—your service credit, your benefit factor, and your final average compensation over a 12-month period
- For non-classic employees—your service credit, your benefit factor, and your final average compensation over a 36-month period

Both classic and non-classic employees must meet the five-year vesting period to be eligible to receive CalPERS pension benefits.

TAKE NOTE

As you read through this section of the Benefits Guide, note that there are two types of CalPERS members:

- Employees hired into the CalPERS system before January 1, 2013, who have not had a break in service of more than six months, are considered CalPERS classic employees.
- Employees hired on or after January 1, 2013, are considered new or non-classic employees under the California Public Employees' Pension Reform Act (PEPRA).

The plan rules vary based on your class of membership.

RETIREMENT

The formula used to calculate your benefit is:

Service Credit—subject to applicable maximums	X	Benefit Factor	X	Final Average Compensation—subject to applicable maximums	=	CalPERS Retirement Benefit

Note that your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and your membership type. Examples based on different employee types and ages are noted below.

Employee Type	CalPERS Benefit Factors
Miscellaneous Classic Member	2.5% at age 55
Safety Classic Member	3% at age 50
Miscellaneous Non-Classic Member *(hired into the CalPERS system on or after 1/1/2013)*	2% at age 62, with a minimum age at retirement of 52 years
Safety CalPERS Non-Classic Member *(hired into the CalPERS system on or after 1/1/2013)*	2.7% at age 57

Here's an example of a retirement calculation for a Miscellaneous Non-Classic Member, assuming retirement at age 62, with 20 years of CalPERS service and final average pay of $65,000.

Service Credit	X	Benefit Factor	X	Final Average Compensation	=	CalPERS Retirement Benefit
20 years	X	2%	X	$65,000	=	$26,000 per year ($2,167 per month)

This an example only. It is not a guarantee of a future benefit by CalPERS. Go to the CalPERS website at **calpers.ca.gov** to learn more about your specific retirement benefit. The site includes a benefit calculator, which you can use to estimate your benefit at different retirement ages. You can also request an official benefit estimate directly from CalPERS.

Contact your **Department's Employee Service Center** (see page 46) if you have questions about your CalPERS contributions.

DEFERRED COMPENSATION PLAN

The Deferred Compensation (DC) Plan is a defined contribution retirement savings plan that allows you to set aside compensation and defer payment of applicable federal and state taxes until you retire and take withdrawals from your account. Participating in this plan may lower your taxable income now; your tax obligation may also be lower in retirement.

You may make pre-tax contributions to this plan, up to an annual maximum limit determined each year by IRS regulations. You may change or stop your payroll contributions on a monthly basis.

NEW! Roth Governmental 457(b) Option

Beginning in May 2024, your Deferred Compensation Plan is expanding to include Roth contribution options. Your current plan lowers your taxable income by allowing you to contribute on a pre-tax basis. Roth contributions, on the other hand, are taxed as regular income before being added to your account. Then, in retirement, your Roth contributions and earnings are generally tax-free.

What's Different About the Roth Governmental 457(b)?

Just like your current plan:

- You elect how much of your salary you wish to contribute, up to an IRS annual maximum.
- Your contribution is based on your eligible compensation.

However, unlike your current plan, the Roth governmental 457(b) allows you to withdraw your money tax free when you retire.* But it will require you to make after-tax contributions now. The table below compares your contribution options.

Taxes: Pay Now or Pay Later

	Deferred Compensation Plan	Roth Governmental 457(b) Option
How You Contribute	Pretax dollars	After-tax dollars
When You Withdraw	Taxable upon withdrawal	Tax free upon withdrawal*

* In the event of either retirement or termination, your earnings can be withdrawn tax free as long as it has been five tax years since your first Roth governmental 457(b) contribution and you are at least 59½ years old. In the event of death, beneficiaries may be able to receive distributions tax free if the deceased started making Roth contributions more than five tax years prior to the distribution. In the event of disability, your earnings can be withdrawn tax free if it has been five tax years from your first Roth governmental 457(b) contribution.

IS A ROTH GOVERNMENTAL 457(B) RIGHT FOR YOU?

A Roth governmental 457(b) could be a good option for:

- Younger employees who have a longer retirement horizon and more time to accumulate tax-free earnings.
- Highly compensated individuals who aren't eligible for Roth IRAs, but who want a pool of tax-free money to draw on in retirement.
- Employees who want to leave tax-free money to their heirs.

Important Plan Information

The administrator for your Deferred Compensation Plan and the Roth governmental 457(b) option is Fidelity Investments. You may invest your pre-tax and Roth 457(b) contributions in a variety of mutual funds and other types of investment vehicles. Making sound investment decisions is your responsibility, and you can take advantage of the tools and resources offered by Fidelity. Go to **netbenefits.com/santaclara** to enroll, review plan investment options, and set up your personal account. To learn more about the investment options available to you, contact Fidelity at **844-SCC-457B (844-722-4572)**. You are also encouraged to consult with a tax professional for specific advice on your personal situation.

If you have questions about the Deferred Compensation Plan or the Roth governmental 457(b) option, contact your **Department's Employee Service Center** (see page 46), or call **408-970-2600**.

Take Note

Generally, you are not allowed to access your DC Plan funds while employed by the County. These funds are held in trust until you separate from service or retire. When you do, you will have various options for payout.

The DC Plan may allow you to take a loan from your account. Also, if you experience a catastrophic financial event, you may be allowed to take an emergency withdrawal from your account. However, this action is governed by very strict IRS regulations. You must pay applicable federal and state taxes on your withdrawal. If a loan is available to a participant, then an emergency withdrawal request will not be granted. For additional information on loans, contact Fidelity directly at **844-SCC-457B (844-722-4572**).

RETIREE MEDICAL COVERAGE

The County provides access to group health plan coverage to eligible retirees based on hire date, as follows:

- **If you were hired before August 12, 1996,** you are eligible for retiree medical coverage with a minimum of 1,305 days (five years) of accrued County service.
- **If you were hired on or after August 12, 1996,** you are eligible for retiree medical coverage with a minimum of 2,088 days (eight years) of accrued County service.
- **If you were hired on or after June 19, 2006,** you are eligible for retiree medical coverage with a minimum of 2,610 days (10 years) of accrued County service.
- **If you were hired into a position covered by a collective bargaining agreement,** the hire date for retiree medical eligibility may vary by labor contract—in many cases, it's on or after January 1, 2013. You are eligible for retiree medical coverage with a minimum of 3,915 days (15 years) of County service.

Review your union memorandum of agreement for more details regarding eligibility.

After submitting your application to CalPERS and approximately 60 days prior to your planned retirement date, you should contact the Employee Benefits Department at **408-970-2600** or **800-541-7749** to set up an appointment to initiate enrollment in retiree medical coverage. **Coverage is not automatic upon retirement; you must complete the necessary paperwork to maintain medical coverage after you retire.**

For most retirees, the County pays for single coverage under the Kaiser retiree-only health plan. Retirees who elect a more expensive medical plan, or who elect to cover an eligible dependent, need to reimburse the County for the difference in the cost of the monthly premium.

MAKING YOUR BENEFITS DECISIONS

ELIGIBILITY

Medical

If you are in a full-time or part-time coded position, you may enroll in one of the three health plans.

You may also enroll the following eligible members for coverage:

- Your current spouse
- Your children, stepchildren, or adopted children until the end of the month after they turn age 26
- Any other children under the age of 26 for whom you have legal guardianship (if legal guardianship was established prior to age 18)
- Your children, stepchildren, adopted children, or any child dependent under your legal guardianship who reaches the age of 26 and is incapable of self-support because of an existing physical or mental disability prior to age 26. Proof of physical or mental disability must be submitted within the time limits of the provider's initial request prior to reaching the age of 26 and thereafter must be submitted annually after reaching the age of 28, at the request of the provider.
- Your registered domestic partner
- Your registered domestic partner's children if the children meet the same criteria of a child as described above

KEEP YOUR INFORMATION UP TO DATE

Be sure that your Department's Employee Service Center has the most up-to-date information for you and your dependents. Make sure your home address is current and that you have properly reported any additions or deletions of your eligible dependents as they occur. Also, remember to provide notification immediately to the Employee Service Center of any address or dependent change during the year.

MEDICAL COVERAGE FOR EXTRA HELP EMPLOYEES

Extra Help (non-coded) County employees may only enroll in certain medical plan options offered by the County:

- **Valley Health Plan (VHP) Preferred HMO Plan:** All Extra Help employees may enroll.
- **Valley Health Plan (VHP) Classic HMO Plan:** Eligibility for enrollment in this plan depends on your union agreement.

All other benefits do not apply.

MAKING YOUR BENEFITS DECISIONS

Dental and Vision

Just as with the medical plans offered by the County, all regular hourly and salaried employees in coded positions, working half time or more in a week are eligible for these plans.

You may enroll the following eligible members in your dental and/or vision plan:

- Your spouse
- Your children, stepchildren, and adopted children who are under age 26
- Any other children under the age of 26 entirely supported by you and for whom you have legal guardianship
- Your children, stepchildren, adopted children, or any child you have legal guardianship for who is over the age of 26 and is incapable of self-support because of a physical or mental disability, which existed continuously prior to the age of 26 and continues to be certified as disabled on a semiannual basis
- Your registered domestic partner
- Your registered domestic partner's children, if the children meet the same criteria of a dependent child as described above

Dependents who turn 26 and are enrolled in dental and vision coverage will be automatically removed from coverage at the end of their birth month.

MAKING YOUR BENEFITS DECISIONS

ENROLLING AS A NEW HIRE

As an eligible employee, you have 30 days from your date of hire to enroll yourself and your eligible members in benefits. (Part-time employees may enroll in a health plan only, waive the dental and vision plan, or choose to enroll in the complete package.)

If you wait longer than 30 days from your date of hire to enroll or if you waive enrollment in your benefits, you must wait to enroll until the next annual Open Enrollment period.

The forms you need will be included with your new hire packet, or you can contact your **Department's Employee Service Center** (see page 46) if you need copies.

ANNUAL OPEN ENROLLMENT

Open Enrollment is your once-a-year opportunity to review your health and financial benefit elections and make changes for the coming plan year. This year's Open Enrollment period runs from **May 1, 2024, to May 31, 2024**.

During Open Enrollment you may choose to:

- Enroll in, waive, or change medical, dental, or vision plans.
- Enroll or reenroll in the Health Care Bonus Waiver Program—**current participants must reenroll!**
- Enroll or remove eligible dependents for medical, dental, and/or vision plans. The following supporting documentation is required to enroll eligible dependents: birth certificate(s), marriage certificate, or certificate of domestic partner registry.

Enrollment for the Health Care Flexible Spending Account and Dependent Care Assistance Program will occur during fall 2024. Elections are effective from January 1, 2025, through December 31, 2025.

DON'T MISS THE DEADLINE

If you wish to take action during Open Enrollment, contact your Department's Employee Service Center to request the forms you need. The deadline is May 31, 2024. Your benefit elections are effective on June 24, 2024.

MAKING CHANGES DURING THE YEAR

You are not allowed to make changes to your benefits during the year unless you have a change in status such as marriage, birth, death, divorce, dissolution of domestic partnership, a dependent losing eligibility, or a change in your or your spouse's job that affects benefits eligibility.

You must notify your **Department's Employee Service Center** (see page 46) within 30 days of your status change. You may be allowed to change your benefits, consistent with the type of change. For example, if you have a baby, you may enroll her in your medical plan; however, you are not allowed to change from Kaiser to the POS medical plan.

Refer to the Annual Required Notices section of this Guide for more information about changing your benefits midyear.

Certain benefits allow you to make changes at any time during the year, including:

- The Deferred Compensation Plan
- Accidental Death and Dismemberment Insurance
- Supplemental Life and Long-Term Disability Insurance

CONTACTS

BENEFITS CONTACT INFORMATION

Need Help With	Contact	Phone or Website
Medical Plans	Valley Health Plan	888-421-8444 **valleyhealthplan.org/scc**
	Kaiser Permanente	800-464-4000 **my.kp.org/santaclaracounty**
	Health Net	800-522-0088 **healthnet.com/portal/member/content/iwc/mysites/sc/home.action**
Dental Plans	Delta Dental	888-335-8227 **deltadentalins.com/index.html**
	LIBERTY Dental	888-359-1088 **client.libertydentalplan.com/scc**
Vision Service Plan	VSP	800-877-7195 **sccgov.vspforme.com**
Employee Assistance Program (EAP)	Concern	800-344-4222 **employees.concernhealth.com** login with company code SCCGOV
Health Care Flexible Spending Account Dependent Care Assistance Program P&A Group Pre-Tax Commuter Benefit	P&A Group	716-852-2611 **padmin.com**
State Disability Insurance	Disability Insurance Program	800-480-3287 **edd.ca.gov**
Supplemental Life Insurance Basic Life Insurance AD&D Insurance Long-Term Disability Insurance	Standard Insurance Company	888-937-4783
Deferred Compensation Plan	Fidelity Investments	844-SCC-457B (844-722-4572) **netbenefits.com/santaclara**
Public Employees Retirement System	CalPERS	888-225-7377 **calpers.ca.gov**
SmartPass Commuter Program	ESA—Employee Benefits	**benefits@esa.sccgov.org**

CONTACTS

EMPLOYEE SERVICE CENTERS

Service Center	Budget Units Served	
District Attorney's Office 70 W. Hedding St., West Wing San Jose, CA 95110 408-792-2686	District Attorney	
ESA Service Center at Race Street 400 Race St., Suite 201, San Jose, CA 95126 408-970-2600	Agriculture & Environmental Mgmt. Assessor Clerk of the Board Controller—Treasurer County Clerk—Recorder County Communications County Counsel County Executive County Library District Dept. of Child Support Services Dept. of Environmental Health Dept. of Tax and Collections Employee Services Agency Facilities Fleet Services LAFCO	Law Library Medical Examiner—Coroner Office of Supportive Housing Parks & Recreation Planning & Development Pretrial Services Probation Procurement Public Defender Registrar of Voters Risk Management Roads & Airports Departments Supervisorial Districts 1–5 TSS Valley Health Plan Vector Control
ESA Service Center at Social Services Agency 333 W. Julian St., San Jose, CA 95110 408-755-7130	Social Services Agency Social Services Agency Nutrition Services	
ESA Service Center at Valley Medical Center 2325 Enborg Ln., #1H105, San Jose, CA 95128 408-885-5450	Behavioral Health Community Health Custody Health	Public Health Valley Medical Center
ESA Service Center at O'Connor Hospital 2105 Forest Ave., San Jose, CA 95128 408-947-2509	Valley Medical Center at O'Connor Hospital	
ESA Service Center at St. Louise Regional Hospital 9400 No Name Uno, Gilroy, CA 95020 408-848-8687	Valley Medical Center at St. Louise Regional Hospital	
Sheriff's Office 55 W. Younger Ave., San Jose, CA 95110 408-808-4611	Department of Corrections Sheriff's Office	

ANNUAL REQUIRED NOTICES

This document contains important employee benefit program notices of interest to you and your family. Please share this information with your family members. Some of the notices in this document are required by law, and other notices contain helpful information. These notices are updated from time to time, and some of the federal notices are updated each year.

This document includes the following:

- Midyear Changes to Your Health Care Benefit Elections
- Important Reminder to Provide the Plan With the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of Each Enrollee in a Health Plan
- Privacy Reminder Notice
- Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice Reminder
- Availability of Summary Health Information: The Summary of Benefit and Coverage (SBC) Document(s)
- Patient Protection Rights of the Affordable Care Act
- COBRA Coverage Reminder
- Important Notice From the County of Santa Clara About Your Prescription Drug Coverage and Medicare for 2024

KEEP YOUR INFORMATION UP TO DATE

If you have any questions regarding these notices and reminders, please contact the Employee Benefits Department by phone at 408-970-2600 or by email at **benefits@esa.sccgov.org**.

ANNUAL REQUIRED NOTICES

MIDYEAR CHANGES TO YOUR HEALTH CARE BENEFIT ELECTIONS

IMPORTANT: After this Open Enrollment period is completed, generally you will not be allowed to change your benefit elections or add or delete dependents until next year's Open Enrollment, unless you have a Special Enrollment Event or a Midyear Change in Status Event as outlined below:

Special Enrollment Event:

- **Loss of Other Coverage Event:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this 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 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- **Marriage, Birth, Adoption Event:** 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 30 days after the marriage, birth, adoption, or placement for adoption.
- **Medicaid CHIP Event:** You and your eligible 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 the Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org**.

Midyear Change in Status Event:

Because the County pre-taxes benefits, we are required to follow Internal Revenue Service (IRS) regulations on if and when benefits can be changed in the middle of a plan year. The following events may allow certain changes in benefits midyear, if permitted by the IRS:

- Change in legal marital status (e.g., marriage, divorce/legal separation, death)
- Change in number or status of dependents (e.g., birth, adoption, death)
- Change in employee's, spouse's, or dependent's employment status, work schedule, or residence that affects their eligibility for benefits
- Coverage of a child due to a Qualified Medical Child Support Order (QMCSO)
- Entitlement or loss of entitlement to Medicare or Medicaid
- Certain changes in the cost of coverage, composition of coverage, or curtailment of coverage of the employee or spouse's plan
- Changes consistent with Special Enrollment rights and FMLA leaves
- If an employee is covered by a County-sponsored medical plan and the employee's work hours are reduced so that the employee is expected to average less than 30 hours of service per month, the employee can request to be dropped from the medical plan to go enroll in the Health Insurance Marketplace or to enroll in their spouse's group medical plan.
- If an employee is covered by a County-sponsored medical plan and the employee is eligible to enroll in the Health Insurance Marketplace during its Open Enrollment or Special Enrollment period, the employee can request to be dropped from the medical plan to go enroll in the Health Insurance Marketplace.

ANNUAL REQUIRED NOTICES

You must notify the plan in writing within 30 days of the midyear change in status event by contacting the Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org**. The Plan will determine if your change request is permitted, and, if so, changes become effective prospectively on the first day of the pay period following the approved change in status event and your first premium payment (except for newborn and adopted children, who are covered back to the date of birth, adoption, or placement for adoption).

Failure to give this Plan a timely notice (as noted above) may:

a. Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,

b. Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,

c. Cause claims to not be able to be considered for payment until eligibility issues have been resolved, or

d. Result in your liability to repay the Plan if any benefits are paid to an ineligible person.

IMPORTANT REMINDER TO PROVIDE THE PLAN WITH THE TAXPAYER IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN) OF EACH ENROLLEE IN A HEALTH PLAN

Employers are required by law to collect the taxpayer identification number (TIN) or Social Security number (SSN) of each medical plan participant and provide that number on reports that will be provided to the IRS each year. Employers are required to make at least two consecutive attempts to gather missing TINs or SSNs.

If a dependent does not yet have a Social Security number, you can go to this website to complete a form to request an SSN: **socialsecurity.gov/online/ss-5.pdf**. Applying for a Social Security number is FREE.

The SSN will also be used to help fulfill mandatory reporting requirements to the Centers for Medicare & Medicaid Services (CMS), for the purposes of permitting Medicare to coordinate benefits for individuals enrolled in both an employer-sponsored medical plan and Medicare.

If you have not yet provided the Social Security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please contact your Department's Employee Service Center to provide this information.

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 health care information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. **You can request a copy of this Notice** from the Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org**.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE REMINDER

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

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

These benefits will be provided subject to the same deductibles, copayment, and coinsurance applicable to other medical and surgical benefits provided under the various medical plans offered by the County. For more information on WHCRA benefits, contact the Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org**.

ANNUAL REQUIRED NOTICES

AVAILABILITY OF SUMMARY HEALTH INFORMATION: THE SUMMARY OF BENEFIT AND COVERAGE (SBC) DOCUMENT(S)

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

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

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

Government regulations are very specific about the information that can and cannot be included in each SBC. Plans are not allowed to customize very much of the SBC documents. There are detailed instructions the Plan has to follow about how the SBCs looks, how many pages long the SBC should be, the font size, the colors used when printing the SBC, and even which words are to be bold and underlined.

A Uniform Glossary that defines many of the terms used in the SBC is available at **dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf**.

To get a free copy of the most current Summary of Benefits and Coverage (SBC) documents for our medical plan options, contact the Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org**.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP) and Direct Access to OB/GYN Providers:

The County-sponsored medical plans do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any in-network (or non-network) health care provider; however, payment by the Plan may be less for the use of a non-network provider. To locate an in-network provider, visit **healthnet.com/portal/member/content/iwc/mysites/sc/home.action** or **vhpservices.sccgov.org/** or **my.kp.org/santaclaracounty**.

You also do not need prior authorization from the Plan 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 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 (OB/GYN), contact Health Net at **800-522-0088** or Kaiser at **800-464-4000** or Valley Health at **888-421-8444**.

COBRA COVERAGE REMINDER

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

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

Qualifying events may include termination of employment, reduction in hours of work making the employee ineligible for coverage, death of the employee, divorce or legal separation, or a child ceasing to be an eligible dependent child under the terms of the plan, if a loss of coverage results.

ANNUAL REQUIRED NOTICES

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 **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 Marketplace coverage or for the tax credit. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

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

In order to have the chance to elect COBRA coverage after a divorce or 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 must be sent to the County's Human Resources department 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 the Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org**.

REMINDER TO KEEP THE PLAN NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

You or your Dependents must promptly furnish to the County's Employee Benefits Department by phone at **408-970-2600** or by email at **benefits@esa.sccgov.org** information regarding change of name, address, marriage, divorce or legal separation, 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 events noted above.

Failure to give your Department's Employee Service Center timely notice of the events noted above may:

a. Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,

b. Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,

c. Cause claims to not be able to be considered for payment until eligibility issues have been resolved, or

d. 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.

ANNUAL REQUIRED NOTICES

IMPORTANT NOTICE FROM THE COUNTY OF SANTA CLARA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE FOR 2024

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 Santa Clara 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. The County of Santa Clara has determined that the prescription drug coverage offered by the Health Net, Kaiser Permanente, and Valley Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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 15 to December 7.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current County of Santa Clara coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:

- For Medicare-eligible Retirees and their Medicare-eligible Dependents, Medicare Part D coverage pays primary and the group health plan pays secondary.
- For Medicare-eligible Active Employees and their Medicare-eligible Dependents, the group health plan pays primary and Medicare Part D coverage pays secondary.

Note that you may not drop just the prescription drug coverage under the County's medical plans. That is because prescription drug coverage is part of the entire medical plan.

If you do decide to join a Medicare drug plan and drop your current County of Santa Clara coverage, be aware that you and your dependents will be able to get this coverage back at the next Open Enrollment opportunity.

ANNUAL REQUIRED NOTICES

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 Santa Clara 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
For further information, contact the County of Santa Clara Employee Benefits Office at **408-970-2600** or toll-free at **800-541-7749**. **NOTE:** You'll get this notice each year. You will also get it before the next period in which you can join a Medicare drug plan, and if this coverage through the County of Santa Clara 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 you can 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).

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