2024 EMPLOYEE BENEFITS GUIDE

COUNTY OF SAN DIEGO

Your Benefits

Learn-Plan-Choose

COUNTY OF SAN DIEGO

The County of San Diego provides a comprehensive flexible benefits program for eligible employees and their dependents. You enroll in the benefits you want and waive coverage you do not want! This guide walks you through the general information about your County of San Diego benefits.

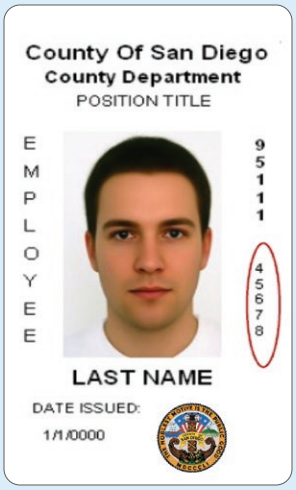
CONTENTS

This guide provides general benefit plan information only. For specific details, conditions, and exclusions please refer to the official Summary Plan Descriptions (SPD). If there is a discrepancy between this guide and official SPDs, the official documents will govern.

Enrolling in Your Benefits

Preparing for Enrollment

- **Review all your enrollment materials,** including this guide, to become familiar with your options.
- **Gather your dependents' information.**
  - Social Security numbers and dates of birth for eligible spouse, domestic partner and children up to age 26.
  - Carriers require this information for dependents enrolling in County benefit plans; without this information, we cannot process the enrollment.
- **Have your** supporting documents ready to show proof of relationship (e.g. marriage certificate for a spouse and birth certificates for children).
- **Gather information about each of your beneficiaries.**
  - For individuals, you need the beneficiary's full name, address, phone number and date of birth (and SSN, if available).
  - For trusts, you need the trust name, address, phone number and trust date.
  - You will designate your beneficiaries through MetLife at **https://online.metlife. com/edge/web/public/uslogin?grpNumber=158540**
- **Determine how much – if anything – you want to contribute** to a Flexible Spending Account and/or Health Savings Account,
- **Make sure** you have County Single Sign On access to PeopleSoft Self Service.
- **Get assistance** by contacting your assigned Help Desk:
  - DA Help Desk: 619-531-4104
  - County Help Desk: 888-298-1222
  - Sheriff's Help Desk: 858-256-2100
- **Update your mailing address** in Self Service for any new insurance cards and communications.



Supporting Documentation for Dependents

When you enroll your dependents in County benefits, you must provide documentation verifying eligibility for the coverage.

Action/Change	Required Documentation (copy of document only; keep the original)
Enroll or add spouse	• Marriage certificate
Enroll or add domestic partner	• Registered Domestic Partnership Certification • Affidavit of Domestic Partnership
Enroll or add a dependent child	• Birth certificate • Adoption papers • Custody award papers • Court order requiring coverage for the child
Drop spouse coverage due to divorce or legal separation[1]	• Divorce decree entered by the judge • Legal separation papers entered by the judge
Drop domestic partner coverage due to termination of domestic partnership[1]	• Domestic Partnership Termination form

[1] You will not receive COBRA paperwork for any dependents removed during the disenrollment process.

How to Submit Supporting Documentation

Have a copy of the scanned documents ready in PDF format. Upload your documents in PeopleSoft by selecting Benefit Details, and Document Upload.

If you need assistance, please contact the Benefits Division at 888-550-2203.

How to Enroll in PeopleSoft Self Service

Enrolling in your County benefits is an easy three step process. Here is what you need to do:

Step 1: Log In	Step 2: Enroll	Step 3: Submit
• Access PeopleSoft • On the Self Service Page, Click on the Open Enrollment Tile (see image below). 	• Click the "Review" button on the right of the benefit plan for each plan you want to change or enroll in. • Follow the instructions on the screen to complete your changes and return to the Benefit Enrollment Summary page • For details on how to enroll, select "Enrollment Instructions"	• Once you have completed your elections, click on "Next" at the bottom of the Benefits Enrollment Summary page • Click "Next" on the top right. Print a copy of your Enrollment summary for your records Note: You will not receive an enrollment confirmation email

Log on Assistance

Make sure you have County Single Sign On access to PeopleSoft Self Service.

Get assistance by contacting, your help desk.

DA Help Desk:
619-531-4104

County Help Desk:
888-298-1222

Sheriff's Help Desk:
858-256-2100

Qualifying Life Events

Making Changes During the Year

You have 60 days from the date of the event to submit documentation and make changes to your benefit elections. If you miss this window, your next opportunity to make changes will be during Open Enrollment.

Effective Dates

Birth Events – New elections due to the birth of a child will be effective the 1st of the month following the date of birth.

All Other Qualifying Life Events – New elections for all other Qualifying Life Events will be effective the 1st of the month after documentation of the event is provided.

Qualifying Life Events May Include the Following

- Birth of a Child
- Adoption, Placement for Adoption, or Guardianship
- Marriage
- Divorce
- Adding or Removing a Domestic Partner
- Gain or Loss of Coverage
- Dependent Moving Into or Out of the Area
- Loss of a Dependent
- Changes to Spending Account
- Spouse's or Parent's Open Enrollment

Any benefit change you make must be consistent with the qualifying life event change. For example, if you have a baby, you can enroll your child in County health plans; however, if you are not currently enrolled in dental coverage, but would like to add it, you must also add your new child to the plan to newly enroll.

Supporting Documentation

If you add a dependent for the first time to any health plans (medical, dental, vision or critical illness), the County requires that you provide supporting documentation to show proof of relationship – such as **a marriage certificate for a spouse and a birth certificate for a child**.

Spending Accounts

It is important to note that Qualifying Life Events can often result in changes to County funded Spending Accounts.

Tag Along Rule

Please note that the County follows the "Tag Along rule" for qualifying life events. The Tag Along rule allows all eligible dependents to be enrolled for coverage upon a qualifying life event. For example, if you have a baby, you will be allowed to enroll your newborn, as well as your spouse and all other eligible children, for medical coverage.

Who Is Eligible

You

You are eligible for benefits if you are:

- An active employee of the County of San Diego who is authorized to work 20 or more hours per week
- An elected official of the County of San Diego

Your Dependents

You may also enroll your dependents if they are:

- Your legal spouse or domestic partner (same-sex, opposite sex, or non-binary)
- Your child(ren)* or your spouse/domestic partner's child(ren)* who are under the age of 26.
- Your child(ren)* or your spouse/domestic partner's child(ren)* of any age if:
  - They are incapable of self-sustaining employment because of a physical or mental disability that occurred before they reached the age limit for the plan, **and**
  - You provide proof of the child's incapacity and dependency within 60 days after the insurance carrier requests the Disabled Dependent Certification

** Children also include stepchildren, legally adopted children, children placed with you for adoption, children for whom you have been appointed legal guardian, and children for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) up to the age limit for the plan.*

Domestic Partners

If you want to enroll your domestic partner:

- They must be at least 18 years of age or older and mentally competent to consent to the domestic partnership
- You must share a close personal relationship and be responsible for each other's common welfare
- You must be each other's sole domestic partner
- You cannot be married to anyone or have another domestic partner within the prior six months
- You must not be related to each other by blood to a degree that would prohibit legal marriage in the State of California
- You must share the same regular and permanent residence with the current intent to continue doing so indefinitely
- You must be mutually financially responsible for each other's "basic living expenses"
- You must complete an **affidavit** or email your registered domestic partner certificate issued by the State to **dhrbenefits.fgg@sdcounty.ca.gov**

Are Your Dependents County of San Diego Employees?

If you and your spouse or domestic partner are County employees, both County employees are eligible to participate in health care benefits.

Flex Credit Allowance

Flex Credits

The County of San Diego provides you with a pay period* allowance, known as Flex Credits, that you can use toward benefits elections. To see the Flex Credit amount available to each job classification, go to the **Benefit Summary**. To opt out of Flex Credits, contact Employee Benefits at 888-550-2203.

Things you should know about Flex Credits:

- They carry no cash value.
- Flex Credit amount is based on your medical coverage selection. If you choose to waive medical coverage or elect employee only coverage, your Flex Credit will be based on the Employee Only selection.
- They are applied to your coverages in the order of the elections listed in PeopleSoft Benefits.
- Any amounts over the Flex Credits is your out-of-pocket expense.

** Based on 24 pay periods in the year/twice monthly deductions.*

Domestic Partner Flex Credits

- You can receive the full Flex Credit when you enroll your domestic partner, but the amount paid by you or the County to cover your domestic partner will be taxed.

Excess Flex Credits

Where Do Excess Flex Credits Go When Waiving Medical Coverage?

You may have excess Flex Credits when waiving health care coverage or if you elect a medical plan that costs less than your Flex Credit allowance. Any excess Flex Credits will be directed to the respective Spending Account based on your reason for waiving.

Things to note:

- You do not have to elect a Spending Account in which to place your excess Flex Credits. They will be allocated to the appropriate Spending Account based on your medical enrollment selection or waive reason.
- Excess Flex Credits applied to a Health Care FSA have a $500 annual limit.
- If you would like any excess Flex Credits to go toward a Dependent Care FSA, you must actively elect a Dependent Care FSA during Open Enrollment and select an annual pledge. Prior Dependent Care FSA elections will not continue and you will not be able to move funds between accounts.

Reminder: Employees who want to waive medical coverage for the plan year must complete their waiver election in PeopleSoft Benefits annually. Your excess Flex Credits must total a minimum of $5 a pay period and $120 annually to be placed in a Spending Account.

Excess Flex Credits

The following table shows how the excess Flex Credits will be allocated when waiving medical coverage:

	Health Savings Account (HSA)[1]	Health Reimbursement Account (HRA)[2]	Health Care Flexible Spending Account (HCFSA)	Dependent Care Flexible Spending Account (DCFSA)
If You Are Waiving County Medical Coverage and...				
...You Have TRICARE; Medicare; Covered California; Medi Cal; or Any Other Individual Plan **or** **...You Have Chosen Not to Disclose Your Waive Reason**	N/A	N/A	**HCFSA** – You may receive up to **$500** excess Flex Credits, which will be defaulted to this account. You may elect out-of-pocket contributions up to a maximum of $3,050 (resulting in a combined annual contribution of $3,550).	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $5,000 contribution limit.
...You Have Other Group Health Plan Coverage (Non-HDHP)	N/A	**HRA** – All excess Flex Credits will be defaulted to this account, up to a maximum of $5,000.	**HCFSA** – You can elect out-of-pocket contributions up to $3,050.[3]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $5,000 contribution limit.
...You Have Other Group Health Plan Coverage That Is a High Deductible Health Plan (HDHP)	**HSA** – All excess Flex Credits will be defaulted to this account up to the HSA family limit of $8,300.[1] You may also elect out-of-pocket contributions combined with excess Flex Credits up to the limit.	N/A	**Limited Purpose HCFSA** – You may elect out-of-pocket contributions up to $3,050.[4]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $5,000 contribution limit.
If You Are Electing County Medical Coverage...				
...Under a County Medical Plan (Non-HDHP)	N/A	**HRA** – Excess Flex Credits will be defaulted to this account up to a maximum of $5,000.	**HCFSA** – You can elect out-of-pocket contributions up to $3,050.[3]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $5,000 contribution limit.
...Under the County HDHP Medical Plan	**HSA** – All excess Flex Credits will be defaulted to this account up to the HSA limit based on the level of coverage that you elect (employee only or family).[1] Note: You can elect out-of-pocket contributions combined with excess Flex Credits up to the limit.	N/A	**Limited Purpose HCFSA** – You may elect out-of-pocket contributions up to $3,050.[4]	**DCFSA** – You can contribute out-of-pocket money or elect excess Flex Credits to this account, up to a $5,000 contribution limit.

Your excess Flex Credits must total a minimum of $5 a pay period and $120 annually to be placed in a Spending Account.

[1] 2024 HSA contribution limits: Employee only coverage: $4,150; Employee + 1 or more coverage: $8,300. If you are not eligible to contribute to the HSA family limit due to outside contributions, contact Employee Benefits at 888-550-2203. NOTE: You cannot contribute to an HSA if you have a balance in a standard (not a limited) Health Care FSA account.

[2] HRA funds can be used for yourself and qualified dependents.

[3] The combination of HRA and HCFSA cannot exceed $5,000. If your FSA election amount causes the combined account total to be more than $5,000, the HCFSA will be reduced.

[4] A Limited Purpose HCFSA can be used for dental and vision expenses only.

2024 Rates for Medical, Dental and Vision Plans

The following shows the per pay period* costs for County Medical, Dental, and Vision plans, and is based on 24 pay periods per year. The amounts below do not include Flex Credits contributions.

Plan	Coverage Level		
	Employee Only	Employee + 1	Employee + 2 or more
MEDICAL			
Kaiser Permanente HMO	$373.72	$747.44	$1,057.63
Kaiser Permanente HDHP with HSA	$291.72	$583.44	$825.57
UnitedHealthcare SignatureValue Performance HMO – Network 1	$388.55	$776.81	$1,099.02
UnitedHealthcare SignatureValue CS VEBA Alliance HMO	$372.79	$745.27	$1,054.40
UnitedHealthcare/UMR Select Plus PPO	$693.32	$1,386.65	$1,962.15
UnitedHealthcare Harmony HDHP	$236.70	$470.69	$663.79
SIMNSA Mexico HMO	$133.86	$235.13	$345.62
DENTAL			
Delta Dental PPO	$23.88	$47.74	$68.16
DeltaCare USA DHMO	$8.48	$15.32	$19.63
VISION			
VSP Vision Service Plan	$4.76	$11.01	$14.92

** Based on 24 pay periods in the year/twice a month deductions.*

Medical Plans

Your selection of medical plans are administered by UnitedHealthcare (UHC and UHC/UMR), Kaiser Permanente, and the VEBA Advocacy Center.

Plan	Major In-Network Providers	Available Coverage	HSA Available?
UnitedHealthcare SignatureValue Performance HMO – Network 1	• Sharp • Rady	In-Network Only	No
UnitedHealthcare SignatureValue CS VEBA Alliance HMO	• Scripps • UCSD • Rady	In-Network Only	No
Kaiser Permanente HMO	Kaiser	In-Network Only	No
SIMNSA Mexico HMO	• SIMNSA Mexicali • SIMNSA Tecate • SIMNSA Tijuana	In-Network Only	No
UnitedHealthcare/UMR Select Plus PPO	Various; please consult the online provider directory (see page 10)	• In-Network • Out-of-Network	No
UnitedHealthcare Harmony HDHP	• Sharp • UCSD	In-Network Only	Yes
Kaiser Permanente HDHP with HSA	Kaiser	In-Network Only	Yes

ID Cards

UHC and UHC/UMR ID Cards

All newly enrolled UHC HMO members, which includes those enrolled in the UHC Harmony HDHP, will receive two ID cards: One medical ID card from UnitedHealthcare and a separate prescription drug ID card from Express Scripts.

UHC/UMR PPO newly enrolled members will receive one ID card for medical and prescriptions combined.

Prescriptions under the UHC plans are covered by Express Scripts.

UHC HMO: 888-586-6365

UHC/UMR PPO: 800-826-9781

Express Scripts: 800-918-8011

Kaiser ID Card

All newly enrolled participants will receive an ID card from Kaiser, which you will use for both medical care and prescription drugs at Kaiser facilities.

Kaiser Permanente: 800-464-4000

SIMNSA ID Card

All newly enrolled participants will receive one ID card from SIMNSA to be used both for medical care and prescription drugs at in-network providers and pharmacies.

SIMNSA: 800-424-4652

Using Your Card

You must present your card whenever you go to the doctor or fill a prescription at a new pharmacy.

If you need medical care before you receive your card, your doctor's office or pharmacist can confirm with your insurance carrier that you are in the system.

Preventive Care

In-network preventive care is 100% covered under all of our medical plans.

What is Preventive Care?

Preventive care services are based on guidelines for your age. Ask your doctors about the right preventive care for you. Some common preventive care services include:

- Annual physicals
- Immunizations
- Medical/family history and physical exam
- Blood pressure checks
- Cholesterol checks
- Other screenings and exams by age and gender

For a complete list of covered preventive services, visit **https://www.healthcare.gov/coverage/preventive-care-benefits/**.

Health Maintenance Organizations (HMOs)

The HMO plan provides cost-effective comprehensive medical care with no deductible and no claim forms to file. You select a primary care physician (PCP) who will coordinate your care and refer you to specialists, if necessary. To receive benefits, you use the HMO facilities and providers as referred by your PCP. Most services are covered at 100% after your copay. **An entire family enrolls in the same network, but may choose different medical groups within the network.**

Doctors/Other Medical Care Providers: You can only use doctors, hospitals, and pharmacies that participate in the HMO network. There is no coverage if you go to out-of-network providers, except for emergency services.

Annual Deductible: There is no annual deductible.

Copays: You pay a set dollar amount when you receive medical care.

Annual Out-of-Pocket Maximum: The HMO plans include an annual out-of-pocket maximum. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Your HMO Options

- UnitedHealthcare (UHC) SignatureValue Performance HMO – Network 1
- UnitedHealthcare (UHC) SignatureValue CS VEBA Alliance HMO
- Kaiser Permanente HMO
- SIMNSA Mexico HMO

Selecting PCPs

If you are enrolling in an HMO plan, you need to designate a Primary Care Physician (PCP).

UHC SignatureValue Performance HMO or UHC SignatureValue CS VEBA Alliance HMO:

1. Go to **https://www.whyuhc.com/cosd**;
2. Click on "Search for a Provider" in the center of the blue top menu bar;
3. Click the "Search the provider network" blue button under the plan you wish to search, then click the blue pop-up "Continue" button;
4. On the next page, click the blue "Continue" button at the bottom of the screen. Now you can search by provider, service, or condition;
5. If your location is different from what's shown, click "Change Location," enter your location information and click "Update Location";
6. For newly enrolled UHC members, a Primary Care Physician will be auto-assigned; to choose another provider, call UHC at 888-586-6365

Kaiser Permanente HMO:

1. Go to **https://my.kp.org/sdcounty/**;
2. Scroll down to the middle of the page, and on the right hand side locate the blue box under "Find a Doctor," click "Go";
3. Under "Find doctors and locations," click "California - Southern";
4. Search by clicking "Doctor" or "Location";
5. Choose your region or enter your ZIP code or city;
6. Click the blue "Search" button

SIMNSA Mexico HMO:

1. Go to **https://www.simnsaee.net/Expediente2010/CitasOnline/proveedores/frm_proveedores.aspx**;
2. Under PROVIDER SEARCH, select the network location, the type of provider, and the provider speciality;
3. Click "Start Search"

The SIMNSA Mexico HMO

This HMO plan is very affordable. It has the lowest cost for coverage and low or no copays. But there are some requirements:

1. You must work in San Diego County, Imperial County or Tijuana;
2. You must use a SIMNSA network provider in Mexicali, Tecate or Tijuana; and
3. You must meet one of the qualifications for a Mexican National.

   A "Mexican National" is defined as one or more of the following:

   - A person born in Mexico;
   - A person born in another country with a Mexican father or a Mexican mother, or both;
   - A foreign man or woman who marries a Mexican man or woman and lives in Mexico; or
   - A foreigner who becomes naturalized in Mexico.

Preferred Provider Organization (PPO)

Doctors/Health Care Providers: You can choose any doctor, hospital or pharmacy and pay less when you use a provider or facility that participates in network.

Annual Deductible: You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services. Services that do not require a deductible first are preventive care, office visits, and prescription drugs (except for the High Deductible Health Plan).

Paying for Care: There are two ways you pay for services:

- **Copays:** You pay a set dollar amount when going to an in-network doctor for an office visit, the emergency room, or picking up a prescription. (You may need to pay the annual deductible first before the copay applies.)
- **Coinsurance:** When services are received, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. (You will need to pay the annual deductible first before coinsurance applies.)

Annual Out-of-Pocket Maximum: This is the maximum amount you pay annually (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year. **Please note:** Your annual out-of-pocket maximum will be lower when you use in-network providers.

Your PPO Option:

- UnitedHealthcare (UHC)/UMR Select Plus PPO

High Deductible Health Plans (HDHP) with an option for a Health Savings Account (HSA)

The High Deductible Health Plan (HDHP) is a unique medical plan that puts you in control of your health care spending and gives you the opportunity to enroll in a Health Savings Account.

Medical Plan

Doctors/Health Care Providers:

- **UnitedHealthcare (UHC) Harmony HDHP:** You can only use doctors, hospitals, and pharmacies that participate in the Harmony network. There is no coverage if you go to out-of-network providers, except for emergency services. Providers in the Rady's network are NOT part of the UHC Harmony Network HDHP.
- **Kaiser Permanente HDHP with HSA:** You must use Kaiser Permanente's network of providers. This network is the same network used with the Kaiser Permanente HMO.

Preventive Care: Preventive care is 100% covered for in-network providers.

Annual Deductible: You pay an annual deductible before the plan begins to pay for a portion of covered medical services. This includes office visits and prescription drugs. The only services that don't require you to pay a deductible first are preventive care.

Coinsurance: Once your annual deductible is met, you pay a percentage of the cost of the medical service, and the plan pays the remaining percentage.

Annual Out-of-Pocket Maximum: This is the maximum amount you must pay for the annual deductible and coinsurance combined. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Embedded Deductible Limits for HDHP Plans: Any individual covered under a plan with dependent(s) will have a maximum deductible of $3,200. This means that no individual member's expenses will exceed the embedded individual deductible amount of $3,200 or the embedded individual out-of-pocket maximum amount of $3,200.

Your HDHP Options

- UHC Harmony HDHP
- Kaiser Permanente HDHP with HSA

Important! Not Everyone Can Open an HSA

All employees are eligible to enroll in a High Deductible Health Plan (HDHP).

However, you may not be eligible to open or contribute to an HSA if you:

- Are enrolled in Medicare or receiving health benefits under TRICARE
- Can be claimed as a dependent on another individual's tax return
- Are considered active military
- Have a balance in a standard (not a limited) Health Care FSA account

Health Savings Account (HSA)

The Health Savings Account is a key part of the High Deductible Health Plans (HDHP) that allows you to save toward out-of-pocket expenses now and in the future in an HSA bank account. You can use HSA funds for any IRS qualified Medical, Dental, and Vision expenses.

The County may also contribute to your HSA if you have excess Flex Credits. If you enroll in a HDHP, excess Flex Credits are automatically placed in your HSA. Unspent funds accumulate tax free and roll over from year-to-year. There is no "use it or lose it" rule. The HSA is your bank account, and you can take it with you wherever you go.

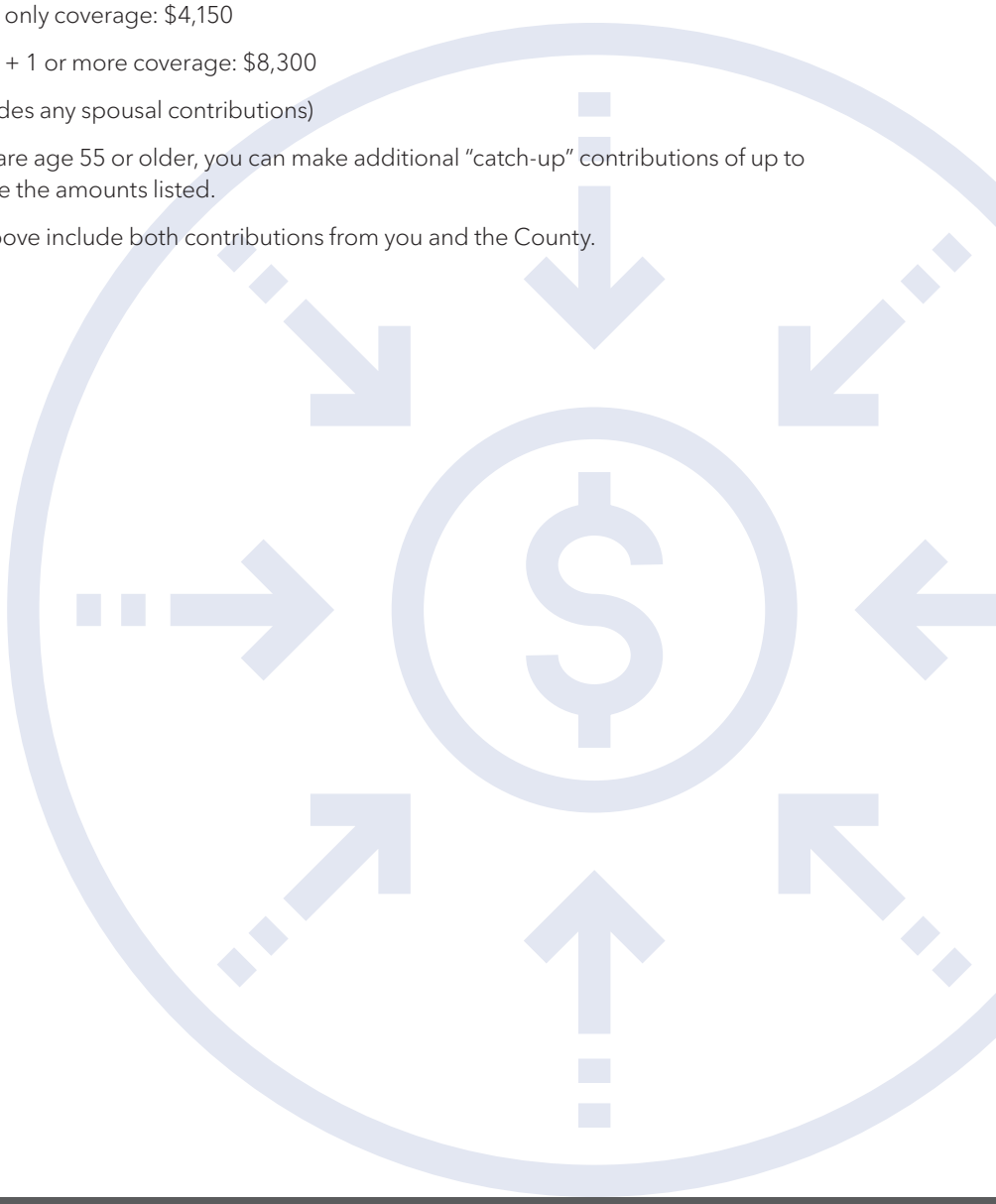
If you want to contribute to your HSA through payroll deductions, you must set up your HSA bank account through Optum Bank. Optum Bank will mail a welcome kit with enrollment instructions to your home. The HSA is not established or administered by the County.

In 2024 here is how much you can contribute to an HSA:

- Employee only coverage: $4,150
- Employee + 1 or more coverage: $8,300
- (this includes any spousal contributions)

Note: If you are age 55 or older, you can make additional "catch-up" contributions of up to $1,000 above the amounts listed.

The limits above include both contributions from you and the County.



How to Set Up and Use Your Health Savings Account (HSA)

Follow the four easy steps below to get started.

Step 1

Enroll in the Health Savings Account Plan in PeopleSoft Benefits to allocate any out-of-pocket contributions.

Step 2

Optum Bank will send a Welcome Kit to your home address. This kit includes details of the HSA account, where to find a list of qualified expenses, and any fees associated with the account. Complete the online account set-up process with Optum.

Step 3

Use your HSA debit card at the point of sale or when receiving qualified services.

Step 4

Save your receipts. If you are audited, you must provide proof that you have used the funds in your HSA according to IRS guidelines.

Questions?

Go to **www.optumbank.com** or call **866-234-8913**.

Domestic Partners and Health Savings Accounts (HSAs)

If you enroll in an HDHP and have an HSA, your domestic partner must set up their own HSA unless they are considered a federally-recognized spouse or a tax dependent.

If you both set up HSAs, you can each contribute up to the maximum amount allowed each year by the IRS.

Health Savings Account Maintenance Fees

There is a monthly maintenance fee associated with this account.

Ask About Generics

If you need medication, ask your doctor if the prescription can be filled with a generic brand. The Food and Drug Administration requires that generic drugs have the same active chemical composition, have the same strength, and be offered in the same dosage form as their brand-name counterparts. Competitive pricing by the different generic drug manufacturers keeps the prices down, which means generic drugs cost a lot less.

Prescription Drug Benefits

When you enroll in a medical plan, you will automatically receive prescription drug coverage. Here are some tips for making the most of your coverage:

- **Opt for generics, whenever possible:** Generic drugs have the same active ingredients as their brand-name counterparts, but cost less. See "Ask About Generics" on this page for more information.
- **Mail order program:** Express Scripts and Kaiser each offer a mail order pharmacy that provides the convenience of home delivery, refill reminders and added savings on maintenance medications. You will be able to obtain up to a 90-day supply of your long-term medication through home delivery.
- **Check your plan's formulary list:** A formulary is a list of approved drugs covered by your plan. This list can change during the plan year – with some drugs removed, new drugs added, and restrictions added or removed. Keeping up-to-date on your plan's formulary will help you save money on prescription medications.
- **Take advantage of preventive medications:** Preventive medications can help you avert or manage illness and better manage chronic conditions. Consult your doctor about preventive medications appropriate for your needs.

For more information about your prescription drugs coverage, refer to your medical plan's prescription drug website listed below.

Medical Plan	Website
Kaiser Permanente HMO	https://healthy.kaiserpermanente.org/southern-california/health-wellness/drug-formulary?kp_shortcut_referrer=kp.org/formulary
Kaiser Permanente HDHP with HSA	https://healthy.kaiserpermanente.org/southern-california/health-wellness/drug-formulary?kp_shortcut_referrer=kp.org/formulary
UnitedHealthcare Signature Value Performance HMO – Network 1	www.express-scripts.com/csvebaplan28
UnitedHealthcare SignatureValue CS VEBA Alliance HMO	www.express-scripts.com/csvebaplan28
UnitedHealthcare/UMR Select Plus PPO	www.express-scripts.com/csvebaplan30
UnitedHealthcare Harmony HDHP	www.express-scripts.com/csvebaplan40
SIMNSA Mexico HMO	English: https://simnsa.com/wp-content/uploads/2020/09/Plan7-10-250-ENG.pdf Spanish: https://simnsa.com/wp-content/uploads/2020/09/PLAN7-10-250-esp.pdf

VEBA Advocacy Center

UnitedHealthcare (UHC and UHC/UMR) and SIMNSA Plan Members Only

How do I contact the VEBA Advocacy Center?

The toll free number is 888-276-0250.

What does the VEBA Advocacy Center do?

The VEBA Advocacy Center is there to help guide UHC, UHC/UMR, and SIMNSA members through the medical system and utilize their VEBA benefits, including support on issues such as:

- Helping members choose a health network
- Accessing care and emergency prescription drugs
- Transitioning care
- Suggestions on quality of care or access to a timely appointment
- Navigating complex health issues
- Assist with pharmacy and medical billing questions
  - If inquiring about a billing issue, the following information is required in order for the VEBA Advocacy Center to help: A copy of the full bill that contains the date of service, dollar amount, type of treatment, provider name and phone number.
  - If inquiring about a prescription or pharmacy issue, provide the name of prescription, dosage and supply, name of pharmacy, date filled or attempted to fill and dollar amount.

The VEBA Advocacy Center will need to verify personal information for the member including first and last name, date of birth or full social, and contact information.

New Fertility Benefit through Kindbody

UHC and SIMNSA Plan members will be able to access fertility and other family-building services, including one round of in vitro fertilization (IVF), through Kindbody.

Kindbody also offers wellness and therapy sessions for a range of needs, such as fertility care, parenting and postpartum anxiety and depression. For details, visit https://kindbody.com/.

Is VEBA Advocacy Center assistance confidential?

Yes. VEBA Advocacy Center follows HIPAA guidelines and will not share any member's information unless authorized by you. They may have to contact your insurance provider or doctor's office to assist you, but will only do so with your permission. In some cases, they may ask you to sign a HIPAA authorization form giving them permission to access your information from your insurance carrier or doctor in order to better assist you.

Medical Plans at a Glance

The following charts provide a comparison of costs and benefits for the County of San Diego medical plans.

	UHC SignatureValue Performance HMO	UHC SignatureValue CS VEBA Alliance HMO	UHC Harmony HDHP	UHC/UMR Select Plus PPO		SIMNSA Mexico HMO
				In-Network	Out-of-Network	
GENERAL						
Annual Deductible • Individual • Individual on a Family Plan • Family	 N/A N/A N/A	 N/A N/A N/A	 $2,700 $3,200[1] $3,200	 $300 N/A $600	 $600 N/A $1,200	 N/A N/A N/A
Out-of-Pocket Maximum • Individual • Individual on a Family Plan • Family	 $2,000 N/A $6,000	 $2,000 N/A $6,000	 $3,200 $3,200[1] $6,000	 $2,300 N/A $4,600	 $4,600 N/A $9,200	 $6,350 N/A $12,700
Coinsurance	N/A	N/A	10%	20%	40%	N/A
PREVENTIVE						
Well-child/Immunizations	No charge	No charge	No charge	No charge	40% after deductible	No charge
Well-women						
Adult Periodic Exams						
Preventive Diagnostic X-Ray/Lab						
OUTPATIENT SERVICES						
Office Visit • PCP	$25/visit	$25/visit	10% after deductible	$20/visit	40% after deductible	$7/visit
• Specialist	$25/visit	$40/visit	10% after deductible	$40/visit	40% after deductible	$7/visit
Telehealth[2]	No copay	No copay	10% after deductible	No copay	40% after deductible	$7/visit
Acupuncture	$20 copay	$20 copay	$30 copay	20% after deductible	40% after deductible	$10/visit
Home Health Care	No charge	No charge	10% after deductible	20% after deductible	40% after deductible	No copay; for post-operative care only, if required
Physical, Occupational, Speech Therapy	$25 copay	$25 copay	10% after deductible	$20 copay	40% after deductible	$10/visit
Chiropractic	$20 copay	$20 copay	$30 copay	$20/visit	40% after deductible	Not covered
Diagnostic X-Ray and Lab	No charge	No charge	10% after deductible	No charge	40% after deductible	No copay
Specialty X-Rays (CT, MRI, PET, CAT)	No copay	No copay	10% after deductible	20% after deductible	40% after deductible	No copay
Durable Medical Equipment	No copay	No copay	10% after deductible	20% after deductible	40% after deductible	No copay

[1] *No individual member's expenses will exceed the embedded individual deductible amount of $3,200 or the embedded individual out-of-pocket maximum amount of $3,200.*

[2] *Telehealth benefits shown are for online and phone visits with health care providers through your plan's telehealth service. If you connect via phone or online with your primary care physician or specialist with whom you already have a relationship, your visit is treated like a PCP or specialist office visit and you will be charged the appropriate amount.*

	UHC SignatureValue Performance HMO	UHC SignatureValue CS VEBA Alliance HMO	UHC Harmony HDHP	UHC/UMR Select Plus PPO		SIMNSA Mexico HMO
				In-Network	Out-of-Network	
HOSPITAL						
Inpatient	$200 per admission	$200 per admission	10% after deductible	$150 per admission; then 20% after deductible	$300 per admission; then 40% after deductible	No charge
Outpatient Surgical	No charge	$100 per surgery	10% after deductible	20% after deductible	40% after deductible	No charge
URGENT/EMERGENT CARE						
Urgent Care	$25 copay	$25 copay	10% after deductible	$75 copay	40% after deductible	$25 if a provider in Mexico is used $50 if provider outside of Mexico is used
Emergency Room	$125/visit (waived if admitted)	$125/visit (waived if admitted)	10% after deductible	$125/visit (waived if admitted); then 20% after deductible	$125/visit (waived if admitted); then 20% after deductible	$250/visit (waived if admitted)
Ambulance	No charge	No charge	10% after deductible	20% after deductible	20% after deductible if True Emergency; 40% after deductible if Non-True Emergency	No copay
MENTAL HEALTH/SUBSTANCE ABUSE						
Inpatient (per admission)	$200 per admission	$200 per admission	10% after deductible	20% after deductible	40% after deductible	No copay
Outpatient Physician Visits (18 and over)	$25/visit; no charge for SA	$25/visit; no charge for SA	10% after deductible	$20/visit	40% after deductible	$7 copay for physician
PRESCRIPTION DRUGS			HDHP Rx Subject to Plan Deductible			
Retail Pharmacy (30-day supply)						
Generic/Tier 1 Brand/Tier 2 Non-Formulary/Tier 3 Specialty/Tier 4	$10 $20 $35 Above applicable copays apply	$10 $20 $35	$10 $20 $35	$10 $20 $35	$10 $20 $35	$10 $10 $10 $10
Mail-order						
Generic/Tier 1 Brand/Tier 2 Non-Formulary/Tier 3 Specialty/Tier 4	$20 $40 $60 Above applicable copays apply	$20 $40 $60	$20 $40 $60	$20 $40 $60	$20 $40 $60	N/A

This chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this chart and the plan terms, then the evidence of coverage (EOC) plan document will prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

	Kaiser Permanente HMO	Kaiser Permanente HDHP with HSA
Network	Kaiser	Kaiser
Annual Deductible • Individual • Individual on a Family Plan • Family	None	$1,600 $3,200[1] $3,200
Out-of-Pocket Maximum • Individual • Individual on a Family Plan • Family	$1,500 $1,500 $3,000	$3,200 $3,200[1] $6,400
OUTPATIENT SERVICES		
Preventive Care	$0	$0
Office Visits • Primary Care • Specialist	$25 copay $25 copay	10%[2] 10%[2]
Telehealth	$0	$0[2]
Acupuncture	Not covered	Not covered
Home Health Care	$0[3]	$0 (up to 100 visits)[2,3]
Physical, Occupational, Speech Therapy	$25 copay	10%[2]
Chiropractic	Not covered	Not covered
Diagnostic X-Ray and Lab	$0	10%[2]
Specialty X-Rays (CT, MRI, PET, CAT)	$0	10%[2]
Durable Medical Equipment	$0[3]	10%[2]
HOSPITAL SERVICES		
Inpatient (per admission)	$100 copay	10%[2]
Outpatient Facility	$25 copay per procedure	10%[2]
EMERGENCY SERVICES		
Emergency Room applicable copay (waived if admitted)	$125 copay	10%[2]
Urgent Care Facility	$25 copay	10%[2]
Ambulance	$0	10%[2]
MENTAL HEALTH/SUBSTANCE ABUSE		
Inpatient (per admission)	$100 copay	10%[2]
Outpatient Physician Visits (18 and over)	$25 copay individual; $12 copay group	10%[2]
PRESCRIPTION DRUGS		All Rx Subject to Plan Deductible
Retail Pharmacy		
Generic	$10 copay for a 30-day supply	$10 copay for a 30-day supply
Brand	$25 copay for a 30-day supply	$30 copay for a 30-day supply
Brand Non-formulary	If prescribed by KP physician, covered at the brand copay for up to 30-day supply	If prescribed by KP physician, covered at the brand copay for up to 30-day supply
Mail Order		
Generic)	$20 copay for a 100-day supply	$20 copay for a 100-day supply
Brand)	$50 copay for a 100-day supply	$60 copay for a 100-day supply
Brand Non-formulary	Not covered	Not covered

[1] No individual member's expenses will exceed the embedded individual deductible amount of $3,200 or the embedded individual out-of-pocket maximum amount of $3,200.

[2] You must meet the deductible first before coinsurance or copay applies.

[3] Limits, exclusions, or utilization review apply.

This chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this chart and the plan terms, then the evidence of coverage (EOC) plan document will prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

GETTING BRACES?

Only Use a DeltaCare Network Orthodontist!

No matter which dental plan you are enrolled in, you MUST use an orthodontist from the DeltaCare Orthodontic Network; otherwise, it will not be covered. **Before receiving treatment, call 844-697-0579 to ensure your orthodontist is in the network.**

Dental Plans

You have two dental plans to choose from, both administered by Delta Dental.

Delta Dental PPO/Premier Plan

Dentists/Other Dental Care Providers: You can choose any dentist you want for all services, with the exception of orthodontics. You'll pay less when you use a provider or facility that participates in the Delta Dental PPO/Premier network, which includes the benefit of receiving the network negotiated pricing.

Preventive Care: Preventive care is 100% covered when you use in-network providers.

Annual Deductible: You pay an annual deductible before the plan begins to pay for a portion of covered services.

Coinsurance: When receiving dental services, you pay a percentage of the cost, and the plan pays the remaining percentage.

Annual Maximum Benefit: This is the maximum amount the plan will pay for your dental services each year. Once reached, you will pay the full cost of any dental services for the remainder of the year.

Orthodontic Care: To receive orthodontic benefits, you **MUST** select a provider in the DeltaCare Orthodontic Network.

DeltaCare DHMO Plan

The DHMO plan allows you to receive comprehensive coverage at set prices in California through the DeltaCare USA DHMO network.

Dentists/Other Dental Care Specialists: You only use dentists to whom you are assigned in network. There is no coverage if you go to an unassigned dentist.

Annual Deductible: There is no annual deductible.

Copays: When you receive dental care, you pay a set dollar amount based on covered treatment codes found in the Dental Plan Summary.

Orthodontic Care: To receive orthodontic benefits, you **MUST** use a provider in the DeltaCare Orthodontic Network, and be referred by your Primary Care Dentist.

Designating a Primary Care Dentist (PCD) for DeltaCare DHMO Participants

Newly enrolled employees can designate a Primary Care Dentist or facility by: scheduling an appointment with an in-network Primary Care Dentist or facility, registering for an online account, or calling Delta at 844-697-0579.

To designate your PCD, go to www.deltadentalins.com and select the "DeltaCare USA" network to select a PCD from their Provider Directory.

You can also contact DeltaCare directly at 844-697-0579.

Want to Change Dentists?
Once you've designated your PCD, you must notify Delta Dental by the 15th of the month for your change to be effective on the first day of the following month.

Dental Plans at a Glance

The following charts provide a comparison of costs and benefits for the County of San Diego dental plans.

	Delta Dental PPO/Premier Plan		DeltaCare DHMO
PLAN FEATURES			
Network of Dental Providers	Delta Dental PPO/Premier Plan dental in-network or out-of-network		DeltaCare USA DHMO dental in-network only[1]
Annual Deductible • Individual • Family Maximum	 $50 $150		Not applicable
Annual Maximum Benefit	$2,000 per person[2]		None
PLAN BENEFITS			
	In-Network	**Out-of-Network**	
Preventive Care[3] (Checkups, cleaning, X-rays, sealants, fluoride treatments, space maintainers)	$0; no deductible required	20% after deductible	100% covered for most services, small copay for sealants and space maintainers
Basic Services (Fillings, simple extractions, root canal, periodontics, etc.)	20% after deductible	20% after deductible	Copays vary – see **Schedule of Benefits**
Major Services[3, 4] (Crowns, dentures, denture reline, implants, fixed bridge)	30% after deductible	40% after deductible	Copays vary – see **Schedule of Benefits**
Orthodontia (24-month banding for children and adults)	You **MUST** use a provider in the DeltaCare Orthodontic Network. Confirm your orthodontist is in the Delta Care Orthodontic Network by calling DeltaCare at 844-697-0579 **BEFORE** you start treatment. You pay $1,695 plus all charges incurred before banding begins and after banding removal.		

1 Only available in California.

2 Diagnostic and preventive services will not count toward the annual benefit maximum of $2,000 per individual.

3 Frequency of some items is limited. Check plan documents for details.

4 Check plan documents for plan limitations on some services.

This chart is a summary of general benefits available to County of San Diego eligible employees. Wherever conflicts occur between the contents of this chart and the plan terms, then the evidence of coverage (EOC) plan document will prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, call the plan for information.

Important Notes About Your Dental Plans

- Neither plan will cover crowns, inlays, onlays, posts and cores, dentures, or orthodontic services prescribed before your plan coverage becomes effective.
- Some major services require pre-authorization in order to be covered. Ask your dentist for a "pre-determination of benefits," which will let you know how much the plan will pay.
- If you are a DHMO member, you and your family members can elect different primary care dentists, as long as they are in-network and in California.

Vision Plan

The County of San Diego offers you vision coverage through Vision Service Plan (VSP). The plan features include:

- **Eye Doctors:** You can choose any vision provider you want.
- **Glasses vs. Contact Lenses:** You will be able to select frames and lenses or contact lenses annually.
- **VSP EasyOptions**[1], which allows for one of the following upgrades with an in-network provider:
  - Additional $100 frame allowance, or
  - Fully covered premium or custom progressive lenses, or
  - Fully covered light-reactive lenses, or
  - Fully covered anti-glare coating, or
  - Additional $50 contact lens allowance

[1] *Members cannot use EasyOptions at Costco, Walmart or Sam's Club. Use your base plan benefits at these locations, and EasyOptions at a VSP in-network provider's office.*

- **Paying for Care:** When you receive vision care, the amount you pay depends on what type of eye doctor you use:
  - **In-network eye doctors:** You generally pay a set dollar amount called a copay. For frames and elective contact lenses, the plan will pay up to an allowance amount, and you pay any cost over this allowance.
  - **Out-of-network eye doctors: You pay for the full service and are reimbursed through VSP up to the allocated amounts.**

Vision Benefits at a Glance

Plan features and costs are highlighted below. You will save money when you use in-network providers.

	In-Network	Out-of-Network
PLAN FEATURES		
Copay	$15 per person	$15 per person
PLAN BENEFITS		
Eye Exams (once per calendar year)	Plan pays 100% after copay	Plan pays 100% after copay, up to $40
Lenses (one pair per calendar year) • Single vision, lined bifocal, polycarbonate, scratch coating, and lined trifocal lenses • Standard progressive lenses	• Plan pays 100% after copay • Plan pays 100% after copay	Plan pays 100% after copay, up to the following amounts. You pay all charges over these amounts: Single vision: Up to $40 Bifocal: Up to $60 Trifocal: Up to $80 Progressives: Up to $80 Lenticular: Up to $125
Frames (once every calendar year)	$170 featured frame brands allowance $150 frame allowance 20% savings on the amount over your allowance $80 Walmart®/Sam's Club®/Costco® frame allowance	Plan pays 100% after copay, up to $45, after copay
Contact Lenses (once a year in lieu of lenses and frames) • Cosmetic • Medically necessary*	 • Plan pays 100% after copay, up to $150 • Plan pays 100% after copay	 • Plan pays 100% after copay, up to $105 • Plan pays 100% after copay, up to $210
Laser Eye Surgery	Plan pays up to $500 per eye *VSP contracts with participating laser vision correction facilities to provide discounts to VSP members. The discounted price will not exceed $1,800 per eye for LASIK, $1,500 per eye for PRK, and $2,300 per eye for Custom LASIK. In the event that you receive laser vision correction services on one eye only, any remaining balance may not be applied toward the cost of surgery in the second eye.*	

* *There are certain eye conditions that can only be corrected by contact lenses. Non-elective contact lenses, also called medically necessary contact lenses, are prescribed by your optometrist to correct these types of eye problems. Your eye doctor will let you know if you need non-elective contact lenses.*

Employee Assistance Program

Who is Eligible

The Employee Assistance Program (EAP) is a confidential service available to you and anyone in your household.

Available Resources

Anthem EAP's trained professionals can easily refer you to the following resources:

- **Face-to-Face Confidential Counseling:** See a licensed counselor up to eight times for each personal situation per calendar year. If more than eight sessions are needed, employees are referred to the health insurance company or to community resources for ongoing care.
- **Telephone and Online Counseling Sessions:** You may also speak to a licensed counselor remotely over the phone or via LiveHealth Online. Call 888-777-6665 for additional information.
- **Talkspace:** *(effective 1/1/2024)* Anthem's EAP offers Talkspace as a confidential and secure online option for personal and professional individual and couples therapy. For added convenience, patients age 13 and above can send text, audio, and video messages to a dedicated licensed therapist anytime, anywhere. Live sessions via chat, audio and video are also available.
- **Crisis Counseling:** If you have an emergency, call 888-777-6665. The service representative will put you in touch with a professional who can help.
- **Learn-to-Live:** The Learn-to-Live program is a no cost online virtual program that supports your emotional health and wellness. Through Learn-to-Live, you can receive online help for:
  - Depression
  - Stress management
  - Social anxiety
  - Insomnia
  - Substance use
  - Comprehensive clinical assessments
  - Personalized, clinician coaching

  You can also take advantage of self-directed programs (English and Spanish).
- **Legal Assistance:** Access to legal consultations up to 30 minutes face to face or by telephone at no charge. For services beyond the initial 30 minutes, you will receive a preferred discount rate of 25% off an attorney's normal hourly fee. You have access to virtually all areas of law such as family/domestic matters, civil matters, criminal, real estate, etc. Matters involving disputes between employees and the County of San Diego are specifically excluded from eligibility for this program.
- **Tobacco Cessation Online Resources:** Free online resources are available through the EAP website to help you learn how to break the tobacco use habit.
- **Dependent Care and Daily Living Resources:** Provides information on child care, adoption, summer camps, college placement relocation, and resources on elder care and assisted living. In addition, you can receive assistance with daily living issues such as household maintenance, moving, pet care, etc. Referrals are available through the Assisted Search feature on the Anthem EAP website (**www.AnthemEAP.com**) or by calling toll-free at 888-777-6665.

Other Online Resources

Informational articles, self-assessment tools and quizzes on behavioral health and health care topics are available through the interactive website at **www.AnthemEAP.com**. Legal information and financial calculators are also available.

Contact the EAP

- By phone: **888-777-6665**
- Online: **www.AnthemEAP.com**

Company code:
For Code access, go to **CoSD Anthem EAP Summary of Benefits (sharepoint.com)**

Spending Accounts (HCFSA, DCFSA and HRAs)

Important!

If you want to participate in a Spending Account, you must enroll every year.

Plan Your FSA Contributions Carefully

The IRS has several rules about FSAs that require you to plan carefully:

- You must enroll annually.
- Expenses must be incurred between January 1 and December 31 of the year for which you are making contributions. If you leave County employment in the middle of the year, expenses incurred after your termination date will not be reimbursable. Please note that if you stop working for the County, you may still submit claims for reimbursement of eligible expenses incurred through December 31st of the year you terminate employment.
- A combination of HRA and Health Care FSA balances up to $610 will roll over for the following year. The rollover will take place as long as the account is active at the end of the year. Any HRA/HCFSA balances over $610 at the end of the year will be forfeited.
- If you enroll in an HSA for the following plan year, any Health Care FSA rollover funds will be directed into a Limited Purpose Health Care FSA (dental and vision purposes only) .
- You can reimburse health care expenses only through the Health Care FSA; you can reimburse dependent day care expenses only through the Dependent Care FSA.

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) provide you with a way to pay for eligible out-of- pocket health care and dependent day care expenses.

The County of San Diego offers FSAs through ASIFlex.

Health Care FSA (HCFSA)

You may generally contribute from $120 to $3,050 per year to the Health Care FSA to pay for out-of-pocket health care expenses for you and your dependents.

Eligible expenses include:

- Deductibles
- Copays
- Coinsurance
- Over-the-counter drugs

For a complete list of eligible expenses, visit **www.asiflex.com/sdcounty**.

Limited Purpose Health Care FSA (LPHCFSA)

The Limited Purpose Health Care FSA is available for employees who enroll in the HDHP with an HSA. You may contribute from $120 to $3,050 per year to a LPHCFSA for reimbursement of dental and vision care expenses only.

Dependent Care FSA (DCFSA)

With the Dependent Care FSA, you can pay for eligible out-of-pocket dependent care expenses you have so that you can work. Eligible dependents include children under age 13 and adult dependents who are identified as dependents on your income tax return and who live with you at least eight hours per day. Eligible expenses include:

- Daycare (provided by someone who is not your spouse or child under age 19)
- Babysitting
- Day camps
- Before and after school care programs

You may contribute from $120 to $5,000 per year to the Dependent Care FSA. If you are married and filing jointly, the combined maximum you can contribute to a Dependent Care FSA between both spouses is $5,000. If you are married and you and your spouse file separate federal income tax returns, the most each of you can contribute to a Dependent Care FSA is $2,500 (for a combined total of $5,000).

Your Participation in an FSA during a Leave of Absence

Your contributions will automatically continue as long as you continue to receive pay and/or your excess Flex Credits are directed to this account. **Although you will continue to contribute to your Dependent Care FSA during a leave of absence, dependent care expenses that you incur during the leave will not be eligible for reimbursement due to IRS rules**.

Your Dependent Care FSA After You Leave County Employment

If you stop working for the County, your contributions to your Dependent Care FSA will end. You may still submit claims for reimbursement of eligible expenses incurred through December 31st of the year you terminate employment, and you will have until March 31st of the following year to submit your claims.

Health Reimbursement Accounts (HRA)

A Health Reimbursement Account is an employer-funded plan that reimburses you for out-of-pocket eligible health care expenses with remaining Flex Credits over $120 a year, up to a $5,000 annual maximum contribution.

The HRAs work just like the Health Care FSA and is administered by ASIFlex.

You will not be eligible for HRA rollover if you elect an HSA for the next plan year.

Spending Account Comparison

Review the table below for a high-level comparison of all of the Spending Accounts available to you.

	Health Care FSA	Limited Purpose FSA	Dependent Care FSA	HSA	HRA
Eligibility	All; except those contributing to an HSA account	Must be covered under a qualified HDHP and have an HSA	All	Must be covered under a qualified HDHP	Those enrolled in a Group Medical Plan
Account Owner	County of San Diego	County of San Diego	County of San Diego	You	County of San Diego
Who Funds	You or County of San Diego	You	You or County of San Diego	You or County of San Diego	County of San Diego
Annual Contribution Maximums	You, up to $3,050; County of San Diego, up to $500 Max of $3,550 combined	You, up to $3,050	$5,000 per calendar year; $2,500 per calendar year if married and filing separate tax returns	$4,150 (individual); $8,300 (family)	Up to $5,000
Eligible Expenses	Code 213(d) medical, dental, and vision expenses of employee, spouse, and children under age 26 incurred during the coverage period	Dental, vision expenses not covered by insurance or under any other source	Child or adult care while working and for the protection and well-being of the dependent	Code 213(d) medical, dental, and vision expenses of employee, spouse, and children under age 26	Code 213(d) medical, dental, and vision expenses of employee, spouse, and children under age 26 incurred during the coverage period
Itemized Statement Required	Yes	Yes	Yes	Yes (HSA account holder must retain records)	Yes
Carries Over Year to Year*	You can carry over up to $610 into the following plan year, combined with an HRA	You can carry over up to $610 into the following plan year	You cannot carry over any remaining balance into the following plan year	Yes	Up to $610 combined with Health Care FSA rollover funds. However, you will not be eligible for HRA rollover if you elect an HSA for the next plan year
HDHP Election	Cannot contribute	Can continue to have the option to contribute to a Limited Purpose Health Care FSA	Can continue to have the option to contribute to a Dependent Care FSA	Can have employee contribution and excess Flex Credits contributed to an HSA account (subject to contribution maximums)	Cannot contribute
Enrollment Requirements	Annually	Annually	Annually	Automatic enrollment if excess Flex Credits are available.* However, you will need to select any out-of-pocket contributions annually	Automatic enrollment if excess flex credits are available*

** Your excess Flex Credits must total a minimum of $5 a pay period and $120 annually to be placed in a Spending Account.*

Life Insurance

Life Insurance is administered by MetLife and provides a financial benefit for your beneficiary(s) in the case of your death.

Basic Life Insurance

The County provides Basic Life Insurance coverage for you at no cost and is determined by your job classification.

In addition, the County provides $2,000 of Life Insurance coverage for your spouse, domestic partner and each dependent child, up to age 26.

Supplemental Life Insurance

You may choose to purchase additional Life Insurance coverage for yourself. Coverage is available up to six times your annual salary, up to a maximum of $2,000,000 of coverage.

Guaranteed Issue Amount

If you enroll in Supplemental Life Insurance when you are first eligible as a new hire, you can purchase up to three times your annual salary without submitting a Statement of Health.

Statement of Health for Supplemental Life Insurance

If you enroll or increase Supplemental Life Insurance outside the initial eligibility period, you will need to complete a Statement of Health. MetLife will email you a request to log in to MyBenefits to complete an electronic Statement of Health. Final approval comes from MetLife and your coverage will become effective the 1st of the following month after approval.

Costs for Supplemental Life

Your cost depends on your age and coverage amount.

Rate per $1,000 of Coverage	AGE (as of September 22, 2023)										
	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 - 79	80>
Per Pay Period*	$0.0128	$0.0187	$0.0266	$0.0325	$0.0517	$0.0970	$0.1137	$0.2507	$0.6383	$0.6383	$0.6383

** Based on 24 pay periods in the year/twice a month deductions.*

For Couples Who Are Both County Employees

- If you and your spouse/domestic partner are both County employees, each of you will receive employee Basic Life Insurance. The County will not provide coverage for either of you as a dependent.
- For your children, the County will provide $2,000 of coverage assigned to one of you, but not to both.

Designate a Life Insurance Beneficiary

All employees are required to access their Life Insurance Beneficiaries using the online beneficiary management system through MetLife.

To designate a beneficiary, follow these steps:

1. Gather the following information about each of your beneficiaries:
   - For individuals, you need the beneficiary's full name, full address, phone number and date of birth (and SSN, if available).
   - For trusts, you need the trust name, address, phone number and trust date.
2. Visit **MetLife**.
3. Log in to your MyBenefits account and register as a new user or enter your previously created user name and password.
4. After you log in, choose Group Life Insurance. At the top of the page, choose the link for 'Beneficiaries'.
5. Enter details about each of your beneficiaries and print a copy for your records.

Changes to your beneficiaries are effective immediately. You will also receive an electronic confirmation notice, which allows you to easily print a paper copy of your designations for your records.

If you prefer, you can **print** a Beneficiary Designation Form to complete and submit. If you don't have access to the internet, contact MetLife at 866-492-6983 to receive a Beneficiary Designation Form by mail.

Remember: It is important that you always keep your beneficiary designations up to date.

Primary and Secondary Beneficiaries

You may designate one or more primary beneficiaries to receive a portion of your Life and AD&D insurance benefits; if you designate more than one beneficiary, the benefit percentage amounts designated to each beneficiary must total 100%.

You may also designate secondary beneficiaries. Secondary beneficiaries receive your Life and AD&D insurance benefits in the event your primary beneficiary(ies) are unable to receive the benefit designated to them (for example, if a primary beneficiary passes away first or cannot be contacted).

Accidental Death & Dismemberment (AD&D) Insurance

The County provides Basic AD&D insurance at no cost to you. The amount of coverage is equal to your Basic Life Insurance coverage, based on your job classification.

Regarding beneficiaries, please note:

- If an accident causes your death, your beneficiary will receive your Basic and any Supplemental Life and AD&D coverage amounts purchased.
- If an accident causes you to lose one or more limbs or senses, you may receive all or part of your coverage amount.
- You are the beneficiary for any dependents on this plan.

For coverage details, review MetLife's **AD&D certificate of insurance**.

Supplemental AD&D Coverage

You may purchase Supplemental AD&D coverage for yourself and for your eligible dependents:

Coverage	Coverage Amount
For You	1, 2, or 3 times your annual salary, up to $1,000,000
For Your Spouse/Domestic Partner Only	60% of your Supplemental AD&D coverage amount
For Your Dependent Children Only	25% of your Supplemental AD&D coverage amount per child, up to $50,000 per child
For Your Spouse/Domestic Partner and Dependent Children	Spouse/domestic partner: 50% of your Supplemental AD&D coverage amount Dependent children: 15% of your Supplemental AD&D coverage amount per child, up to $50,000 per child

Costs for Supplemental AD&D

Your cost depends on your coverage level and amount elected.

Coverage Level	**Per Pay Period*** (rate per thousand)
Employee Only	$0.0075
Employee + Family	$0.0125

** Based on 24 pay periods in the year/twice a month deductions.*

Ancillary Benefit Plans

The ancillary insurance options available through the County of San Diego are offered at a special discounted group rate, which are paid through payroll deductions.

Voluntary Short-Term Disability Insurance (STD)

When a non-work related illness or injury makes it impossible for you to work for a short period of time, STD guards you against financial loss.

There are two voluntary Short-Term Disability plans offered through Lincoln Financial Group. The plans are designed separately for employees who currently pay into the State Disability Insurance (SDI) through their paycheck, and for those who do not.

There is a three month look-back period for pre-existing conditions. Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures) during the 3 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

If you become pregnant prior to the effective date voluntary Short-Term Disability, your preganancy will be consider pre-existing and will not be eligible for STD benefits. However, you still will be eligible for Paid Family Leave under the Non-CA/SDI STD plan.

For more details please refer to the table below:

SHORT-TERM DISABILITY INSURANCE		
	Employees who are CA/SDI Participants	**Employees who are NON-CA/SDI Participants**
Benefit Waiting Period	14 days	7 days
Weekly Maximum Benefit	25% to $1,000	60% to $1,620
Weekly Minimum Benefit	$100 per week	$100 per week
Maximum Benefit Duration	24 weeks	3, 7, or 12 weeks Be sure to review your County-paid LTD waiting period so that you choose the STD benefits that matches as closely as possible to your LTD waiting period
Benefits Reductions due to other income	Social Security payments	Social Security payments, a retirement plan, workers' compensation and any income received from the employer

When you take a PFL, the Non-CA/SDI STD plan will pay 60% to 70% of your weekly salary each week, up to $1,620 depending on your job class. There's no waiting period or pre-existing condition exclusions for this benefit.

Employees covered by CA/SDI have similar PFL benefits under the California state plan.

Non-CA/STD Paid Family Leave Benefits

In addition to the Short-Term Disability benefits shown in the table at right, participants in the NON-CA/SDI Plan can receive up to eight weeks of Paid Family Leave (PFL) each year under the plan to:

1. Bond with a child
2. Care for a seriously ill family member
3. Participate in a qualifying event because of a family member's military deployment to a foreign country

Under this STD plan, you are not required to use up your vacation or sick days first before the plan pays benefits.

The per pay period* costs are shown below.

Rates for CA/SDI Participants:

Age	Cost per $10 of weekly covered benefit
<50	$0.310
50 - 54	$0.310
55 - 59	$0.345
60 - 64	$0.405
65 - 99	$0.440

Rates for **NON**-CA/SDI Participants:

Age	Rate per $10 of Weekly Covered Benefit 3 - week Duration (Option 1)	Rate per $10 of Weekly Covered Benefit 7 - week Duration (Option 2)	Rate per $10 of Weekly Covered Benefit 12 - week Duration (Option 3)
<50	$0.53	$0.86	$1.00
50 - 54	$0.53	$0.86	$1.00
55 - 59	$0.59	$0.96	$1.11
60 - 64	$0.68	$1.12	$1.30
65 - 99	$0.75	$1.23	$1.42

** Based on 24 pay periods in the year/twice a month deductions.*

Voluntary Long-Term Disability Insurance (LTD)

This plan, offered through Lincoln Financial Group, pays Long-Term Disability benefits monthly to replace a portion of your income until you are able to return to work, as shown below. **Refer to your Benefit Summary to determine if you are eligible for this plan**.

LONG-TERM DISABILITY INSURANCE	
Benefit Waiting Period	180 days
Monthly Benefit	60% to $5,000
Monthly Minimum Benefit	$100
Maximum Benefit Duration	Social Security normal retirement age
Benefits Reductions	Social Security payments, state disability and any income received from the employer

Please see your Summary Plan Description for a complete description of plan provisions, exclusions and limitations for the plan.

The per pay period* costs are shown below.

Age	Rate per $100 of pay period covered payroll	Age	Rate per $100 of pay period Covered Payroll
<20	$0.035	**45 - 49**	$0.272
20 - 24	$0.035	**50 - 54**	$0.377
25 - 29	$0.045	**55 - 59**	$0.400
30 - 34	$0.087	**60 - 64**	$0.422
35 - 39	$0.135	**65 - 69**	$0.438
40 - 44	$0.202	**70+**	$0.449

** Based on 24 pay periods in the year/twice a month deductions.*

County-Paid Long-Term Disability (LTD)

Depending on your job classification, you may be eligible for long-term disability insurance paid by the County and administered through MetLife. **Refer to your Benefit Summary to determine if you are eligible for this plan.**

COUNTY-PAID LONG-TERM DISABILITY INSURANCE	
Benefit Waiting Period	30, 60 or 90 days, depending on job classification
Monthly Benefits	66 2/3% of earnings, up to $8,000 or $12,000, depending on job classification
Monthly Minimum Benefit	$100 or 10% of LTD benefit before income reduction (e.g., benefits reduced because of work earnings, Workers' Compensation benefits, state disability payments, etc.)
To Make a Claim	Contact Employee Benefits Division at 888-550-2203

See the MetLife LTD Summary of Benefits for more details, including determination of eligibility and waiting period.

Critical Illness Insurance

Critical Illness Insurance is being offered by Lincoln Financial Group. This plan pays a cash benefit to you for any of a comprehensive list of serious illnesses.

You are eligible to cover yourself, your spouse/domestic partner, and your children under this plan. Coverage for children is offered at no cost when you cover yourself. You can elect coverage in four different amounts.

Critical Illness		
Benefit Amounts	Employee: $10,000, $20,000, $30,000, or $40,000 Spouse/Domestic Partner & children: 50% of employee elected amount	
Benefit Triggers (100%)	Invasive cancer Coma Heart attack End stage renal failure Major organ transplant	Benign brain tumor Complete blindness Complete loss of hearing Paralysis Stroke
Benefit Triggers	25% enhancement: • Coronary artery bypass surgery • Multipliable sclerosis	30% enhancement: • Carcinoma in situ (non-invasive cancer)
Pre-Existing Condition Clause	Waived	
Wellness Screening Benefit	$100 annually	
Second Event Benefit	100% with 6-month separation of diagnoses or treatment	
Skin Cancer Benefit	$750 – once per lifetime	

By enrolling in this plan you are confirming you currently have comprehensive health benefits.

Health Assessment Benefit

If you enroll in Critical Illness Insurance, you are eligible for a $100 health assessment benefit each year. To receive your health assessment benefit, you must undergo a single covered exam, screening or immunization, such as EKG (Electrocardiogram), mammogram, PSA (prostate specific antigen blood test) and more. For a complete list of eligible health assessment procedures, see the Critical Illness Summary, or call Lincoln Financial at 888-480-8710.

You can submit a health assessment claim:

- **Online:** Through our secure self-service portal
- **Email:** FileClaim@LFG.com
- **Fax:** 888-735-7636
- **Mail:** The Lincoln National Life Insurance Company
  P.O. Box 2609
  Omaha, NE 68103
- **Phone:** 888-480-8710

Using the Lincoln Financial Website

To register on Lincoln Financial's self-service portal, visit LincolnFinancial.com, then:

1. Click Register on the top right of the page.
2. Click the Product link under Employee Benefits.
3. Enter requested information.
4. Validate your identity, and create username and password. Click Log in Now.
5. Enter your username and password, and create your security question.

Once registered, log in to your account and select Critical Illness to access the portal, where you can:

- View policy information
- Download a Beneficiary Form – Send the completed form to Lincoln Financial to designate a beneficiary for your critical illness benefits in the event of your death. You must designate your beneficiary with Lincoln Financial directly. Please note that if you do not designate a beneficiary, your benefit will be paid to your estate.
- File claims

The per pay period[1] costs are shown below.

$10,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$1.81	$3.17
25 - 29	$2.26	$3.85
30 - 34	$2.91	$4.81
35 - 39	$3.56	$5.79
40 - 44	$4.83	$7.70
45 - 49	$6.54	$10.27
50 - 54	$8.49	$13.20
55 - 59	$11.72	$18.04
60 - 64	$18.03	$27.50
65 - 69	$26.94	$40.86
70 - 74	$32.18	$48.73
75 - 79	$32.18	$48.73
80+	$32.18	$48.73

$20,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$3.61	$6.33
25 - 29	$4.52	$7.70
30 - 34	$5.81	$9.62
35 - 39	$7.11	$11.58
40 - 44	$9.66	$15.40
45 - 49	$13.08	$20.53
50 - 54	$16.98	$26.39
55 - 59	$23.44	$36.08
60 - 64	$36.05	$54.99
65 - 69	$53.87	$81.72
70 - 74	$64.36	$97.46
75 - 79	$64.36	$97.46
80+	$64.36	$97.46

$30,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$5.41	$9.49
25 - 29	$6.78	$11.55
30 - 34	$8.71	$14.43
35 - 39	$10.66	$17.36
40 - 44	$14.48	$23.10
45 - 49	$19.61	$30.79
50 - 54	$25.47	$39.58
55 - 59	$35.16	$54.11
60 - 64	$54.07	$82.48
65 - 69	$80.80	$122.57
70 - 74	$96.53	$146.18
75 - 79	$96.53	$146.18
80+	$96.53	$146.18

$40,000 Policy[2]		
Ages	EE, EE+CH	EE+SP, FAM
18 - 24	$7.22	$12.66
25 - 29	$9.04	$15.40
30 - 34	$11.62	$19.24
35 - 39	$14.22	$23.15
40 - 44	$19.31	$30.80
45 - 49	$26.15	$41.06
50 - 54	$33.96	$52.78
55 - 59	$46.88	$72.15
60 - 64	$72.10	$109.98
65 - 69	$107.74	$163.43
70 - 74	$128.71	$194.91
75 - 79	$128.71	$194.91
80+	$128.71	$194.91

[1] Based on 24 pay periods in the year/twice a month deductions.

[2] Insured spouse & each insured dependent are covered at 50% of Employee Benefit Amount

Where to Get More Information

For Information About Eligibility and General Questions	
Address	County of San Diego | Department of Human Resources | Employee Benefits Division 5530 Overland Avenue, Suite 210 San Diego, CA 92123
Hours	Monday through Friday, 8:00 a.m. to 5:00 p.m. (except County holidays)
Telephone	888-550-2203
Fax	858-467-9708
Mail Stop	O-7
Email	DHRBenefits.FGG@sdcounty.ca.gov
Benefits Information	www.sandiegocounty.gov/content/sdc/hr/EmployeeBenefits.html

Plan and Benefits Information			
Carrier	**Group Number**	**Member Services**	**Website**
Medical and Prescription Drug Plans			
UHC Performance HMO **UHC Alliance HMO** **UHC Harmony HDHP HMO** **Select Plus PPO**	Medical Group Number / Rx Group Number 685700 / MVISDD133 685710 / MVISDAH33 685726 / MVISDHDS33 (EE Only), MVISDHDF33 (EE+Dep) 76-414102 / MVISDSPPO	888-586-6365 800-826-9781	https://www.whyuhc.com/cosd www.umr.com
VEBA Advocacy Center (for UHC, UHC/UMR, and SIMNSA members)	N/A	888-276-0250 Follow the prompts for "COSD Advocacy Department"	www.vebaonline.com/
SIMNSA Mexico HMO	560	800-424-4652	www.simnsa.com
Kaiser Permanente	104301	800-464-4000	https://my.kp.org/sdcounty/
Express Scripts pharmacy	N/A	800-918-8011	www.express-scripts.com
Health Savings Account (HSA) For HDHP Plans			
Optum Bank	HB2505A	866-234-8913	www.optumbank.com
Dental Plans			
Delta Dental PPO DHMO	 17214 76990	 877-688-3503 844-697-0579 Confirm Network Orthodontist: 844-697-0579 (PPO and DHMO)	https://www.deltadentalins.com/countyofsandiego/
Vision Plan			
VSP Vision Service Plan	00107506	800-877-7195	http://countyofsd.vspforme.com/
Spending Accounts (FSA and HRA)			
ASIFlex	N/A	800-659-3035	http://www.asiflex.com/sdcounty/
Life and AD&D Insurance			
MetLife Life AD&D	 158540 158540	Submit a claim: 800-638-6420 Beneficiary Designation: 866-492-6983 Statement of Health status: 877-963-8932	www.metlife.com/countyofsandiego To designate beneficiaries: www.metlife.com/mybenefits Benefits login: County of San Diego
Disability Insurance			
Lincoln Financial Group Paid Family Leave Short-Term Disability Voluntary Long-Term Disability	 N/A 010261914-00000 010261917-00000	 Submit a claim: 888-480-8710	 Questions or claims Claims@lfg.com https://www.sandiegocounty.gov/content/sdc/hr/EmployeeBenefits/ancillary-benefits.html
MetLife County-paid Long-Term Disability	 158540	 888-550-2203	www.metlife.com/countyofsandiego
CRITICAL ILLNESS			
Lincoln Financial Group	V8728	888-480-8710	File a claim: https://www.sandiegocounty.gov/content/sdc/hr/EmployeeBenefits/open-enrollment/critical-illness.html
Employee Assistance Program			
Anthem EAP	N/A	888-777-6665	www.anthemeap.com Company Code: For Code access, go to CoSD Anthem EAP Summary of Benefits (sharepoint.com)