2022 EMPLOYEE BENEFITS GUIDE

OPEN ENROLLMENT

• • • REGULAR HIRE • • •

COUNTY OF MARIN

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 from the County Human Resources Department. If there is a conflict between the Evidence of Coverage (EOC) of the plan you selected and the information in this guide, the plan's Evidence of Coverage (EOC) will prevail.

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

Copies of documents are available in alternative formats upon request.

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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:

a) 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, other formats)

b) 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 with the Civil Rights Coordinator for the County of Marin at the following location:

Civil Rights Coordinator for the County of Marin
ATTN: Human Resources Department: Roger Crawford
3501 Civic Center Drive, Suite 415, San Rafael, CA 94903
Phone: 1-415-473-2095 or 1-415-473-3232 (TDD/TTY)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator for the County of Marin is available to help you. You may also call (415) 473-4381 (Voice), (415) 473-3232 (TDD/TTY).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* 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, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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।

WHAT'S NEW IN 2022

Virtual Open Enrollment: October 11th – November 5th, 2021

The Benefits & Wellness Team will be hosting a virtual Open Enrollment through our new cloud-based platform – Airbo. Eligible employee will go through a series of tiles (think "booth" at a live event) to learn about the County's Benefits and Wellness Program. This interactive experience will give you the opportunity learn about the County's robust Benefits & Wellness program as well as make any changes to your benefits elections. You will get to participate and answer questions on each tile to earn points to be eligible to win great raffle prizes!

Your Benefits on Your Time: How to Access Our Virtual Benefits Experience

This year, you will complete your Open Enrollment from your phone, tablet, laptop or computer. On October 11, 2021, you will receive an email from marincountyvirtualbenefitfair@ourairbo.com to your work email address. This email will invite you to attend our Virtual Employee Benefits & Wellness Fair. Once you join our virtual experience, employees can invite their spouse's/domestic partners to attend.

You can participate in a variety of virtual live employee benefit sessions, wellness activities, watch brain shark videos and review benefit summaries. If you do not receive an email from Airbo, please check your junk/spam folders as this will be the most effective way to complete Open Enrollment.

This is your one-time a year opportunity to learn about your benefit program and make changes to your current elections! You will have the opportunity to learn about:

- Medical Plan Options:
  - Western Health Advantage Premiere 15C or Premiere 25C HMO
  - Kaiser Silver HMO or Kaiser Low HMO
  - Teamsters Anthem PPO
- Delta Dental Plan
- Vision Services Plan (VSP)
- Flexible Spending Accounts (FSA) – Health Care or Dependent Care
- Term Life Insurance & Long-Term Disability
- Any benefit plan changes will be **effective December 26, 2021**
- E3 Wellness Program & Wellness Activities
- Employee Assistance Program (EAP)
- Retirement - MCERA and Nationwide 457(b) Plan
- Ride Green Transit Program
- You can make an appointment with any Benefits and Wellness Team member

ConnectYourCare (CYC) is now Optum Financial. If you are enrolled in the Flexible Spending Accounts; Health Care or Dependent Care, Health Reimbursement account or Transit Programs, you should have received a communication about this change, if you have an email address on file. Optum Financial requested participants to set up a new username and password. If you have questions, you can contact Optum Financial at 877-292-4040.

Premium and Employer Contributions Changes

- Employer Fringe Contributions have changed for 2022. See Page 14 for more information.
- Premium and Employer Fringe Contribution changes will be reflected on the January 7, 2022 paycheck.
- Review plan costs and employer contributions before making your 2022 enrollment decisions.
- **Any benefit plan changes will be effective December 26, 2021.**

Medical Waiver Requirement

- Employees who waive medical coverage must submit a Waiver of Participation annually in order to receive cash back of unused fringe. See Page 28 for more information on these requirements.
- If you currently waive medical and receive cash back, you must submit a Waiver of Participation Form during this Open Enrollment or you will not receive cash back in 2022.

Questions? Contact the Marin County Benefits Team:

Suzanne Griffiths *Human Resources Technician*	(415) 473-6375	sgriffiths@marincounty.org
Freeman Suen *Human Resources Technician*	(415) 473-7843	fsuen@marincounty.org
Kori Graff *Wellness Coordinator*	(415) 473-7532	kgraff@marincounty.org
Lisa Hatt *Benefits Manager*	(415) 473-6548	lhatt@marincounty.org

OPEN ENROLLMENT: How to Enroll or Make Changes to Your Health Benefits

2022 Open Enrollment Period:
Monday, October 11, 2021 - Friday, November 05, 2021 @ 4:30pm

Open enrollment is the *only* time you can make changes to your health benefit elections, unless you have a "mid-year change event." That means once you have made your elections during the Open Enrollment period, in accordance with law, no changes can be made until the next Open Enrollment period, unless you have a "mid-year change event" such as marriage, divorce, birth, adoption, etc.

Benefits-eligible new and rehired employees must enroll in health benefits within 30 calendar days from date of hire or rehire. If you do not enroll within this 30-day period, you can only enroll in benefits during the next Open Enrollment period or within 30 days of a mid-year change event.

Action Items, Step-by-step

1. Start your virtual Open Enrollment experience with Airbo. On October 11, 2021 you will receive an email from marincountyvirtualbenefitfair@ourairbo.com to your work email address. This email will invite you to attend our Virtual Employee Benefits & Wellness Fair. If you do not see an invitation, please check your junk/spam inbox.

2. If you wish to make benefit changes for 2022, complete appropriate enrollment forms. All benefits information and digital enrollment forms will be on the appropriate tile/"booth" on the Airbo virtual benefits experience.

3. If you plan to waive medical coverage in 2022, you must complete the Waiver of Participation form, also in the respective tile/"booth" on the Airbo virtual benefits experience.

4. If you plan to enroll in a Flexible Spending Account (Health or Dependent Care), you must submit an enrollment form for 2022. Enrollments from 2021 *do not* automatically enroll you in the 2022 plan year.

5. Submit all required forms and documentation to Human Resources by 4:30pm on Friday, November 05, 2022. Forms not received by Human Resources by the deadline will not be processed, no exceptions. This includes any forms you have mailed but have yet not been delivered to Human Resources by the deadline.

6. **If you do not waive medical insurance, do not plan to have an FSA account in 2022 and do not plan on making any other benefit changes for 2022, no action is needed.** Your 2021 benefit elections will continue into the 2022 plan year (except for FSA elections).

7. Completing the Airbo Virtual Open Enrollment experience (regardless if you have changes to make or not) will make you eligible for the many raffle prizes**.**

For a complete list of covered services and plan limitations, see the plan's Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC) available from the Human Resources Department by contacting the Marin County Benefits Team at 415-473-2197.

In the event that the information in this guide differs from the Evidence of Coverage, the EOC will prevail.

BENEFITS ELIGIBILITY

Member Eligibility
The County provides an allowance to regular hire full-time and part-time employees working half-time or more that can be used to purchase health benefits including medical, dental, vision as well as 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). All employees that are contingent hire status may be eligible only for the Kaiser high-deductible health plan (HDHP) medical plan. For more information about medical benefits for contingent hire employees see the Employee Benefits guide for Contingent Hires.

Dependent Eligibility
Spouse or Domestic Partner

All benefits-eligible employees may enroll a legal spouse or registered domestic partner 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 domestic partner, child under a qualified medical child support order, and legal guardianship child are eligible for coverage in health benefits up to 26 years of age. The employee will be responsible for all taxes incurred under rules set by the Internal Revenue Service (IRS) and the Franchise Tax Board regarding imputed income. See Domestic Partner Health 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) are considered the "Primary Payer" 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 healthcare 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, "2022 Medicare & You"
- Marin County Employees' Retirement Association (MCERA), Telephone (415) 473-6147
- Social Security Administration (www.SSA.gov) 1 (800) 772-1213

DOMESTIC PARTNER HEALTH BENEFITS TAXATION

Health Coverage for a domestic partner and a partner's children may be taxable benefits under federal law.

A Domestic Partner 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 domestic partner coverage is what must be used for computing taxes on fringe benefits provided to non-tax qualified domestic partners or children of domestic partners 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 premiums or a domestic partner that qualifies as a tax dependent. The fair market value is calculated for the domestic partner and *each* child of the domestic partner if the domestic partner 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 domestic partner 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 Domestic Partner Benefits

Fair market value of the domestic partner benefit will be the cost difference between the employee only and the employee plus one dependent premium rate. Fair market value for each domestic partner child is the family rate less the two-party rate. Examples for how fair market value is determined are highlighted below using 2022 Kaiser Plan S bi-weekly rates:

EE Only ……...$355.55
EE + 1 Dependent……..$711.10
EE + Family…….$945.77

Examples	Bi-Weekly Kaiser Rate	Base for Calculating Taxability
Covered Individuals ○ Employee ○ Domestic Partner (DP) ○ DP Child 1 ○ DP Child 2 ○ DP Child 3 ○ DP Child 4	$945.77	Employee……n/a Domestic Partner……..$355.55 DP Child 1……..$234.67 DP Child 2……..$234.67 DP Child 3……..$234.67 DP Child 4……..$234.67 **Total……$1,294.23**
Covered Individuals ○ Employee ○ Domestic Partner ○ 5 Employee's children ○ DP Child 1	$945.77	Employee……..n/a Domestic Partner…….$355.55 5 Employee's Children…n/a DP Child 1……$234.67 **Total……..$590.22**

Consult Your Tax Advisor

This is a brief overview regarding the tax treatment of health benefits to domestic partners and children of domestic partners. 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.

CHANGING BENEFIT ELECTIONS OUTSIDE OF OPEN ENROLLMENT: MIDYEAR CHANGE IN STATUS

You may only change health 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 "mid-year 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 mid-year change of status event. To make a change in benefit elections due to a mid-year 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/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 documentation must be completed by the deadlines listed below. 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.

Common Scenarios[1]	How to Enroll:	Important Timing
Marriage or Domestic Partnership	To enroll a new spouse or domestic partner and eligible children of a spouse or partner 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 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 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.

Common Scenarios[1]	How to Enroll:	Important Timing
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

[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.*

RETIREMENT AND YOUR RETIREE BENEFITS

If you are considering retirement, you should be sure to review the MCERA Retiree Health Benefits Booklet. Depending upon your date of entry into the retirement system and applicable Benefit tier, making changes during Open Enrollment 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 415-473-6147 or you can email: MCERABenefits@marincounty.org.

CHOOSING YOUR MEDICAL PLAN

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.

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

- Kaiser Permanente HMO Plan L
- Kaiser Permanente HMO Plan S
- Western Health Advantage 15C HMO
- Western Health Advantage 25C HMO
- Teamsters Anthem PPO

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 and 1 dependent
- Employee and 2 or more dependents

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.

2022 Bi-Weekly Medical Plan Costs:
All medical plans are experiencing rate increases for 2022. To help employees pay for the cost of health benefits, the County contributes a bi-weekly Fringe allowance. Employer contribution amounts are determined by salary and the medical coverage level elected. Some employer contributions go up in 2022. See page 31 for more information on your bi-weekly benefit payments.

Medical Plan	2022 Bi-Weekly Medical Plan Rates		
	Employee Only	Employee + 1 Dependent	Employee + Family
Kaiser S HMO	$355.55	$711.10	$945.77
Kaiser L HMO	$393.58	$787.16	$1,046.92
Western Health Advantage 15C HMO	$342.29	$684.59	$910.50
Western Health Advantage 25C HMO	$321.76	$643.51	$855.87
Teamsters Anthem PPO	$397.11	$796.98	$1,114.66

COUNTY OF MARIN EMPLOYER FRINGE CONTRIBUTIONS

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

About Fringe Contributions
Employer fringe contributions can be used to purchase health benefits including medical, dental, vision as well as 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 and this amount is taxable unless a Waiver of Participation is completed, but not pensionable.

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. For specific questions about your eligibility to receive cash back of unspent fringe dollars, please refer to your labor agreement at https://www.marincountyhr.org/get-to-know-us/employee-and-labor-relations/labor-agreements-and-contractsor contact the Human Resources Benefits Team. Eligible part-time regular hire employees receive a prorated employer fringe contribution.

Employer Contributions (Fringe) for 2022

2022 Bi-Weekly Employer Contributions			
	Employee Only	**Employee +1 Dependent**	**Employee +Family**
BUFGS: MAPE (General Unit, HHS, Nurses) and Unrepresented			
Bi-weekly Fringe – Under 75k	$514.60	$690.56	$934.53
Bi-weekly Fringe – Over 75k	$514.60	$677.66	$908.74
BUFGS: Firefighters, Battalion Chiefs and DSA			
Bi-weekly Fringe – Under 74k	$540.33	$690.56	$934.53
Bi-weekly Fringe – Over 74k	$540.33	$677.66	$908.74
BUFGs: MCMEA, PMA, Probation, DDA, SSOA and IATSE			
Bi-weekly Fringe – Under 74k	$514.60	$690.56	$934.53
Bi-weekly Fringe – Over 74k	$514.60	$677.66	$908.74

ABOUT YOUR MEDICAL PLAN OPTIONS

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

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 copays 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:

- Kaiser Plan S
- Kaiser Plan L
- Western Health Advantage 15C
- Western Health Advantage 25C

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 copayments 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 PPO

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 and part-time employees must submit an annual Wavier 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 26 of this guide for more information.

2022 MEDICAL PLAN BENEFITS AT-A-GLANCE

This chart 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 available during Open Enrollment. 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.

Plan Components	Kaiser S HMO	Kaiser L HMO	Teamsters Anthem PPO		Western Health Advantage 15C HMO	Western Health Advantage 25C HMO
			In-Network	Out-of-Network		
Deductible						
Individual	None	None	$250	$250	None	None
Family	None	None	$500	$500	None	None
Annual Out-of-Pocket Max			(Coinsurance Max)			
Individual	$1,500	$1,500	$2,000	None	$1,500	$1,500
Family	$3,000	$3,000	$2,000	None	$3,000	$3,000
GENERAL CARE						
Routine Physical/ Preventative Care	No charge	No charge	No charge (Deductible waived)	Not covered	No charge	No charge
Primary Care Visit	$25	$5	$20 (Deductible Waived)	40% UCR	$15	$25
Well Baby Care	No charge	No charge	No charge (Deductible waived)	Not covered	No charge	$25
Immunizations	No charge	No charge	No charge (Deductible waived)	Not covered	No charge	No charge
Chiropractic	$15	$10	20%	40% UCR	$15	$15
TESTING AND SPECIALTY CARE						
Specialty Visit	$25	$5	$20 (Deductible Waived)	40% UCR	$15	$25
Lab and X-Ray	No charge	No charge	20%	40% UCR	$15	none
Occupational, Physical & Speech	$25	$5	20%	40% UCR	$15	$25
Skilled Nursing Facility	No charge	No charge	20%	40% UCR (physician) 50% UCR (facility)	No charge	No charge
Hospice Care	No charge	No charge	20%	40% UCR	No charge	No charge
Emergency Room	$50	$50	20%	20%	$75	$50
Hospital						
Inpatient	No charge	No charge	20%	40% UCR (physician)	No charge	No charge
Outpatient	$25	$5	20%	50% UCR (facility)	$15	$25

MATERNITY & INFERTILITY						
Pre/Post-Partum Care	No charge	No charge	20%	40% UCR (physician) 50% UCR (facility)	No charge	No charge
MENTAL HEALTH AND SUBSTANCE ABUSE						
Inpatient	No charge	No charge	20%	40% UCR (physician) 50% UCR (facility)	No charge	No charge
Outpatient Visit	$25	$5	$20 (Deductible Waived)	40% UCR	$15	$25
PRESCRIPTIONS (Rx)						
Pharmacy (Retail)		$5 (Up to 100-day supply)				
Generic	$10 (up to 30-day supply)	$5 (Up to 100-day supply)	$10 (Up to 100-day supply)	$10 (Up to 100-day supply)	$5 (up to 30-day supply)	$10 (up to 30-day supply)
Formulary Brand	$25 (up to 30-day supply)		$20 (Up to 100-day supply)	$20 (Up to 100-day supply)	$20 (up to 30-day supply)	$25 (up to 30-day supply)
Non-Formulary Brand	Physician Authorized Only	Physician Authorized Only	N/A (Open Formulary)	N/A (Open Formulary)	$50 (up to 30-day supply)	$35 (up to 30-day supply
Specialty	$25 (up to 30-day supply)	$5 (Up to 30-day supply)	$20 (up to 30-day supply)	$20 (up to 30-day supply)	Covered Under Applicable Tier	Covered Under Applicable Tier

NURSELINE, URGENT CARE AND CUSTOMER SERVICE

A free, 24/7 nurse line is available for the Kaiser Permanente, Western Health Advantage and Teamsters Trust Anthem 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 Permanente	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 (510) 752-1190 • Petaluma Medical Offices (707) 765-3960 • San Francisco Medical Center (415) 833-2200 • San Rafael Medical Center (415) 444-2940 • Santa Rosa Medical Center (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 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 https://www.anthem.com/ca and click "find 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

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

Kaiser Permanente offers convenient video visits with your doctor from your home or office. All you need is a computer with an internet connection and a webcam or a smartphone mobile device (iOS iPhone or iPad or Android mobile device) using the latest version of the KP Preventative Care App. Visit kp.org/mydoctor/videovisits for more information. You can also email your doctor, schedule routine appointments, see your lab results and refill most prescriptions through the KP Preventative Care App available for download at www.kp.org/mobile.

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 copay, 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. Go to www.livehealthonline.com 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 https://www.westernhealth.com/search-for-providers/the-wha-network/connect-with-your-doctor/ to find out what your provider offers.

DENTAL COVERAGE

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

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 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. Although it is mandatory for all regular hire employees who are eligible for benefits to be enrolled in the Delta Dental plan, you can elect to enroll/waive dependents each year during the open enrollment period.

2022 Bi-Weekly Dental Plan Costs:

Delta Dental PPO	Employee Only	Employee +1 Dependent	Employee +Family
Group Number: 01909-01001	$24.31 **mandatory**	$45.84	$72.02

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 social security number) 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 www.deltadentalins.com.

Summary of Delta Dental PPO Benefits[4]

Delta Dental PPO – **Group Number: 01909-01001**	
Deductible	**None**
Plan year maximum *maximum amount the dental plan will pay per Member in a calendar year*	$2,100 per person
Covered Services	**Co-Insurance Paid by Member[4]**
Diagnostic and preventative	20%
Extractions and fillings	20%
Crowns and cast restoration	20%
Prosthodontics (includes implants)	50%
Endodontic/Root Canals	20%
Oral Surgery	20%
Orthodontia	40% *(lifetime maximum per member $1,500)*

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

VISION COVERAGE

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

Vision Plan Offered by VSP
The County of Marin offers vision coverage through VSP to employees, dependents and dependent children up to age 26. Visit a provider in the VSP 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 VSP provider. Although it is mandatory for all regular hire employees who are eligible for benefits to be enrolled in the Vision plan, you can elect to enroll/waive dependents each year during the open enrollment period.

2022 Bi-Weekly Vision Plan Costs:

	Employee Only	Employee +1 Dependent	Employee +Family
VSP Vision Plan	$2.34 **mandatory**	$5.25	$7.48

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 www.vsp.com.

Accessing Your Vision Benefits
To find a VSP provider, visit www.vsp.com or call 1-800-877-7195. At your appointment, tell them you have VSP. You can choose a VSP provider or out-of-network provider. Keep in mind you will pay less out of your own pocket when you visit an in-network VSP provider.

Summary of VSP Signature Plan Benefits[5]

VSP Signature Plan	Copayment Paid by Member[5]	Frequency
Well vision exam	$10	Every 12 months
Materials (Frames and Lenses)	$25 (Up to $160 allowance)	Every 24 months
Contacts (instead of glasses)	$0 (Up to $150 allowance)	Every 24 months

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

FLEXIBLE SPENDING ACCOUNTS (FSAS)

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

How an FSA works
A flexible spending account is a tax-advantaged account that allows you to use pre-tax dollars to pay for qualified medical (Health FSA) or dependent care (DCAP) expenses. During Open Enrollment, you choose how much money you want to contribute to an FSA for 2022. You will be able to access these funds throughout the year for qualified expenses. Both the Health FSA and DCAP plans are administered by Optum Financial.

Eligible Health FSA Expenses
Health 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 www.optumfinancial.com/tools/eligible-expenses.

Health 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 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 FSA contributions are currently limited by the IRS to $2,750 per person. This means that you may only set aside up to $2,750 for the 2022 calendar year on a pre-tax basis.
- You cannot change FSA contributions during the January to December plan year unless you have a mid-year change in status.

Eligible DCAP Expenses

A Dependent Care FSA can pay for qualifying dependent care expenses with pre-tax funds such as certified day care, pre-school, day camp, before/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 www.optumfinancial.com/tools/eligible-expenses.

Dependent Care Assistance Program (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 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 qualifying event.

ENROLLING IN A HEALTH FSA OR DEPENDENT CARE FSA

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

To enroll in the Health or Dependent Care Flexible Spending Account(s) benefit, complete the enrollment form during your Open Enrollment experience on Airbo. It is your responsibility to contact the HR Benefits representative assigned to your department prior to the close of Open Enrollment to confirm your FSA enrollment. The effective date for FSAs is January 1, 2022, with the first deduction appearing on the January 7, 2022 paycheck. Remember, if you do not complete and submit your enrollment form during this Open Enrollment, you will not have an account for 2022.

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 $550 in unused funds in your Health FSA; any unreimbursed funds in excess of $550 are forfeited at the end of the plan year and cannot be returned to you.

Avoid Forfeiting FSA Contributions
FSA expenses for the 2022 plan year must be incurred in 2022 and received by Optum Financial no later than March 31, 2023. 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.

Using your Health Flexible Spending Account
There are two ways to pay for health care expenses with your Health FSA:

1. **Use your FSA debit/payment 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.

Using your Dependent Care Flexible Spending Account (DCAP)
If you have a dependent care account, you should pay for your qualified dependent care expenses using personal funds 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.

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.

Questions about FSAs? Contact Optum Financial at 1-877-292-4040

GROUP LIFE INSURANCE

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

Life insurance offers you and your loved one's 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 you leave behind pay bills like a mortgage or college tuition.

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

Supplemental Life Insurance and AD&D Coverage
Newly hired employees may purchase Supplemental Life Insurance and AD&D. Supplemental 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 Life Insurance and AD&D 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 Life Insurance and AD&D Coverage
Newly hired employees may purchase Dependent Life Insurance and AD&D. Employees may purchase Life Insurance and AD&D for dependents that provides $5,000 for spouse/domestic partner, $1,500 for children from 6 months to 21 years old and $500 from birth to 6 months. One premium covers all eligible dependents.

Initial Eligibility Period
Benefit eligible newly hired employees who enroll in Supplemental Life and Dependent Life Insurance are automatically approved if elected within 31 calendar days of their start date (limits apply). Employees who wish to enroll in Dependent Life and/or Supplemental Life Insurance after their initial eligibility period can only do so during the Open Enrollment period. Applications for Dependent and/or Supplemental 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.

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

2022 Bi-Weekly Life Insurance Costs

2022 Bi-Weekly Life Insurance Rates			
Basic Life	**Dependent Life**	**Supplemental**	
$.84	$0.36	**1x**	**2x**
		.0035 times bi-weekly salary	.007 times bi-weekly salary

LONG TERM DISABILITY INSURANCE (LTD)

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

Long Term Disability Coverage
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. 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 LTD coverage details, see plan's Evidence of Coverage.

2022 Bi-Weekly Long-Term Disability Insurance Costs

	2022 Bi-Weekly Long-Term Disability Insurance Rates	
	Deputy Probation Officers Probation Managers & Group Counselors	**Others**
Benefit	Up to 66.67% of monthly base earnings; $3,000 maximum 90-day elimination period	Up to 60% of monthly base earnings; $3,000 maximum 90-day elimination period
Bi-weekly rate	.0022 times bi-weekly salary	.0022 times bi-weekly salary
Maximum bi-weekly rate	$4.57	$5.08

LEAVE OF ABSENCE AND HEALTH BENEFITS

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

Medical, Dental, Vision, and Health FSA Benefits While on an Approved Leave of Absence
Job-protected medical leaves such as 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, and 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).

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 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 Department's 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 benefits, which may not be reinstated until you return to work or during the annual Open Enrollment. More information can be found online at https://www.marincountyhr.org/find-employee-tools/policies-procedures-and-contracts/leaves-of-absence.

Your Responsibilities During a Paid or Unpaid Leave of Absence

1. Notify your Supervisor and a member of the Human Resource Benefits 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 https://www.marincountyhr.org/find-employee-tools/policies-procedures-and-contracts/leaves-of-absence.

2. Contact the Human Resources Benefits Division and the Department of Finance, DOF-Payroll@marincounty.org as soon as your leave begins. You may choose to continue or waive health 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 benefits.

3. When leave ends, contact 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 FSA, bi-weekly employee contributions to the FSA cannot be made. When the employee returns to work, bi-weekly Health FSA contributions resume at a higher amount to ensure the appropriate annual amount is collected. The Optum Financial Health 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

HEALTH COVERAGE CALENDAR - 2022

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 12, 2021 through December 25, 2021 are covered for December 26, 2021 – January 08, 2022.

If you take an unpaid leave of absence, you must pay Finance-Payroll 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 benefits coverage ends. For example, if your coverage ended on December 26, 2020, you must make the premium payment for the December 27, 2020 – January 09, 2022 benefits coverage period no later than the February 5, 2022 pay date.

Pay Period	Work Dates	Pay Date	Benefits Coverage Period
1	December 12, 2021 - December 25, 2021	January 7, 2022	December 26, 2021 - January 8, 2022
2	December 26, 2021 - January 8, 2022	January 21, 2022	January 9, 2022 - January 22, 2022
3	January 9, 2022 - January 22, 2022	February 4, 2022	January 23, 2022 - February 5, 2022
4	January 23, 2022 - February 5, 2022	February 18, 2022	February 6, 2022 - February 19, 2022
5	February 6, 2022 - February 19, 2022	March 4, 2022	February 20, 2022 - March 5, 2022
6	February 20, 2022 - March 5, 2022	March 18, 2022	March 6, 2022 - March 19, 2022
7	March 6, 2022 - March 19, 2022	April 1, 2022	March 20, 2022 - April 2, 2022
8	March 20, 2022 - April 2, 2022	April 15, 2022	April 3, 2022 - April 16, 2022
9	April 3, 2022 - April 16, 2022	April 29, 2022	April 17, 2022 - April 30, 2022
10	April 17, 2022 - April 30, 2022	May 13, 2022	May 1, 2022 - May 14, 2022
11	May 1, 2022 - May 14, 2022	May 27, 2022	May 15, 2022 - May 28, 2022
12	May 15, 2022 - May 28, 2022	June 10, 2022	May 29, 2022 - June 11, 2022
13	May 29, 2022 - June 11, 2022	June 24, 2022	June 12, 2022 - June 25, 2022
14	June 12, 2022 - June 25, 2022	July 8, 2022	June 26, 2022 - July 9, 2022
15	June 26, 2022 - July 9, 2022	July 22, 2022	July 10, 2022 - July 23, 2022
16	July 10, 2022 - July 23, 2022	August 5, 2022	July 24, 2022 - August 6, 2022
17	July 24, 2022 - August 6, 2022	August 19, 2022	August 7, 2022 - August 20, 2022
18	August 7, 2022 - August 20, 2022	September 2, 2022	August 21, 2022 - September 3, 2022
19	August 21, 2022 - September 3, 2022	September 16, 2022	September 4, 2022 - September 17, 2022
20	September 4, 2022 - September 17, 2022	September 30, 2022	September 18, 2022 - October 1, 2022
21	September 18, 2022 - October 1, 2022	October 14, 2022	October 2, 2022 - October 15, 2022
22	October 2, 2022 - October 15, 2022	October 28, 2022	October 16, 2022 - October 29, 2022
23	October 16, 2022 - October 29, 2022	November 11, 2022	October 30, 2022 - November 12, 2022
24	October 30, 2022 - November 12, 2022	November 25, 2022	November 13, 2022 - November 26, 2022
25	November 13, 2022 - November 26, 2022	December 9, 2022	November 27, 2022 - December 10, 2022
26	November 27, 2022 - December 10, 2022	December 23, 2022	December 11, 2022 – December 24, 2022

WAIVER OF PARTICIPATION - 2022

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

Waiver of Participation
During Open Enrollment or within 30 days of a qualifying event, an employee may waive medical insurance by completing the Wavier of Participation form available during your virtual Open Enrollment experience, affirming that the employee and all members of the employee's "tax family" have other group "minimum essential coverage" for the 2022 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.

Important: Annual Waiver of Participation Requirement

If you currently waive the County's medical insurance and receive cash back, be sure to submit a Waiver of Participation during this Open Enrollment!

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 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 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 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 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. See the 2020 Health Coverage Calendar on page 25 of this guide for more information. If the termination date falls on the first day of the coverage period, coverage ends that same day. 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 your Human Resources Benefits Division representative within 30 days of the qualifying event and request COBRA enrollment information. Failure to give notice to Human Resources Benefits Division of your 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 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

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

About Transportation Benefits
Employees may use up to $270 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:

- 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.

Log in to your online account at: marincounty.optumfinancial.com

1.
    a. 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.
2. 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.
3. 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 steps 1-3 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 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 www.marincounty.org/RideGreen.

Questions about the RideGreen program? Contact ridegreen@marincounty.org or 415-473-3485.

E3 EMPLOYEE WELLNESS PROGRAM

What is E3 Wellness Program?

The County of Marin offers an Employee Wellness Program. The mission of the E3 Employee Wellness Program is to provide opportunities that engage, educate, and empower our workforce in leading healthy and active lifestyles that support overall well-being. 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 competitions, webinar workshops to annual events like the American Heart Association Heart Walk and the annual Employee Health and Wellness Fair. 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 Ambassador's and on https://www.marincountyhr.org/learn-about-benefits/wellness-program.

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

The Employee Assistance Program (EAP) is offered by MHN and provides free services to eligible employees and their family members that can help balance work and life challenges.

Employee Assistance Program (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
- Problems in the workplace
- Stress, anxiety and sadness
- Grief, loss or responses to traumatic events
- Concerns about your use of alcohol or drugs
- Childcare and eldercare assistance
- Financial services
- Legal services: Talk to a lawyer over the phone or face to face about:
    - Civil, consumer and criminal law
    - Personal and family law including adoption, divorce and custody issues
    - Financial or tax matters
    - Real estate
    - Estate planning
- Identify theft recovery
- Daily living chores

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?

Managed Health Network (MHN) is our EAP provider. You can reach MHN toll-free, 24 hours a day, seven days a week: 1-800-227-1060
TTY users should call 1-800-327-0801

Or visit www.members.mhn.com and register with the company code: marin

You are entitled to 5 face-to-face sessions or telephonic or web-video consultations combined per incident, per calendar year.

IMPORTANT CONTACT INFORMATION

Benefit	Plan	Group #	Member Services	Contact
Medical	Kaiser Plan S	603194-11	Member Services (California) 1-800-464-4000 (English) 1-800-788-0616 (Spanish)	www.kp.org/memberservices
	Kaiser Plan L	463-0		
	Teamsters Anthem PPO	280558	Member Services 1-800-288-2539	www.anthem.com/ca
	Western Health Advantage	950340	Member Services 1-800-563-2250	www.westernhealth.com
Dental	Delta Dental PPO	01909-01001	1-800-335-8227	www.deltadentalins.com
Vision	VSP Signature	0010983/0001	1-800-877-7195	www.vsp.com
Life	The Hartford	681127	1-888-563-1124	www.thehartfordatwork.com
LTD	The Hartford	681127	1-888-563-1124	www.thehartfordatwork.com
FSAs	Optum Financial	NA	1-877-292-4040	www.optumfinancial.com
EAP	MHN	Marin	1-800-227-1060	www.members.mhn.com

Human Resources Benefits Team

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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 respective Evidence of Coverage (EOC), which is available by contacting the Human Resources Department Benefits Line at 415-473-2197. If there is a conflict between the evidence of coverage (EOC) of the plan you selected and the information in this guide, the plan's evidence of coverage (EOC) will prevail.