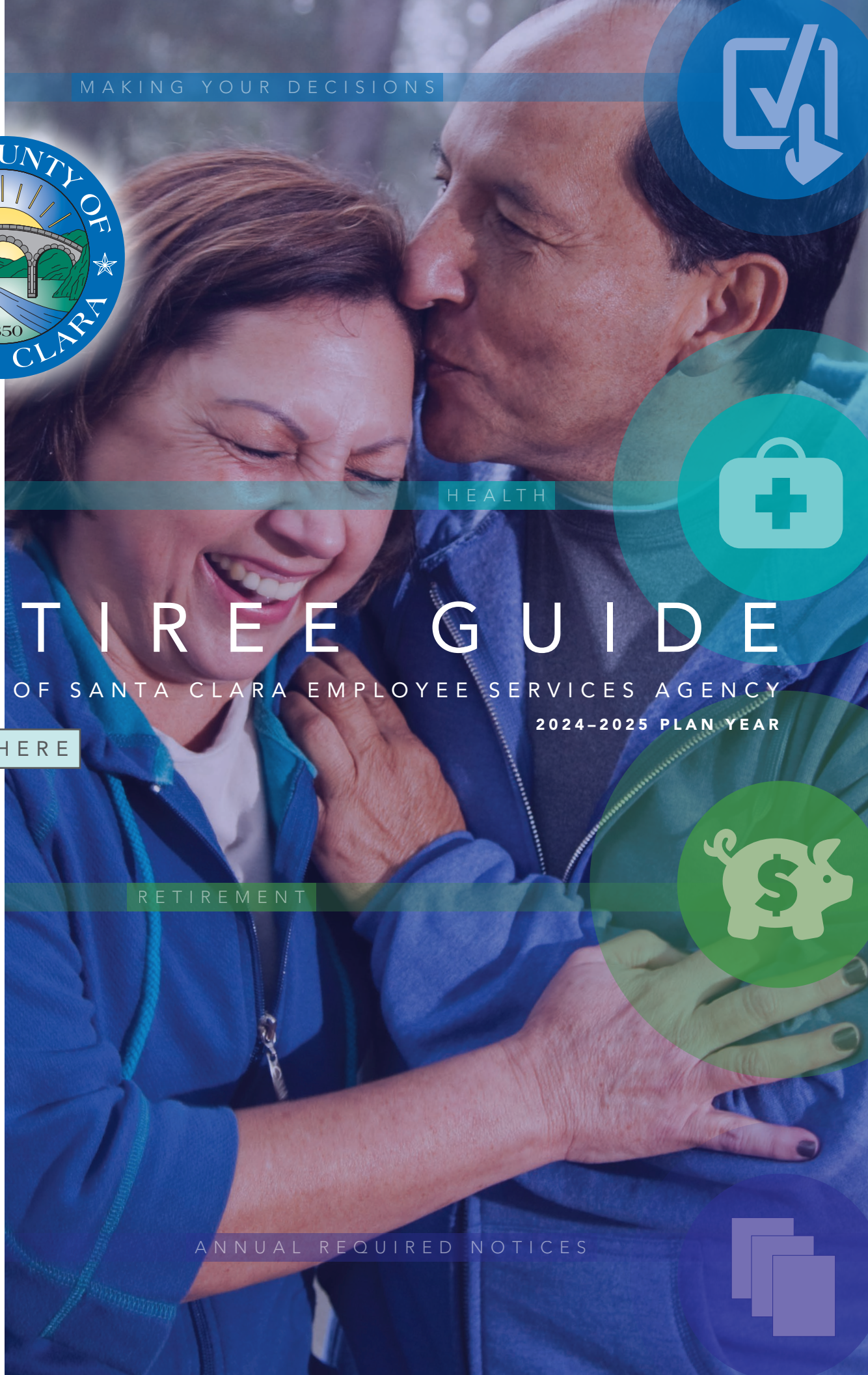

RETIREE GUIDE

COUNTY OF SANTA CLARA EMPLOYEE SERVICES AGENCY

2024–2025 PLAN YEAR

BEGIN HERE

ABOUT YOUR COUNTY OF SANTA CLARA RETIREE BENEFITS

The County of Santa Clara values its retirees and their family members. We strive to provide you and your family with programs, tools, and resources to help you continue to live a healthy life once you have retired.

The Retiree Benefits Guide provides the information you need to make your benefit elections during this year's Open Enrollment period.

In addition to this printed copy, an easy-to-navigate guide will be posted online.

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

Where to Get More Information

When making your medical plan decision for the coming year, we encourage you to review the rates carefully and consider each plan's coverage features and potential out-of-pocket costs when you need care. You can request information about the coverage provided under each plan from your designated **Employee Benefits Representative** (see chart on **page 6**).

When you're ready to enroll, follow the instructions on **page 5** of this Guide.

OPEN ENROLLMENT—MAY 1–31, 2024

This is your opportunity to change your medical plan option, enroll in a medical plan if you previously waived coverage, and enroll or drop coverage for your eligible dependents.

For the 2024–2025 plan year, retirees will see the cost of medical premiums increase for some insurance plans. The premium rates for the 2024–2025 benefit plan year are included in your Open Enrollment letter. You can also view the rates through the **Employee Services Agency (ESA) website**:

esa.santaclaracounty.gov/retiree-open-enrollment

MAKING YOUR DECISIONS

Eligibility

The County provides access to group health plan coverage to eligible retirees upon meeting the required years of service and retiring from the County and CalPERS at the same time. County vesting requirements are as follows:

- **If you were hired before August 12, 1996,** you are eligible for retiree medical coverage with a minimum of 1,305 days (5 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 (8 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.

TAKE NOTE

You **only** need to take action during Open Enrollment if you want to change your medical plan, enroll in a County-sponsored plan if you previously waived coverage, and/or add or drop coverage for your eligible dependents.

Remember: This is your only opportunity to make a change to your medical plan for this plan year (unless you experience a qualified life event, such as marriage or divorce, or if you move away from the service area covered by your current medical plan).

Eligible Dependents

You may also enroll the following eligible dependents for coverage:

- Your current, lawful 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

Making Your Premium Payments

Changes to coverage made during Open Enrollment go into effect on July 1, 2024. As a reminder, **premium rate changes go into effect in the month of June 2024 for coverage in July**.

Premium payments may only be made through PERS direct authorization. This authorizes a premium deduction from your monthly CalPERS pension check and is an easy way for you to make your premium payment (payment for July coverage will be deducted from the July 1 warrant).

If you recently retired, you will need to complete and submit an Authorization Form—Retiree Medical Premium Payment. Contact your Employee Benefits Representative to request this form.

READY TO ENROLL?

OPEN ENROLLMENT CHECKLIST

No changes? No action is required.

Making changes?

- ☑ View the online Open Enrollment presentation to get more information about your options.
- ☑ Contact your Employee Benefits Representative to request the forms you need.
- ☑ Establish your premium deduction authorization through your monthly CalPERS pension check if you:
  - Are not currently enrolled in medical coverage, or
  - Now have a cost for coverage.
- ☑ Return all required forms to the Employee Benefits Department by May 31, 2024.

Changing Your Medical Plan?

If so, it is very important that you verify coverage before seeking services. It normally takes the plan providers about 3–4 weeks to send out an official enrollment packet and new membership ID card(s). If you need health services before you receive your member packet, contact Employee Benefits. A representative can help expedite your enrollment with your new plan provider.

How to Enroll

If you want to enroll or make a change during Open Enrollment, contact your Employee Benefits Representative to discuss your options and request the required forms. Return your forms to the Employee Benefits Department by fax or email as shown below. **Do not** send any enrollment forms directly to the medical plan carriers.

County of Santa Clara, Employee Benefits Department
Fax: **408-277-0318**
Email: **retirement@esa.sccgov.org**

The contact information for the County's Employee Benefits Representatives is shown in the chart on the next page.

Employee Benefits Representatives

First Initial of Your Last Name	Your Representative	Direct Phone Number	Email
A, B, V	Melinda Lum	408-970-2618	Melinda.lum@esa.sccgov.org
C, G, O, P, Z	Crystal Nicolas	408-970-2613	Crystal.nicolas@esa.sccgov.org
D, H, I, M, Q, U	Michele Dallara	408-970-2615	Michele.dallara@esa.sccgov.org
E, F, J, R, T, W	Rosalina (Rosie) Moreno	408-970-2677	Rosalina.moreno@esa.sccgov.org
K, L, N, S, X, Y	Rosalinda De La Cerda	408-970-2623	Rosalinda.delacerda@esa.sccgov.org

Remember: When sending an email, please cc: **retirement@esa.sccgov.org**

Don't miss the deadline. The County must receive your forms by 5 p.m. on May 31, 2024. The effective date for changes you make (if any) is July 1, 2024. Premium rate changes go into effect in the month of June 2024 for coverage in July.

Questions? We've Got Answers!

You are very important to us. We know that choosing a medical plan and using your benefits wisely are top priorities. If you have questions, feel free to reach out to your Employee Benefits Representative. Your Representative is committed to providing you with the information you need and to helping you navigate your health care. The chart above identifies your Representative, their phone number, and their email. If you email your Representative, please be sure to copy **retirement@esa.sccgov.org**. You can also contact any of our staff members by phone at **408-970-2600**.

Do not hesitate to connect! We are here for you!

SOME IMPORTANT THINGS TO REMEMBER

If You Turn 65 and Become Eligible for Medicare

If you'd like to keep your health care coverage through County of Santa Clara after you retire, you (and your Medicare-eligible dependents) must enroll in Medicare Parts A and B when you turn age 65 and are eligible for Medicare. Once enrolled in Medicare, please provide a copy of your Medicare card to the County of Santa Clara, Employee Benefits Department. If you are not eligible to enroll in Medicare Part B, you must provide a statement from Social Security confirming ineligibility. Your group coverage may be terminated if you fail to enroll in Medicare Part B, resulting in a lapse in your health care coverage. For some medical plans, most retirees may be eligible for up to the full reimbursement of your Medicare Part B premium.

Don't Enroll in the Medicare Part D Prescription Drug Program

The County's medical plans provide retirees with prescription drug coverage that is equal to or greater than the drug coverage provided under Medicare Part D.

The Centers for Medicare & Medicaid Services notifies the County when a retiree and/or covered spouse enrolls in Medicare Part D or is covered by Medicare Part D through another group plan. The County will send a notice to the retiree advising them to disenroll within 30 days or risk losing their County-sponsored medical coverage.

Payment in Lieu of Medical Coverage Option

Payment in Lieu of Medical Coverage is an option available to retirees who move out of the state of California. In order to qualify, you will need to permanently reside outside of California and provide annual proof of major medical insurance coverage. If you have Medicare Parts A and B, your Medicare card is adequate proof of coverage. Please give us a call if you plan to switch to this program. You can reach us at **408-970-2600** or toll free at **800-541-7749**.

Coverage Outside of California

If you're living outside of California, you may still enroll in the County-offered Health Net PPO medical plan.

SURVIVOR COVERAGE AFTER RETIREE DEATH

The County offers medical coverage to your eligible dependents after your death under the following conditions:

- Your spouse and/or dependent is covered on your health plan at the time of your death.
- Your spouse and/or dependent pays 100% of the group premium in a timely and in a consistent manner.

Please note: The County does not contribute toward survivor coverage. Please contact the Employee Benefits Department with any questions about this coverage.

MEDICAL

During enrollment every year, retirees may review their current medical plan and enroll in another plan. The County of Santa Clara is pleased to offer retirees several medical plan options:

- Valley Health Plan HMO (Classic Network): Under 65
- Valley Health Plan HMO (Classic Network): Medicare
- Valley Health Plan HMO (Preferred Network): Under 65
- Valley Health Plan HMO (Preferred Network): Medicare
- Kaiser Permanente HMO: Senior Advantage (Medicare)
- Kaiser Permanente HMO: Under 65
- Health Net Select POS: Under 65
- Health Net Select PPO: Under 65
- Health Net Out-of-State PPO: Under 65
- Health Net Select POS: Medicare
- Health Net PPO: Medicare
- Health Net: OOS & CA Medicare PPO COB*
- Health Net Seniority Plus: Medicare

* Replaces the Health Net Flex Net Medical Plan

Medical plan charts with these plans' details are on pages 13–21.

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.

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.

If you choose one of the Valley Health plans or Kaiser Permanente plans: To be eligible to enroll in a Valley Health Plan, you must reside in Santa Clara, San Francisco, San Mateo, Alameda, Stanislaus, Merced, San Benito, Monterey, or Santa Cruz County.

If you are under 65 and a non-Medicare retiree with Kaiser, you must live or work within a 30-mile radius of a Kaiser hospital.

If you are over 65 and Medicare-eligible, you must live in a Kaiser Permanente Service Area. If you have questions, contact Kaiser Permanente at **800-464-4000**.

Most services are covered at 100% with minimal or no office visit copayments. Out-of-network services are generally not covered except for emergency conditions (please refer to the health plan's Evidence of Coverage document for specific coverage information).

About the Health Net POS Plan

The Health Net Point of Service plans are types of managed care health insurance plans that offer 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. Here's how it works:

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

- You 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.*

- You 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. In addition, 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 the Employee Benefits Department or the plans directly:

Contact	Customer Service	Website
Employee Benefits Department	408-970-2600	esa.santaclaracounty.gov/county-retirees
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

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. Meetings can be held by 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

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.

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.

NEED A DOCTOR NOW?

Telemedicine gives you 24/7 access to U.S. board-certified doctors through the convenience of the web or over the phone. Get the care you need in minutes from the comfort of your home or while you are traveling. This is an affordable alternative to costly urgent care and ER visits when you need immediate care.

Contact your health plan's telemedicine department:

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

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

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

Health Net—Teladoc
teladoc.com/hn
800-835-2362 (TTY: 711)

COMPARISON CHARTS—VALLEY HEALTH PLAN

Medical Plans at a Glance

The charts below and on the following pages offer an overview of some of our medical plans' features.

	Valley Health Plan HMO Classic: Under 65	Valley Health Plan HMO Preferred: Under 65
	In-Network	In-Network
Calendar-Year Deductible		
Individual / Family	$0	$0
Annual Out-of-Pocket Maximum		
Individual / Family	$1,000 / $2,000	$1,000 / $2,000
Physician Office Visit	$0	$0
Specialist Copay	$0	$0
Preventive Care	$0	$0
Lab and X-Ray		
CT, MRI, PET Scans	$0	$0
Other Lab and X-Ray Tests	$0	$0
Hospitalization		
Inpatient	$0	$0
Outpatient	$0	$0
Emergency Room	$0	$0
Urgent Care Services	$0	$0
Durable Medical Equipment	$0	$0
Chiropractic Care	$10 per visit up to 24 per calendar year	$10 per visit up to 24 per calendar year
Acupuncture Care	$10 per visit up to 24 per calendar year	$10 per visit up to 24 per calendar year
Prescription Drugs—Generic / Brand		
Rx Copay Out-of-Pocket Maximum	N/A	N/A
Retail: 30-day supply	$0	$0
Mail Order: up to 90-day supply	$0	$0

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

COMPARISON CHARTS—VALLEY HEALTH PLAN

	Valley Health Plan HMO Classic: Medicare	Valley Health Plan HMO Preferred: Medicare
	In-Network	In-Network
Calendar-Year Deductible		
Individual / Family	$0	$0
Annual Out-of-Pocket Maximum		
Individual / Family	$1,000 / $2,000	$1,000 / $2,000
Physician Office Visit	$0	$0
Specialist Copay	$0	$0
Preventive Care	$0	$0
Lab and X-Ray		
CT, MRI, PET Scans	$0	$0
Other Lab and X-Ray Tests	$0	$0
Hospitalization		
Inpatient	$0	$0
Outpatient	$0	$0
Emergency Room	$0	$0
Urgent Care Services	$0	$0
Durable Medical Equipment	$0	$0
Chiropractic Care	$10 per visit up to 24 per calendar year	$10 per visit up to 24 per calendar year
Acupuncture Care	$10 per visit up to 24 per calendar year	$10 per visit up to 24 per calendar year
Prescription Drugs—Generic / Brand		
Rx Copay Out-of-Pocket Maximum	N/A	N/A
Retail: 30-day supply	$0	$0
Mail Order: up to 90-day supply	$0	$0

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

COMPARISON CHARTS—KAISER

	Kaiser Permanente HMO: Senior Advantage (Medicare)	Kaiser Permanente HMO: Under 65
	In-Network	In-Network
Calendar-Year Deductible		
Individual / Family	None	None
Annual Out-of-Pocket Maximum		
Individual / Family	$1,500 per person	$1,500 / $3,000
Physician Office Visit	$10	$10
Specialist Copay	$10	$10
Preventive Care	No charge	No charge
Lab and X-Ray		
CT, MRI, PET Scans	No charge	No charge
Other Lab and X-Ray Tests	No charge	No charge
Hospitalization		
Inpatient	$100 per admittance	$100 per admittance
Outpatient	$10 per surgery	$10 per surgery
Emergency Room	$35 (waived if admitted)	$35 (waived if admitted)
Urgent Care Services	$10	$10
Durable Medical Equipment*	No charge	No charge
Chiropractic Care	Not covered	Not covered
Acupuncture Care	Not covered	Not covered
Prescription Drugs—Generic / Brand		
Rx Copay Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Retail: 30-day supply	$5 / $10	$5 / $10
Mail Order: up to 100-day supply	$10 / $20	$10 / $20

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

* 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.

COMPARISON CHARTS—HEALTH NET

Select POS: Under 65 | PPO: Under 65 | Out-of-State PPO: Under 65 | OOS & CA Medicare PPO COB
Select POS Medicare | PPO: Medicare | Seniority Plus: Medicare

	Health Net Select POS: Under 65		
	HMO Network	**PPO Network**	**Out-of-Network**
Calendar-Year Deductible			
Individual / Family	None	None	$200 / $600
Annual Out-of-Pocket Maximum			
Individual / Family	$1,500 / $4,500	$2,000 / $6,000	$3,000 / $9,000
Physician Office Visit	$15	$20	30%
Specialist Copay	$15	$20	30%
Preventive Care	No charge	No charge	No charge through age 17; not covered age 18 and over
Lab and X-Ray			
CT, MRI, PET Scans	No charge	10%	30%
Other Lab and X-Ray Tests	No charge	10%	30%
Hospitalization			
Inpatient	No charge	10%	30%
Outpatient	No charge	10%	30%
Emergency Room	$50 (waived if admitted)	$75 (waived if admitted)	30%
Urgent Care Services	$35 (waived if admitted)	$50 (waived if admitted)	30%
Durable Medical Equipment	No charge	50%	Not covered
Chiropractic Care	$5 (20 visits/calendar year)	Not covered	Not covered
Acupuncture Care	Not covered	Not covered	Not covered
Prescription Drugs—Generic / Brand / Non-Formulary			
Rx Copay Out-of-Pocket Maximum	$2,000 (member) / $4,000 (family)		
Retail: 30-day supply	$5 / $15 / $30 / $0 self-injectable		
Mail Order: up to 100-day supply	$10 / $30 / $60		

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

COMPARISON CHARTS—HEALTH NET

Select POS: Under 65 | PPO: Under 65 | Out-of-State PPO: Under 65 | OOS & CA Medicare PPO COB
Select POS Medicare | PPO: Medicare | Seniority Plus: Medicare

	Health Net PPO: Under 65	
	In-Network	**Out-of-Network**
Calendar-Year Deductible		
Individual / Family	None	$200 / $600
Annual Out-of-Pocket Maximum		
Individual / Family	$2,000 / $6,000	$4,000 / $12,000
Physician Office Visit	$20	30%
Specialist Copay	$20	30%
Preventive Care	No charge	30%
Lab and X-Ray		
CT, MRI, PET Scans	10%	30%
Other Lab and X-Ray Tests	10%	30%
Hospitalization		
Inpatient	10%	30%
Outpatient	10%	30%
Emergency Room	$100* + 10% (*waived if admitted)	$100* + 10% (*waived if admitted)
Urgent Care Services	$100* + 10% (*waived if admitted)	$100* + 10% (*waived if admitted)
Durable Medical Equipment	10%	30%
Chiropractic Care	$20 (12 visits per calendar year)	30% ($25 max payable per visit)
Acupuncture Care	10% (12 visits per calendar year)	30% (12 visits per calendar year)
Prescription Drugs—Generic / Brand / Non-Formulary		
Rx Copay Out-of-Pocket Maximum	$2,000 (member) / $4,000 (family)	
Retail: 30-day supply	$5 / $15 / $30 / $20 self-injectable	$5 / $15 / $30 + 50%
Mail Order: up to 100-day supply	$10 / $30 / $60	$10 / $30 / $60 + 50%

Note: Please contact the Employee Benefits Department for rates and contributions requirements for this plan.

COMPARISON CHARTS—HEALTH NET

	Health Net Out-of-State PPO: Under 65	
	In-Network	**Out-of-Network**
Calendar-Year Deductible		
Individual / Family	None	$200 / $600
Annual Out-of-Pocket Maximum		
Individual / Family	$2,000 / $6,000	$4,000 / $12,000
Physician Office Visit	$20	30%
Specialist Copay	$20	30%
Preventive Care	No charge	Not covered
Lab and X-Ray		
CT, MRI, PET Scans	10%	30%
Other Lab and X-Ray Tests	10%	30%
Hospitalization		
Inpatient	10%	30%
Outpatient	10%	30%
Emergency Room	$100* + 10% (*waived if admitted)	$100* + 10% (*waived if admitted)
Urgent Care Services	$100* + 10% (*waived if admitted)	$100* + 10% (*waived if admitted)
Durable Medical Equipment	10%	30%
Chiropractic Care	$20 (12 visits per calendar year)	30% ($25 max payable per visit) (12 visits per calendar year)
Acupuncture Care	10% (12 visits per calendar year)	30% (12 visits per calendar year)
Prescription Drugs—Generic / Brand / Non-Formulary		
Rx Copay Out-of-Pocket Maximum	$2,000 (member) / $4,000 (family)	
Retail: 30-day supply	$5 / $15 / $30 / $20 self-injectable	$5 / $15 / $30 + 50%
Mail Order: up to 100-day supply	$10 / $30 / $60	$10 / $30 / $60 + 50%

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

COMPARISON CHARTS—HEALTH NET

Select POS: Under 65 | PPO: Under 65 | Out-of-State PPO: Under 65 | OOS & CA Medicare PPO COB
Select POS Medicare | PPO: Medicare | Seniority Plus: Medicare

	Health Net: OOS & CA Medicare PPO COB*	
	In-Network	**Out-of-Network**
Calendar-Year Deductible		
Individual / Family	None	None
Annual Out-of-Pocket Maximum		
Individual / Family	$6,350 (individual) / $12,700 (family)	$6,350 (individual) / $12,700 (family)
Physician Office Visit	No charge	No charge
Specialist Copay	No charge	No charge
Preventive Care	No charge	No charge
Lab and X-Ray		
CT, MRI, PET Scans	No charge	No charge
Other Lab and X-Ray Tests	No charge	No charge
Hospitalization		
Inpatient	Refer to Evidence of Coverage (EOC) for details	Refer to Evidence of Coverage (EOC) for details
Outpatient	No charge	No charge
Emergency Room	No charge	No charge except 20% for non-network professional services (outside U.S.)
Urgent Care Services	No charge	No charge
Durable Medical Equipment	No charge	No charge
Chiropractic Care	No charge	No charge
Acupuncture Care	Not covered	Not covered
Prescription Drugs—Generic / Brand		
Rx Copay Out-of-Pocket Maximum	$1,000 (member) / $2,000 (family)	$1,000 (member) / $2,000 (family)
Retail: 30-day supply	$5 / $10 / $0 self-injectable	$5 / $10 / $0 self-injectable
Mail Order: up to 100-day supply	$10 / $20	$10 / $20

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

***** Replaces the Health Net Flex Net Medical Plan

COMPARISON CHARTS—HEALTH NET

Select POS: Under 65 | PPO: Under 65 | Out-of-State PPO: Under 65 | OOS & CA Medicare PPO COB
Select POS Medicare | PPO: Medicare | Seniority Plus: Medicare

	Health Net Select POS: Medicare		
	HMO Network	**PPO Network**	**Out-of-Network**
Calendar-Year Deductible			
Individual / Family	None	None	$200 / $600
Annual Out-of-Pocket Maximum			
Individual / Family	$1,500 / $4,500	$2,000 / $6,000	$3,000 / $9,000
Physician Office Visit	$15	$20	30%
Specialist Copay	$15	$20	30%
Preventive Care	No charge	No charge	No charge through age 17; not covered age 18 and over
Lab and X-Ray			
CT, MRI, PET Scans	No charge	10%	30%
Other Lab and X-Ray Tests	No charge	10%	30%
Hospitalization			
Inpatient	No charge	10%	30%
Outpatient	No charge	10%	30%
Emergency Room	$50 (waived if admitted)	$75 (waived if admitted)	30%
Urgent Care Services	$35 (waived if admitted)	$50 (waived if admitted)	30%
Durable Medical Equipment	No charge	50%	Not covered
Chiropractic Care	$5 (20 visits per calendar year)	Not covered	Not covered
Acupuncture Care	Not covered	Not covered	Not covered
Prescription Drugs—Generic / Brand / Non-Formulary			
Rx Copay Out-of-Pocket Maximum	$2,000 (member) / $4,000 (family)		
Retail: 30-day supply	$5 / $15 / $30 / $0 self-injectable		
Mail Order: up to 100-day supply	$10 / $30 / $60		

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

COMPARISON CHARTS—HEALTH NET

	Health Net PPO: Medicare		Health Net Seniority Plus: Medicare
	In-Network	**Out-of-Network**	**In-Network**
Calendar-Year Deductible			
Individual / Family	$100 / $300		None
Annual Out-of-Pocket Maximum			
Individual / Family	$2,000 / $6,000	$4,000 / $12,000	$3,400 per member
Physician Office Visit	$20	30%	No charge
Specialist Copay	$20	30%	No charge
Preventive Care	No charge	30%	No charge
Lab and X-Ray			
CT, MRI, PET Scans	10%	30%	No charge
Other Lab and X-Ray Tests	10%	30%	No charge
Hospitalization			
Inpatient	10%	30%	No charge
Outpatient	10%	30%	No charge
Emergency Room	$100* + 10% (*waived if admitted)	$100* + 10% (*waived if admitted)	$20 (waived if admitted)
Urgent Care Services	10% for medical services; $20 for behavioral health, chemical dependency, or substance abuse	10%	$20 (waived if admitted)
Durable Medical Equipment	10%	30%	No charge
Chiropractic Care	$20 (12 visits per calendar year)	30% ($25 max payable per visit) (12 visits per calendar year)	No charge (limited to Medicare allowed chiropractic benefit)
Acupuncture Care	10% (12 visits per calendar year)	30% (12 visits per calendar year)	Not covered
Prescription Drugs—Generic / Brand / Non-Formulary			
Rx Copay Out-of-Pocket Maximum	$2,000 (member) / $4,000 (family)		Combined with Medical
Retail: 30-day supply	$5 / $15 / $30 / $20 self-injectable	$5 / $15 / $30 + 50%	$3 / $7 / $7 / $0 self-injectable
Mail Order: up to 100-day supply	$10 / $30 / $60	$10 / $30 / $60 + 50%	$6/ $14 / $14

Note: The Monthly Retiree Medical Plan Rates & Contribution Requirement for this plan is included in your kit as a separate document.

RETIREMENT

DEFERRED COMPENSATION PLAN

The Deferred Compensation (DC) Plan is the County's supplemental defined contribution retirement savings plan that allowed you to set aside compensation while actively working for the County and defer payment of applicable federal and state taxes after you retired. As a retiree of the County, you have the option to leave your assets in the County's Deferred Compensation Plan and maintain control over your investment options. You can also begin making withdrawals from your account as needed or request scheduled automatic payments. Withdrawals are generally taxable, but unlike other retirement accounts, the 10% penalty tax does not apply to distributions prior to age 59½.

The plan's administrator is Fidelity Investments. For information about your personal account, go to:

netbenefits.com/santaclara

On this site, you can view helpful investment tips and tools, including a retirement calculator, as well as access important plan documents.

Log in to the site, or download the Fidelity app, to manage your account. You can also call Fidelity directly to speak with a representative.

If you have questions about the Deferred Compensation Plan, contact Fidelity at **844-SCC-457B** (**844-722-4572**).

IMPORTANT

If you have an account, you are strongly encouraged to contact Fidelity and establish a beneficiary. Any beneficiary you may have established with the prior plan administrator **did not** carry over.

NEW! Roth Governmental 457(b) Option

The County is adding a new Roth option to the 457(b) Deferred Compensation Plan effective May 1, 2024. If you have an account, you have the option to do a Roth In-Plan Conversion. Please contact Fidelity Investments to learn more about whether this option is right for you. Visit **Fidelity.com/schedule** or call **800-642-7131** to schedule an appointment.

ANNUAL REQUIRED NOTICES

This document contains important retiree 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:

- Medicare Notice of Creditable Coverage Reminder
- 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
- Important Notice From the County of Santa Clara About Your Prescription Drug Coverage and Medicare for 2024

MEDICARE NOTICE OF CREDITABLE COVERAGE REMINDER

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the medical plan options available to you are or are not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the County-sponsored medical plan options is or is not creditable, you should review the plan's Medicare Part D Notice of Creditable Coverage at the end of this section.

It is also available upon request from the Employee Benefits Department by phone at **408-970-2600** or by email at **retirement@esa.sccgov.org**.

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/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: **www.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 the Employee Benefits Department 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 **retirement@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 updated 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, when 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 Employee Benefits Department, preferably within 30 days after any of the above-noted events, by phone at **408-970-2600** or by email at **retirement@esa.sccgov.org**.

Failure to give the Employee Benefits Department timely notice of the above-noted events 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.

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

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

Note: This does NOT apply for individuals covered through a Medicare Advantage Plan or Medicare Supplement Plan.

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.

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

Contact the person listed below for further information, or call 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 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 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).

County of Santa Clara, Employee Services Agency

400 Race Street, Suite 201, San Jose, CA 95126

Phone 408-970-2600

Email retirement@esa.sccgov.org

esa.santaclaracounty.gov/retiree-open-enrollment