SACRAMENTO COUNTY

Effective January 1, 2013

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The County of Sacramento believes this health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Department of Personnel Services, Employee Benefits Office at 916-874-2020 or DPSBenefits@saccounty.net. You may also contact the U.S. Department of Health and Human Services at 1-877-696-6775 or *www.healthcare.gov*

OVERVIEW

As an employee of the County of Sacramento, you have a wide variety of benefits available. These benefits include: medical, dental, vision, and life insurance; flexible spending account options for dependent care and unreimbursed medical, dental, and/or vision costs; a retiree health savings plan; health savings accounts; a Section 457 deferred compensation program; Section 401(a) deferred compensation program; and an employee assistance program.

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, and/or the level of coverage you select. The portion of the cost that you pay for medical insurance for yourself and any eligible dependent that meets the definition of dependent as defined by the Internal Revenue Service will be paid on a pre-tax basis.

These benefit programs bring considerable value to you as a Sacramento County employee. We encourage you to thoroughly review this Employee Benefit Summary and contact the Department of Personnel Services Employee Benefits Office with any questions you might have.

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

This Summary provides an overview of:

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

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.

DEPARTMENT OF PERSONNEL SERVICES

EMPLOYEE BENEFITS OFFICE WEBSITE
http://hra.co.sacramento.ca.us/employ/ben/content.htm

You will be able to find this Summary of Benefits, forms, and links to carriers on this website.

Changes to your benefits during the year or at open enrollment should be made online using the BenefitBridge system available through the Employee Benefits Office website.

ELIGIBILITY

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, as approved by the County Board of Supervisors.

For the purposes of County benefit plans, 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

Coverage is available for your eligible dependents under the following County benefit programs:

Dental Insurance	Available at no premium cost to the employee.
Life Insurance	Available at no premium cost to the employee (may incur imputed income taxes*)
Medical/Vision Insurance	Available with premiums based on the medical plan selected.
Employee Assistance Program	Available at no premium cost to the employee.

*Any dependent life insurance benefit exceeding $2,000 is subject to imputed income taxes.

Eligible dependents include :

- The employee's lawful spouse or domestic partner (**NOTE: Ex-spouses must be removed within 30 days of the divorce**); and
- natural, step, adopted, a child that you have legal guardianship of, and/or foster dependent minor children of the employee or spouse/domestic partner (up to age 26);

Dependents of minor dependents or of adult dependents of the employee or spouse/domestic partner are not covered unless there is legal guardian or foster child status with the employee, spouse or domestic partner.

If you enroll a domestic partner, same sex spouse, or children of a domestic partner who are not your IRS-defined dependents for tax free benefit purposes you will be required to pay applicable federal taxes on the value of the benefit (imputed income).

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 or same sex marriage is established outside of California.

DEPENDENT COVERAGE

ADDING DEPENDENTS

To add eligible dependents you must enroll the dependents in benefits **within 30 days*** of the date of birth, adoption, adoptive placement, placement for foster care or guardianship, loss of other group coverage, marriage, or registration of a domestic partnership. Supporting documentation is required to verify the identity of the dependent, the relationship to the employee, and the date and nature of the event.

Supporting documentation must be submitted to the Department of Personnel Services Employee Benefits Office within 7 days of the enrollment and if the enrollment is approved, coverage changes will be effective the 1st of the month following the enrollment. Failure to add newly eligible dependents within the 30 day time frame* or present required verification documents **within 7 days** will result in your inability to add your dependents until the next Open Enrollment period or appropriate qualified status change event.

***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.

Examples of acceptable documents include:

- Legal spouse/domestic partner - a copy of your marriage certificate/Declaration of Domestic Partnership.

- Children - a copy of the birth certificate, hospital birth verification letter, the armband, or crib card for a newborn up to 30 days old is accepted. Adoption or legal guardianship papers will satisfy the requirement for newly adopted/placed children.

- Loss or gain of other coverage - verification of the date of the event and of who lost/gained other group coverage such as HIPPA Certificate, COBRA notice, or other employer documentation indicating the effective date of the loss/gain of eligibility for other group coverage.

A Social Security Number is required. If you do not have the social security number for a child, you may enroll the child and provide the social security number within 30 days.

When you are first hired, and during Open Enrollment, if you do not have these documents within your enrollment period, the enrollment and coverage will be "pended" for a limited time to allow for the submission of the verification documents. **Outside of Open Enrollment, enrollment is normally effective 1st of the month following your election.**

DELETING DEPENDENTS

The employee is responsible for deleting a dependent when there is a change that effects the employee's dependent eligibility, for example, marriage or divorce, gaining other coverage, etc. A dependent ceases to be an eligible covered dependent at the end of the month they no longer meet the definition of a dependent, regardless of when notice is given to the Employee Benefits Office, or whether a family court requires continued benefits for an ex-spouse.

AVOIDING MISTAKES

DEPENDENT LOSES ELIGIBILITY

In situations where it is determined that the dependent lost eligibility more than 30 days in the past, the Employee Benefits Office will terminate coverage under administrative guidelines on a retroactive basis. Retroactive premiums will be refunded where possible in accordance with the terms of the contract with the carrier.

In addition, **you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility**. The carrier will be notified of the date of ineligibility and the dependent and/or the employee may be liable for any claims paid during the period of ineligibility. The employee and/or dependent may also be subject to any sanctions or actions taken by the carrier.

Except for a change in status "qualifying event", you may only delete dependents from your medical and dental coverage during Open Enrollment with an effective date of January 1st of the following year. For purposes of this section, a change in status "qualifying event" includes the loss of eligibility due to a dependent reaching maximum age, divorce, termination of a domestic partnership, or gaining other group coverage.

You may NOT cover a divorced spouse. You must remove the ex-spouse within 30 days of the divorce. If the court orders you to provide insurance for the spouse, you may do that through COBRA or a private policy. You may not continue their coverage through the active plan.

When your child turns 26 years old, the child will automatically be dropped from County coverage at the end of the month that they turn 26. You will not receive notice of coverage termination until after it occurs when the child receives a COBRA notice. The child may elect continued coverage through COBRA or a private policy.

ADDING A NEWBORN OR NEW DEPENDENT

You have 30 days to enroll a newborn child. If you don't have a social security number within 30 days, you may enroll the child without it and provide it to the Benefits Office when you receive the child's social security number.

When adding a dependent to County-sponsored coverage, you must provide documentation such as a birth certificate or marriage certificate, even if the dependent has been covered through the County in the past. If you do not have this documentation, you may add the dependent on BenefitBridge within 30 days of the event and contact the Benefits Office regarding the documentation. The Benefits Office may be able to "pend" the enrollment until you provide the documentation. The important thing is to enroll the dependent within 30 days of the event.

COVERAGE FOR DEPENDENTS LIVING OUT-OF-AREA

Medical

All of the County's health insurance carriers provide a plan of benefits for dependents that live outside of the carrier's local HMO service areas and/or in states other than California. However, in some cases, only emergency services may be available. We refer to this as "Out-of-Area" coverage. Eligibility and access through each of the health plans is different. It is very important that you choose a plan that will provide Out-of-Area coverage to meet your particular situation. Your best source of information is the toll-free customer service number for the specific plan(s).

Dental

Dependents living out of the area may seek services from any licensed dentist. It may be necessary to pay for the dental services and submit an itemized bill along with a claim form to our dental plan. (See page 18 for more information about the Dental Benefits.)

COVERAGE EFFECTIVE DATES

COVERAGE EFFECTIVE DATE

Medical, dental, and vision insurance for eligible employees and their eligible dependents are effective on the first day of the month following online benefit elections and the timely submission of the required documentation— **not from the date of the event** (except as allowed under HIPAA). Although you have 30 days from an event to make an election, your coverage cannot be retroactive under Section 125 IRS regulations. Employee Assistance Program (EAP) benefits are effective the first of the month after date of hire. On initial enrollment, basic and optional life insurance is effective the first day of the month following employment upon which you are active at work.

In order to enroll in the benefit plans of your choice, online 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://hra.co.sacramento.ca.us/employ/ben/content.htm

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. If you do not enroll at the time of your initial eligibility, 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 mid year qualifying events, the coverage is effective the first day of the month following eligibility, online enrollment and timely submission of required documentation. Refer to the particular benefit section for any special rules and coverage effective dates for dependents.

OPEN ENROLLMENT INFORMATION

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. (See Dependent Eligibility on page 4 for additional information). During Open Enrollment you may make changes online, either at home or at work, by using BenefitBridge available through the Employee Benefits Office main web page at: http://hra.co.sacramento.ca.us/employ/ben/content.htm.

Any required supporting documentation 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 effective on January 1st of the following year.

All mid-year enrollment changes must be made online within 30* days of the qualifying event or you will not be able to make additions or changes until Open Enrollment. Changes are effective first of the month following elections.

***(see NOTE page 5)**

LEAVE OF ABSENCES

LEAVE OF ABSENCE

There are occasions where you may not be able to work a normal schedule and have to take a leave of absence. There are many different types of leaves, both paid and unpaid, such as Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Uniformed Services Employment and Reemployment Rights Act (USERRA), Workers Compensation, Paid Family Leave, and others.

DETERMINATION OF LEAVE TYPE

The determination of the type of leave is made by your Human Resource team or representative and is based on your individual circumstances. Once a determination of the type of your leave has been made, it may have a significant impact on your benefits. After your department informs the Employee Benefits Office of your leave of absence, we will notify you regarding your options and obligations for your benefit coverage(s) while on leave. Notification from the Employee Benefits Office is provided by mail to the last address on record, but you may contact the Employee Benefits Office at any time. We recommend that you contact the Benefits Office either before or immediately at the start of your leave and just before returning to work for benefit related questions.

TERMINATION / REINSTATEMENT OF BENEFITS

The start date of your leave as well as the timing of your return play an important role in your benefit coverage. If your leave commences in the middle of the month, then you will be removed from the active employee plans at the end of that month. If you return from leave before your benefits are terminated and are considered to be in Active status on the first day of the following month, your benefits will not be terminated and your coverage is uninterrupted.

If your benefit coverage (or that of your dependents) has been terminated while on a leave, you must complete new enrollment forms to reflect any changes in coverage when you return to work. Coverage is effective the first of the month following your return from leave or the first of the month following receipt of the forms by the Employee Benefits Office, whichever is later. It is therefore extremely important that you contact the Employee Benefits Office before you return to work.

EMPLOYEE CONTRIBUTIONS

As a general rule, if you are making a contribution via payroll deduction for your benefit coverage or the cost of your dependent's coverage, you are responsible for continuing to make your contribution to keep that coverage in effect while on leave. If your paycheck will not cover your contribution or you are not receiving a paycheck, you will be notified by the Employee Benefits Office about coverage continuation options while on leave. If you do not continue contributions while on leave, benefit coverage will be terminated.

Please contact the Employee Benefit Office if you have any questions about how your leave will affect your benefits.

MEDICARE WHILE WORKING

If you are eligible to participate in the County medical plans as an active employee (page 4) 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

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 coverage when first eligible, and you do not remain covered under a group medical plan sponsored by an employer or union, you may incur a Part B 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 employee 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 on average, 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. Medicare Part D is generally sold by insurance companies and drug stores.

If you are within 3 months of retirement, please contact the Employee Benefits Office for information on Retiree medical benefits. Retiree medical benefits have different rules associated with Medicare. Please be aware that The Department of Personnel Services Employee Benefits Office does not enroll you in any Medicare benefit.

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.

MEDICAL PLANS

An overview of the benefit plan options offered by the County of Sacramento is included in this Summary. The County offers five (5) medical plan options. You may choose from three (3) traditional Health Maintenance Organization (HMO) plans, or two (2) High Deductible Health Plans (HDHP), one of which is an HMO plan, and the other is a Preferred Provider Organization (PPO) plan. **Employees and all family members must be eligible for and enrolled in the same plan option.**

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 listed on page 32 of this Summary, 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.

HEALTH MAINTENANCE ORGANIZATION (HMO)

One of the medical plan options available to employees is a Health Maintenance Organization or HMO. Under an HMO plan, a Primary Care Physician (PCP) generally directs all medical care and specialty referrals for members. You and each of your enrolled family members select a PCP and/or Primary Medical Group (PMG). Each family member may choose his or her own PCP or PMG. 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.

PREFERRED PROVIDER ORGANIZATION (PPO)

The County also offers employees a medical plan called a Preferred Provider Organization (PPO). A PPO plan allows you the freedom to choose your doctor without using a Primary Care Physician (PCP) and you may self-refer to specialists.

PPO plans have a calendar-year deductible, which is the amount that must be paid before benefits will be paid. After the deductible is satisfied, you must pay the coinsurance or co-payments, plus the cost of any non-covered services to the provider.

The PPO plan has a list of contracted providers called preferred providers. These providers are considered "in network." You also have the choice of using a doctor who is not under contract, or a non-preferred provider. These providers are considered "out of network." Employees may go to any licensed physician or hospital, in or out of network, but members will receive a higher benefit when utilizing a preferred provider.

Out of network benefits are based on "usual, customary, and reasonable" (UCR) benefit schedules. Deductibles and co-pays apply to out of network benefits. You will be financially responsible for your share of non-preferred provider allowable charges. In addition, if the non-preferred provider charges more than the allowable fee or provides non-covered services, you must pay the balance of any charges that are over the allowable amount. These charges can increase your cost of care.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

A High Deductible Health Plan (HDHP) is defined by Internal Revenue Code 223(c)(2). To qualify as an HDHP both medical (except for certain types of preventative care) and prescription expenses must apply to the deductible. Deductible and out of pocket limits are set annually by the IRS. The County offers two HDHP options: Kaiser High Deductible HMO and Blue Shield High Deductible PPO. These plans are lower in monthly premium than traditional plans but have a larger initial out of pocket expense so consider them carefully. If you choose an HDHP plan, you may want to consider establishing a Medical Reimbursement Account (MRA, page 19) or a Health Savings Account (HSA, page 21) for the reimbursement of your expenses.

HMO MEDICAL PLANS

	Blue Shield HMO Plan (#H30839)	Health Net HMO Plan (#66047)
General Plan Information		
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductibles	None	None
Annual Out-of-Pocket Limit	$1,000 Indiv / $2,000 Family	$1,500 Indiv / $4,500 Family
Office Visit/Exam	$15 copay	$15 copay
Outpatient Specialist Visit	$15 copay, $30 for self referred Access+ specialist	$15 copay
Outpatient Services (Preventive)		
Adult Periodic Exams with Preventive Tests	100% covered	$15 copay
Well-Child Care	100% covered	$15 copay
Immunizations	100% covered	100% covered (80% covered occupational purposes/foreign travel)
Well Woman Exams	100% covered	$15 copay
Mammograms	100% covered	100% covered
Diagnostic X-Ray and Lab Tests	100% covered	100% covered
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal)	100% covered	$15 copay
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board)	100% covered (Semi-Private Room & Board)
Outpatient Facility Charge	$50 copay	100% covered
Emergency Services		
Emergency Room	$50 copay (waived if admitted)	$35 copay (waived if admitted)
Mental Health Benefits		
Inpatient Care	100% covered	100% covered; limited to 30 days/ calendar year (non-severe) combined with Inpatient Substance Abuse
Outpatient Care	$25 copay; limited to 20 visits/calendar year (non-severe) combined with Outpatient Substance Abuse. $15 copay for severe mental health, no visit limit	$30 copay (non-severe); limited to 20 visits/calendar year combined with Outpatient Substance Abuse; $15 copay (severe), no visit limit
Substance Abuse		
Inpatient Hospitalization	100% covered after $50 copay/day; limited to 30 days/ calendar year combined inpatient & partial hospitalization (residential care not covered)	100% covered; Limited to 30 days/calendar year combined with Inpatient Mental Health
Inpatient Acute Detoxification Services	100% covered	100% covered
Outpatient Services	$25 copay; limited to 20 visits/calendar year combined with Outpatient non-severe mental health	$30 copay; Limited to 20 visits/calendar year combined with Outpatient Non-Severe Mental Health
Prescription Drugs		
Retail	30-Day Supply Limit	30-Day Supply Limit
Generic	$10 copay	$10 copay
Brand (Formulary/Preferred)	$20 copay	$20 copay
Brand (Non-Formulary/Non-preferred)	$35 copay[2]	$35 copay
Mail Order	90-Day Supply Limit	90-Day Supply Limit
Generic	$15 copay	$15 copay
Brand (Formulary/Preferred)	$30 copay	$30 copay
Brand (Non-Formulary/Non-preferred)	$50 copay	$50 copay
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	80% covered of allowable charges (Prosthetic Devices are 100% covered)	100% covered
Home Health Care	$15 copay; limited to 100 visits/calendar year	$15 copay; copay starts 31st calendar day after 1st visit
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days/calendar year	100% covered; Limited to 100 days/calendar year
Chiropractic Services	$10 copay; 30 visits/calendar year	$5 copay; Limited to 40 visits/calendar year; $50 annual allowance for chiro appliances
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	$15 copay	100% covered if significant improvement is expected

** The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.*

NOTES:

[2] Brand Copay for Non-Formulary/Non-preferred drugs does not accrue to annual out-of-pocket maximum. If a generic drug is available and a brand drug is requested, member is responsible for the generic copay plus the difference between cost of generic and brand drug.

HMO MEDICAL PLANS

	Kaiser HMO Traditional Plan (#600644)	Kaiser HMO High Deductible Plan (HDHP) (#600644)
General Plan Information		
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductibles	None	$1,500 Indiv / $3,000 Family[1]
Annual Out-of-Pocket Limit	$1,500 Indiv / $3,000 Family	$1,500 Indiv / $3,000 Family
Deductible Included In Out-of-pocket Limits?	N/A	Yes
Office Visit/Exam	$15 copay	100% covered after calendar year deductible
Outpatient Specialist Visit	$15 copay	100% covered after calendar year deductible
Outpatient Services (Preventive)		
Adult Periodic Exams with Preventive Tests	$15 copay	100% covered, calendar yr deductible does not apply
Well-Child Care	$15 copay for birth thru 23 months	100% covered birth thru 23 months; calendar year deductible does not apply
Immunizations	100% covered	100% covered
Well Woman Exams	$15 copay	100% covered ; calendar yr deductible does not apply
Mammograms	100% covered	100% covered ; calendar yr deductible does not apply
Diagnostic X-Ray and Lab Tests	100% covered	100% covered after calendar year deductible
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal)	$15 copay	100% covered ; calendar yr deductible does not apply
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board)	100% covered after calendar year deductible
Outpatient Facility Charge	$15 copay	100% covered after calendar year deductible
Emergency Services		
Emergency Room	$35 copay (waived if admitted)	100% covered after calendar year deductible
Mental Health Benefits		
Inpatient Care	100% covered; limited to 45 days/calendar year	100% covered after calendar year deductible; limited to 30 days/calendar year
Outpatient Care	$15 copay/individual therapy visit; $7 group therapy visit; limited to 20 individual & group therapy visits/calendar year. Up to additional 20 group visits that meet Medical Group criteria during same calendar year	100% covered after calendar year deductible; limited to 20 individual & group therapy visits/calendar year. Up to additional 20 group visits that meet Medical Group criteria during same calendar year
Substance Abuse		
Inpatient Hospitalization	100% covered (detox only)	100% covered (detox only) after calendar yr deductible
Inpatient Detoxification Services	100% covered	100% covered after calendar year deductible
Outpatient Services	$15 copay/individual therapy visit; $5 group therapy visit	100% covered after calendar year deductible
Prescription Drugs		
Retail	100-Day Supply Limit	100-Day Supply Limit
Generic	$10 copay	100% covered after calendar year deductible
Brand (Formulary/Preferred)	$20 copay	100% covered after calendar year deductible
Brand (Non-Formulary/Non-preferred)	N/A	N/A
Mail Order	100-Day Supply Limit	100-Day Supply Limit
Generic	$10 copay	100% covered after calendar year deductible
Brand (Formulary/Preferred)	$20 copay	100% covered after calendar year deductible
Brand (Non-Formulary/Non-preferred)	N/A	N/A
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	100% covered; formulary applicable	100% covered after calendar year deductible; limited to $2,500 benefit max/calendar year; formulary applicable
Home Health Care	100% covered; limited to 100 two-hour visits/calendar year	100% covered after calendar year deductible; limited to 100 two-hour visits/calendar year
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days/calendar year	100% covered; limited to 100 days/calendar year
Chiropractic Services	$10 copay; limited to 30 visits/calendar year	Not covered
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	$15 copay	100% covered after calendar year deductible

** The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.*

NOTES:

[1] **For family coverage, the full family deductible amount must be met before benefits will be paid for any covered member.**

PPO MEDICAL PLAN

Blue Shield PPO - High Deductible Health Plan (HDHP) (#975834)

General Plan Information	In-Network Schedule of Benefits	Out-of-Network Schedule of Benefits
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductible	$1,500 Indiv/$3,000 Fam[1] (combined in/out of network)	$1,500 Indiv/$3,000 Fam (combined in/out of network)
Annual Out-of-Pocket Limit	$4,500 Indiv/$9,000 Fam (combined in/out of network)	$4,500 Indiv/$9,000 Fam (combined in/out of network)
Deductible Included In Out-of-pocket Limits?	Yes	Yes
Coinsurance	80%	60%
Office Visit/Exam	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Specialist Visit	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Services (Preventive)		
Adult Periodic Exams with Preventive Tests	100% covered; calendar year deductible does not apply	Not covered
Well-Child Care	100% covered - birth-36 months; deduct does not apply	Not covered
Immunizations	100% covered; calendar year deductible does not apply	Not covered
Well Woman Exams	100% covered; calendar year deductible does not apply	Not covered
Mammograms	100% covered; calendar year deductible does not apply	Not covered
Diagnostic X-Ray and Lab Tests	80% covered after calendar year deductible	60% covered after calendar year deductible
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal)	80% covered after calendar year deductible	60% covered after calendar year deductible
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Facility Charge	80% covered after calendar year deductible	60% covered after calendar year deductible
Emergency Services		
Emergency Room	80% covered after calendar year deductible	80% covered after calendar year deductible
Mental Health Benefits		
Inpatient Care	80% covered after calendar year deductible, combined inpatient & partial hospitalization	60% covered (severe mental health only) after calendar year deductible. $600/day maximum allowed
Outpatient Care	50% covered after cal yr deductible (non-severe), limits apply*, 80% covered after cal yr deductible (severe)	Not covered (non-severe), 60% covered after calendar year deductible (severe)
Substance Abuse		
Inpatient Hospitalization	80% covered (detox only) after cal yr deductible, max 30 days/cal yr combined in/out network (non-detox)	60% covered (detox only) after cal. yr deduct, max 30 days/ $175/day cal yr combined in/out of network/(non-detox)
Outpatient Services	50% covered after cal yr deductible, max 20 visits/cal yr combined outpatient non-severe mental health	Not covered
Prescription Drugs		
Retail	30-Day Supply Limit	
Generic	$10 copay only after calendar year deductible	25% + $10 copay only after calendar year deductible
Brand (Formulary/Preferred)	$25 copay only after calendar year deductible	25% + $25 copay only after calendar year deductible
Brand (Non-Formulary/Non-preferred)	$40 copay only after calendar year deductible[2]	25% + $40 copay only after calendar year deductible [2]
Mail Order	90-Day Supply Limit	
Generic	$20 copay only after calendar year deductible	Not covered
Brand (Formulary/Preferred)	$50 copay only after calendar year deductible	Not covered
Brand (Non-Formulary/Non-preferred)	$80 copay only after calendar year deductible [2]	Not covered
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	80% covered after cal yr deductible	60% covered after cal yr deductible;
Home Health Care	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network
Skilled Nursing or Extended Care Facility	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network
Chiropractic Services	80% covered after calendar year deductible; limited 20 visits/calendar year combined in & out of network	60% covered after calendar year deductible; limited 20 visits/calendar year combined in & out of network
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	80% covered after calendar year deductible	60% covered after calendar year deductible

**The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.*

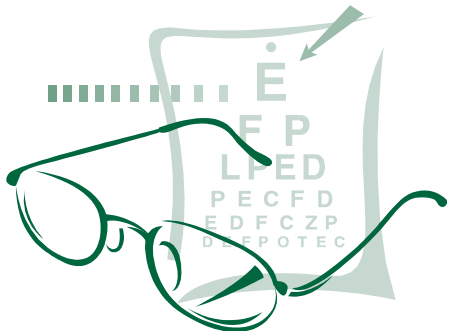
NOTES: **[1] For family coverage, the full family deductible amount must be met before benefits will be paid for any covered member.**

[2] Brand Copay for Non-Formulary/Non-preferred drugs does not accrue to the annual out of pocket maximum. If a generic drug is available and a brand drug is requested, member is responsible for the generic copay plus the difference between the cost of the generic and brand drug.

VISION BENEFITS

If you are enrolled in a County sponsored medical plan you also have vision benefits packaged with your medical plan. If you enroll in a Health Net or Blue Shield medical plan, your vision benefits are managed through Vision Service Plan (VSP). If you enroll in Kaiser, your vision services are provided through Kaiser. You will not have vision coverage if you waive County medical coverage.

	Vision Service Plan (VSP)	Kaiser HMO Traditional Plan	Kaiser HMO High Deductible Health Plan (HDHP)
Vision Benefits			
Allowance Amount	$100 every 24 months for frames	$175 every 24 months for frames & lenses combined	Not covered
Examination	$15 copay (exam and materials)	$15 copay	100% covered after calendar year deductible
Benefit Frequency			
Examination	12 months	24 months	24 months
Lenses	24 months	24 months	Not covered
Frames	24 months	24 months	Not covered
Contacts	24 months	24 months	Not covered



IMPORTANT INFORMATION ABOUT 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.

INSURANCE SUBSIDY

The County provides an insurance subsidy contribution for eligible employees to help pay for the cost of medical insurance. The insurance subsidy amount varies, depending on when you began working for the County and according to your representation unit (Recognized Employee Organization [REO]). Insurance subsidies are categorized as Tier A or Tier B.

TIER A— INSURANCE SUBSIDY

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 for your benefit subsidy and you may be eligible for Cash Back or the Plan Selection Incentive (PSI). Your bargaining agreement describes the eligibility for these programs and is available on the website at: http://www.laborrelations.saccounty.net.

The subsidy is determined by your bargaining agreement for represented employees or a Board of Supervisors resolution for unrepresented employees. If the plan you select costs more than the amount of your subsidy, the extra amount will be deducted from your pay, pre-tax*, unless otherwise requested. If you choose a plan that costs less than your subsidy, there is no out of pocket premium expense to you.

CASH BACK

Each REO has a “designated date” that determines eligibility for Cash Back. To determine the applicable designated date for your REO, see the chart in the back of this summary.

For employees hired before the “designated date": if the coverage you select costs more than the subsidy, the extra amount will be deducted from your pay, pre-tax* or post tax when requested. If the cost of your insurance is less than your Cash Back limit, or if you do not elect the County provided medical benefit, you may receive a payment as Cash Back in your paycheck, less appropriate taxes.

PLAN SELECTION INCENTIVE

If you were hired before January 1, 2007 and your Recognized Employee Organization (REO) has negotiated with the County for this benefit, or you are an eligible unrepresented employee, a Plan Selection Incentive (PSI) payment of $150/month will be made to employees who waive the County provided medical benefit. If you are eligible for this benefit, in most cases you must provide documentation showing that you have other group health insurance. Eligibility for this benefit requires that you maintain your other group health plan. It is your responsibility to notify the Employee Benefits Office within 30 days of the loss of your other group coverage. You may be required to re-establish your eligibility by providing acceptable proof of your continuing coverage under another **group** health plan. Check your labor contract to determine if this benefit has been negotiated by your REO.

If you waive your coverage and later choose to enroll, you must do so within 30 days[1] of a mid-year “change of status” event or at Open Enrollment.

[1](See NOTE on Page 5 for information on a special 60 day window).

*Premiums associated with same sex spouses, domestic partners, the dependents of domestic partners or same sex spouses who do not meet the IRS definition of a dependent, and/or other children who do not meet the IRS requirements for a dependent child are subject to applicable federal taxes. Premiums associated with domestic partners, same sex spouses, and/or dependents of domestic partners are exempt from State tax.

TIER B— INSURANCE SUBSIDY

Employees hired or rehired into benefit eligible positions on or after January 1, 2007 or who have voluntarily chosen to move from Tier A, are in Tier B for benefit subsidy determination. 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 lowest cost plan offered, you will be responsible for the extra amount above the County's contribution, and your contribution portion will be deducted from your pay, pre-tax* or post tax if requested. There is no Cash Back or PSI eligibility if you are in Tier B.

Medical premiums, subsidies, and cash back amounts are listed on page 17.

*Premiums associated with same sex spouses, domestic partners, the dependents of domestic partners or same sex spouses who do not meet the IRS definition of a dependent, and/or other children who do not meet the IRS requirements for a dependent child are subject to applicable federal taxes. Premiums associated with domestic partners, same sex spouses, and/or dependents of domestic partners are exempt from State tax.

WAIVER OF COVERAGE

If you have other group health coverage, you may wish to waive the County provided medical benefit. The County requires you to provide documentation verifying you have other group medical coverage.

You may waive coverage during your initial eligibility period, during Open Enrollment, or within 30 days[1] of gaining other group coverage. If you choose to waive coverage, you will be allowed to enroll in a County sponsored medical plan only if you enroll within 30 days[1] of the loss of other group coverage. Documentation of the loss of other group coverage will be required to enroll in the County provided medical benefit.

[1](see NOTE on page 5 for information on a special 60 day window).

VOLUNTARY IRREVOCABLE ELECTION

Depending on the level of your subsidy as negotiated by your REO, your choice of medical plans, and your level of coverage (single or family), you may be able to reduce your portion of the medical plan premium by moving from Tier A to Tier B.

Once you voluntarily move from Tier A to Tier B, you cannot return to Tier A status. A change from Tier A to Tier B can only be made during Open Enrollment, or during a "change of status" event.

A change from Tier A to Tier B status 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.

Please carefully consider your coverage situation, as well as the costs of any other medical coverage you may have before making a final decision.

2013 MEDICAL PLAN PREMIUMS CONTRIBUTIONS/SUBSIDIES/CASHBACK

Definitions			Tier B Hired after 12/31/2006	Tier A (2) Bargaining Units 003, 006, 017, 019, 030		Tier A (1) All Other Units	
Monthly Subsidy Single (S)			$477.08 Subsidy	$1,148.80 Subsidy		$826.90 Subsidy	
Monthly Subsidy Family (F)			$1,220.02 Subsidy	$1,148.80 Subsidy		$826.90 Subsidy	
Cash Back Maximum Or PSI			N/A	$894.52 Cashback	N/A No Cashback	$535.00 Cashback	$150 PSI
Plan	Single/ Family	Total Monthly Premium	Employee Cost Per Pay Period	Cashback or Deduction (-)	Employee Cost Per Pay Period	Cashback or Deduction (-)	Employee Cost Per Pay Period
Kaiser HMO	S	$596.34	-$59.63	$138.49	$0	$0	$0
	F	$1,525.02	-$152.50	-$188.11	-$188.11	-$349.06	-$349.06
Health Net HMO	S	$787.24	-$155.08	$49.83	$0	$0	$0
	F	$2,013.16	-$396.57	-$432.18	-$432.18	-$593.13	-$593.13
Blue Shield HMO	S	$919.16	-$221.04	$0	$0	-$46.13	-$46.13
	F	$2,353.06	-$566.52	-$602.13	-$602.13	-$763.08	-$763.08
Kaiser HD HMO	S	$470.06	$0	$197.14	$0	$30.16	$0
	F	$1,202.08	$0	-$26.64	-$26.64	-$187.59	-$187.59
Blue Shield HD PPO	S	$771.06	-$146.99	$57.34	$0	$0	$0
	F	$1,851.32	-$315.65	-$351.26	-$351.26	-$512.21	-$512.21
Waivers			$0	$415.46	$0	$248.48	$75.00

Subsidy = the County contribution amount available for medical coverage according to labor agreements*

"$" = your net Cash Back amount after FICA reduction per paycheck.

"-$" is the deduction that will come out of each paycheck (24 times a year)

Monthly Premium includes separate vision cost where applicable.

***Refer to your specific labor agreement for details.**

Example: Employee in Tier B with Family coverage receives $1220.02 subsidy towards family coverage; Kaiser HMO Family premium costs $1525.02 per month.

The difference of $305.00 is deducted over two pay periods at $152.50 per pay period.

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. The County pays 100% of the dental plan premium cost.* Dental benefits are effective on the first day of the month following your employment and the receipt of your completed enrollment application by the Department of Personnel Services Employee Benefits Office. General information about your dental benefits is included in this Summary. An Evidence of Coverage booklet, that contains details about the plan, is available in the Employee Benefits Office or on the Employee Benefits website.

**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 (imputed income).*

What if I already have dental insurance?

Even if you have other group dental coverage, you still must enroll in the County dental plan as your primary 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.

How does the plan pay?

This plan provides three levels of benefit:

If you receive services from a Delta PPO dentist, the plan will pay 100% of the preventative and diagnostic services; 90% for basic services; and 80% for major services.

If you receive services from a non-PPO Delta dentist, the plan will pay 80% of preventative and diagnostic services; 80% for basic services; and 80% for major services.

If you receive services from a non-Delta dentist, the plan will pay 80% of covered services based upon the Maximum Plan Allowance as defined by Delta Dental. Any amount over the amount paid by Delta Dental 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.

FLEXIBLE SPENDING ACCOUNTS

These accounts permit employees to set money aside on a pre-tax basis, via payroll deduction, for eligible medical, dental, vision, or dependent care expenses not covered by insurance or other benefit plans. **A new enrollment is required each year, even if you do not plan to change the amount(s) set aside.** Except for a change in status event, the only time you can enroll, change, or stop your FSA is during Open Enrollment.

MEDICAL REIMBURSEMENT ACCOUNT (MRA)

The Medical Reimbursement Account allows you to set aside pre-tax money to pay for out-of-pocket expenses incurred for yourself, your spouse or your eligible dependents up to age 26 that are not paid by your insurance or reimbursed by any other benefit plan. Expenses for a same sex spouse, domestic partner or for children that do not qualify as an IRS dependent are generally not allowed, per Federal law. Expenses include, but are not limited to, insurance co-pays, deductibles, dental or vision expenses, pharmacy bills, and other similar out-of-pocket costs. Treatments, services, and surgeries that are performed for cosmetic reasons and over the counter medications without a doctor's prescription are not reimbursable from a Flexible Spending Account.

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.**

Who is eligible?

All County employees who are eligible for health insurance benefits are eligible to participate in the MRA and/or the DCRA.

How much can be set aside?

With the Medical Reimbursement Account (MRA), you may set aside up to $2,500 per calendar year to pay for qualified unreimbursed health expenses. For Dependent Care (DCRA), you may defer up to $5,000 ($2,500 if you are married and file separate tax returns) to pay for qualified dependent care expenses.

Are there any special rules?

The most important rule is "use it or lose it." Each year you enroll, you contribute a pre-determined portion of your salary, on a pre-tax basis, to your Flexible Spending Account(s) for dependent and/or health care expenses. You may file claims that are incurred on or after your effective date of participation but before March 16th of the following plan year against these accounts. Any funds you defer that are left over after all eligible claims have been paid, will be forfeited. It is very important to plan carefully and conservatively. Funds cannot be moved between the medical and dependent care reimbursement accounts.

When can I enroll?

You may enroll within 30 days of your hire date or during Open Enrollment each year. You may also be eligible to enroll during the year if a "change in status" event occurs. Please contact the Plan Coordinator at (916) 874-2020 for more information. Remember: You only have 30 days from a "change in status" event to enroll or make a change.

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

How do I request reimbursement?

Flex-Plan Services, Inc. is the claims administrator. They will provide you with an initial reimbursement voucher that you send to them with proof of the expenses that you incurred. Copies of receipts (e.g., itemized bills/proof of expenses) need to be attached to your reimbursement voucher. Additional claim forms are available from the administrator, on their website, on the Department of Personnel Services Employee Benefits website, or from the Employee Benefits Office.

The administrator offers a direct deposit option so that reimbursement checks may be deposited directly into your bank account. Forms are available at the Employee Benefits Office or on the Employee Benefits website, and are to be submitted to the administrator.

When can I change my election amount?

The only time you may make any type of change in your deduction elections is during Open Enrollment, or within 30 days of a "change in status" event. Remember: 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.

What happens if I leave County employment?

Your contributions will cease when your employment ends. The Plan shall reimburse any eligible expenses which were incurred during your coverage in the Plan Year, less benefits already paid during the Plan Year. For Dependent Care expenses, the plan reimburses up to the amount of your contribution for benefits less benefits paid, and for medical expenses incurred prior to your employment termination up to the amount of your annual benefit less benefits paid.

Depending on the timing of the event and your remaining balance available to you, post employment expenses may be eligible for claim reimbursements if you elect to continue contributions on a post tax basis through COBRA but only for the balance of the plan year. Information regarding COBRA options for the Medical Reimbursement Account, if you qualify, will be sent to your mailing address after your employment ends.

Are Social Security benefits affected?

Your election may reduce your Social Security contributions. However, the reduction is generally small. You may wish to contact your tax advisor prior to making your election.

How do I obtain more information?

You may contact the Department of Personnel Services Employee Benefits Office to obtain a copy of the Flexible Benefit Plan Summary or Plan Document.

You may contact the administrator regarding claims questions.

Flex-Plan Services, Inc.
P.O. Box 70366
Bellevue, WA 98007

(800) 669-3539
(425) 452-3500
(866) 535-9227 (fax)

www.flex-plan.com

IMPORTANT NOTE:
You must enroll every year during Open Enrollment for each plan (MRA and/or DCRA) if you wish to continue your participation for the following year.

PRIVACY STATEMENT

The County of Sacramento protects the privacy of your Protected Health Information (PHI) as required by the Health Insurance Portability Act (HIPAA). PHI is health information that includes your name, Social Security Number, or other information that reveals who you are. We also require insurance carriers and business associates to protect your PHI. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI. For more information regarding your PHI, please review the "Notice of Privacy Practices" provided by each carrier for medical, dental, and EAP coverage, or the County Employee Benefits Office for the Medical Reimbursement Account.

HEALTH SAVINGS ACCOUNT

HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is a voluntary savings account established for reimbursement of qualified medical expenses. HSAs were created to provide individuals with a tax saving benefit for certain medical expenses when covered under a High Deductible Health Plan (HDHP). Having coverage under an HDHP is the only way to be eligible to contribute to an HSA.

An HSA is not a medical plan with a carrier. It is an individual account established for your contributions and reimbursement of expenses. It is able to reimburse the same category of eligible expenses as a Flexible Spending Medical Reimbursement Account, however your maximum available reimbursement is limited to your account balance.

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, Wells Fargo (contact information on page 32). 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: Wells Fargo may charge the account holder a monthly administrative fee for the HSA.

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 as listed under IRS Code 213 (d) such as co-pays, deductibles, dental and vision expenses and more;
- 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 be eligible 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 2013, the maximums are:

Coverage	Under Age 55	Age 55+
Individual	$3,250.00	$4,250.00
Family	$6,450.00	$7,450.00

You may enroll in the HSA at any time. You may change or stop your contributions at any time. Separate enrollment forms are required for an HSA.

*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 Medical Reimbursement Account. For more details, please contact the Department of Personnel Services Employee Benefits Office.

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.

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. The amount of that contribution is based upon when you each enrolled in medical coverage and your age. 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 Wells Fargo 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 (the 20% penalty does not apply if you are disabled or age 65 or older).

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 premium payments that allow you to retain health coverage 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 up to age 26. 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 <u>following year</u> 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 change your payroll deduction amounts.

RETIREE HEALTH SAVINGS PLAN

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

All regular full-time employees are eligible to participate in County-sponsored Retiree Health Savings Plan (RHSP). Regular part-time employees who work a minimum of forty (40) hours per biweekly pay period are also eligible to participate.

What is the Retiree Health Savings Plan (RHSP)?

The Retiree Health Savings Plan (RHSP) is an employer-sponsored health savings benefit that allows you to accumulate assets to get reimbursed for qualified medical expenses on a tax-free basis for you, your eligible spouse and/or your eligible dependents when you leave County employment.

How much money will be in the plan?

The County of Sacramento in accordance with your bargaining agreement will contribute $25 for each pay check you receive into your RHSP account. At the current time, the IRS does not allow for employee contributions into this plan.

Where will the money go?

The funds will be held by ICMA-RC in their VantageCare Retirement Health Savings Plan. You will be able to decide how to invest the money.

What are the benefits of the VantageCare Retiree Health Savings Plan?

RHSP offers you a number of benefits, including tax-deferred accumulation of earnings, and, when account assets are used to pay for tax qualified medical benefits for you, your spouse and/or your dependents up to age 26, the additional benefit of tax-free withdrawals.

How do I get started?

If your REO has negotiated for you to participate in the program, there are no enrollment forms necessary. You should, however, go to www.icmarc.org to select your investment options. Once on the website, you will be able to complete this information by logging into "Account Access." For further assistance with Account Access, please contact ICMA's Investor Services Line at 1-800-669-7400.

Where will my RHSP assets be invested?

The investment funds available to RHS participants are ICMA-RC's Vantagepoint Funds*. This family of SEC registered mutual funds consist of actively managed funds, index funds, model portfolio funds**, and target date funds**. Upon initial enrollment in the RHSP, 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 anytime. Changes can be made one of three ways:

- VantageLine – toll-free at 1-800-669-7400
- Online through Account Access:www.icmarc.org
- Investor Services Representative (1-800-669-7400, then press 0 to speak to a representative)

** Please consult the current Vantagepoint Funds Prospectus carefully for a complete summary of all fees, expenses, charges, financial highlights, investment objectives, risks and performance information. Investors should consider the Fund's investment objectives, risks, charges and expenses before investing or sending money. The prospectus contains this and other information about the investment company. Please read the prospectus carefully before investing. Vantagepoint Funds are distributed by ICMA-RC Services LLC, a wholly owned broker-dealer subsidiary of ICMA-RC, member NASD/SIPC. For a current prospectus, contact ICMA-RC Services LLC, 777 North Capitol Street NE, Washington, DC 20002-4240. 1-800-669-7400.*

*** Please be advised that with model portfolio and target date funds, additional underlying fees may apply. Please consult the prospectus for details.*

When will I be fully vested?

Your account will be 100 percent vested at all times. That means that the funds in that account are available for you to receive reimbursements when you leave County employment.

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.

What is the procedure for submitting a claim for medical reimbursement? How long does it take?

Once you leave County employment, the County notifies ICMA-RC of your benefit eligibility. ICMA-RC notifies Meritain Health, the claims administrator that you are in benefit eligible status. After you become benefit-eligible, claims for medical expenses that qualify under RHSP are submitted for reimbursement on *VantageCare Retirement Health Savings Plan Benefits Reimbursement Request Form*. This form is available from the Department of Personnel Services Employee Benefits Office, the Benefits Office Website, or directly from Meritain Health, (1-888-587-9441). 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 are eligible expenses?

Benefits eligible for reimbursement consist of Medical Expenses eligible under the Internal Revenue Code Section 213 other than direct long-term care expenses.

Examples are as follows:

Medical Insurance Premiums, Medical Out-of-Pocket Expenses, Medicare Part B Insurance Premiums, Medicare Part D Insurance Premiums, Medicare Supplemental Insurance Premiums, Prescription Drug Insurance Premiums, COBRA Insurance Premiums, Dental Insurance Premiums, Dental Out-of-Pocket Expenses, Vision Insurance Premiums, Vision Out-of-Pocket Expenses, Qualified Long-Term Care Insurance Premiums, and other qualifying medical expenses.

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 dependents for their own qualifying health expenses.

How are payments from RHSP accounts treated for tax purposes?

RHSP benefits paid in the form of medical expense reimbursements will never be taxed to you, your spouse, or dependents. No income tax withholding or reporting is required, and you do not need to report any medical benefits on your itemized income tax return.

Whom should I contact with questions regarding the RHSP?

Depending upon your question, you may contact ICMA-RC, the Employee Benefits Office, or Meritain Health, Inc.

For all account issues not claim-related;
With questions regarding your account statement;
to change personal data (also to inform Meritain Health if you are eligible for benefits), contact:
ICMA-RC (800) 669-7400

For eligibility and Plan details, contact:
Employee Benefits Office (916) 874-2020

For all claim related issues once you are eligible to receive benefits;
To change personal data if you are eligible for benefits inform ICMA-RC and contact:
Meritain Health, Inc. 1-888-587-9441 (please ask to speak with the ICMA-RC VantageCare RHS claims representative).

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 through payroll deduction. All life insurance benefits and coverages described in this Summary are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this Summary and the insurance polices, the insurance policies will always govern. All decisions concerning the payment of claims under the plan are at the sole discretion of the insurance company.

AMOUNT OF LIFE INSURANCE

The County provides a Basic life insurance benefit at no premium cost to you. The Basic life insurance includes dependent coverage (detailed in the Group Insurance Certificate). The Basic benefit is either $15,000, $18,000 or $50,000, depending upon your classification and/or REO.

Bargaining Unit	Basic Life Coverage	Dependent Life Coverage	Dependent Enrollment Required?
005, 008	$15,000	$5,000*	**Yes**
020, 021, 027, 029, 032, 033, 050	$50,000	$2,000	No**
All others	$18,000	$2,000	No**

*Must pay taxes on imputed income.
**Domestic Partner/Same Sex Spouse and dependents of a domestic partner require an enrollment form for coverage to be effective.

All County employees covered under the Basic life benefit have Accidental Death & Dismemberment (AD&D) benefits equal to the amount of County paid Basic life insurance. Refer to the Group Insurance Certificate for AD&D terms and exclusions.

OPTIONAL LIFE INSURANCE OPTIONS

The choices for optional life insurance program are:

Option A - 1 times your annualized salary, up to $50,000 (This Option includes your Basic Coverage).

Option B - 1 times your annualized salary, up to $500,000, plus your Basic Coverage.

Option C - 2 times your annualized salary, up to $500,000, plus your Basic Coverage.

Option D - 3 times your annualized salary, up to $500,000, plus your Basic Coverage.

Option E – 4 times your annualized salary, up to $500,000, plus your Basic Coverage.

Premiums for optional life coverage will be deducted post-tax from your paycheck. For newly eligible employees, there is no medical underwriting if you enroll within 30 days of eligibility.

CHANGING COVERAGE AMOUNTS

You may increase or decrease the optional life insurance coverage at any time. There are two ways to increase your coverage: (1) If you have experienced certain life events such as getting married or having a baby, your increase does not require a health statement questionnaire (specific life events not requiring a health statement are listed in the Group Insurance Certificate available on the Employee Benefits Office web page); (2) If no life event has occurred, then you must ***apply*** for the increase. You need to complete Prudential's short form health statement questionnaire as well as the County's life insurance change form and return both forms to the Employee Benefits Office. Prudential may require additional information, and the increase is not guaranteed. You will be notified by mail.

Decreases can be made anytime online by using BenefitBridge which is available through the Employee Benefits Office web page at: http://hra.co.sacramento.ca.us/employ/ben/content.htm

COST OF OPTIONAL INSURANCE

The cost of the optional life coverage is based upon your annualized salary and your age and is subject to rounding. You can determine the cost of the optional coverage utilizing the following table (the premium listed is the cost per thousand ($1,000) of employee-paid life insurance per month):

AGE	PREMIUM
Under 30	$0.036
30—34	$0.048
35—39	$0.073
40—44	$0.084
45—49	$0.140
50—54	$0.214
55—59	$0.364
60—64	$0.571
65—69	$1.105
70 or older	$1.785

Example:

Non-management employee is age 43 on January 1, 2013.

Employee's annualized salary is $43,257.

Employee chooses Option C (2x annualized salary).

$15,000 Basic life insurance is provided by the County – at no cost to employee.

Calculation:

Two times employee's salary is $86,514.

Salary rounded up to nearest $1,000 is $87,000.

Monthly premium for a 43-year-old employee is $7.32/month. ($0.084 [from the rate table] times 87 {the number of $1,000 of coverage} equals $7.32 with rounding).

Employee's premium is $3.66 per payday. A deduction of $3.66 will be taken the first two paydays in each month.

The employee's total life insurance coverage would be $102,000 ($87,000 Optional + $15,000 Basic).

"AGE-RATED" PREMIUMS

Your premium for the same amount of life insurance will stay the same only as long as you remain within the same age bracket. It will change when you age into a new age bracket. If the employee in the example has no salary change, in two years the employee will be age 45 and move into the next age bracket. At that time the employee's life insurance premium would increase from $7.32/month to $12.18/month (from $3.66/payday to $6.09/payday). (Calculation: $0.140 times 87 equals $12.18).

PREMIUMS BASED UPON SALARY

If the employee in the example above at age 43 receives a 3% salary increase, the annualized salary would be $44,554.71. Two times $44,554.71 is $89,109.42; rounded up to the nearest $1,000 would be $90,000. The premium would increase to $7.56 month or $3.78/payday. (Calculation: $0.084 times 90 equals $7.56)

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 one-half (1/2) of their total benefit amount. Contact the Employee Benefits Office for more information.

WAIVER OF PREMIUM

If you become disabled while you are 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.

BENEFICIARIES

You may change your beneficiary at any time. Beneficiaries can be changed online by using BenefitBridge which is available through the Employee Benefits Office web page at: http://hra.co.sacramento.ca.us/employ/ben/content.htm

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.

DEPENDENT COVERAGE

Employees covered under the Basic life insurance are eligible to receive a dependent coverage benefit of $2,000 or $5,000 for their spouse/domestic partner and dependent children (including the dependents of a domestic partner) age six months to age 19. Dependents attending school as full-time students in an accredited secondary school, college, or university, who are not yet 24 years of age and are unmarried, are also covered. For infants less than six months of age, the benefit is reduced.

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, same sex spouse, or the dependents of domestic partners that are not your IRS defined dependents. In these situations dependents must be enrolled in the life insurance plan to be covered and in order to calculate the taxes and receive the benefit.

Where enrollment is required, new spouses, domestic partners, and dependent children must be enrolled within 30 days of initial employment and/or a "change in status" event in order for coverage to be effective. Dependents may also be enrolled during Open Enrollment. Spouses, domestic partners, and dependent children may be deleted from coverage at any time.

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	VALUE PER PAY PERIOD FOR $5,000 OF LIFE INSURANCE
Under 25	$.13
25—29	$.15
30—34	$.20
35—39	$.23
40—44	$.25
45—49	$.38
50—54	$.58
55—59	$1.08
60—64	$1.65
65—69	$3.18
70 or older	$5.15

Based upon 24 pay periods with "rounding"

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).

FUNERAL CONCIERGE SERVICES

The life insurance policy will include a **funeral assistance** benefit provided by Everest. This program assists employees and their family members make informed decisions regarding funeral-related products and expenses. Contact Everest at 800-913-8318 or online at www.everestfuneral.com/enroll (Identification Code PEF09100) for more information.

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 for retirement purposes 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 maximum for participants under age 50 in 2013 will be $17,000 + COLA determined by the IRS.

The maximum for participants age 50+ in 2013 will be $22,500 + 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. **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.**

401(a) Plan
The match of 1% of gross pay paid by the County is automatic if the eligible employee (REO 020, 021, 032, 033, Unrepresented Management [050] and Elected Officials) 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 is 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 the vacation and sick leave pay out 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 Employees Retirement System or the defined benefit plan(s) of the other employer for details 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. If you find the need for a Hardship Withdrawal, you should contact the Deferred Compensation office for details.

The IRS has very specific rules about what qualifies as a Hardship Withdrawal. Once an application is made for a Hardship Withdrawal, you can not contribute to the 457(b) Plan for six months.

INVESTMENT ALLOCATION

Contributions to the 457(b) Plan (and 401(a) if eligible) will be deposited into each plan's Qualified Default Investment Allocation (QDIA) which is the Fidelity Freedom Fund for your age if you do not specifically direct your deposits into accounts that you select. 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.

CONTACT INFORMATION

Fidelity Investments 800-343-0860 or
http://plan.fidelity.com/saccounty

Deferred Compensation Office 916-874-2020 or
DPSBenefits@saccounty.net
Website: http://hra.co.sacramento.ca.us/deferred_comp_website/content.htm

It's never too late to start saving!

EMPLOYEE ASSISTANCE PROGRAM

The County provides an Employee Assistance Program (EAP), which is administered by Managed Health Network (MHN). EAP provides confidential, professional short-term counseling services for you and your eligible family members. The EAP also provides online services for County employees.

Who is eligible?

All eligible full-time or part-time employees can receive assistance and counseling through MHN. Your dependents, as described on page 4 of this Summary, may also receive EAP benefits.

How do I access the Employee Assistance Program?

Call MHN directly, using the toll-free number (800) 227-1060 to make an appointment. This number is available 24 hours a day, 7 days a week. All services are confidential and private. TDD callers dial (800) 327-0801.

How do I access the EAP online?

You can access MHN's online EAP services at:

www.members.mhn.com.

Your Access Code is: sacramento

This service is intended to help you better manage a wide range of emotional health, working, and living challenges.

What benefits does the EAP provide?

The program provides six (6) counseling sessions for each incident/issue per year for you and for each of your eligible dependents, at no cost to you. There are no co-payments, coinsurance, or deductible payments.

- **Face-to-Face Counseling** for marital/family concerns, alcohol/drug dependency, relationships, emotional problems, stress, and other issues.

- **Telephonic Counseling and/or Web-Video Consultations** for a broad range of life management issues including:

  Legal Matters: Advice for family law, consumer issues, landlord/tenant disputes, personal injury, contracts, and criminal matters

  Financial: Budgeting, credit issues, and financial planning

  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

CONTINUATION COVERAGE

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, same sex spouses, 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), and Employee Assistance Program (EAP) at your own expense. 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.

What should I do when there is a qualifying event?

Your department will notify the Department of Personnel Services 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 and submit the Medical and/or Dental change forms to 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. Supporting documentation is required along with the form, which is available on the Employee Benefits Office website, or in the Employee Benefits Office. 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 of Coverage?

Direct your questions about your Continuation Coverage rights to:

Department of Personnel Services

Employee Benefits Office
Attn: Cobra Coordinator
700 H Street, 4th Floor, Room 4650
Sacramento, CA 95814

Phone: (916) 874-2020

DPSBenefits@saccounty.net

CONTACTS

Contact	Phone	E-mail or Web Site
BenefitBridge	**(800) 814-1862**	www.benefitbridge.com/saccounty
County Employee Benefits Office	**(916) 874-2020**	DPSBenefits@saccounty.net
COBRA (County COBRA Coordinator)	(916) 874-2020	DPSBenefits@saccounty.net
Deferred Compensation		
County of Sacramento	(916) 874-2020	DPSBenefits@saccounty.net
Fidelity Investments	(800) 343-0860	http://plan.fidelity.com/saccounty
Dental Plan		
Delta Dental	(800) 765-6003	www.deltadentalca.org
Employee Assistance Program (EAP)		
Managed Health Network (MHN)	(800) 227-1060	www.members.mhn.com
Flexible Spending Accounts		
Flex Plan Services	(800) 669-3539	www.flex-plan.com
Funeral Concierge Service		
Everest	(800) 913-8318	www.everestfuneral.com
Health Plans		
Blue Shield HMO	(800) 642-6155	www.blueshieldca.com
Blue Shield PPO	(800) 642-6155	www.blueshieldca.com
Blue Shield PPO Pre-Certification (Radiology)	(888) 642-2583	
Blue Shield PPO Mental Health and Substance Abuse Pre-Certification	(877) 263-7178	
Blue Shield HMO Mental Health and Substance Abuse Pre-Certification	(877) 263-8827	
Health Net HMO	(800) 522-0088	www.healthnet.com
Health Net's Mental Health & Substance Abuse	(888) 426-0030	
Kaiser Permanente HMO	(800) 464-4000	www.kaiserpermanente.org
Health Savings Accounts		
Wells Fargo	(866) 884-7374	http://wellsfargo.com/hsa
Life Insurance		
Prudential	(800) 524-0542	www.prudential.com
Retiree Health Savings Plan		
ICMA-RC	(800) 669-7400	www.icmarc.org
Meritain Health	(888) 587-9441	www.meritain.com
Vision		
VSP	(800) 877-7195	www.vsp.com

Index of REO—Bargaining Unit– Illustrative Classes

REO Unit #	Title of Bargaining Unit	Illustrative Classes	Cash Back if Hired on/ before
001	General Supervisory Unit, Teamsters, Local 150	Most supervisory classes other than Law enforcement, Nursing, Welfare, Attorneys, Accountants, Env. Spec., Engr. & Architects, and Probation	2/1/98
002	Supervisory Law Enforcement Support Sacramento County Alliance of Law Enforcement (SCALE)	Supv. Child Support Ofcr; Supv. Criminalist; Supv ID Tech.	11/21/99
003	Law Enforcement, Non-Supervisory. Sacramento County Deputy Sheriff's Association (SCDSA)	Dep. Sheriff (incl Perm P/T & On-call); Sheriff Sgt. & Sheriff Sgt. Detective; Dep. Sheriff Tnee; 911 Dispatcher; Sheriff Rec. Ofcr; Sheriff Comm. Dispatcher; ID Tech; Comm. Svc. Specialist	10/24/99
004	Law Enforcement Support, Sacramento County Alliance of Law Enforcement (SCALE)	Child Spt. Ofcr; Criminalist; Forensic Lab. Tech; Inv. Asst; Process Svr.	11/21/99
005	Office-Technical. United Public Employees, Local 1 (UPE)	Office support and technical classes, such as: Acct Clk; Assessment Tech; Assoc. Real Estate Agt.; Bus. Lic. Inspector;(Sr) Auditor Aprsr; Code Enf. Ofcr; Comm/Ops Disp; Dep. Pub. Guardian; Legal Sect'y; Med. Rec. Tech; (Sr.) Ofc. Asst;(Sr.) Ofc. Spec; (Sr.) Imaging Spec; Sheriff's Rec. Spec. Utility Billing Svc. Rep.	12/27/97
006	Operations & Maintenance. International Union of Operating Engineers, Stationary Engineers, Local 39 (IUOE)	Animal control, airports, highway equipment, building custodial, parks, and refuse classes. Does not include water quality, stationary engineering or building trades.	10/11/98
007	Health Services. American Federation of State, County & Municpal Employees (AFSCME), Local 146 AFL-CIO	Mental Health Counselors, LVN's, General Service Workers, Cooks, Bakers, Pharmacists, Laundry Workers, Food Service workers, X-Ray Technicians, Therapists, Community Health Workers, Does not include Registered Nurses	8/30/98
008	Welfare Non-Supervisory Unit. United Public Employees, Local 1 (UPE)	Human Svcs. Soc. Workers; Human Svcs. Social Workers Masters Degree, Fam. Svcs. Wkr; (Sr.) Elig. Spec; Human Svcs. Spec.; Child Dev. Spec.; Voc. Assess. Counselor; Workforce Coordinator; and related Spec. Skills Classes	8/15/99
010	Accountants Non-Supervisory Unit. Sacramento County Professional Accountants Association (SCPAA)	Accounting professionals	8/2/98
013	Environmental Specialists, Supervisory. Environmental Management Specialists of Sacramento County (EMSSC)	Dep. Ag. Cmsr & Sealer of Weights & Measures; Env. Specialist 4; Supv Env. Svcs. Spec.; and Supv. Waste Mgt Spec.	12/6/98
014	Environmental Specialists, Non-Supervisory. Environmental Management Specialists of Sacramento County (EMSSC)	Ag. Standards Inpector; Asst. Env. Svcs. Spec.; Asst Waste Mgt. Spec; Assoc. Env. Svcs. Spec.; Assoc. Waste Mgt. Spec.; Env. Compliance Tech; Env Spec; Sr. Ag. Stds. Inspector; and, Sr. Ag. Stds. Inspector Aide	12/6/98
016	Nurses, Non-Supervisory. California Nurses Association (CNA)	Registered Nurses and Public Health Nurses	7/18/99
017	Water Quality/Stationary Engineers. Stationary Engineers. International Union of Operating Engineers, Local 39 (AFL-CIO)	Stationary Engineers and Water Quality Underground, Mechanical, and Plant Operations classes. Does not include Higher classes.	11/22/98
018	Building Trades. Sacramento-Sierra Building & Construction Trades Council	Electricians, painters, carpenters and plumbers	11/7/99
019	Probation Non-Supervisory. Sacramento County Probation Association (SCPA)	Deputy Probation Officers and Senior Probation Officers, Probation assistants and On-Call Probation Assistants. Does not include Supv. Prob. Ofcr.	7/19/98
020	Attorneys, Non-Supervisory. Sacramento County Attorney's Association (SCAA)	Attorney-Criminal I through IV. It does not include positions in the County Counsel's Office	6/20/99
021	Attorneys, Supervisory. Sacramento County Attorney's Association (SCAA)	Supervisors in the Attorney-Criminal class	6/20/99
022	Engineers & Architects, Non-Supervisory. Association of Professional Engineers of Sacramento County (APECS)	Asst & Assoc Engineers and Architects; Engr/ Arch Student Intern	4/12/98
023	Engineers & Architects, Supervisory. Association of Professional Engineers of Sacramento County (APECS)	Supervisors of Associate Engineers (C.E., M.E., E.E.); Assoc. Engr/Architect; Assoc. Land Surveyor; Assoc. Landscape Arch; Bldg. Proj. Coord; and, Const. Mgt.	4/12/98
025	Welfare Supervisory. Social Services Unit, Local 1021 (SEIU)	Child Dev. Supv; Elig Supv; Fam. Svcs. Supv.; Human Svcs. Pgm. Spec.; Human Svcs. Supv.; Human Svcs. Supv. Master's Deg.; and, Workforce Career Assess Supv.	11/21/99
026	Engineering Technicians & Technical Inspectors (ETTI)	Construction, building, and agricultural weights and measures inspectors, and engineering aides	6/20/99
027	Physicians & Dentist. Union of American Physicians & Dentists	Senior and Associate Physicians, Physicians, and Dentists	1/18/98
028	Data Processing. Data Processing Professionals Association	Information Technology and Data Processing classes	2/1/98
029	Law Enforcement Management Association (LEMA)	Law enforcement management positions	2/1/98
030	Firefighters - Aircraft Rescue & Firefighting Unit (Sacramento Area Firefighters, Local 522)	Firefighter, Aircraft Rescue & Firefighting	10/11/98
031	Peace Officers (SCALE)	Crim. Investigator; Crim. Investigator, Pub Def; Dep Coroner; Park Ranger 1 LPO	11/21/99
032	Management, Sacramento County Management Association	Management classes below Dept. Head level; classes not involved in Labor Relations	2/1/98
033	Attorney-Civil, Sacramento County Management Association	Attorney—Civil; County Counsel's Office	2/1/98
034	Sacramento County Administrative Professional Association	Administrative classes	2/1/98
050	Unrepresented Management	Management classes	2/1/98
060	Administrative	Administrative classes	2/1/98
070	Confidential	Confidential classes	2/1/98
080	Unrepresented	Unrepresented classes	2/1/98

DEPARTMENT OF PERSONNEL SERVICES
EMPLOYEE BENEFITS OFFICE
700 H Street, Room 4650
Sacramento, CA 95814
http://hra.co.sacramento.ca.us/employ/ben/content.htm
(916) 874-2020