Photo Credit: Marin Convention and Visitors Bureau

2024 County of Marin Employee Benefits Guide

REGULAR HIRE

COUNTY OF MARIN

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This Guide is designed to help you understand your benefits. Review the materials carefully before making your enrollment decisions. Specific details, plan limitations and exclusions, and notices of your legal rights are provided in the Evidence of Coverage (EOC), which are available from the County Human Resources Department. If there is a conflict between the EOC of the plan you selected and the information in this Guide, the plan's EOC will prevail.

GENERAL STATEMENT OF NONDISCRIMINATION

Discrimination Is Against the Law

The County of Marin complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The County of Marin does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The County of Marin:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, etc.)
2. Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Civil Rights Coordinator for the County of Marin.

If you believe that the County of Marin has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance at:

Civil Rights Coordinator for the County of Marin
ATTN: Human Resources Department – Roger Crawford
3501 Civic Center Drive, Suite 415
San Rafael, CA 94903

You can file a grievance in person or by mail, fax, or email. If you need help, you may email Roger Crawford, call 1-415-473-2095, or fax 1-415-473-5960.

You can also file a civil rights complaint electronically with the U.S. Department of Health and Human Services, Office for Civil Rights, Complaint Portal Assistant, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019 or 1-800-537-7697 (TDD)

How to file a complaint: https://www.hhs.gov/regulations/complaints-and-appeals/index.html.

Disability Access

Requests for accommodations can be made by calling 1-415-473-4381 (voice), 1-415-473-3232 (TTY), or by email at disabilityaccess@marincounty.org.

Copies of documents are available in alternative formats upon request.

CHART FOR FREE LANGUAGE ASSISTANCE ON NEXT PAGE.

Free Language Assistance

The following chart displays the top 15 languages spoken by individuals with limited English proficiency in the state of California:

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	**Message About Language Assistance**
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-415-473-2095 (TTY: 1-415-473-3232).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-415-473-2095 (TTY: 1-415-473-3232)。
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-415-473-2095 (TTY: 1-415-473-3232).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-415-473-2095 (TTY: 1-415-473-3232).
Persian (Farsi)	**توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-415-473-2095 (TTY: 1-415-473-3232) تماس بگیرید.
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-415-473-2095 (TTY: 1-415-473-3232) पर कॉल करें।
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-415-473-2095 (TTY: 1-415-473-3232).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-415-473-4381 (رقم هاتف الصم والبكم: 1- 415-473-2095).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-415-473-2095 (TTY: 1-415-473-3232) 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-415-473-2095 (TTY: 1-415-473-3232).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-415-473-2095 (телетайп: 1-415-473-3232).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-415-473-2095 (TTY: 1-415-473-3232) まで、お電話にてご連絡ください。
Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-415-473-2095 (TTY (հեռատիպ)՝ 1-415-473-3232):
Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-415-473-2095 (TTY: 1-415-473-3232)។
Punjabi	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-415-473-2095 (TTY: 1-415-473-3232) 'ਤੇ ਕਾਲ ਕਰੋ।

BENEFITS ELIGIBILITY

Member Eligibility

The County provides an allowance to regular hire full-time employees and part-time employees working half-time or more that can be used to purchase health care benefits including medical, dental, vision, as well as group term life and long-term disability insurance. Eligible employees may take some of the unused portion of the cash allowance as taxable cash back according to the IRS (IRC, Section 125).

Generally, your Benefit elections will be effective the start of the third pay period after your Date of Hire. All employees of contingent hire status may be eligible only for the Kaiser High-Deductible Health Plan (HDHP). For more information about medical benefits for contingent hire employees see the Employee Benefits Guide for Contingent Hire.

Dependent Eligibility

SPOUSE OR DOMESTIC PARTNER (DP)

All benefits-eligible employees may enroll a legal spouse or registered DP in the County's benefits plans, including medical, dental, vision, and dependent life insurance. Proof of legal marriage or domestic partnership is required. Enrollment in benefits must be completed within 30 days of the date of marriage or partnership or during the annual Open Enrollment period.

NATURAL CHILDREN, STEPCHILDREN, ADOPTED CHILDREN

A member's natural child, stepchild, adopted child (including a child placed for adoption), the natural or adopted child of a legal spouse or DP, child under a qualified medical child support order, and legal guardianship child are eligible for coverage in health care benefits up to 26 years of age. There is no age limit for children who are disabled. The employee will be responsible for all taxes incurred under rules set by the IRS and the Franchise Tax Board regarding imputed income. See the Domestic Partner Health Care Benefits Taxation section on page 5 of this Guide for more information.

Regular Hire Employees and Group Medicare

By law, the County of Marin health plans (Kaiser, Western Health Advantage, and Teamsters' Anthem Blue Cross) are considered the "Primary Payers" and Medicare is a "Secondary Payer" (except for employees with end-stage renal disease, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second). This means a County of Marin-sponsored group health plan pays up to the limits of coverage first and the "Secondary Payer" only pays if there are costs the primary insurer didn't cover.

Because of this "coordination of benefits" between the Primary and Secondary Payers, regular hire full-time and part-time Medicare-eligible employees who receive their health care coverage through a County of Marin-sponsored medical plan, are not required to sign up for Medicare Part B or Part D when they turn 65. County of Marin employees who become eligible for Medicare while working will have an opportunity to sign up for Medicare prior to retirement during a Medicare Special Enrollment Period without penalty. If you are over age 65 at retirement, your Medicare benefits must be effective on or prior to your retirement date. There are premium penalties if your benefits become effective after retirement, so it is recommended to begin the Medicare enrollment process no later than three months before you plan to retire.

Below is a list of resources for more information about Medicare eligibility and enrollment:

- **Centers for Medicare and Medicaid Services (CMS) official Medicare handbook, "Medicare & You 2024"**
- **Marin County Employees' Retirement Association (MCERA), 1-415-473-6147**
- **Social Security Administration, 1-800-772-1213**

DOMESTIC PARTNER HEALTH CARE BENEFITS TAXATION

Health coverage for a domestic partner (DP) and a DP's children may be taxable benefits under federal law.

A domestic partner (DP) will generally not qualify as a tax dependent under federal law. According to the IRS code (Revenue Ruling 58-66), the "fair market value" of DP coverage is what must be used for computing taxes on Fringe benefits provided to non-tax qualified DPs or children of DPs enrolled under an employee's plan. This is true whether the costs are paid out of your Fringe benefit dollars provided by the County or paid out of pocket by the member as both are paid with pre-tax dollars. By comparison, no taxable imputed income results from employer contributions to a legal spouse's health care premiums or a DP that qualifies as a tax dependent. The fair market value is calculated for the DP and ***each*** child of the DP if the DP and/or the child do not qualify as dependents of the employee per the IRS definition found in the IRS code, Section 152 (Code 105 (b)). The County of Marin is required to include the fair market value of your DP coverage for federal, and in some cases state, tax purposes in your taxable income. This amount is reflected on your annual Form W-2 from the County, which employees receive in January of each year. This means that your taxable income will be higher than the actual cash wages that you have received.

Fair Market Value of DP Benefits

Fair market value of the DP benefit will be the cost difference between the employee only and the employee plus one dependent premium rate. Fair market value for each DP child is the family rate less the two-party rate.

Employee Only $436.38
Employee + 1 Dependent $872.76
Employee + Family $1,160.77

Examples for how fair market value is determined are highlighted below using 2024 Kaiser S HMO bi-weekly rates:

Examples	Base for Calculating Taxability	Bi-Weekly Kaiser S HMO Rate
COVERED INDIVIDUALS		
Employee	n/a	$1,160.77
Domestic Partner (DP)	$436.38	
DP Child 1	$288.01	
DP Child 2	$288.01	
DP Child 3	$288.01	
DP Child 4	$288.01	
Total	**$1,588.42**	
COVERED INDIVIDUALS		
Employee	n/a	$1,160.77
Domestic Partner (DP)	$436.38	
Employee's 5 Children	n/a	
DP Child 1	$288.01	
Total	**$724.39**	

Consult Your Tax Advisor

This is a brief overview regarding the tax treatment of health care benefits to DPs and children of DPs. Laws are subject to change. Please consult with a professional tax advisor for information needed to make these determinations. It is your responsibility to comply with state and federal tax law.

MIDYEAR CHANGE IN STATUS:
Changing Benefit Elections Outside of Open Enrollment

You may *only* change health care benefit elections outside of Open Enrollment if you have a midyear change in status.

Under the IRS Code, Section 125, the employee must pay the same amount of pre-tax premium each month during the year, unless the employee has a "midyear change event." This means once you have made your elections during the Open Enrollment period, no changes can be made until the next Open Enrollment period unless you have a midyear change of status event. To make a change in benefit elections due to a midyear change event, you must complete the election change process, including the submission of all required documentation, no later than 30 calendar days after the qualifying event occurs. If the election change process is not completed within 30 calendar days of the date of the qualifying event, you must wait until the next Open Enrollment to make the change. Examples of qualifying events include marriage or divorce, birth or adoption, loss of other non-County of Marin group medical coverage, an unpaid leave of absence taken by the employee or spouse, spouse/domestic partner (DP) gains coverage through an employer, etc.[1] If you have any questions concerning your benefits and/or the enrollment process, please contact a Human Resources Benefits representative to discuss.

Enrollment and Required Documentation

Required forms and documentation must be completed by the deadlines listed in the table on the following page. Late documentation, enrollment, and change forms will not be processed. If you are concerned because you cannot obtain all of the needed documentation, please call your HR Benefits representative to discuss.

1. Change in coverage due to a qualifying event may change premium contributions. Review your paycheck to make sure premium deductions are correct. If your premium deduction is incorrect, contact your HR Benefits representative. You must pay premiums that are owed. Unpaid premium contributions can result in termination of coverage.

2. Overage Dependents: The carrier will automatically drop overage dependents (age 26) from your health plan coverages, but you will need to email EmployeeBenefits@marincounty.org to adjust your health plan coverage level and premium if necessary.

(MIDYEAR CHANGE IN STATUS: QUALIFYING EVENTS EXAMPLES)
Table on following page

Midyear Change In Status: Qualifying Events Examples

Common Scenarios	How to Enroll	Important Timing
Marriage or Domestic Partnership	To enroll a new spouse or domestic partner (DP) and eligible children of a spouse or DP, you must submit the following: • Appropriate application forms • Copy of the marriage certificate or certificate of domestic partnership • Birth certificate for each child	Request for enrollment and required documentation must be made to the County of Marin within 30 days of the legal date of the marriage or partnership.
Birth or Adoption	To enroll your newborn or newly adopted child, you must submit the following: • Appropriate application forms • Copy of the birth certificate or adoption documentation	Request for enrollment and required documentation must be made to the County of Marin within 30 days of the legal date of the child's date of birth, adoption, or placement of adoption.
Legal Guardianship or Court Order	Coverage for a child under legal guardianship is effective the date guardianship takes effect, if all documentation is submitted by the 30-day deadline. Coverage per court order will be effective the date of court order, if all documentation is submitted by the 30-day deadline. You must submit the following: • Court-appointed legal guardianship documents • Birth certificate for each child	Request for enrollment and required documentation must be made to the County of Marin within 30 days of the effective date of court order.
Loss or Gain of Other Health Care Coverage Coverage can be lost due to termination of employment, loss of eligibility for coverage such as change from full-time work to part-time work, ineligibility for Medicare or Medicaid, unpaid leave, or return from military service. Gain of coverage through spouse/DP's employer or other change in status that results in eligibility under spouse/DP plan.	Employees and eligible dependents who lose or gain other coverage may enroll by submitting the following: • Appropriate application forms • Proof of loss or gain of coverage • Documentation of loss or gain in coverage must state the date other coverage ends or begins and the names of the individual(s) losing or gaining coverage	Request for enrollment or termination, along with required documentation, must be made within 30 days of the date other coverage terminates or begins.
Loss or Gain of Medicaid/CHIP Coverage If you or your dependent(s) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your dependents lose eligibility for that coverage, or do not have such coverage but become eligible for a premium assistance program through Medicaid or CHIP.	Employees and eligible dependents who lose or gain Medicaid or CHIP eligibility may enroll by submitting the following: • Appropriate application forms • Proof of loss or gain of coverage or eligibility for Premium Assistance Program • Documentation of loss or gain in coverage or eligibility for Premium Assistance Program must state the date other coverage ends or begins and the names of the individual(s) losing or gaining coverage/eligibility	Request for enrollment or termination must be made to the County of Marin within 60 days of the date other coverage terminates or eligibility begins.

RETIREMENT AND YOUR RETIREE BENEFITS

If you are considering retirement, you should be sure to review the MCERA Retiree Medical Benefits booklet. Depending upon your date of entry into the retirement system and applicable benefit tier, making changes during Open Enrollment or a qualified midyear change in status could potentially affect your benefit subsidy eligibility. You can find the retiree medical information at **https://www.mcera.org/retirees/health-benefits/county**.

We urge you to contact MCERA to discuss your retirement and benefits by calling 1-415-473-6147 or you can email: **MCERABenefits@marincounty.org**.

COUNTY OF MARIN EMPLOYER FRINGE CONTRIBUTIONS

About Fringe Contributions

Employer Fringe contributions can be used to purchase health care benefits including medical, dental, vision, as well as group term life and long-term disability insurance. Some of the unused portion of the cash allowance may be taken as taxable cash back according to the IRS (IRC, Section 125) and as applicable in the MOU for your bargaining unit. Employer Fringe contributions are not taxable or pensionable if used towards the cost of eligible benefits. Up to $100 of the unused portion of the employer Fringe contribution may be taken as cash back if a Waiver of Participation is completed, but the cash back is taxable and not pensionable.

Regular hire full-time employees and part-time employees working half-time or more are provided with a bi-weekly allowance to pay for qualified health care benefits called "Fringe."

With the exception of employees who waive County medical benefits, please note that not all employees are eligible to receive cash back from unspent Fringe. Your eligibility to receive cash back is determined by your date of hire or whether you received cash back as of a certain date (before July 1, 2018). For specific questions about your eligibility to receive cash back of unspent Fringe dollars, please refer to your labor agreement at Collective Bargaining Agreements or contact the Human Resources Benefits Team. Eligible regular hire part-time employees receive a prorated employer Fringe contribution.

2024 Bi-Weekly Employer Fringe Contributions

	Employee Only	Employee + 1 Dependent	Employee + Family
BUFGs: MAPE (General Unit, HHS, Nurses) and Unrepresented, MCMEA, PMA, DDA, SSOA, IATSE, and Probation			
Bi-weekly Fringe – Under $79k	$515.25	$835.29	$1,128.12
Bi-weekly Fringe – Over $79k	$515.25	$789.01	$1,056.91
BUFGs: Firefighters, Battalion Chiefs, and DSA			
Bi-weekly Fringe – Under $79k	$540.98	$835.29	$1,128.12
Bi-weekly Fringe – Over $79k	$540.98	$789.01	$1,056.91

CHOOSING YOUR MEDICAL PLAN

Regular hire full-time employees and part-time employees working at least half-time are eligible to enroll in any of the following medical plans:

- Kaiser L HMO – $10 co-pay for approved services
- Kaiser S HMO– $25 co-pay for approved services
- Kaiser Deductible HMO
- Western Health Advantage 15C HMO
- Western Health Advantage 25C HMO
- Teamsters Anthem Blue Cross PPO

It is mandatory for all employees who are eligible for benefits to be enrolled in a Medical Plan unless a Waiver of Participation is filed and accepted by the County.

Coverage Level Options

When you enroll in a medical plan, you also have the option to enroll your eligible dependents in coverage. You can choose one of three coverage levels, as follows:

- Employee Only
- Employee + 1 Dependent
- Employee + 2 or More Dependents (Family)

Although it is mandatory for all employees who are eligible for benefits to be enrolled in a medical plan, you can elect to enroll/waive dependents each year during the Open Enrollment period.

2024 Bi-Weekly Medical Plan Costs

All medical plans are experiencing rate increases for 2024. To help employees pay for the cost of health care benefits, the County contributes a bi-weekly Fringe allowance. Employer contribution amounts are determined by salary and the medical coverage level elected. Employer contributions have increased in 2024. See page 9 for more information on your bi-weekly employer fringe contribution amount.

Medical Plan	2024 Bi-Weekly Medical Plan Rates		
	Employee Only	Employee + 1 Dependent	Employee + Family
Kaiser L HMO	$474.40	$948.80	$1,261.90
Kaiser S HMO	$436.38	$872.76	$1,160.77
Kaiser Deductible HMO	$403.13	$806.26	$1,072.32
Western Health Advantage 15C HMO	$376.21	$752.43	$1,000.73
Western Health Advantage 25C HMO	$353.64	$707.28	$940.68
Teamsters Anthem Blue Cross PPO	$435.73	$874.50	$1,223.08

ABOUT YOUR MEDICAL PLAN OPTIONS

Health Maintenance Organization (HMO)

With an HMO plan, you must choose a Primary Care Physician (PCP) from a network of local healthcare providers who will refer you to in-network specialists or hospitals when necessary. For non-emergency care, you must access service through that PCP. You do not pay a deductible before accessing benefits, and co-pays at the point of service are set at a contracted rate. This helps to limit out-of-pocket costs. Except for emergencies, there are no plan benefits paid for provider services obtained outside of the HMO network. The County of Marin offers the following HMO plans:

The County provides two types of medical plans to choose from: HMO and PPO.

- **Kaiser L HMO**
- **Kaiser S HMO**
- ***NEW Medical Plan Option:***
  Kaiser Deductible HMO

  We are now offering a lower-cost plan with Kaiser. This plan offers co-pays for Physician and Specialist visits. An annual deductible and co-pays apply to the out-of-pocket maximum for inpatient and outpatient services, emergency services, and most x-rays/labs. Please refer to the Medical Plan Benefits Comparison on page 13 for plan highlights or the Benefits Summary on the HUB Employee Benefits page.

  Provider Search: To look for Kaiser Plan providers and locations go to:
  https://healthy.kaiserpermanente.org/northern-california/doctors-locations#/simple-form

- **Western Health Advantage 15C HMO**
- **Western Health Advantage 25C HMO**

  Provider Search: To find WHA providers such as Physicians, Specialists and Facilities go to:
  https://www.westernhealth.com/search-for-providers/advanced-search/

Preferred Provider Organization (PPO)

A PPO plan offers benefits through in-network and out-of-network healthcare providers and allows for a greater selection of providers. The greater flexibility that comes with a PPO plan often comes with higher out-of-pocket costs such as deductibles and the uncertainty of coinsurance. There is an in-network coinsurance maximum of $2,000 per year, which if met, would limit any additional in-network covered expenses to applicable co-payments only for covered benefits. While you can receive care from any doctor, specialist, or hospital you choose, you will save money and protect yourself from large and unexpected charges by choosing an in-network provider whenever possible. It is very important to remember that in addition to higher charges and higher coinsurance, there is no out-of-pocket coinsurance (or other) limit or protection for services obtained out-of-network. Also, you are not assigned to a primary care physician (PCP), so you have more responsibility in coordinating your care. The County offers the following PPO plan:

- **Teamsters Anthem Blue Cross PPO**

  Provider Search: To find Anthem Blue Cross Physicians, Specialists, and Facilities go to:
  https://www.anthem.com/ca/find-care/

  Use Member ID for Basic Search tool and enter **NPL**, then search by type of care.

(continued on next page)

Individual Mandate and Health Care Reform

The health care reform legislation that became law in 2010, known officially as the Affordable Care Act, requires most Americans to have health insurance. In December 2017 Congress passed a new law (the Tax Cuts and Jobs Act) that reduced the federal individual mandate penalty to zero starting in 2019. This means that starting in 2019 there will no longer be a federal individual mandate penalty for failure to maintain medical plan coverage.

Note that if you are a resident of certain states including California, Massachusetts, New Jersey, Rhode Island, or Vermont, or the District of Columbia, you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state's minimum coverage requirements. Consult with your own state's insurance department for information on whether your state has adopted or will be adopting a state individual mandate penalty.

County of Marin regular hire full-time and part-time employees must submit an annual Waiver of Participation form to waive medical and continue receiving cash back of unused Fringe. Coverage through the exchanges such as Covered California is not group coverage. See the Waiver of Participation section on page 27 of this Guide for more information.

2024 MEDICAL PLAN BENEFITS COMPARISON

This table (continued on following page) provides a summary of benefits. For a detailed description of benefits and exclusions for each plan, please review your plan's Summary of Benefits and Coverage (SBC) or Plan Document.[3]

PLAN COMPONENTS	Kaiser L HMO	Kaiser S HMO	Kaiser Deductible HMO
Deductible: Individual Family	None None	None None	$250 $500
Annual Out-of-Pocket Max: Individual Family	$1,500 $3,000	$1,500 $3,000	$3,000 $6,000
GENERAL CARE			
Routine Physical/Preventative Care	No charge	No charge	No charge††
Primary Care Visit	$10	$25	$25††
Specialty Visit	$10	$25	$40††
Well Baby Care	No charge	No charge	No charge††
Immunizations	No charge	No charge	No charge††
TESTING AND SPECIALTY CARE			
Most Labs and X-Rays	No charge	No charge	$10 after Deductible
Chiropractic	$10	$15	$15
Occupational, Physical, & Speech	$10	$25	$25 after Deductible
Skilled Nursing Facility	No charge	No charge	No charge after Deductible
Hospice Care	No charge	No charge	No charge††
Ambulance Services	$50 per trip	$50 per trip	No charge after Deductible
Urgent Care	$10	$25	$25††
Emergency Room	$50	$50	$250 after Deductible
Hospital: Inpatient Outpatient	No charge $10	No charge $25	No charge after Deductible $350 after Deductible
MATERNITY & INFERTILITY			
Pre/Post-Partum Care	No charge	No charge	No charge††
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient	No charge	No charge	No charge after Deductible
Outpatient	$10	$25	$25††
Group Outpatient	$5	$12	$12††
PRESCRIPTIONS (Rx) – PHARMACY (Retail)			
Most Generics	$5**	$10†	$15†
Most Formulary Brands	$5**	$25†	$30†
Most Non-Formulary Brands	Physician authorized only	Physician authorized only	Physician authorized only
Most Specialty Items	$5†	$25†	20% Coinsurance†

3. In the event that the information in this Guide differs from the Evidence of Coverage (EOC) or Plan Document, the EOC or Plan Document will prevail.
*Deductible waived.
**Up to 100-day supply.
†Up to 30-day supply.
††Deductible does not apply.

(continued on next page)

2024 MEDICAL PLAN BENEFITS COMPARISON *(continued)*

PLAN COMPONENTS	Western Health Advantage 15C HMO	Western Health Advantage 25C HMO	Teamsters Anthem Blue Cross PPO: In-Network	Teamsters Anthem Blue Cross PPO: Out-of-Network
Deductible: Individual Family	None None	None None	$250 $500	$250 $500
Annual Out-of-Pocket Max: Individual Family	$1,500 $3,000	$1,500 $3,000	$2,000 $2,000	None None
GENERAL CARE				
Routine Physical/Preventative Care	No charge	No charge	No charge*	Not covered
Primary Care Visit	$15	$25	$20*	40% UCR
Specialty Visit	$15	$25	$20*	40% UCR
Well Baby Care	No charge	$25	No charge*	Not covered
Immunizations	No charge	No charge	No charge*	Not covered
TESTING AND SPECIALTY CARE				
Most Labs and X-Rays	$15	None	20%	40% UCR
Chiropractic	$15	$15	20%	40% UCR
Occupational, Physical, & Speech	$15	$25	20%	40% UCR
Skilled Nursing Facility	No charge	No charge	20%	40% UCR (physician) 50% UCR (facility)
Hospice Care	No charge	No charge	20%	40% UCR
Ambulance Services	No charge	No charge	20%	40% UCR
Urgent Care	$15	$25	20%	40% UCR
Emergency Room	$75	$50	20%	20%
Hospital: Inpatient Outpatient	No charge $15	No charge $25	20% 20%	40% UCR (physician) 50% UCR (facility)
MATERNITY & INFERTILITY				
Pre/Post-Partum Care	No charge	No charge	20%	40% UCR (physician) 50% UCR (facility)
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient	No charge	No charge	20%	40% UCR (physician) 50% UCR (facility)
Outpatient	$15	$25	$20*	40% UCR
Group Outpatient	$15	$25	$20*	40% UCR
PRESCRIPTIONS Rx (Retail)				
Most Generics	$5†	$10†	$10**	$10**
Most Formulary Brands	$20†	$25†	$20**	$20**
Most Non-Formulary Brands	$50†	$35†	N/A (Open formulary)	N/A (Open formulary)
Most Specialty Items	Covered under applicable tier	Covered under applicable tier	$20†	$20†

*Deductible waived.
**Up to 100-day supply.
†Up to 30-day supply.
††Deductible does not apply.

NURSELINE, URGENT CARE, AND CUSTOMER SERVICE

A free, 24/7 nurseline is available for the Kaiser HMO, Western Health Advantage HMO, and Teamsters Anthem Blue Cross PPO plans. You can call the free nurse advice line and speak to a registered nurse and get answers to your questions about health problems, illness, or injury. The nurse can also help you decide if you need routine, urgent, or emergency service. If you have an emergency medical condition, call 911 or go to the nearest hospital.

Plan	24/7 Nurseline	Urgent After-Hours Care	Customer Service
Kaiser HMO	1-866-454-8855	**Note:** All Kaiser urgent care visits are by appointment only. For hours, call the Appointment and Advice Call Center at the facility you plan to visit. This is a partial list. For additional Kaiser urgent care facilities **visit** www.kp.org. Oakland Medical Center 1-510-752-1190 Petaluma Medical Offices 1-707-765-3960 San Francisco Medical Center 1-415-833-2200 San Rafael Medical Center 1-415-444-2940 Santa Rosa Medical Center 1-707-393-4044	Member Services—California 1-800-464-4000 (English) 1-800-788-0616 (Spanish) Online www.kp.org/memberservices
Western Health Advantage HMO	1-877-793-3655	In the event that you cannot reach your PCP, go to the nearest Urgent Care Facility. Use WHA's urgent care provider list to find the facility affiliated with your PCP. Emergency hospitalizations in a non-participating facility requires notification to WHA within 24 hours.	Member Services 1-888-563-2250 Coverage while Traveling 1-800-872-1414 www.assistamerica.com Online www.mywha.org
Teamsters Anthem Blue Cross PPO	1-800-977-0027	For the most up-to-date in-network list of urgent care facilities, contact member services or sign in at www.anthem.com/ca and click **URGENT CARE**.	Member Services 1-800-288-2539 Coverage While Traveling in US 1-800-810-2583 Online www.anthem.com/ca

VIDEO VISITS WITH A DOCTOR

Kaiser Permanente

Offers convenient video visits with your doctor from your home or workplace. All you need is a computer with an internet connection and a webcam or a mobile device using the latest version of the Kaiser Permanente App. See Video Visits for more information. You can also email your doctor, schedule routine appointments, see your lab results, and refill most prescriptions through the Kaiser Permanente App.

Video visits can be a convenient way to speak face-to-face with a doctor from the comfort of your home or workplace.

Anthem's LiveHealth Online

Connects you with a board-certified doctor in just a couple of minutes. Doctors are available 24/7, 365 days a year. For the same price of an office visit co-pay, you can meet with a doctor face-to-face through your mobile device or a computer with a webcam. It is a convenient option for care when your physician is not available. Visit with a doctor 24/7 or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. Once connected, you can talk and interact with the doctor as if you were in a private exam room.

Western Health Advantage

Offers a variety of online ways to stay in touch with your doctor 24/7. Go to Doctor Connection to find out what your provider offers.

DENTAL COVERAGE

Delta Dental PPO Plan

The County of Marin offers one Delta Dental PPO plan to employees, dependents, and dependent children up to age 26. Visit a dentist in the national PPO network to maximize your savings. You can visit any licensed provider under the plan; however, you will pay less out of your own pocket when you visit an in-network Delta Dental PPO provider.

It is mandatory for all regular hire employees who are eligible for benefits to be enrolled in the Delta Dental plan.

2024 Bi-Weekly Delta Dental PPO Plan Costs

Employee Only (MANDATORY)	Employee + 1 Dependent	Employee + Family
$24.21	$45.09	$70.49

ID Cards

If you've been looking for your dental plan ID card, the good news is that you don't need one! Just tell your dental office that you're covered by Delta Dental and provide your name, your date of birth, your enrollee ID number (or the last four (4) digits of your SSN), and the name of your employer. If you have dependents on your plan, they will need to provide your details. If you prefer to have an ID card anyway, you can pull it up on your smartphone or print one from online at Delta Dental.

Summary of Delta Dental PPO Benefits[4]

Delta Dental PPO: Deductible: None Plan Year Maximum:* $2,100 per person	**Non-Delta Dental PPO:** Deductible: None Plan Year Maximum:* $2,000 per person
NOTE: Diagnostic and Preventative Services paid by the dental plan are excluded from Plan Year Maximum.	

Benefits and Covered Services**	Delta Dental PPO† Co-Insurance Paid by Member	Non-Delta Dental PPO† Co-Insurance Paid by Member
Diagnostic and Preventative	20%	20%
Extractions and Fillings	20%	20%
Endodontics (root canals)	20%	20%
Periodontics (gum treatment)	20%	20%
Oral Surgery	20%	20%
Crowns and Cast Restoration	20%	20%
Prosthodontics (includes implants)	50%	50%
Orthodontia	40% *(lifetime maximum per member $1,500)*	50% *(lifetime maximum per member $1,500)*

4. For a complete list of covered services and plan limitations, see the plan's Evidence of Coverage (EOC) available by contacting Human Resources Benefits at 1-415-473-2197. In the event that the information in this Guide differs from the EOC, the EOC will prevail.

*Maximum amount the dental plan will pay per member in a calendar year.

**Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

†Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

VISION COVERAGE

The County of Marin offers vision coverage through VSP to employees, dependents, and dependent children up to age 26. Although it is mandatory for all regular hire employees who are eligible for benefits to be enrolled in a Vision plan, employees can elect to add or remove dependents each year during the annual Open Enrollment period.

The County offers two plans: The Core Plan and the Buy-Up Plan. See comparison charts below.

It is mandatory for all regular hire employees who are eligible for benefits to be enrolled in a Vision plan.

2024 Bi-Weekly VSP Vision Plans Costs

CORE PLAN			BUY-UP PLAN		
Employee Only (MANDATORY)	Employee + 1 Dependent	Employee + Family	Employee Only (MANDATORY)	Employee + 1 Dependent	Employee + Family
$2.25	$5.05	$7.20	$4.21	$9.44	$13.46

ID Cards

No ID cards are issued for the vision plan. If you would like a card as a reference, you can print one at VSP Vision Care.

Accessing Your VSP Vision Benefits

To find a VSP provider, visit Find an Eye Doctor or call 1-800-877-7195. Visit a VSP provider to maximize your savings. Keep in mind you will pay less out of your own pocket when you visit an in-network VSP provider.

Summary of VSP Signature Plans Benefits[5]

	CORE PLAN	BUY-UP PLAN
Exams	• WellVision Exam covered every 12 months with $10 co-pay • Retinal imaging exam covered in full every calendar year for no more than $39	
Essential Medical Eye Care	Additional exams & services beyond routine care for immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions. Coordination with your medical coverage may apply.	
Frame Allowance	• $25 co-pay for glasses (lenses & frame) • $160 frame allowance • $180 featured frame brand allowance *Every 24 months*	• $25 co-pay for glasses (lenses & frame) • $220 frame allowance • $240 featured frame brand allowance *Every 12 months*
Lenses	• Single vision, bifocal, or trifocal lenses—fully covered *Every 24 months*	• Single vision, bifocal, or trifocal lenses—fully covered *Every 12 months*
Lens Enhancements	• Progressive lenses—fully covered • Impact-resistant lenses for dependent children—fully covered • Average savings of 40% on other lens enhancements	• Progressive lenses—fully covered • Impact-resistant lenses for dependent children—fully covered • UV coating—fully covered • Anti-glare—covered with $30 co-pay • Average savings of 40% on other lens enhancements
Contact Lens Allowance (instead of glasses)	• $150 allowance for contact lenses and contact lens exam • 15% off contact lens exam (fitting & evaluation) *Every 24 months*	• $220 allowance for contact lenses and contact lens exam • $60 co-pay for contact lens exam (fitting & eval.) • 15% off contact lens exam (fitting & eval.) *Every 12 months*

5. For a complete list of covered services and plan limitations, see the plan's Evidence of Coverage (EOC) available by contacting Human Resources Benefits at 1-415-473-2197. In the event that the information in this Guide differs from the EOC, the EOC will prevail.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

How an FSA works

An FSA is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical (Health Care FSA) or Dependent Care (DCAP) expenses. During your initial benefits eligibility period or annual Open Enrollment, you choose how much money you want to contribute to an FSA for 2024. You will be able to access these funds throughout the year for qualified expenses. Both the Health Care FSA and DCAP plans are administered by Optum Financial.

You can save money for many everyday expenses, such as health care, child daycare, and elder day-care with tax- free money.

Eligible Health Care FSA Expenses

Health Care FSAs can pay for health care expenses with pre-tax funds, such as medical, pharmacy, dental and vision co-payments, other dental and vision care expenses, acupuncture and chiropractic care, and more. For a complete list of eligible health care expenses, visit Optum at Medical expense eligibility tool, filter by account type and click on: ◉ **FSA** (Health Care Flexible Spending Account).

HEALTH CARE FSA RULES

- You must re-enroll in FSAs every Open Enrollment if you want to continue this benefit for the upcoming plan year.
- The IRS requires that all FSA purchases be verified as eligible expenses. Sometimes, purchases are automatically verified when you use your FSA payment card. Other times, Optum Financial will request itemized receipts. Always save your itemized receipts!
- You can receive reimbursements up to the full amount of your annual election regardless of the amount you have already contributed.
- Health Care FSA contributions are currently limited by the IRS to $3,050 per person. This means that you may only set aside up to $3,200 for the 2024 calendar year on a pre-tax basis.
- You cannot change FSA contributions during the January to December plan year unless you have a midyear change in status.

Have you downloaded the Optum Financial App?

Eligible Dependent Care Assistance Program (DCAP) FSA Expenses

A Dependent Care FSA can pay for qualifying dependent care expenses with pre-tax funds such as certified daycare, preschool, day camp, before- and after-school programs, late pick-up fees, placement fees for a dependent care provider such as an au pair, and qualifying custodial care for dependent adults.

For a complete list of eligible dependent care expenses, visit Optum at Medical expense eligibility tool, filter by account type and click on: ◉ **DCFSA** (Dependent Care Flexible Spending Account).

NEW! **County Contribution for Dependent Care.**

We are excited to announce a two-year pilot program offering assistance to families with Dependent Care expenses (Child Care and Elder Care). The County will provide a dollar-for-dollar match up to $46.15 pretax per bi-weekly pay period ($1,200 annually). For example, for the 2024 year, if an employee elects the $5,000 DCAP annual cap, the employee will contribute $3,800 and the County will contribute $1,200. Note: The W-2 will reflect the full $5,000 election in box 10.

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FLEXIBLE SPENDING ACCOUNTS (FSAs) *(continued)*

Eligible Dependent Care Assistance Program (DCAP) FSA Expenses *(continued)*

DCAP FSA RULES

- Enrollment is required each year. You must re-enroll in DCAP every Open Enrollment if you want to continue this benefit.
- Covered dependent may include any qualifying child under the IRC regulations who is under the age of thirteen, or a spouse, child, or other person who is your federal tax dependent who is physically and/or mentally unable to care for themselves and has the same principal place of abode as you for more than half of the year.
- DCAP expenses are not eligible if the spouse is a stay-at-home parent.
- The IRS requires that all DCAP reimbursements be verified as eligible expenses. This includes amounts that reoccur each month.
- The IRS limits contributions to $5,000 per year per family. This means you may only set aside up to $5,000 in a calendar year in a DCAP FSA on a pre-tax basis.
- Unlike the Health Care FSA, you may only receive reimbursement from your DCAP account equal to the amount you have actually deposited.
- You cannot change DCAP FSA contributions during the January to December plan year unless you have a midyear change in status.

ENROLLING IN A HEALTH CARE FSA OR DEPENDENT CARE FSA

To enroll in the Health Care or Dependent Care FSA benefit, complete the enrollment form during your initial benefits eligibility period. Any elected FSA will be effective the 3rd pay period and you will see the pretax deduction on your pay advice.

IMPORTANT!
You must re-enroll in Flexible Spending Account(s) *every* Open Enrollment if you want to continue this benefit.

Determining What to Set Aside

Before enrolling, be sure to work out a detailed estimate of the eligible expenses you are likely to incur for the plan year ahead. Based on federal law, you may carry forward to the next plan year up to $640 in unused funds in your Health Care FSA; any unreimbursed funds in excess of $640 are forfeited at the end of the plan year and cannot be returned to you.

Avoid Forfeiting FSA Contributions

FSA expenses for the 2024 plan year must be incurred in 2024 and received by Optum Financial no later than March 31, 2025. Per IRS rules, you forfeit all funds remaining in an FSA by the end of the claim filing period unless they are covered by the carry forward provision described above. There are no exceptions.

If your employment ends with the County, the last date worked is the final date to incur FSA eligible expenses. You will then have 90 days to submit any outstanding claims to Optum for reimbursement. You will be offered COBRA continuation of your Health Care FSA.

Using your Health Care FSA

There are two ways to pay for health care expenses with your Health Care FSA:

1. **Use your FSA debit card:** Provide your card to a qualified merchant or provider, and they will swipe your card like any other credit or debit card to pay for your purchase. There is a preset PIN associated with your card, which are the last 4 digits of your card number. To select a different PIN, call Card Services at 1-888-999-0121. Remember, even when you use your card, IRS rules require purchases be verified for eligibility. Sometimes Optum Financial can do that automatically, but sometimes documentation is needed. Always save your documentation. Your card has been programmed to work only at merchant locations that are designated as health care merchants based on their Merchant Category Code (MCC). Examples of qualified merchants include doctor's offices and hospitals.
2. **Pay with personal funds and request reimbursement:** Pay using your own personal credit card, cash, or check and keep your itemized receipt as documentation. Then, log on to your online account to file for reimbursement and upload your documentation. You can receive reimbursement funds via check or direct deposit. Set up direct deposit online to receive quicker reimbursements.

Use Optum Financial's Qualified Medical Expense Tool to check if an item is FSA eligible.

Requesting Reimbursement

Sometimes Optum Financial receives a claim directly through your health insurance plan or through your payment card. In this case, there is no need for you to enter a separate request unless more documentation is requested. To request reimbursement for expenses paid using your personal funds, you will need to submit a claim. For more information on submitting claims and proper documentation, contact Optum Financial at 1-877-292-4040.

Using your Dependent Care Assistance Program (DCAP) FSA

If you have a DCAP account, you should pay for your qualified dependent care expenses using personal funds

(continued on next page)

ENROLLING IN A HEALTH CARE FSA OR DEPENDENT CARE FSA *(continued)*

and request reimbursement from your account. You will need to submit your itemized receipt as documentation. Remember, receipts for these expenses must include the name of the dependent and the tax identification number of the dependent care provider.

County Contribution to DCAP. For the County Employer Contribution to your DCAP account, you will receive a dollar-for-dollar match up to $46.15 per pay period on your paycheck advice. For example, if you contribute $40, you will receive the dollar-for-dollar employer match of $40 bi-weekly. You can contribute up to the IRS maximum and the total of the employee and employer contribution will be on your W-2 box 10. You will also see the Employer bi-weekly contribution in your Optum DCAP Account. You can set up your user account or download the Optum app.

QUESTIONS ABOUT FLEXIBLE SPENDING ACCOUNTS? CONTACT OPTUM FINANCIAL AT 1-877-292-4040.

GROUP TERM LIFE INSURANCE

Life insurance offers you and your loved ones basic financial protection if you die. Not only does life insurance help cover unexpected final expenses, it can also provide you and your loved ones with a financial safety net to help those left behind pay bills like a mortgage or college tuition.

It is mandatory for all regular hire employees who are eligible for benefits to be enrolled in Basic Group Term Life Insurance.

Mandatory Basic Group Term Life Insurance Coverage

Regular hire employees who are eligible for benefits receive mandatory Basic Group Term Life Insurance of $10,000. Employees are covered for Accidental Death and Dismemberment (AD&D) in the same amount as their life insurance. Group Term Life Insurance is administered through The Hartford. For details, see the plan's Evidence of Coverage.

Supplemental Group Term Life Insurance and AD&D Coverage

Employees may purchase Supplemental Group Term Life Insurance and AD&D coverage. Supplemental Group Term Life Insurance may be purchased at one or two times their basic yearly earnings without proof of good health *if* application is made within 31 calendar days of their new hire date (limits apply). Applications for Supplemental Group Term Life Insurance and AD&D coverage that fall outside of the initial eligibility period will require proof of good health for the entire benefit amount and may only be completed during the annual Open Enrollment period.

Dependent Group Term Life Insurance and AD&D Coverage

Newly hired employees may purchase Dependent Group Term Life Insurance and AD&D coverage. Employees may purchase Group Term Life Insurance and AD&D coverage for dependents that provides $5,000 for spouse/domestic partner, $1,500 for children from 6 months to 26 years old, and $500 from birth to 6 months. One premium covers all eligible dependents.

Initial Eligibility Period

Benefits-eligible newly hired employees who enroll in Supplemental Group Term Life and Dependent Group Term Life Insurance are automatically approved if elected within 31 calendar days of their start date (limits apply). Employees who wish to enroll in Dependent Group Term Life and/or Supplemental Group Term Life Insurance after their initial eligibility period can only do so during the Open Enrollment period and qualifying midyear changes in status. Applications for Supplemental Group Term Life Insurance that fall outside of the initial eligibility period will require proof of good health and may only be completed during the Open Enrollment period and qualifying midyear changes in status.

Please note that pre-tax Group Term Life Insurance coverage over $50K will be considered taxable income and will be shown on the W-4 as taxable imputed income.

2024 Bi-Weekly Group Term Life Insurance Costs

Basic Group Term Life	Dependent Group Term Life	Supplemental Group Term Life	
$0.84	$0.36	1x .0035 x bi-weekly salary	2x .007 x bi-weekly salary

GROUP LONG-TERM DISABILITY (LTD) INSURANCE

Group LTD Coverage

Group LTD Insurance may replace a portion of your income if you become sick or injured and unable to work for an extended period.

Group LTD is administered by The Hartford. If you submit a long-term disability claim and it is approved, The Hartford may pay up to a maximum percentage of pre-disability income of $3,000 per month. Group LTD payments will be reduced if you qualify for other sources of income or disability earnings, such as workers' compensation or state disability benefits. For Group LTD coverage details, see plan's Evidence of Coverage. Employees who wish to enroll in LTD Insurance after their initial eligibility period can only do so during the Open Enrollment period and qualifying midyear changes in status. Applications for LTD Insurance that fall outside of the initial eligibility period will require evidence of good health and may only be completed during the Open Enrollment period and qualifying midyear changes in status

NEW! The County has rate relief for 2024 voluntary Long-Term Disability Insurance. Hartford has decreased the rate for voluntary Long-Term Disability Insurance. See rates below.

2024 Bi-Weekly Group LTD Insurance Costs

	Others	Deputy Probation Officers, Probation Managers, & Group Counselors
Benefit	Up to 60% of monthly base earnings; $3,000 maximum 90-day elimination period	Up to 66.67% of monthly base earnings; $3,000 maximum 90-day elimination period
Bi-weekly rate	.0019 x bi-weekly salary	.0019 x bi-weekly salary
Maximum bi-weekly rate	$4.38	$3.95

LEAVE OF ABSENCE AND HEALTH CARE BENEFITS

Medical, Dental, Vision, and Health Care FSA Benefits While on an Approved Leave of Absence

Job-protected medical leaves such as the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and Pregnancy Disability Leave (PDL) are unpaid. In order to be paid during your leave, you may use your own sick, vacation, and other leave accruals. You may also be eligible to apply for benefits under State Disability Insurance (SDI), Paid Family Leave (PFL), and/or Long-Term Disability (LTD) Insurance to help pay for your approved time off.

During the time you are on an approved FMLA, CFRA, or PDL leave of absence, the County will continue to provide your Fringe contribution while you are on paid status. If you run out of accrued leave time, you will be placed on leave without pay (unpaid leave).

You must notify Human Resources about a leave of absence. You may elect to continue or waive health coverage for the duration of your approved leave of absence.

Unpaid Leave of Absence

While you are on an unpaid leave and not receiving a paycheck, out-of-pocket premium costs (employee contributions) for health care coverage cannot be deducted from your paycheck. To maintain coverage, you must pay your portion of any premium contributions for yourself and any enrolled dependents. Payments are made directly to the Department of Finance. It is your responsibility to work with the Human Resources Benefits Division and Department of Finance to pay for the premiums or revoke your coverage during the leave. Failure to make timely premium payments for your benefits can result in the termination of your health care benefits, which may not be reinstated until you return to work or during the annual Open Enrollment. More information can be found online at HR Leaves of Absence.

Your Responsibilities During a Paid or Unpaid Leave of Absence

1. Notify your supervisor and a member of the Human Resources Employee & Labor Relations Division prior to your leave. They will help you understand the process and documentation required for an approved leave. If you need leave suddenly to care for yourself or a family member, you must notify your supervisor or HR as soon as practical. For more information go to HR Leaves of Absence.
2. Contact the Human Resources Benefits Division and the Department of Finance, as soon as your leave begins. You may choose to continue or waive health care coverage while on leave. If you continue coverage, you must pay employee premium contributions while you are on leave. If premium payments are not deducted from your paycheck while you are on leave, you must pay the Department of Finance directly. Failure to do so will result in the termination of your health care benefits.
3. When leave ends, contact the Human Resources Benefits Division and the Department of Finance to reinstate your benefits within 30 days of returning to work.

Flexible Spending Accounts (FSAs) While on Leave

When an employee is on leave without pay and has a Dependent Care FSA and/or Health Care FSA, bi-weekly employee contributions to the FSA cannot be made. When the employee returns to work, bi-weekly Health Care FSA contributions resume at a higher amount to ensure the appropriate annual amount is collected. The Optum Financial Health Care FSA card can still be used while an employee is on leave. Dependent Care FSA will be suspended.

IF YOU HAVE QUESTIONS ABOUT YOUR LEAVE OF ABSENCE, PLEASE CONTACT: HRLEAVES@MARINCOUNTY.ORG.

2024 HEALTH CARE COVERAGE CALENDAR

Coverage for benefits is provided and paid for on a bi-weekly basis. Benefits are paid for in the two-week period prior to the coverage period. For example, employees working December 10, 2023–December 23, 2023 are covered for December 24, 2023–January 6, 2024.

If you take an unpaid leave of absence, you must pay the Department of Finance directly for the premium contributions that had been deducted from your paycheck. Employee premium contributions are due no later than two (2) pay dates (i.e., four (4) weeks) after the last day your health care benefits coverage ends. For example, if your coverage ended on December 23, 2022, you must make the premium payment for the December 24, 2023–January 6, 2024 benefits coverage period no later than the February 2, 2024 pay date.

Pay Period	Work Dates	Pay Date	Benefits Coverage Period
1	December 10, 2023–December 23, 2023	January 5, 2024	December 24, 2023–January 6, 2024
2	December 24, 2023–January 6, 2024	January 19, 2024	January 7, 2024–January 20, 2024
3	January 7, 2024–January 20, 2024	February 2, 2024	January 21, 2024–February 3, 2024
4	January 21, 2024–February 3, 2024	February 16, 2024	February 4, 2024–February 17, 2024
5	February 4, 2024–February 17, 2024	March 1, 2024	February 18, 2024–March 2, 2024
6	February 18, 2024–March 2, 2024	March 15, 2024	March 3, 2024–March 16, 2024
7	March 3, 2024–March 16, 2024	March 29, 2024	March 17, 2024–March 30, 2024
8	March 17, 2024–March 30, 2024	April 12, 2024	March 31, 2024–April 13, 2024
9	March 31, 2024–April 13, 2024	April 26, 2024	April 14, 2024–April 27, 2024
10	April 14, 2024–April 27, 2024	May 10, 2024	April 28, 2024–May 11, 2024
11	April 28, 2024–May 11, 2024	May 24, 2024	May 12, 2024–May 25, 2024
12	May 12, 2024–May 25, 2024	June 7, 2024	May 26, 2024–June 8, 2024
13	May 26, 2024–June 8, 2024	June 21, 2024	June 9, 2024–June 22, 2024
14	June 9, 2024–June 22, 2024	July 5, 2024	June 23, 2024–July 6, 2024
15	June 23, 2024–July 6, 2024	July 19, 2024	July 7, 2024–July 20, 2024
16	July 7, 2024–July 20, 2024	August 2, 2024	July 21, 2024–August 3, 2024
17	July 21, 2024–August 3, 2024	August 16, 2024	August 4, 2024–August 17, 2024
18	August 4, 2024–August 17, 2024	August 30, 2024	August 18, 2024–August 31, 2024
19	August 18, 2024–August 31, 2024	September 13, 2024	September 1, 2024–September 14, 2024
20	September 1, 2024–September 14, 2024	September 27, 2024	September 15, 2024–September 28, 2024
21	September 15, 2024–September 28, 2024	October 11, 2024	September 29, 2024–October 12, 2024
22	September 29, 2024–October 12, 2024	October 25, 2024	October 13, 2024–October 26, 2024
23	October 13, 2024–October 26, 2024	November 8, 2024	October 27, 2024–November 9, 2024
24	October 27, 2024–November 9, 2024	November 22, 2024	November 10, 2024–November 23, 2024
25	November 10, 2024–November 23, 2024	December 6, 2024	November 24, 2024–December 7, 2024
26	November 24, 2024–December 7, 2024	December 20, 2024	December 8, 2024–December 21, 2024

2024 WAIVER OF PARTICIPATION

During your initial benefits eligibility period, Open Enrollment, or within 30 days of a qualifying event, you may choose to waive your participation in the County of Marin medical insurance program by completing a Waiver of Participation form, affirming that you and all members of your "tax family" have other group "minimum essential coverage" for the 2024 plan year. Your "tax family" is anyone you claim as a dependent on your tax returns. The Waiver of Participation form must be submitted each calendar year during Open Enrollment or within 30 days of a qualifying event. Employees waiving coverage through the County's medical insurance plans who fail to provide a signed Waiver of Participation during Open Enrollment or within 30 days of a qualifying event will be ineligible to receive cash back of unused Fringe.

Employees may waive County-sponsored medical insurance if they provide a Waiver of Participation form showing other group "minimum essential coverage."

IMPORTANT:
Annual Waiver of Participation Requirement

Once you waive medical insurance participation, you will be required to submit a Waiver of Participation annually during our Open Enrollment period.

Employees waiving coverage through the County's medical insurance plans who fail to provide a signed Waiver of Participation will be ineligible to receive cash back of unused Fringe.

About Minimum Essential Coverage

Minimum essential coverage means coverage under another group health care plan that satisfies the requirements of the Affordable Care Act. Individual policies, whether obtained through Covered California or elsewhere, do not constitute group minimum essential coverage.

COBRA

COBRA, which stands for the Consolidated Omnibus Budget Reconciliation Act, is a federal law that allows employees and their dependents who lose eligibility for group medical, dental, and vision coverage to temporarily continue that coverage by paying for it themselves. Optum Financial administers COBRA for the County of Marin.

Eligibility

Employees may elect to temporarily continue health care coverage through COBRA if coverage is lost due to:

- Voluntary or involuntary termination of employment
- Hours of employment reduced, making the employee ineligible for employer-sponsored health care coverage

Covered spouses or domestic partners may also elect to be covered under COBRA if coverage is lost due to:

- Voluntary or involuntary termination of employee's employment
- Hours of employment reduced, making the employee ineligible for employer-sponsored health care coverage
- Divorce, legal separation, or dissolution of domestic partnership from the covered employee
- Death of the covered employee

Covered dependent children may elect COBRA coverage if health care is lost due to:

- Loss of dependent child status under the plan rules
- Voluntary or involuntary termination of employee's employment
- Hours of employment reduced, making the employee ineligible for employer-sponsored health care coverage
- Parent's divorce, legal separation, or dissolution of domestic partnership from the covered employee
- Death of the covered employee

Note: Dependents dropped from coverage during Open Enrollment are not eligible for COBRA.

COBRA Notification and Election Time Limits

Employee health care coverage ends on the last day of the coverage period for which the employee worked. Generally, employee health care coverage ends on the last day of the pay period following the pay period in which the employee separates. See the 2024 Health Care Coverage Calendar on page 26 of this Guide for more information. For questions, contact EmployeeBenefits@marincounty.org. If an enrolled dependent of an employee loses coverage due to divorce, dissolution of partnership, or loss of dependent child status, the employee or the dependent must notify the Human Resources Benefits representative within 30 days of the qualifying event and request COBRA enrollment information. Failure to give notice to Human Resources Benefits of the dependent's loss of eligibility within 30 days of the event will cancel the dependent's rights to continued coverage under COBRA. Employees or dependents have 60 days from the COBRA notification date to complete a COBRA election form and submit it to Optum Financial. Initial payment for COBRA is required within 45 days of COBRA election. Coverage will be retroactive to the date of the COBRA qualifying event, so there is no break in coverage.

Paying for COBRA

It is the responsibility of covered individuals enrolled in COBRA to pay required health care premium payments directly to Optum Financial. COBRA premiums are not subsidized by the County.

COBRA and Open Enrollment

COBRA beneficiaries may change plans and/or add family members during annual Open Enrollment.

Termination of COBRA

COBRA coverage is generally available for a maximum of 18 months. COBRA coverage will end if:

- You obtain coverage under another group plan or Medicare
- You fail to pay the premium required under the group plan in full and within the payment grace period or the applicable COBRA period ends

QUESTIONS ABOUT COBRA? CONTACT OPTUM FINANCIAL AT 1-855-687-2021.

TRANSPORTATION BENEFITS

About Transportation Benefits

Employees may use up to $315 per month of pre-tax dollars to purchase transit passes through our vendor, Optum Financial. To take advantage of this benefit, you must register and set up an account through Optum Financial and your expenses will automatically be deducted from your paycheck—tax free.

Eligible Expenses

Eligible expenses include public transportation used for your transit to work. Only your work transportation expenses are eligible. You may not use this benefit for your spouse's or dependents' transportation expenses. Eligible transit and parking expenses include:

Benefits-eligible employees may use pre-tax dollars towards the purchase of eligible commuting expenses.

- Buses
- Trains and subways
- Ferries
- Vanpools
- Parking at a location from which you commute to work or at or near your place of employment

Examples of ***ineligible expenses*** are bridge tolls, highway tolls, and expenses for someone other than you.

Ordering: Where to Begin

You must place your order by the 10th of the month for the following month. Orders received by the 10th of the month are processed and mailed no later than the 23rd of the month. ***Example:*** passes ordered by November 10th are for December and mailed no later than November 23rd. To make an order, follow the instructions below.

1. Log in to your online account at optumfinancial.com.
2. If you have not registered before, follow instructions to set your username and password. Click on TRANSPORTATION BENEFITS in your participant portal to land on the Transit and Parking home page.
3. **Repeat Orders:** Products you ordered in the previous month will be displayed on the left-hand side. Just click on the button next to your product if you wish to order the same product again.
4. **New Orders:** Click on the PLACE AN ORDER tab in the header menu. Select TRANSIT, PARKING, or VANPOOL, depending on your preference.

Transit Orders

Once you have completed the steps above, select the transit authority of your choice. If you do not see your transit agency, remove the zip code and type in the name of your transit agency. Confirm your selection and click CHECKOUT. Review your order for accuracy and click PLACE ORDER. You will need to check the disclaimer box before proceeding with your order.

For questions about ordering transportation benefits, contact Optum Financial at 1-877-292-4040.

The RideGreen program is the County's comprehensive commute alternatives program that includes incentives for carpooling in addition to the pre-tax benefits for transit commuting. For more information, please visit RideGreen.

QUESTIONS ABOUT THE RIDEGREEN PROGRAM?
CONTACT RIDEGREEN@MARINCOUNTY.ORG OR 1-415-473-3485.

EMPLOYEE E3 WELLNESS PROGRAM

What is the E3 Wellness Program?

The County of Marin offers an Employee Wellness Program. The mission of the Employee E3 Wellness Program is to provide opportunities that engage, educate, and empower our workforce in leading healthy and active lifestyles that support overall wellbeing. The wellness program has implemented a variety of programs to support employees in being proactive about reducing their lifestyle risks and taking advantage of a multitude of available health and wellness resources.

What Resources Are Available to Me?

Throughout the year, the E3 Wellness Program offers ongoing opportunities for you to champion your health and wellbeing. Communications and programs address relevant issues such as building resilience, maintaining active lifestyles, and managing stress, etc. Wellness initiatives include things from organization-wide challenges, webinar workshops, a membership to Frankly Fitness, and virtual opportunities to practice mindfulness, meditation, stretching, and breathing exercises. Offerings are continually evolving, and employee ideas are always welcome.

How Do I Get Involved?

All employees are invited to participate in programs and events. Communications are shared via email, through Department Wellness Ambassadors and on the E3 Wellness Program on the HUB.

If you're passionate about wellness and interested in advancing the culture of health within the organization, consider joining the Wellness Ambassador Program. Ambassadors take data-driven health and wellness information, as well as program updates and marketing materials back to their departments to help make wellness a relevant message within the microclimate of each department. If you are interested in learning more about the Wellness Ambassador Program, contact County of Marin Wellness Coordinator Kori Graff at E3Wellness@marincounty.org.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Optum EAP Services

EAP is available to help with life's challenges. EAP is available 24/7 to connect or refer you to a professional who can help with:

- Marriage, family, and relationship issues
- Stress, anxiety, and sadness
- Grief, loss, or responses to traumatic events
- Concerns about your use of alcohol or drugs
- Challenges in the workplace
- Identity theft support
- Legal counseling and mediation services
- Convenient phone apps:
  - Talkspace: Connect with a licensed therapist Monday–Friday, anytime, anywhere via text, voice, or video
  - AbleTo: On-demand self care tools such as mood tracking, meditations, resources, and a behavioral health road map you can use at your own pace

Optum EAP provides eligible employees and their household family members free services that can help balance life and work challenges.

Work Life Services available:

- Childcare and eldercare support assistance
- Chronic illness and condition support
- Educational resources
- Financial coaching
- Convenience services

Using EAP

EAP provides employees and their family members with confidential information support, short-term counseling, and/or referral services. Consultations are available face-to-face, by phone, or through web-video. EAP services are not medical care or mental health treatment. EAP services are confidential. Your privacy is protected by state and federal laws.

Need Help?

You can reach Optum EAP toll-free, 24 hours a day, seven days a week: 1-866-248-4096.

Visit Optum at liveandworkwell.com. Register by creating a username and password or browse as a guest with our company access code: MARIN.

Optum is committed to ensuring its website and mobile applications are accessible to individuals with disabilities. If you need assistance using the website, mobile application, or with a document on the website, please call toll-free at 1-866-894-5795 Monday–Friday, 8:00 am–10:00 pm EST, TTY 711.

You are entitled to five (5)* face-to-face sessions, telephonic, or web–video consultations combined per event per calendar year.

*Safety Fire and Sheriff employees providing emergency response services are entitled to eight (8) face-to-face sessions, telephonic, or web–video consultations per event per calendar year.

IMPORTANT CONTACT INFORMATION

Benefit	Plan	Group #	Member Services	Contact
Medical	Kaiser L HMO	463-0	Member Services—California 1-800-464-4000 (English) 1-800-788-0616 (Spanish)	www.kp.org/memberservices
	Kaiser S HMO	603194-11		
	Kaiser Deductible HMO	607896		
	Teamsters Anthem Blue Cross PPO	280558	Member Services 1-800-288-2539	www.anthem.com/ca
	Western Health Advantage HMO	950340	Member Services 1-888-563-2250	www.westernhealth.com
Dental	Delta Dental PPO	01909-01001	1-888-335-8227	www.deltadentalins.com
Vision	VSP Core	00109803/0001	1-800-877-7195	www.vsp.com
	VSP Buy-Up	00109803/1001		
Life	The Hartford	681127	1-888-563-1124	https://www.thehartford.com/employee-benefits/group-life-insurance
LTD	The Hartford	681127	1-888-563-1124	https://www.thehartford.com/employee-benefits/group-life-insurance
FSAs	Optum Financial	NA	1-877-292-4040	www.optumfinancial.com
EAP	Optum	Marin	1-866-248-4096	http://liveandworkwell.com

This Guide is designed to help you understand your benefits. Review the materials carefully before making your enrollment decisions. Specific details, plan limitations and exclusions, and notices of your legal rights are provided in the respective Evidence of Coverage (EOC), which is available by contacting Human Resources Benefits at 1-415-473-2197. If there is a conflict between the EOC of the plan you selected and the information in this Guide, the plan's EOC will prevail.

Got Questions?
Contact the Marin County Benefits & Wellness Team:

email EmployeeBenefits@marincounty.org or
call the Employee Benefits Line at 1-415-473-2197

Samantha Phillips, HR/Benefits Technician
1-415-473-7257 • sphillips@marincounty.org

Jolie Huynh, HR/Benefits Technician
1-415-473-6548 • jhuynh@marincounty.org

Freeman Suen, Senior HR/Benefits Technician
1-415-473-7843 • fsuen@marincounty.org

Kori Graff, Wellness Coordinator
1-415-473-7532 • kgraff@marincounty.org

Lisa Hatt, Principal, Employee Benefits & Wellness Division
1-415-473-7006 • lhatt@marincounty.org

List of Acronyms

AD&D: Accidental Death and Dismemberment
BUFGs: Bargaining Unit Fringe Groups
CBA: Collective Bargaining Agreement
CFRA: California Family Rights Act
CHIP: Children's Health Insurance Program
CMS: Centers for Medicare and Medicaid Services
COBRA: Consolidated Omnibus Budget Reconciliation Act
DCAP: Dependent Care Assistance Program
DDA: Deputy District Attorneys
DP: Domestic Partner
DSA: Deputy Sheriffs' Association
EAP: Employee Assistance Program
EE: Employee
EOC: Evidence of Coverage
FMLA: Family and Medical Leave Act
FSA: Flexible Spending Account
HDHP: High-Deductible Health Plan
HHS: Health & Human Services
HMO: Health Maintenance Organization
HR: Human Resources
IATSE: International Alliance of Theatrical Stage Employees
IRC: Internal Revenue Code
IRS: Internal Revenue Service
KP: Kaiser Permanente
LTD: Long-Term Disability
MAPE: Marin Association of Public Employees
MCC: Merchant Category Code
MCERA: Marin County Employees' Retirement Association
MCMEA: Marin County Management Employee's Association
MOU: Memorandum of Understanding
PCP: Primary Care Physician
PDL: Pregnancy Disability Leave
PFL: Paid Family Leave
PMA: Probation Managers Association
PPO: Preferred Provider Organization
SBC: Summary of Benefits and Coverage
SDI: State Disability Insurance
SSA: Social Security Administration
SSOA: Sheriff Staff Officers' Association
UCR: Usual, customary, and reasonable
VSP: Vision Service Plan
WHA: Western Health Advantage