2015

MyBenefits Summary

TABLE OF CONTENTS

Overview 2
Eligibility for Benefits 3
Changes to Coverage 4
Coverage Effective Dates 5
Medicare While Working 6
Insurance Subsidy 7
Medical Premium Deductions 8
Medical Plans 9
HMO Plan Comparisons 10
High Deductible Plan Comparisons 11
Health Savings Accounts 12
Dental Benefits 14
Vision Benefits 15
Flexible Spending Accounts 16
Retiree Health Savings Plan 18
Life Insurance 19
Critical Illness 22
Employee Assistance Program 24
Deferred Compensation 25
Leave of Absence 27
Continuation Coverage (COBRA) 28
Contacts 29
REO Index 30

OVERVIEW

As an employee of the County of Sacramento, you have a wide variety of benefits available. This Summary provides an overview of:

- Medical Plan options
- Dental, Vision, Life, and Employee Assistance Program (EAP) benefits
- Coverage for your dependents
- Health Savings Accounts
- Flexible Spending Account (FSA) options
- Retiree Health Savings Plan
- Deferred Compensation
- Leave of absence
- COBRA Continuation Coverage

For some benefits the County pays the entire cost of your coverage. For others, you may contribute all or just a portion of the cost of coverage. Your premiums will vary according to the plan and number of dependents you enroll, your representation unit, your hire date, and/or the level of coverage you select.

BENEFITS AND BARGAINING

While all regular County employees receive a wide selection of benefits, benefit options may vary from employee to employee. Represented employees may have different benefit packages that have been negotiated by their union representatives.

The benefit options offered to any given employee are determined through the collective bargaining process with the Recognized Employee Organizations (REOs). County Management recommends and the Board of Supervisors determines benefits for unrepresented employees. Both the REOs and the County are committed to providing a quality benefits package that meets employee needs.

USING THIS SUMMARY

These benefit programs bring considerable value to you as a Sacramento County employee. We encourage you to thoroughly review this Benefit Summary and contact the Department of Personnel Services Employee Benefits Office with any questions you might have. This Summary may not address all of your specific questions. The Department of Personnel Services Employee Benefits Office has additional, comprehensive benefit information for all of the benefit programs, which you may review at 700 H Street, Room 4650 (4th Floor), in the County Administration Center from 8:00 a.m. until 5:00 p.m., Monday through Friday, or you may call your benefit specialist at (916) 874-2020.

YOUR GROUP INSURANCE COVERAGE

Your benefits are subject to the schedule of covered services as described in the applicable Evidence of Coverage (EOC) which is available through the Department of Personnel Services Employee Benefits Office or on the Employee Benefits Office website. The Plan summaries contained in this book are for comparison purposes only. For detailed or specific plan information, you may call the plan's toll-free number, you may refer to the full Evidence of Coverage booklet that is available on the Employee Benefits website, or the Summary of Benefits and Coverage (SBC) chart will also be available online during Open Enrollment and in paper upon request.

ELIGIBILITY FOR BENEFITS

EMPLOYEE

An "Eligible Employee" is defined as:

1) a regular employee who is working full-time or part-time for the County;

2) an elected official and his or her exempt deputy or assistant;

3) any regular employee who temporarily transfers to a benefitted temporary position; or

4) full-time and part-time employees of Special Districts

For the purposes of benefit eligibility, a regular employee means any officer or employee, in civil service or not in civil service, who occupies a permanent position, whether part-time or full-time, established in accordance with the annual salary ordinance, in the class which is intended for permanent or career-type employment. A regular employee includes an employee who is not working full-time, but who is still considered to be in active pay status. (This includes the use of any combination of sick leave, vacation, overtime, workers' compensation, or §4850 pay.)

A part-time employee is defined as working at least twenty (20) hours per week or forty (40) hours in a bi-weekly pay period. A full-time employee is defined as working at least forty (40) hours per week or eighty (80) hours in a bi-weekly pay period. An "eligible employee" is not an employee of a temporary agency, a contractor, or any other person who does not occupy a permanent position in accordance with the annual salary ordinance.

DEPENDENTS

Eligible dependents include:

- **Your spouse**-lawfully wedded;
- **Your domestic partner**-registered with the Secretary of State;
- **Children**-natural, step, adopted, a child that you have legal guardianship of (up to age 26), and/or foster minor children of the employee or spouse/domestic partner.

➢ Dependents of your children are not eligible unless you or your spouse/domestic partner has legal guardianship or a foster placement agreement of that child.

COVERAGE AVAILABLE FOR DEPENDENTS

PLAN	COST
Medical/Vision Coverage	Premiums are based on the coverage selected
Dental Coverage	No cost for dependents
Life Insurance	Imputed income for coverage exceeding $2,000
Employee Assistance Program	No cost for dependents

If you enroll a domestic partner or children of a domestic partner who are not your IRS-defined dependents for tax free benefit purposes you will be required to pay imputed income (federal taxes on the value of the benefit). The term "domestic partner" has the same meaning as defined by Section 297 of the California Family Code or Section 308c of the California Family Code if the domestic partnership is established outside of California.

CHANGES TO COVERAGE

After your initial enrollment you can generally only make changes to coverage during qualified "life events" and/or Open Enrollment. The change must be on account of and consistent with the event, and must be made online within 30 days of the event using BenefitBridge. Documentation to verify the event is also required.

MAKING CHANGES-In order to make changes three things must occur:

1. Experience a Life Event-Examples of common life events:

Birth of child	Child turning 26	Loss of other group coverage*
Marriage	Gain other coverage*	Divorce

***NOTE**: You have **60** days to enroll in or waive County coverage if you gain or lose either Medi-Cal or SCHIP/Healthy Families coverage under certain conditions.

2. Submit your request within 30 days

Changes to coverage should be made online at www.benefitbridge.com/saccounty. It is the employee's responsibility to submit the enrollment within 30 days of the event. Upon approval, changes are effective the first day of the month following the enrollment.

3. Provide supporting documentation-Examples of supporting documents include:

Event	Documentation
Spouse/domestic partner	Marriage certificate/Declaration of Domestic Partnership
Child	Birth certificate; hospital verification letter (newborns only); Adoption or legal guardianship papers for newly adopted/placed children
Loss or gain of other coverage	HIPAA Certificate, COBRA notice, or employer letter indicating the date of the loss/gain of other group coverage

Documentation should be submitted with the event, but not more than 7 days after. A Social Security number is required for dependents, but if you do not have it at the time of enrollment, you should enroll the dependent and request additional time to provide it.

Failure to submit your request within 30 days or provide supporting documentation will result in your inability to make changes until the next qualified status change event or Open Enrollment. **If you do not have the supporting documentation, you still need to complete the enrollment within 30 days and request additional time for documents.**

INELIGIBLE DEPENDENTS

You must remove ineligible dependents within 30 days of their loss of eligibility. Notifications beyond 60 days will result in the loss of COBRA rights and **you** may be financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.

COMMOM MISTAKES

New Baby

Submitting your paperwork to your department HR to request FMLA or Parental Leave for the birth of a newborn does not add your new baby to coverage. We cannot assume your intentions for enrollment so you must take action and request enrollment!

Divorced Spouse

Ex-spouses must be removed within 30 days of the divorce; If family court orders continued benefits for an ex-spouse, you would need to elect COBRA or purchase coverage privately; s/he cannot stay on County coverage.

COVERAGE EFFECTIVE DATES

Medical, dental, and vision insurance for eligible employees and their eligible dependents are effective on the first day of the month following online enrollment and the timely submission of the required documentation— **not from the date of the event**. Although you have 30 days from an event to make an election, your coverage cannot be retroactive under Section 125 IRS regulations (except as allowed under HIPAA).

NEW HIRES

In order to enroll in the benefit plans of your choice, benefit elections must be made within the first 30 days of becoming an eligible participant. You may enroll online, either at home or at work, by using BenefitBridge which is available through the Employee Benefits Office web page at: http://www.personnel.saccounty.net/Benefits. Any required supporting documentation must be submitted to your department Service Team or the Employee Benefits Office for final approval within 7 days of your benefit elections. Coverage is effective the 1st day of the month following approved enrollment.

If you do not enroll within the first 30 days of becoming eligible or provide the required documentation timely you will be enrolled in the default plans described in your labor agreement.

MID YEAR QUALIFYING EVENTS

During the year, you may experience a “qualifying event” such as marriage, divorce, domestic partnership, birth, loss or gain of group coverage, etc. For mid-year enrollment changes associated with a birth or adoption, the coverage becomes effective on the date of birth or adoption in accordance with HIPAA regulations. For all other midyear qualifying events, the coverage is effective the first day of the month following eligibility, enrollment and timely submission of required documentation.

OPEN ENROLLMENT

Our health plan contracts allow one opportunity each year during “Open Enrollment” for all eligible County employees to change health insurance plans. Employees may also add or delete dependents at this time and enroll in or re-enroll in Flexible Spending Accounts for Dependent Care and Medical Reimbursement.

If you add dependents or waive medical coverage supporting documentation is required and must be submitted to the Employee Benefits Office for final approval of your benefit elections or your changes may not go into effect. Changes made during Open Enrollment are generally done in October and coverage is effective on January 1st of the following year.

WAIVER OF COVERAGE

If you have other group health coverage you may waive your County medical plan when you are first eligible, during Open Enrollment or within 30 days of gaining other group coverage. You are required to provide documentation to verify the other coverage. You will only be permitted to re-enroll in a County medical plan within 30 days of the loss of your other group coverage, or during Open Enrollment; proof of the loss of coverage is required.

MEDICARE WHILE WORKING

If you are eligible to participate in the County medical plans as an active employee (page 5) and wish to continue working after reaching age 65, you have important options to consider. While you are still an active benefited employee under a County medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your County active medical plan remains primary to Medicare while you are working. That is, the County plan will pay claims first.

Medicare coverage consists of the following options:

Part A - Hospital Insurance - covers inpatient hospital stays and related services, skilled nursing facilities, home health care, and hospice services. Part A entitlement is based on age, disability or End Stage Renal Disease (ESRD). For most people entitlement based on age occurs at age 65. Entitlement is automatic if you have reached age 65 and are receiving Social Security benefits. There is usually no premium cost for Part A. However, if you are not receiving Social Security benefits you may apply for Part A benefits separately. It is recommended that you contact your local Social Security office at least three (3) months before age 65 for more information.

Part B - Medical Insurance - covers medically necessary physician services such as office visits, lab and X-ray services, outpatient surgical procedures, and wide variety of other benefits. Part B entitlement generally occurs at the same time as Part A. However, because there is a premium cost to Part B, you may decline coverage. As long as you are covered under a County of Sacramento employee medical plan, you can delay enrollment in Part B without incurring a late enrollment penalty. Once your active County coverage ends, you have a Special Enrollment opportunity to sign up for Part B benefits.

Important: if you decline Part B when first eligible and you do not remain covered under a group medical plan sponsored by an employer or union, you may incur a late enrollment penalty.

Part C - Medicare Advantage Plans - Advantage plans are approved by Medicare and are administered by private companies to provide all of your Part A and Part B benefits. These plans are generally not available until you are no longer covered under a County sponsored plan.

Part D - Prescription Drug Coverage - individual separate prescription drug plans are usually administered by insurance companies approved by Medicare. Each plan can vary in cost and drugs covered. Part D entitlement generally occurs at the same time as Part A. However, because there is a premium cost to Part D, you may decline coverage. As long as you are covered under a County of Sacramento employee medical plan, you can delay enrollment in Part D without incurring a late enrollment penalty. That is because the prescription coverage for every County sponsored medical plan is considered "creditable" which means that, it expects to pay as much as or more than the standard Medicare drug coverage. Once your active County coverage ends, you have a Medicare Special Enrollment opportunity to sign up for Part D benefits, with no late enrollment penalty.

For details of what's covered under Medicare, how to enroll, and your options regarding Medicare coverage, contact your local Social Security office or visit www.medicare.gov on the web.

INSURANCE SUBSIDY

The County provides an insurance subsidy to help pay for the cost of medical insurance. The amount varies, depending on when you began working for the County and your Recognized Employee Organization (REO). Subsidies are categorized as **Tier A(1), Tier A(2)** or **Tier B**.

TIER A

If you were hired into a benefit eligible position before January 1, 2007 and have not voluntarily elected to move to Tier B, you are in Tier A. The subsidy amount is determined by your bargaining agreement (or Board of Supervisors resolution for unrepresented employees) and you are either Tier A(1) or Tier A(2). If the plan you select costs more than the amount of your subsidy, the extra amount will be deducted from your pay, pre-tax*. If you choose a plan that is less than your subsidy, there is no payroll deduction.

CASH BACK

Some employees may be eligible for cashback. If you were hired into your REO prior to the "designated date" you may be eligible. The applicable designated date is listed on the last page of this summary.

If the coverage you select costs more than the subsidy, the extra amount will be deducted from your pay, pre-tax*. If the cost of the coverage you select is less than your cashback limit, or if you waive the County provided medical benefit, you may receive a payment as cashback in your paycheck, less appropriate taxes.

PLAN SELECTION INCENTIVE (PSI)

If you were hired before January 1, 2007 and your REO has negotiated with the County for PSI, or you are an eligible unrepresented employee, a PSI payment of $150/month will be made to you if you waive medical coverage.

To waive medical coverage you must provide documentation showing that you have other group health insurance. You may be required to re-establish your eligibility by providing acceptable proof of your continuing coverage under another group health plan.

TIER B

You may be able to reduce your portion of the medical premium by moving from Tier A to Tier B. Employees hired or rehired into a benefit eligible position on or after January 1, 2007 or who have voluntarily chosen to move from Tier A, are in Tier B. The maximum County subsidy is 80% of the premium for the level of coverage selected (employee only or employee and dependents) of the lowest cost traditional HMO. If the plan you select costs more than the subsidy, the difference will be deducted from your pay, pre-tax*. There is no cashback or PSI eligibility if you are in Tier B.

Once you move from Tier A to Tier B, you cannot return to Tier A status. The change can only be made during Open Enrollment, or during a "change of status" event, and is not mandatory or required. It is a voluntary decision that can be made only once and is irrevocable once made.

Important: Employees in Tier A who are eligible for Cash Back or PSI and move to Tier B forfeit all future rights to Cash Back or PSI.

*Premiums associated with domestic partners, the dependents of domestic partners who do not meet the IRS definition of a dependent, are subject to applicable federal taxes, but are exempt from State tax.

MEDICAL PREMIUM DEDUCTIONS

The chart below reflects the total monthly cost of medical coverage for each carrier; employer contribution plus the employee contribution. Deductions are pre-tax and taken the first two paychecks of the month.

2015 MONTHLY MEDICAL PLAN PREMIUMS

	HMO PLANS			HIGH DEDUCTIBLE HMO PLANS		
	Kaiser	**Sutter**	**WHA**	**Kaiser HD**	**Sutter HD**	**WHA**
Single	$626.38	$631.22	$649.74	$493.74	$491.64	$496.30
Family	$1,601.82	$1,614.48	$1,663.38	$1,262.66	$1,257.26	$1,270.60

2015 PER PAY PERIOD MEDICAL DEDUCTIONS

SINGLE COVERAGE--For employees enrolling in a plan with **no family members**

Medical Carrier	**TIER A(1)** All Other Units **Subsidy $826.90**	**TIER A(2)** Units 003, 006, 017, 019, 030 **Subsidy $1,148.80**	**TIER B** Hired after 12/31/06 **Subsidy $501.10**
Kaiser $15 HMO	$0	$0	$62.64
Sutter $15 HMO	$0	$0	$65.06
WHA $15 HMO	$0	$0	$74.32
Kaiser HD HMO	$0	$0	$0
Sutter HD HMO	$0	$0	$0
WHA HD HMO	$0	$0	$0

FAMILY COVERAGE--For employees enrolling in a plan with **one or more family members**

Medical Carrier	**TIER A(1)** All Other Units **Subsidy $826.90**	**TIER A(2)** Units 003, 006, 017, 019, 030 **Subsidy $1,148.80**	**TIER B** Hired after 12/31/06 **Subsidy $1,281.46**
Kaiser $15 HMO	$387.46	$226.51	$160.18
Sutter $15 HMO	$393.79	$232.84	$166.51
WHA $15 HMO	$418.24	$257.29	$190.96
Kaiser HD HMO	$217.88	$56.93	$0
Sutter HD HMO	$215.18	$54.23	$0
WHA HD HMO	$221.85	$60.90	$0

CASHBACK

Employees eligible for cashback/PSI should use this table to determine any amount you may receive in your check. Amounts listed are for SINGLE enrollments.

	TIER A(1)-Cap $535	**TIER A(2)-Cap $894.52**	**TIER B-No Cashback/PSI**
Waiver	$248.48	$415.46	$0
Kaiser $15 HMO	$0	$124.54	$0
Sutter $15 HMO	$0	$122.29	$0
WHA $15 HMO	$0	$113.69	$0
Kaiser HD HMO	$19.16	$186.14	$0
Sutter HD HMO	$20.14	$187.12	$0
WHA HD HMO	$17.97	$184.95	$0

MEDICAL PLANS

The County offers several medical plan options. You may choose from three (3) traditional Health Maintenance Organization (HMO) plans or three (3) High Deductible Health Plans (HDHP); there are also options for employees who are not eligible for HMO coverage.

Employees and enrolled dependents must be enrolled in the same plan.

HEALTH MAINTENANCE ORGANIZATION (HMO)

Under an HMO plan, a Primary Care Physician (PCP) directs all medical care and specialty referrals. You and each of your enrolled family members select a PCP and/or a medical group. Each family member may choose his or her own PCP and may have a different medical group under the plan. Except for emergencies as defined by your medical plan, you must contact your PCP first in order for your health care to be covered. Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization. Although you normally need to stay in network for services to be covered, you may change your PCP or medical group throughout the year and do not need to wait for a mid-year Qualifying Event or Open enrollment.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

High Deductible plans are still HMO plans requiring in network services. However, in a High Deductible Health Plan (HDHP) both medical (except for certain types of preventative care) and prescription expenses must apply to the deductible. These plans are lower in monthly premium than traditional plans but have a larger initial out of pocket expense. You pay for services at the time of care. Once you reach the deductible, any additional services you incur have no out of pocket costs. If you choose an HDHP plan, you may want to consider establishing a Health Savings Account (HSA) to assist with paying or reimbursing your upfront medical costs.

EXAMPLE: HMO vs HDHP Annual Cost Savings

This example highlights the difference in the annual premium deduction cost for an HMO plan vs a HD plan for Tier B family coverage

	WHA HMO	WHA HDHP
Bi-Weekly Deduction	$190.96	$0
Annual Deduction	$4,583.04	$0

$1,583.04 Minimum Savings

Since the maximum deductible cost under the HD plan is $3,000 and services are covered at 100% after that limit, the annual HMO premium deduction of $4,583.04 is more than the maximum cost of services under the HD plan (without factoring in co-pays on top of that amount each time services are utilized). And, if you do not use $3,000 in HD services, your savings is even greater!

HMO VS HDHP CONSIDERATIONS

Although there can be substantial annual savings when selecting an HDHP over a traditional HMO, there may be some important factors to consider. For family coverage, the entire deductible must be met before services are covered at 100%, even if one person has met the individual threshold. Additionally, prescriptions are charged at the full network price, and generally must be paid in full at the time of pick-up, so you could face early out of pocket expenses at the beginning of the calendar year when deductibles are reset. You can find out the cost of any ongoing prescriptions by contacting your medical carrier ahead of time.

HMO PLAN COMPARISONS

	Kaiser HMO	Sutter Health Plus HMO	Western Health Advantage HMO
General Plan Information			
Lifetime Plan Maximum	None	None	None
Annual Deductibles	None	None	None
Annual Out-of-Pocket Limit	$1,500/Individual--$3,000/Family	$1,500/Individual--$3,000/Family	$1,500/Individual--$3,000/Family
Deductible Included In Out-of-pocket Limits	N/A	N/A	N/A
Office Visit/Exam	$15	$15	$15
Outpatient Specialist Visit	$15	$15	$15
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests Well-Child Care Immunizations Well Woman Exams Mammograms Diagnostic X-Ray and Lab Tests	100% covered	100% covered	100% covered
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal)	$15	100% covered	100% covered
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization	100% covered	100% covered	100% covered
Outpatient Facility Charge	$15	$15	$15
Emergency Services			
Emergency Room (Waived if admitted)	$35	$35	$35
Air or Ground Ambulance	100% covered	100% covered	100% covered
Mental Health Benefits			
Inpatient Care	100% covered	100% covered	100% covered
Outpatient Care	$15/individual--$7/group	$15	$15
Substance Abuse			
Inpatient Hospitalization	100% covered (detox only)	100% covered	100% covered
Outpatient Services	$15/individual--$5/group	$15	$15
Prescription Drugs			
Retail	100 Day Supply	30 Day Supply	30 Day Supply
Generic	$10	$10	$10
Brand (Formulary/Preferred)	$20	$20	$20
Brand (Non-Formulary/Non-preferred)	N/A	$35	$35
Mail Order	100 Day Supply	90 Day Supply	90 Day Supply
Generic	$10	$20	$20
Brand (Formulary/Preferred)	$20	$40	$40
Brand (Non-Formulary/Non-preferred)	N/A	$70	$70
Other Services and Supplies			
Durable Medical Equipment & Prosthetics	100% covered	100% covered	100% covered
Home Health Care (limited to 100 visits per calendar year)	100% covered (3 visits per day)	100% covered	100% covered
Skilled Nursing or Extended Care Facility (limited to 100 days per calendar year)	100% covered	100% covered	100% covered
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	$15	$15	$15
Chiropractic Services; Calendar year limit	$10; 30 visits	$10; 30 visits	$15; 20 medically necessary visits
Acupuncture Services; Calendar year limit	N/A	$10; 30 visits	$15; 20 medically necessary visits

HIGH DEDUCTIBLE HMO PLAN COMPARISONS

	Kaiser HDHP	Sutter Health Plus HDHP	Western Health Advantage HDHP
General Plan Information			
Lifetime Plan Maximum	None	None	None
Annual Deductibles	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family
Annual Out-of-Pocket Limit	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family
Deductible Included in out-of-pocket limits?	Yes	Yes	Yes
Office Visit / Exam Outpatient Specialist Visit	100% covered after deductible	100% covered after deductible	100% covered after deductible
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests Well-Child Care Immunizations Well Woman Exams Mammograms	100% covered Deductible Waived	100% covered Deductible Waived	100% covered Deductible Waived
Diagnostic X-Ray and Lab Tests--Deductible waived for prevent screens	100% covered after deductible	100% covered after deductible	100% covered after deductible
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal) Deductible Waived	100% covered	100% covered	100% covered
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization Outpatient Facility Charge	100% covered after deductible	100% covered after deductible	100% covered after deductible
Emergency Services			
Emergency Room Air or Ground Ambulance	100% covered after deductible	100% covered after deductible	100% covered after deductible
Mental Health Benefits			
Inpatient Care Outpatient Care	100% covered after deductible	100% covered after deductible	100% covered after deductible
Substance Abuse			
Inpatient Hospitalization Outpatient Services	100% covered after deductible	100% covered after deductible	100% covered after deductible
Prescription Drugs			
Retail	100 Day Supply	30 Day Supply	30 Day Supply
Generic Brand (Formulary/Preferred)	100% covered after deductible	100% covered after deductible	100% covered after deductible
Brand (Non-Formulary/Non-preferred)	N/A		
Mail Order	100 Day Supply	90 Day Supply	90 Day Supply
Generic Brand (Formulary/Preferred)	100% covered after deductible	100% covered after deductible	100% covered after deductible
Brand (Non-Formulary/Non-preferred)	N/A		
Other Services and Supplies			
Durable Medical Equipment & Prosthetics Annual limits	100% covered after deductible; $2,500	100% covered after deductible; $2,500	100% covered after deductible
Home Health Care (limited to 100 visits per cal year)	100% covered after deductible (3 visits per day)	100% covered after deductible	100% covered after deductible
Skilled Nursing or Extended Care Facility--limited to 100 days per cal year	100% covered after deductible	100% covered after deductible	100% covered after deductible
Chiropractic Services	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	100% covered after deductible	100% covered after deductible	100% covered after deductible

HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is a voluntary savings account used for reimbursement of qualified medical expenses. Enrollment in a HDHP is the only way to be eligible to contribute to an HSA. You may enroll in the HSA at any time, and you may change or stop your contributions at any time. Separate enrollment forms are required to establish an HSA.

An HSA is not a medical plan with a carrier. It is an individual account that you contribute to and use for reimbursement of medical expenses. Reimbursements are the same category of eligible expenses as a Flexible Spending Medical Reimbursement Account; however your maximum available reimbursement is limited to your account balance.

Among the benefits of an HSA are:

- Contributions, earnings and interest are exempt from Federal (not State) taxes;
- Distributions are tax free when used for qualified medical expenses;
- Assets roll over from year to year—no "use it or lose it";
- You can change the contribution at any time;
- The HSA is portable, so you can use the assets even if you leave County employment.

In order to contribute to an HSA, you must:

- Be enrolled in an HDHP;
- Have no other non-HDHP health coverage*;
- Not be enrolled in Medicare;
- Have not received VA medical benefits at any time over the past three months;
- Not be able to be claimed as a dependent on someone else's tax return.

Even if you are no longer eligible to contribute to an HSA, whether you switch from a HDHP or leave County employment, your HSA account remains active for the reimbursement of qualified medical expenses until it is depleted. Non-medical withdrawals are considered taxable income. A 20% penalty for non-medical withdrawals will apply if you are under 65.

Contribution maximums are set by the IRS. For 2015, the maximums are:

Coverage	Under Age 55	Age 55+
Individual	$3,350.00	$4,350.00
Family	$6,650.00	$7,650.00

You are not required to have an HSA if you enroll in HDHP coverage. However, if you decide that you wish to have an HSA and want a Federal pre-tax payroll deduction, your contributions will be sent to the HDHP carrier's preferred HSA financial partner. Otherwise, you may select the institution of your choice on a post-tax basis taking a deduction when filing your itemized Federal income tax return. Note: You may incur a monthly administrative fee for the HSA by the financial institution.

*You cannot be covered as a dependent on another plan that is not also an HDHP. Also, you cannot create or contribute to an HSA account if you also have a balance in your General Medical Reimbursement Account at the end of the calendar year. However, you can have a Limited Purpose Flexible Spending Account and still remain HSA eligible. For more details, please contact the Department of Personnel Services Employee Benefits Office.

HEALTH SAVINGS ACCOUNTS (cont'd)

Can my spouse and I both contribute to an HSA if we have the *same* insurance coverage?

Yes. If both you and your spouse individually meet the criteria for making an HSA contribution, you can both make HSA contributions. However, if both you and your spouse are covered by the same family coverage, you will need to allocate the HSA contribution limit between the two of you. HSA payroll deductions will only occur if you are also enrolled in a County HDHP medical plan.

Can my spouse and I both establish an HSA if we have *separate* insurance coverage?

If you and your spouse have separate insurance coverage, then each of you will need to determine if you are eligible for an HSA contribution. Separate insurance coverage means that your insurance doesn't cover your spouse and your spouse's insurance doesn't cover you.

What are qualified health care expenses?

Qualified health care expenses include co-payments and deductibles at doctors' offices, pharmacies, medical labs, dentists and orthodontists, medical supply stores, chiropractors, hospitals, vision centers, podiatrists and more. You can also use HSA funds tax-free for eyeglasses and contact lenses, mail order prescriptions, and online prescriptions. Over-the-counter (OTC) medications are not reimbursable without a doctor's prescription.

The claims process is described in the HSA enrollment materials. Remember, however, it is up to you to keep the supporting receipts to show the Internal Revenue Service that you used the funds to pay for qualified medical expenses.

Can I use funds from my HSA for non-medical expenses?

Yes. However, you will be required to pay Federal income tax and a 20% penalty on the amount used for a non-medical expense (20% penalty does not apply if you are disabled or over age 65).

Can I use the money in my HSA to pay medical insurance premiums?

Generally, you cannot use your HSA to pay premiums for health insurance coverage. Exceptions include COBRA premiums, long-term care premiums or health premium payments while you are receiving unemployment compensation.

Do the qualified health care expenses have to be for myself?

No. Health care expenses can be for yourself, your spouse or your dependent children you claim on your tax return up to age 24. Your spouse and dependents do not need to be covered by your high-deductible health plan.

How much can I contribute if my HDHP coverage starts in the middle of the year?

If you become newly eligible to contribute to an HSA during the year, you have two choices. You can prorate your contribution by dividing your maximum contribution amount by the number of months remaining in the year. Or, if you are an HSA eligible individual on December 1, you can contribute the maximum full-year HSA coverage level contribution for that year, even if you were not covered under an HDHP for the full period. You must continue to remain eligible for a period beginning December 1 of the year in which you become eligible and ending on December 31 of the following year to avoid a tax penalty.

Can I change my contribution amounts during the year if I have payroll deduction?

You can change your contribution amount at any time during the year. Changes are effective the first of the following month. Please contact the Department of Personnel Services Employee Benefits Office to determine how to change your payroll deduction amounts.

DENTAL BENEFITS

The County provides a comprehensive dental plan through Delta Dental of California for eligible full-time and part-time employees and their enrolled dependents.

What if I already have dental insurance?
Even if you have other group dental coverage, you still must enroll in the County dental plan. "Coordination of Benefits" rules will be applied in determining how benefits will be paid. You may find that many dental services will be paid in full between your two dental plans.

What if both my spouse/domestic partner and I are County employees?
You are encouraged to evaluate the benefits of you both enrolling all members of your family in the County's dental plan since the plan will provide full coordination of benefits for married couples and domestic partners who are both County employees. The County pays 100% of the dental plan premium cost (*As required by Federal tax law, federal taxes must be paid if you enroll a dependent that does not meet the IRS definition of a dependent. These taxes are based upon the value of the benefit).*

How does the plan pay?
This plan provides three levels of benefit:

If you receive services from a Delta PPO dentist	If you go to a non-PPO Delta dentist	If you access a non-Delta dentist
the plan will pay 100% of the preventative and diagnostic services; 90% for basic services; and 80% for major services	the plan will pay 80% of preventative and diagnostic services; 80% for basic services; and 80% for major services.	the plan will pay 80% of covered services based upon the Maximum Plan Allowance. Any remaining balance is your financial responsibility

Is there a deductible?
There is a $25 per person calendar-year deductible. The maximum family deductible is $75 per policyholder per calendar year. The deductible will be waived in the third year of coverage for any member who has had two (2) preventive cleanings in each of the two (2) previous calendar years, provided there is no break in coverage under this plan. The deductible will continue to be waived as long as you receive two cleanings per plan year.

How much will the plan pay each year?
The calendar year maximum is $2,500 per person if you receive all services from a PPO provider ($2,000 for non-PPO providers). The calendar year maximum excludes orthodontia. The plan's orthodontic benefit is 50% of UCR with a lifetime benefit maximum of $1,500 per person.

How do I access my benefits?
Delta Dental of California does not generally mail out ID cards after you enroll; and in most cases, a card is not required. Simply provide your dentist's office with the social security number of the subscriber(s).

VISION BENEFITS

Vision benefits are available to all employees eligible for benefits; it is either bundled with your medical plan, or you have the option to purchase coverage through VSP if you have waived medical coverage or are enrolled in one of the high deductible plans.

BUNDLED PLANS

The cost for vision coverage is included with your medical premium for the plans listed in the chart below. Vision coverage is included so no enrollment for vision is required. Any dependent also enrolled in these medical plans have vision coverage.

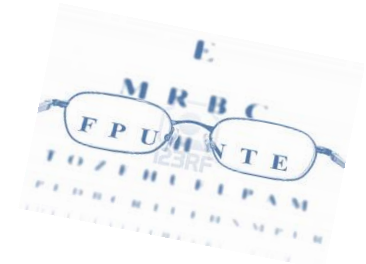
Schedule of benefits	Kaiser HMO	WHA HMO	Sutter Health Plus HMO
Coverage is through	Kaiser Vision	VSP	VSP
Eye exam	$15 copay	$15 copay	$15 copay
Allowance amount	$175 frames/lenses	$130 frames	$130 frames
Exam frequency	24 months	12 months	12 months
Lenses frequency	24 months	12 months	12 months
Frames frequency	24 months	24 months	24 months
Contacts frequency	24 months	12 months	12 months

OPTION TO PURCHASE

If you enroll in a plan that does not have vision benefits or you waive medical coverage vision benefits are available through separate enrollment under Vision Service Plan (VSP).

The monthly cost for VSP enrollment is $5.14 for single coverage and $13.18 for family coverage. Premiums are pre-tax and deducted the first two paychecks of the month.

Schedule of benefits	VSP
Eye exam	$15 copay
Allowance amount	$130 frames
Exam frequency	12 months
Lenses frequency	12 months
Frames frequency	24 months
Contacts frequency	12 months



ENROLLMENT

You can enroll in the vision plan within 30 days of becoming newly eligible for benefits, during any Open Enrollment period, or within 30 days of a qualified life event. Once coverage takes effect, coverage changes can only be made during a life event or Open Enrollment.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSA's) permit employees to set money aside on a pre-tax basis, via payroll deduction, for eligible health or dependent care expenses not covered by insurance or other benefit plans. Each year you enroll, you contribute a pre-determined portion of your salary to your Flexible Spending Account(s) for dependent and/or health care expenses. The most important rule is "use it or lose it", i.e. unused funds are forfeited at the end of the plan year.

GENERAL PURPOSE MEDICAL REIMBURSEMENT ACCOUNT (MRA)

This account allows you to set aside pre-tax money to pay for out-of-pocket expenses incurred during the plan year for yourself or your eligible dependents that are not paid by your insurance or reimbursed by any other benefit plan. Expenses include, but are not limited to, insurance co-pays, deductibles, dental or vision expenses, and pharmacy bills. Treatments for cosmetic reasons and over the counter medications without a doctor's prescription are not reimbursable.

Your entire annual election amount is available to be reimbursed to you upon incurring expenses from the first day your coverage begins, even if you have not contributed anything at that point in the year. Should you end employment after receiving more in reimbursements than payroll contributions, IRS regulations protect you from having to make up the difference. Although you elect an MRA for a calendar year (Jan 1-Dec 31), you have an additional 2 ½ month "grace period" (Jan 1 –March 15 of the following year) to incur expenses and be reimbursed if you still have funds left in your MRA.

IRS regulations do not permit you to participate in a General Purpose MRA and contribute to a Health Savings Account at the same time.

LIMITED PURPOSE MEDICAL REIMBURSEMENT ACCOUNT (MRA)

This account functions exactly the same as the General Purpose MRA except that reimbursable expenses are limited to only dental and vision costs. The key benefit of a Limited Purpose MRA is that you can remain eligible to contribute to a Health Savings Account all year long (provided that you are also enrolled in a High Deductible Health Plan and have no other disqualifying coverage). This provides you with an additional pre-tax reimbursement account for your dental and vision expenses and allows you to preserve more of your HSA funds over time to take with you after your employment ends.

IRS regulations prevent you from having a General Purpose and a Limited Purpose MRA simultaneously, but there is an exception for the overlapping 2 ½ month grace period if you have any MRA funds carried over into the next calendar year.

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

You may set aside pre-tax dollars to pay for qualified childcare or dependent care expenses that are necessary for you and your spouse (domestic partner is not included in this definition) to continue working or going to school full time. A new dependent care contract for automatic reimbursement is required every year.

When can I enroll?

You may enroll within 30 days of your hire date or within 30 days of a "change in status" event. You may also enroll during Open Enrollment each year. A new enrollment is required each year, even if you do not plan to change the amount(s) you wish to set aside.

How much can be set aside?

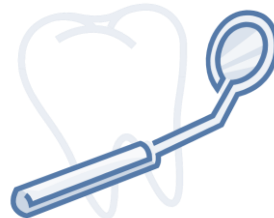
You may set aside up to $2,500 per calendar year to pay for qualified unreimbursed health expenses in either the General Purpose or Limited Purpose MRA; and $5,000 ($2,500 if you are married and file separate tax returns) for DCRA to pay for qualified dependent care expenses.

When can I change my election amount?

The only time you may make a change in your deduction elections during the calendar year is within 30 days of a "change in status" event. IRS guidelines require that any change you request must be on account of, consistent with, and correspond to your "change in status" event. All changes are on a prospective basis only. Otherwise, since an FSA must be renewed every year, adjustments in amounts during Open Enrollment are effective January 1 of the following year.

How do I request reimbursement?

Submit a reimbursement voucher with proof of the expenses that you incurred (e.g., itemized bills/proof of expenses).The administrator offers a direct deposit option so that reimbursement checks may be deposited directly into your bank account.



RETIREE HEALTH SAVINGS PLAN

What is the Retiree Health Savings Plan (RHSP)?

The Retiree Health Savings Plan (RHSP) a post-employment health savings benefit where the County contributes $25 per pay period into your RHSP account to be used for reimbursement of qualified medical expenses. Upon separation from County employment (for any reason) you may use the funds for reimbursement for you, your eligible spouse and/or your eligible dependents.

Who is eligible to participate in the Retiree Health Savings Plan?

If your REO has negotiated for you to participate in the program, enrollment is automatic for regular full-time employees and regular part-time employees who work a minimum of forty (40) hours per biweekly pay period.

Where will my RHSP assets be invested?

The investment funds available to RHS participants are ICMA-RC's Vantagepoint Funds. Upon initial enrollment, your investment allocation is automatically established as the age-based Milestone Funds. However, you may change the investment allocation for future contributions or transfer existing balances at any time by contacting ICMA-RC at:

- VantageLine – toll-free at (800) 669-7400
- Online through Account Access:www.icmarc.org

Who handles medical benefit claims?

Your post-employment medical benefit claims processing and payment will be handled by ICMA-RC's third-party claims administrator, Meritain Health, Inc. There is a $7.50 claims administration charge to your account each quarter after you leave County service. The claims are generally processed within 10 days (and no more than 30 days). If a claim is suspended or denied, you will be notified in writing within 30 days.

What is the procedure for submitting a claim for medical reimbursement?

Once you leave County employment, the County notifies ICMA-RC of your benefit eligibility. You will receive a packet in the mail with a claim form and information on the claims process.

What happens to the account balance if I die?

Upon your death, remaining assets will be transferred to an account for continued tax-free use by your surviving spouse and/or eligible dependents for their own qualifying health expenses.

Whom should I contact with questions?

- For questions regarding your account statement, contact:
  ICMA-RC at (800) 669-7400

- For eligibility and plan details, contact:
  County of Sacramento Employee Benefits Office at (916) 874-2020

- For all claim related issues once you separate from County employment, contact:
  Meritain Health, Inc. at (888) 587-9441

LIFE INSURANCE

The County provides a Basic life insurance benefit to all eligible employees. This coverage is effective on the first day of the month following employment upon which you are active at work. You may also purchase additional coverage for yourself through payroll deduction.

BASIC LIFE INSURANCE

The County provides a Basic life insurance benefit at no premium cost to you. The Basic benefit is $15,000, $18,000 or $50,000, depending upon your classification and/or REO. All County employees have Accidental Death & Dismemberment (AD&D) benefits equal to the amount of County paid Basic life insurance.

OPTIONAL LIFE INSURANCE PLANS

In addition to County paid basic coverage, you can purchase additional coverage for yourself in multiples equal to your annual salary.

Option 1A - 1 times your annualized salary, up to $50,000, includes your basic coverage
Option 1 - 1 times your annualized salary, up to $600,000, plus your basic coverage
Option 2 - 2 times your annualized salary, up to $600,000, plus your basic coverage
Option 3 - 3 times your annualized salary, up to $600,000, plus your basic coverage
Option 4 - 4 times your annualized salary, up to $600,000, plus your basic coverage
Option 5 - 5 times your annualized salary, up to $600,000, plus your basic coverage

HOW DO I INCREASE MY COVERAGE?

Life insurance changes can be made at any time. Newly eligible employees can enroll in any level of optional coverage without medical underwriting if the enrollment is within 30 days of eligibility.

Current employees looking to increase optional coverage can make the request by the following:

- If you have experienced a life event within 30 days (such as getting married or having a baby), simply elect the new option on your enrollment.
- If no life event has occurred, then you must *apply* for the increase. You need to complete Prudential's short form health questionnaire AND the County's life insurance change form; return both forms to the Employee Benefits Office. Prudential may require additional information, and the increase is not guaranteed.

HOW MUCH DOES THE OPTIONAL COVERAGE COST?

The cost of optional coverage is based on your annualized salary and your age. Premiums for optional life coverage will be deducted from your paycheck post-tax. Use the chart below to calculate the premium.

Age	< 30	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70+
Cost Per thousand	$.034	$.045	$.069	$.080	$.133	$.203	$.345	$.541	$1.046	$1.690

Formula: Multiply your salary by the option you are requesting, round up to the nearest thousand. Find the cost for your age band; multiply that number by the requested coverage amount.

LIFE INSURANCE (cont'd)

<u>Example</u>
Employee in BG05, annualized salary is $43,257. Employee requests Option 2; two times salary is $86,514, rounded up is $87,000. Employee is age 43; cost per thousand is $.080.

($0.080 times 87 equals $6.96 with rounding). Monthly premium is $6.96/month; premium is $3.48 per payday and will be taken the first two paydays in each month post-tax. The employee's total life insurance coverage would be $102,000 ($87,000 Optional + $15,000 Basic).

HOW DO I DECREASE MY COVERAGE?

Decreasing or waiving optional coverage can be done anytime by logging into BenefitBridge at www.benefitbridge.com/saccounty. The change is effective the first day of the month following the request.

DEPENDENT COVERAGE

Dependent coverage for your spouse/domestic partner and dependent children up to age 26 is available in amounts of $2,000 or $5,000, depending on your BG unit. For infants less than six months of age, the benefit is $200; there is no coverage for newborns from birth to 14 days. There is no option to purchase additional coverage for dependents.

Employees in BG units 005 and 008 (UPE) have $5,000 in dependent coverage available and <u>must enroll</u> dependents for coverage. Employees in all other units automatically have dependent coverage of $2,000, no enrollment is required.

Where enrollment is required, dependents must be enrolled within 30 days of initial employment and/or a "change in status" event. Dependents may also be enrolled during Open Enrollment. Dependents may be deleted from life insurance coverage at any time.

Although there is no direct cost to cover a dependent, the Internal Revenue Code requires that federal taxes be paid on the value (imputed income) of the total benefit if the benefit exceeds $2,000, or when the coverage applies to a domestic partner or the dependents of domestic partners that are not your IRS dependents. In these situations you must enroll your dependents in the life insurance plan in order to calculate the taxes and receive the benefit.

For example:

An employee elects to cover a spouse and a child. The spouse is 43 years old and the child is 10 years old. The spouse has $5,000 in coverage and the child has $5,000 in coverage.

The "value" (imputed income) of the benefit based upon the IRS regulations is:

AGE	< 25	25—29	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70+
Value	$.13	$.15	$.20	$.23	$.25	$.38	$.58	$1.08	$1.65	$3.18	$5.15

The value of the spouse's benefit each pay period is $.25. The value of the child's benefit each pay period is $.13. Federal taxes must be withheld on the $.38 each pay period ($.25 for the spouse's benefit and $.13 for the child's benefit).

LIFE INSURANCE (cont'd)

PREMIUM CHANGES

Age Rated-Your premium will change when you age into a new age bracket.

Salary changes- when your salary changes, your premiums will change accordingly.

BENEFICIARY CHANGES

Upon hire, you should designate a beneficiary. As life events occur you are encouraged to update your beneficiary designation. You may change your beneficiary at any time. Employees seeking to know who their current beneficiary on record is will be instructed to complete a new beneficiary designation form. For your protection, beneficiary information will not be released over the phone or by email, but will be provided by coming to the Employee Benefits Office in person with ID.

ACCELERATED DEATH BENEFIT

The life insurance program includes an accelerated death benefit, that allows terminally ill participants with a life expectancy of less than 12 months to withdraw up to 90% of their total benefit amount. Contact the Employee Benefits Office for more information.

WAIVER OF PREMIUM

If you become disabled while under age 60 and covered under this plan, you may apply for a waiver of premium. That is, your benefit may continue while you are disabled even if only temporarily without having to continue to pay the premium.

CONVERSION / PORTABILITY

When your employment ends, your life insurance coverage will terminate at the end of the month in which you terminate employment. You may be eligible to convert to an individual life insurance policy. You will need to contact the Employee Benefits Office within 31 days of your coverage termination to request a conversion or portability application.

CRITICAL ILLNESS

The County provides an optional Critical Illness policy on a voluntary post tax deduction basis. This policy is designed to pay out a tax free lump sum benefit payment upon the occurrence of certain events that may be used in any way you need it, including medical-related expenses, mortgage or rent payments, credit card bills, daily expenses, car payments, insurance premiums, housekeeping, childcare, or to establish a trust, or inheritance.

WHAT DOES THE POLICY COVER?

Full benefits are paid out upon diagnosis of the following categories of critical illnesses:

Heart Attack, Full Benefit Cancer, Major Organ Transplant, Renal (kidney) Failure, Stroke

Partial benefits are paid out upon diagnosis of the following categories:

Cancer in Situ (partial benefit), Alzheimer's Disease, Coronary Artery Bypass Surgery, Coma, Deafness, Heart Valve Replacement, Parkinson's Disease , Terminal Illness

Reoccurrence benefits may also be possible if more than 180 days has passed between a previous diagnosis and payment and a diagnosis of reoccurrence. For more detailed information of what is covered, please review the Critical Illness policy which is available through the Employee Benefits Office web page at: http://www.personnel.saccounty.net/Benefits.

WHAT ARE THE COVERAGE AMOUNTS?

Unlike the Optional Life insurance program, the Critical Illness coverage is purchased in set increment levels and the levels vary depending on whether the coverage is for the employee, spouse/domestic partner or dependent child. Spouse/DP and dependent child coverage is only available if the employee is enrolled and cannot exceed a percentage of the employee's coverage limit. Employees who are married cannot cover each other as dependents, and there is no double coverage for children either.

	Employee	Spouse/DP	Dependent Child
Minimum Coverage	$10,000	$5,000	$2,500
Maximum Coverage	$100,000	Lessor of $50,000 or 50% of employee amount	Lessor of $15,000 or 50% of employee amount
Step Increment Amount	$10,000	$5,000	$2,500
Lifetime Maximum	200% of coverage amount	200% of coverage amount	200% of coverage amount
Guaranteed Issue Level	$30,000	$15,000	All amounts guaranteed

Guaranteed issue is the maximum amount you can receive without providing proof of good health through underwriting or medical questionnaires. Proof of good health, also known as Evidence of Insurability (EOI) is required if you elect to purchase more coverage than the guaranteed coverage amount for either you or your spouse/DP, or if you enroll as a late entrant after the initial eligibility period.

You may elect coverage during open enrollment, as a new hire, or as a result of a mid year qualifying event, by using BenefitBridge, which is available through the Employee Benefits Office web page at: http://www.personnel.saccounty.net/Benefits.

CRITICAL ILLNESS (con't)

HOW MUCH DOES THE COVERAGE COST?

The coverage cost is age rated just like Optional Life insurance, but is linked to the age of the covered individual. Premiums for the coverage will be deducted from your paycheck post-tax. Use the charts below to calculate the premium.

Employee Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
Cost Per $1,000	$.174	$.242	$.366	$.582	$.948	$1.522	$2.290	$3.364	$4.916	$6.808	$9.556	$13.350

Sp/DP Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
Cost Per $1,000	$.160	$.240	$.360	$.580	$.960	$1.540	$2.340	$3.440	$5.020	N/A

Dependent children are a flat rate of $.240 per $1000 of coverage.

Formula: To find the cost for your age band; multiply that number (age)by the number of $1000 increments. For example: Employee is age 43 and wants $30,000 in coverage; cost per thousand is $.948. Cost is calculated as follows: 30 x $.948 = $28.44 per month.

HOW DO I INCREASE MY COVERAGE LATER?

Current employees looking to increase coverage can make the request by the following:

- If you have experienced a life event within 30 days (such as getting married or having a baby), you may elect up to the guaranteed issue amount. Amounts over the guaranteed issue will require EOI approval.
- If no life event has occurred, and you request coverage as a late entrant you must *apply* for the increase by obtaining the appropriate forms from the Employee Benefits Office and returning them for submission. You will be notified if your request was approved.

Changes can be made by logging into BenefitBridge at www.benefitbridge.com/saccounty.

ARE THERE ANY PRE-EXISTING EXCLUSIONS?

Once enrolled in the Critical Illness plan, pre-existing exclusions will not apply. You cannot be turned down for coverage if you elect up to the guaranteed issue amount during your initial 30 day eligibility period. Anyone electing coverage as a late entrant will be required to satisfy the medical underwriting (EOI) requirement prior to enrollment.

HOW DO I FILE A CLAIM?

To receive benefits, you only need to provide written documentation of the diagnosis of the covered critical condition. To file, visit www.myprubenefits.com or call 877-920-4778.

WHERE CAN I FIND MORE INFORMATION?

For more details of the program, please review the Critical Illness policy which is available through the Employee Benefits Office web page at: http://www.personnel.saccounty.net/Benefits.

EMPLOYEE ASSISTANCE PROGRAM

The County provides an Employee Assistance Program (EAP), which is administered by Managed Health Network (MHN). The EAP provides confidential, professional short-term counseling services for you and your eligible family members and is available 24 hours a day, 7 days a week. This service is intended to help you better manage a wide range of emotional health, working, and living challenges. All services are confidential and private. Services are provided at no cost to you; there are no co-payments, coinsurance, or deductible payments.

Who is eligible?

All eligible full-time or part-time employees can receive assistance and counseling through MHN. Your eligible dependents may also receive EAP benefits.

What services does the EAP provide?

Counseling sessions are available for a broad range of life management issues:

- Family Matters: Marital/family concerns, alcohol/drug dependency, stress, emotional issue
- Legal Matters: Advice for family law, consumer issues, landlord/tenant disputes, personal injury, contracts, and criminal matters
- Financial: Budgeting, credit issues, and financial planning
- Wellness Coaching programs including smoking cessation and weight management
- Child & Elder Care Assistance: Assessing needs, choosing resources, and exploring payment options
- Federal Tax Consultation/Representation: Unpaid taxes, IRS audits, and past due tax returns
- Organizing Life's Affairs: Organizing records and vital documents
- Pre-Retirement Planning: Help for retirement planning

How do I access the Employee Assistance Program?

Access to the EAP is available 24 hours a day, 7 days a week.

- ✓ By phone: Call (800) 227-1060; TDD callers dial (800) 327-0801
- ✓ Online: www.members.mhn.com, access code: sacramento

How are services provided?

Services can be provided by Face-to-Face Counseling or Telephonic Counseling and/or Web-Video Consultations.

DEFERRED COMPENSATION

The County of Sacramento Deferred Compensation 457(b) and 401(a) Plans provide retirement income for employees or their beneficiaries. The County of Sacramento Deferred Compensation Plan (the Plan) is an Internal Revenue Code Section 457(b) non-qualified government deferred compensation plan. In this plan, participants are deferring taxes on currently earned wages to a time in the future when the account distribution will be taxed as normal income. The 401(a) Plan is an Internal Revenue Code Section 401(a) Plan and is designed to accumulate additional income for retirement for County employees in Recognized Employee Organizations (REO) 020, 021, 032, 033, Unrepresented Management (050) and Elected Officials.

The plans are both long-term, non-liquid retirement plans; therefore, distributions can only occur under limited circumstances including but not limited to; departure from County service through retirement or other separation, qualification for a hardship withdrawal, loan, or death.

ELIGIBILITY

457(b) Plan

The 457 Plan is a voluntary plan for all active County full time and part time employees who are active members of the Sacramento County Employees Retirement System (SCERS). To become a participant eligible employees should contact Fidelity directly.

401(a) Plan

County employees in Recognized Employee Organizations (REO) 020, 021, 032, 033, Unrepresented Management (050) and Elected Officials are eligible to participate. To be a participant in the 401(a) Plan the eligible employee must contribute 1% or more of gross pay into the 457(b) Plan. Enrollment in this plan is automatic. If the contribution into the 457(b) Plan drops below 1% of gross pay the 401(a) Plan match will stop for the remainder of the calendar year.

CONTRIBUTIONS

457(b) Plan

You designate an amount of your biweekly pay that you want deducted on a pretax basis from your pay check to contribute to the Plan. The minimum contribution is $25 per pay period and the maximum is determined by the IRS on an annual basis:

- The 2015 maximum for participants under age 50 is $17,500 + COLA determined by the IRS.
- The 2015 maximum for participants age 50+ is $23,000 + COLA determined by the IRS.

Some employees are eligible to put more funds into the plan under an option known as the "3-Year Limited Catch-Up". This option may be available for employees that have not contributed the maximum into the program throughout their working career. The maximum for "Catch-Up" is up to twice the under age 50 limit. To take advantage of this option, please contact the Deferred Compensation Office.

Contribution amounts may be changed at any time by contacting Fidelity. Contribution changes made by the 18th of the month, will take effect on the first pay period of the following month.

Note: The contribution on your very last check will be zero ($0) if you do not complete a Final Compensation Amendment at least one month prior to your separation date.

DEFERRED COMPENSATION (cont'd)

401(a) Plan

The match of 1% of gross pay paid by the County is automatic if the eligible employee contributes 1% or more of gross pay into the 457(b) Plan. The match will stop for the remainder of the calendar year if the contributions fall below 1%. It's important to remember when calculating the 457(b) contribution that the 1% of gross pay includes vacation cash out, Holiday in Lieu, and Compensatory Time Off. On the final check vacation and sick leave payouts will be used in calculating the 1%.

ROLLOVER

Active Participants may transfer balances from other "eligible retirement plan(s)" into the County 457 Plan. Eligible retirement plans are defined in Section 302(c) (8) (B) of the Internal Revenue Code and include IRA, 403(b), 401(k), and 457(b) plans. Please contact Fidelity for more information.

INVESTMENT OPTIONS

There are predefined investment options offered in the 457(b) Plan plus access to the Fidelity BrokerageLink which allows you the opportunity to select from thousands of additional mutual funds and other investment options. Please contact Fidelity for more information. The 401(a) Plan has the same investment options as the 457(b) plan.

PURCHASING SERVICE CREDIT

Active Participants may use the 457 Plan funds to purchase service credits or Additional Retirement Credits (ARC) on a pre-tax basis. You should contact the Sacramento County about purchasing the service.

LOANS

Loans are available in the 457(b) Plan. Fees may apply. Please contact Fidelity for more information about the loan option.

HARDSHIP WITHDRAWALS

Hardship Withdrawals are available in the 457(b) Plan. The IRS has very specific rules about what qualifies as a Hardship Withdrawal. Once an application is made for a Hardship Withdrawal, you cannot contribute to the 457(b) Plan for six months. If you find the need for a Hardship Withdrawal, you should contact the Deferred Compensation office for details.

INVESTMENT ALLOCATION

Contributions to the 457(b) Plan (and 401(a) if eligible) will be deposited into the Fidelity Freedom Fund for your age unless you specify your deposits into accounts. You may change the investment allocation at any time and the changes are effective immediately. You may also move assets between funds at any time and the changes will take place at the next market closure. These transactions may be accomplished by contacting Fidelity.

DISTRIBUTIONS

Since both the 457(b) and the 401(a) Plans are long-term non-liquid retirement plans, distributions can only occur under limited circumstances. Distributions will be taxed as normal income. While distributions may be made after separation from service, the 401(a) Plan will incur a 10% penalty if distribution takes place prior to age 59 ½.

LEAVE OF ABSENCE

There are times during your employment where you may need to take a leave of absence from work. There are many types of leaves and some leaves may cover all of your benefits, while other leaves types require you to pay all or a portion of the cost to maintain coverage. Leave of absence situations vary vastly and are based on individual circumstances, so contact the Benefits Office staff if you have coverage on how your leave impacts your benefits.

COMMENCEMENT OF LEAVE

Regardless of when your leave begins, your benefits will terminate the last day of the month you are in paid status. You will receive a notice from our office regarding your responsibilities and options to continue coverage. As a general rule, if you have a payroll deduction for benefit coverage while working, you must continue to make those payments to keep coverage in effect while on leave of absence. Your notice will contain specific details on how to continue coverage.

LIFE EVENTS WHILE ON LEAVE

During your leave of absence, you may experience a life event such as getting married or having a baby. You must contact the Benefits Office within 30 days of experiencing a life event. Your newborn or new spouse is not automatically added to coverage! If you miss the 30 day time frame you may not be able to make changes to your coverage until Open Enrollment. Since the length of your leave and your leave type play a significant role in how your coverage is impacted, you should contact the Benefits Office staff immediately with any questions.

RETURNING TO WORK

Depending on the length and type of your leave, you may need to take action to enroll in benefits, or coverage reinstatement may be automatic. Where enrollment is required, coverage is effective the first day of the month following your return from leave AND your completed enrollment; therefore it is important to contact the Benefits Office staff before you return to work.

CONTINUATION COVERAGE (COBRA)

What is Continuation Coverage?

Federal legislation requires most employer sponsored group health plans to offer employees and their dependents an extension of health coverage at group rates. This applies to situations in which the coverage would otherwise end due to certain qualifying events. This program is often referred to as "COBRA." (Consolidated Omnibus Budget Reconciliation Act 1985).

Who is eligible for Continuation Coverage?

Any employee or family member, who loses County-sponsored group coverage due to a Qualifying Event, is eligible to elect continuation coverage. A Qualifying Event is the loss of group coverage due to the reduction in hours, termination of employment (except for gross misconduct), death, spouse's enrollment in Medicare Part A and/or B, divorce, or legal separation, or loss of dependent status.

Generally, each person losing their health, dental, and/or EAP coverage has an independent right to this coverage as a Qualified Beneficiary (QB).

Domestic partners of employees and the children of domestic partners are not eligible to independently elect to continue coverage after a loss of eligibility. Domestic partners, however, may continue coverage as a dependent of a former employee who elects continuation coverage.

What County benefit plans can be continued?

Subject to certain limitations you may elect to continue your medical, dental, Medical Reimbursement Account (MRA), vision, and Employee Assistance Program (EAP) benefits at your own expense.

What should I do when there is a qualifying event?

Your department will notify the Employee Benefits Office of your termination or reduction in hours. However, it is the responsibility of each employee and/or covered family member to notify the Employee Benefits Office within 60 days of a divorce, legal separation, Social Security disability or a child ceasing to be a dependent in order to be eligible to continue coverage. You will receive a notice that explains the benefits you may continue, the election time frames, the cost, and the length of time that you may continue your coverage. Failure to provide proper notification will result in the loss of continuation rights.

How long can benefits continue under Continuation Coverage?

Coverage may generally be continued for up to 36 months (except for MRA) under a combination of Federal and State (CalCOBRA) benefits continuation laws. For information on CalCOBRA, you should contact the insurance carrier directly.

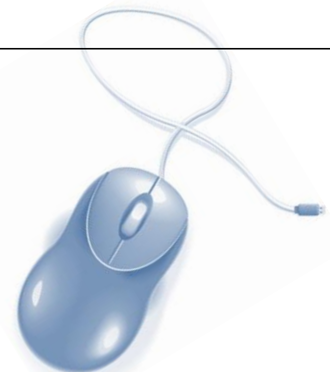
What if I have questions about Continuation Coverage?

Direct your questions about your Continuation Coverage rights to:

Employee Benefits Office Attn: Cobra Coordinator
700 H Street, Room 4650
Sacramento, CA 95814
(916) 874-2020
MyBenefits@saccounty.net

CONTACTS

BENEFITS CONTACTS	PHONE	WEBSITE
Employee Benefits Office	916-874-2020	http://www.personnel.saccounty.net/Benefits
BenefitBridge	800-814-1862	www.benefitbridge.com/saccounty
MEDICAL CARRIERS		
Kaiser Permanente	800-464-4000	www.kp.org
Sutter Health Plus	855-315-5800	www.sutterhealthplus.com
Western Health Advantage	888-563-2250	www.mywha.org/personalaccess
HSA VENDORS		
Wells Fargo	866-884-7374	http://wellsfargo.com/hsa
Health Equity	877-300-4987	www.myhealthequity.com
US Bank	877-470-1771	http://www.mycdh.usbank.com
OTHER VENDORS		
Delta Dental	800-765-6003	www.deltadentalins.com/cos
Fidelity Investments	800-343-0860	http://plan.fidelity.com/saccounty
Flex-Plan Services	800-669-3539	www.flex-plan.com
ICMA-RC	800-669-7400	www.icmarc.org
Managed Health Network	800-227-1060	www.members.mhn.com
Meritain Health	888-587-9441	www.meritain.com
Prudential (Life Insurance)	800-524-0542	www.prudential.com
Prudential (Critical Illness)	877-920-4778	www.myprubenefits.com
SCERS	916-874-9119	www.retirement.saccounty.net
VSP	800-877-7195	www.vsp.com



REO INDEX

REO	REO Title	Cutoff Date
001	General Supervisory Unit, Teamsters, Local 150	2/1/1998
002, 004	Sacramento County Alliance of Law Enforcement (SCALE)	11/21/1999
003	Sacramento County Deputy Sheriff's Association (DSA)	10/24/1999
005	Office-Technical, United Public Employees (UPE)	12/27/1997
006	Operations & Maintenance, Local 39	10/11/1998
007	Health Services (AFSCME)	8/30/1998
008	Welfare Non-Sup, United Public Employees (UPE)	8/15/1999
010	Accountants, Non-Supervisory (SCPAA)	8/2/1998
013, 014	Environmental Specialists (EMSSC)	12/6/1998
016	Nurses, Non-Supervisory (CNA)	7/18/1999
017	Water Quality/Stationary Engineers, Local 39	11/22/1998
018	Building Trades	11/7/1999
019	Probation, Non-Supervisory (SCPA)	7/19/1998
020, 021	Attorneys (SCAA)	6/20/1999
022, 023	Engineers & Architects (APECS)	4/12/1998
024	Probation Supervisory	2/1/1998
025	Welfare Supervisory (SEIU)	11/21/1999
026	Engineering Technicians & Technical Inspectors (ETTI)	6/20/1999
027	Physicians & Dentists	1/18/1998
028	Data Processing	2/1/1998
029	Law Enforcement Management (LEMA)	2/1/1998
030	Firefighters	10/11/1998
031	Peace Officers (SCALE)	11/21/1999
032	Management (SCMA)	2/1/1998
033	Attorney-Civil (SCMA)	2/1/1998
034	Administrative Professionals Association (SCAPA)	2/1/1998
050	Unrepresented Management	2/1/1998
060	Administrative	2/1/1998
070	Confidential	2/1/1998
080	Unrepresented	2/1/1998

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