SACRAMENTO COUNTY

Restated: October 2012

FLEXIBLE BENEFITS PLAN

SUMMARY OF BENEFITS

DEPENDENT CARE REIMBURSEMENT ACCOUNT

MEDICAL REIMBURSEMENT ACCOUNT

HEALTH SAVINGS ACCOUNT

PREMIUM ONLY

COUNTY OF SACRAMENTO
FLEXIBLE BENEFIT PLAN
TABLE OF CONTENTS

COUNTY OF SACRAMENTO
FLEXIBLE BENEFIT PLAN
TABLE OF CONTENTS (cont.)

INTRODUCTION

The County is pleased to sponsor an employee benefit program known as the "Flexible Benefit Plan" (the Plan). The Plan has five components:

The Flexible Spending Account (FSA) which has two plans:

1) the Medical Reimbursement Account (MRA) and

2) the Dependent Care Reimbursement Account (DCRA)

3) the Premium Conversion Option

4) the Health Savings Account (HSA) and

5) the Cash Benefit feature

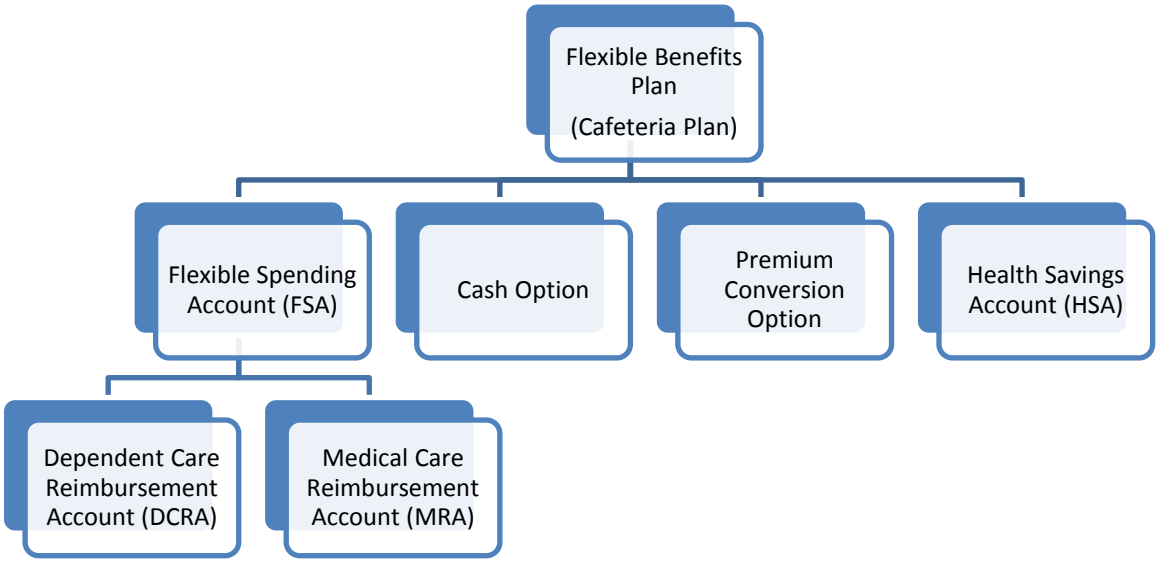
Participation is voluntary in all the plans. The County assumes most of the cost of administering the plan. Each plan is described in the Summary of Benefits Booklet and the Evidence of Coverage.

This document/summary plan description is designed to provide you with the information you need to use your flexible benefits wisely. Please read it carefully and refer to it when you have questions.

HOW THE FLEXIBLE BENEFIT PLAN WORKS

When you enroll in the County of Sacramento's Flexible Benefit Plan you may elect to participate in some or all of the following benefit options. Specifics about each plan's coverage are described in the Summary of Benefits or the Evidence of Coverage for the specific plan, both of which are available at the Sacramento County Department of Personnel Services Employee Benefits Office website.

- Flexible Spending Account
  - Medical Reimbursement Account allows you to set aside a portion of your before-tax salary dollars to reimburse yourself for eligible expenses which are not covered by a group medical, prescription drug, vision or dental plan.
  - Dependent Care Reimbursement Account allows you to use before-tax salary dollars to reimburse yourself for work-related dependent care expenses.
- Premium Conversion Option allows you to pay contributions for the medical, dental, and vision coverage you have selected for you or your family members through the County's benefit plans with before-tax salary dollars.
- Health Savings Account allows you to set aside a portion of your before-tax salary dollars to establish an account to reimburse yourself for qualified medical expenses. You must be enrolled in one of the High Deductible Plans in order to participate in this option.
- Cash Benefit Feature allows those eligible to elect a health plan whose premiums are less than the amount the County will subsidize so the "extra" amount will be added to your paycheck as taxable income. If you waive coverage you may be eligible to receive additional cash in your paycheck. Eligibility for this benefit is determined by your date of hire and your bargaining unit. Not all employees are eligible.



The amounts you decide to contribute towards certain benefit options provided through the Plan are deducted from your paycheck on a before-tax basis. In other words, your cafeteria plan contributions are deducted from your paycheck before FICA (Social Security and Medicare), Federal and State income taxes are withheld. This lowers your taxable income, so you pay less in taxes.

FLEXIBLE SPENDING ACCOUNT

MEDICAL REIMBURSEMENT ACCOUNT

Your Medical Reimbursement Account is a valuable benefit that enables you to reimburse yourself for your out-of-pocket medical expenses with before-tax money. All County employees who are eligible for health insurance benefits are eligible to participate in the Medical Reimbursement Account.

Monies you deposit into your Medical Reimbursement Account can be used towards expenses which you are responsible for after your regular medical coverage makes payment. All expenses must be for services provided during the Plan Year or during the grace period extension which allows you to incur expenses up to March 15th of the following year.

If you have elected to have a portion of your pay deposited in your Medical Reimbursement Account, those funds will be withheld from your pay on a before-tax basis. This means those salary reductions will come out of your paycheck before taxes are calculated. You will not be subject to taxation on those amounts even when you make a withdrawal from the account to reimburse yourself for an eligible expense. The annual maximum that you can deposit into your account is $2,500.00.

SPECIAL RULES

- The Federal Tax law has a "use it or lose it" rule. Any unused amounts in your account at the end of the Grace Period will be forfeited if not claimed by April 30th following the end of the Plan Year. Likewise, any unreimbursed medical expense incurred in a previous Plan Year cannot be paid with funds from your current Plan Year account.

  Any forfeited funds will be used as follows: first, to offset any losses experienced by the County during the Plan Year; second, to offset the cost of administering the Flexible Benefit Plan during the Plan Year; and third, to provide increased benefits or reduced premiums to Participants in subsequent Plan Years.

  An exception to this rule would be if you qualify for a distribution under the Heroes Earnings Assistance and Relief Act of 2008 (the "HEART Act"). If you are qualified for this exception you may withdraw all or a portion of the balance of your Medical Reimbursement Account to be included as taxable wages and income when you are called to active duty for more than 179 days or an indefinite period.

- A new enrollment is required each year, even if you do not plan to change the amount set aside.

- Except for a change in status event, the only time you can enroll, change, or stop your Medical Reimbursement Account is during Open Enrollment. You only have 30 days from date of hire or

a change in status event to enroll or make a change. 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.

- Orthodontia expenses are reimbursable if the treatment is designed to correct a medical condition such as malocclusion. Orthodontia expenses for treatment designed primarily to improve your appearance are not reimbursable. Expenses for orthodontic care may be reimbursed in one of the following ways:
    1) If you pay an initial down payment at the start of treatment, then spread the remaining balance out under a payment plan, you may be reimbursed for the down payment amount at the time it is paid, and for the monthly service amounts paid through the Plan Year, or
    2) If you spread the full contract amount out under a payment plan, you may be reimbursed for your monthly service amounts paid through the Plan Year, or
    3) If you pay the complete amount due when treatment begins, you may be reimbursed for the full contract amount as of the date paid.

  If you selected #1 or 2 above you may sign an "Orthodontia Contract" to allow for automatic reimbursement. The contract is available on the Employee Benefits Office website. You will have 3 options for frequency of reimbursement to choose from on the contract. A new contract will have to be completed each calendar year. The orthodontist will have to sign the contract. Payments made toward orthodontia treatment in a previous plan year or before your eligibility period are not reimbursable.

ELIGIBLE EXPENSES

With some exceptions, expenses that are eligible for reimbursement from the Medical Reimbursement Account are any expenses that are deductible on your federal income tax. You can find guidance on what is an eligible expense by contacting your tax consultant, the IRS, or consulting IRS Publication 502 available through the IRS website www.irs.gov.

Eligible expenses are those for yourself, your spouse or your dependent either when the services were provided or when you paid for them.

Spouse

The IRS says you can include medical expenses you paid for your spouse as long as you were married to him/her either at the time your spouse received the medical services or at the time you paid the medical expenses.

Dependent

The dependent must have been your dependent either at the time the medical services were provided or at the time you paid the expenses. To qualify as your dependent for the Medical Reimbursement Account the person must meet both of the following requirements.

- The person was a qualified child or a qualified relative, and
- The person was a U.S. citizen or national or a resident of the United States, Canada, or Mexico.

Qualified Child

A qualified child is a dependent child who:

1) Is your natural born child, stepchild, foster child, legally adopted child, or one that you have legal guardianship of, and
2) Is:
    a. Under age 26, or
    b. Any age and physically and/or mentally incapable of self care

Qualified Relative

A Qualified Relative is a person:

1) Who is your:
    a. Son, daughter, stepchild, or foster child, legally adopted child, or a descendant of any of them (for example, your grandchild),
    b. Brother, sister, half-brother, half-sister, or a descendant of any of them,
    c. Father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle),
    d. Stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law brother-in-law, or sister-in-law, or
    e. Any other person (other than your spouse) who lived with you all year as a member of your household if your relationship did not violate local law,
2) Whose gross income for the calendar year in which such taxable year begins is less than the exemption amount (as defined in USC Section 151(d)),
3) With respect to whom you provide over one-half of the individual's support for the calendar year in which such taxable year begins, and
4) Who was not a qualified child.

NOTE: Domestic partners and their dependents are not qualified dependents unless they meet the above definition.

A partial list of eligible expenses (For a complete list refer to IRS Publication 502)

Acupuncture
Alcoholism treatment
Ambulance service
Artificial limbs
Birth control pills
Breast pumps
Braille books and magazines
Car controls for the handicapped
Chiropractic care
Contact lenses – corrective
Contact lens solutions and cleaners
Crutches
Dental fees
Dental implants
Diagnostic tests
Doctors' fees
Duplicate prosthetic devices
Drug addiction treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Health and dental insurance deductibles and co-insurance
Hearing aids and exams
Hearing treatment
Hospital services
In-patient or out-patient therapy for mental or nervous disorders
Injections
In vitro fertilization
Lab fees
Laser eye surgery
Learning disability tuition
Massage therapy
Medical mileage
Nursing services
Optometrist fees
Orthodontic treatment
Over the counter drugs with a prescription
Orthopedic shoes
Oxygen
Psychoanalysis
Periodontal fees
Prescription drugs to alleviate nicotine withdrawal symptoms
Reconstructive surgery after mastectomy
Smoking cessation programs/treatments
Radial keratotomy
Special schools for the handicapped
Surgery
Telephone for the deaf
Transplants of organs
Transportation for local and medically necessary out-of-town care
Vaccinations
Vitamins/natural supplements - prescribed
Weight-loss programs/meetings
Wheelchairs
X-rays

Some of these items may require a Letter of Medical Necessity from the treating healthcare provider or may only be reimbursable if a physician prescribes the treatment as medically necessary to prevent, treat or alleviate a specific diagnosed medical illness (such as hypertension, diabetes, or obesity).

INELIGIBLE EXPENSES

Airborne
Books
Boutique practice fees
COBRA premiums
College Insurance
CPR classes
Electrolysis/laser hair removal
Face lift
Imported OTC items
Imported prescriptions
Insurance premiums
Late fees
Liposuction
Marijuana
Marriage counseling
Massage chair

Finance charges
Funeral expenses
Gender reassignment
Gym membership
Hair transplant
Household help
Hygiene products
Illegal operations/substances
Mattress
Missed appointment fee
Hair growth products
Electric toothbrush/picks
Teeth whitening
Toiletries
Veneers
Warranties

This is a partial list. For a complete list please refer to IRS Publication 502.

ENROLLMENT AND MAKING CHANGES

You may enroll during the 30 day period following your date of hire, or during Open Enrollment.

Mid-year changes are only allowed if you have a "change in status" event (see page 25). If this occurs, you must inform the County with 30 days of the "change in status" event.

HOW TO MAKE A CLAIM

The County uses a third party as claims administrator. Once you enroll in the Plan they will send you an enrollment kit which explains how the Plan works, how to get reimbursed, including the online process if available, and how to contact them. They will provide you with an initial reimbursement voucher that you submit to them along 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.

You can also complete a Flexible Spending Account Claim Form available at the Sacramento County Department of Personnel Services Employee Benefits Office website http://hra.co.sacramento.ca.us/Employ/ben/content.htm.

As long as you are continuing your salary reductions, the annual amount you have elected for this account will be available for reimbursement at any time during the Plan Year, reduced by the amount of prior reimbursements received during the Plan Year.

Reimbursement claims must be submitted to the claims administrator by April 30th following the close of the Plan Year for which the benefit election is effective.

The claims administrator processes and pays claims weekly. You will either receive a check sent to your home address or, if you have signed up for direct deposit, your reimbursement will be deposited directly into your bank account.

PARTICIPATION TERMINATION AND COBRA CONTINUATION COVERAGE

Your contributions will cease when your employment ends. The Plan shall reimburse any eligible expenses which were incurred before your employment ended, less benefits already paid during the Plan Year up to the amount of your annual benefit. However, you have the option to continue coverage past your termination date by electing COBRA coverage.

If you elect COBRA coverage under the MRA, you must continue contributing to your MRA, and you will continue to be reimbursed for claims incurred up through the last month for which you made contributions. If you were a participant on December 31st of that year you would be eligible for the grace period feature which allows you to continue to incur and be reimbursed for eligible expenses 2 months and 15 days into the following year. (Note: This is a separate COBRA election from the COBRA election you may want to make to continue coverage under your group health plan.) You can elect MRA COBRA coverage only if you have not overspent your MRA as of the date your employment terminated (taking into account all claims incurred up through that date).

If you elect MRA COBRA coverage, you will have to continue contributing on an after-tax basis the same amount that was being deducted from your paycheck on a before-tax basis. In addition, a 2% administrative fee will be added on.

FLEXIBLE SPENDING ACCOUNT

DEPENDENT CARE REIMBURSEMENT ACCOUNT

Your Dependent Care Reimbursement Account is a valuable benefit that enables you to reimburse yourself for your child care expenses with before-tax money. All County employees who are eligible for health insurance benefits are eligible to participate in the Dependent Care Reimbursement Account.

Monies you deposit into your Dependent Care Reimbursement Account can be used for qualified childcare or dependent care expenses that you have so you (and your spouse) may work, look for work, or go to school full time. All expenses must be for services provided during the Plan Year.

If you have elected to have a portion of your pay deposited in your Dependent Care Reimbursement Account, those funds will be withheld from your pay on a before-tax basis. This means those salary reductions will come out of your paycheck before taxes are calculated. You will not be subject to taxation on those amounts even when you make a withdrawal from the account to reimburse yourself for an eligible expense. Your annual election limits are explained below:

- If you are single, the maximum contribution is $5,000
- If you file your income taxes as "head of household" or "married, filing jointly", the maximum is $5,000
- If either you or your spouse earn less than $5,000 a year, you can contribute only as much as the lower of the two incomes
- If your spouse is a full time student or incapable of self-care, the maximum contribution is $3,000 a year for one dependent and $5,000 a year for two or more dependents
- If you are married, but your spouse maintains a separate residence for the last six months of the calendar year and you provide more than one-half of the cost of maintaining your dependent and you file a separate tax return, the maximum is $5,000
- If you are married, live with your spouse and file a separate tax return, the maximum is $2,500

SPECIAL RULES

- The Federal Tax law has a "use it or lose it" rule. Any unused amounts in your account at the end of the Grace Period (January 1st to March 15th) will be forfeited if not claimed by April 30th following the end of the Plan Year. Likewise, any unreimbursed dependent care expense incurred in a previous Plan Year cannot be paid with funds from your current Plan Year account.

  Any forfeited funds will be used as follows: first, to offset any losses experienced by the County during the Plan Year; second, to offset the cost of administering the Flexible Benefit Plan during

the Plan Year; and third, to provide increased benefits or reduced premiums to Participants in subsequent Plan Years.

- A new enrollment is required each year, even if you do not plan to change the amount set aside.

- Except for a change in status event, the only time you can enroll, change, or stop your Dependent Care Reimbursement Account is during Open Enrollment. However, in addition to the normal list of qualifying events, there are some special events exclusive to the DCRA;

    - A change in your day care costs, such as a rate decrease or increase, or receiving free day care
    - A change in your need for day care (your spouse loses employment or has a change in work schedule)
    - Your dependent ceases to satisfy the eligibility requirements

  You only have 30 days from date of hire or a change in status event to enroll or make a change. 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.

- Eligible expenses may be reimbursed through your Dependent Care Reimbursement Account up to the balance available in the account on the date your claim is processed. If your claim exceeds the amount available in your account, the reimbursement will be made using the available funds. Additional reimbursements will be made after further funds are withheld from your paycheck by the County and deposited into your Dependent Care Reimbursement Account.

- To elect automatic reimbursement you must complete a Dependent Care Contract. A new contract needs to be completed each calendar year. You will have 3 choices of the frequency of reimbursement. The contract is available on the Employee Benefits Office website. Your provider will need to sign the contract.

ELIGIBLE EXPENSES

Expenses that are eligible for reimbursement under the Dependent Care Reimbursement Account are any expenses that you or your spouse incur so you can work, look for work, or go to school full time. Eligible dependents include:

- Dependent children under the age of 13 for whom you are entitled to a tax deduction
- Dependent parents, provided they have a gross income of less than the exemption amount in IRC 151(d) (income test);
- Any dependent who lived with you for more than half of the year and who is physically or mentally unable to care for himself/herself while you or your spouse are at work.

Examples of types of dependent care:

- Babysitters
- Family daycare, which is childcare in the home of the provider
- Childcare centers, which are usually a separate facility and not in a residence
- Nanny/au pair, which is a paid household employee who provides care in your home
- Nursery school and preschool, which are primarily for care and not education
- After-school programs, church programs and other state licensed programs
- Day camp, if the purpose of sending the child is for the care and wellbeing of the child

INELIGIBLE EXPENSES

Expenses not eligible for reimbursement because they are not primarily for care but for education include:

- First-grade or higher grade expenses
- Kindergarten costs
- Expenses for the educational portion of the boarding school
- Care provided by a nursing home
- Care provided by another dependent
- Cost of food, clothing or education
- Transportation costs between your home and where the services were provided
- Overnight camp
- Payments to your child who is under age 19 at the end of the calendar year or someone for whom you or your spouse could claim a deduction under IRC 151(c), such as a relative living in the home
- Payments to your spouse or to the parent of the employee's under age 13 qualifying child

These are examples, and not a complete list, of the types of care that are either eligible or not eligible for reimbursement. Check with your tax consultant or the IRS for guidance.

ENROLLMENT AND MAKING CHANGES

You may enroll during the 30 day period following your date of hire or return from an unpaid leave of absence. You may also enroll during Open Enrollment for a January 1st effective date.

Mid-year changes are only allowed if you have a "change in status" event (see page 25). If this occurs, you must inform the County with 30 days of the "change in status" event.

HOW TO MAKE A CLAIM

The County uses a third party as the claims administrator. Once you enroll in the Plan they will send you an enrollment kit which explains how the Plan works, how to get reimbursed and how to contact them. They will provide you with an initial reimbursement voucher that you return to them along with proof of the expenses that you incurred. Copies of receipts need to be attached to your reimbursement voucher. If you elect automatic reimbursement you will need to complete a Dependent Care Contract which is available on the Sacramento County Department of Personnel Services Employee Benefits Office website.

The amount in your account will be available for reimbursement at any time during the Plan Year. However, the reimbursement cannot exceed the account balance. It is not necessary for you to have actually paid an amount due for eligible dependent care expenses, only that you have incurred the expense, and that services have been rendered.

PARTICIPATION TERMINATION

Your participation will cease when you stop making contributions either due to your termination of employment or any allowable change event. If you have a balance left in your account you can continue to submit claims for expenses incurred before your participation ceased.

Exception: The County allows you a grace period of 2 months and 15 days following the end of the calendar year. Claims that you incur during the grace period may be reimbursed from money set aside during the prior plan year. A grace period shall apply only if you are participating on the last day of the plan year (i.e. had a full required salary reduction for the month of December).

PREMIUM CONVERSION OPTION

The Premium Conversion Option reduces your before-tax salary in order to pay your contribution for coverage you have elected through the County's medical plan, dental plan, and vision plan.

The portion of your salary which is "converted" to a premium coverage contribution is deducted from your paycheck before Social Security, Medicare, Federal and State Income taxes are withheld.

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 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.

If you wish to opt out of this benefit contact the County of Sacramento Department of Personnel Services Employee Benefits Office at (916) 874-2020 or DPSBenefits@saccounty.net for the appropriate form.

HEALTH SAVINGS ACCOUNT

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

You are not required to have an HSA if you enroll in HDHP coverage. If you elect to establish an HSA with another financial institution, you will make your contributions on an after-tax basis and you may claim these contributions on your itemized tax return.

If you set up your HSA with the County's preferred provider your contributions will be taken from your salary on a before-tax basis. The provider may charge you a monthly administrative fee for the HSA.

SPECIAL RULES

- You must be enrolled in a HDHP
- You must be enrolled with the HDHPs preferred provider if you want the before-tax salary reduction
- You must have no other non-HDHP coverage (including group coverage through your spouse or an FSA or MRA)
- You cannot create or contribute to an HSA account if you have a balance in your Medical Reimbursement Account
- You must not be enrolled in Medicare
- You must not have received VA medical benefits at any time over the past three months
- You must not be able to be claimed as a dependent on someone else's tax return

ELIGIBLE EXPENSES

The Internal Revenue Code 213(d) states that eligible expenses must be made for "medical care." This is defined as amounts paid for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

Qualified medical expenses are eligible for reimbursement through your HSA as long as they are not reimbursed through insurance or other sources.

The medical expenses can be for yourself, your spouse or your dependent children that you claim on your tax return up to age 24. Your spouse and dependents do not need to be covered by the same high deductible health plan.

NOTE: Domestic partners and their dependents are not qualified dependents.

The following examples are provided by the IRS and may be subject to change. This is a partial list. For the most current list you can refer to IRS Publication 502.

Acupuncture
Alcoholism treatment
Ambulance services
Artificial limb or prosthesis
Artificial teeth
Birth control pills
Braille books/magazines (portion of costs)
Car adaptations (for a person with a disability)
Chiropractors
Christian Science practitioners
Contact lenses (including saline solution and cleaner)
Crutches
Dental treatment (x-rays, fillings, extractions, dentures, braces, etc.)
Diagnostic devices (such as blood sugar test kit)
Vasectomy
X-rays
Guide Dog (for visually or hearing impaired)
Hearing aids and hearing aid batteries
Hospital services (including meals and lodging)
Insulin
Laboratory fees
Lactation assistance supplies
Prescription medicines or drugs
Nursing home
Nursing services
Operations or surgery
Psychiatric care
Psychologist
Telephone equipment for hearing impaired
Telephone equipment for visually impaired
Therapy or counseling
Transplants
Transportation for medical care
Wheelchair

Generally, you cannot use your HSA to pay premiums for health insurance coverage. However, the following types of insurance premiums typically do qualify:

- Continuation coverage under federal law (i.e., COBRA)
- Qualified long-term care insurance contract
- Any health plan maintained while an individual is receiving unemployment compensation under federal or state law
- For those age 65 and over (i.e., those eligible for Medicare), premiums for any health insurance (including Medicare and Medicare Part D premiums) other than a Medicare supplemental policy

INELIGIBLE EXPENSES

Items that are merely beneficial to your general good health, such as vitamins or dietary supplements, are not qualified medical expenses.

There may be situations when your doctor recommends a treatment that will be good for your health, but it still may be considered ineligible, such as a vacation.

As the HSA owner, you are ultimately responsible for determining whether a healthcare expense is eligible for reimbursement from your HSA.

Examples of expenses that DO NOT qualify for reimbursement through an HSA:

Babysitting, childcare, and nursing services for a normal, healthy baby
Controlled substances obtained in violation of federal law
Cosmetic surgery
Dancing lessons
Diaper service
Electrolysis or hair removal
Funeral expenses
Hair transplant
Health club dues
Household help
Illegal operations and treatments
Maternity clothes
Over-the-counter medications (without a doctor's prescription)
Personal use items
Swimming lessons
Teeth whitening
Vacation or Travel
Veterinary fees
Weight loss programs for improvement of appearance, general health or sense of well-being

HOW TO MAKE A CLAIM

The institution that you set up your Health Savings Account with will give you instructions on how to submit claims to them.

ENROLLMENT AND MAKING CHANGES

You will need to enroll in one of the County's High Deductible Health Plans first. Once enrolled you must determine what institution you want your account set up with. If you are setting your account up with the County's preferred provider, their forms are located on the Employee Benefits Office website.

You can enroll or make a change in your contribution amount at any time. If you become newly eligible during the year you can prorate your contribution amount by the number of months remaining in the year or if you are eligible on December 1st you can contribute the maximum full year coverage level contribution for that year. You must continue to remain eligible for a period beginning December 1st of the year in which you become eligible and ending on December 31st of the following year to avoid a tax penalty.

CONTRIBUTION LIMITS

The maximum you can contribute annually to an HSA is determined by the IRS. For 2013 the maximum is $3,250.00 for single coverage and $6,450.00 for family coverage. If you are age 55 or older you can

make an additional catch-up contribution of up to $1,000.00. For the most recent contribution limits consult your tax advisor or the IRS.

WHAT HAPPENS WHEN YOU LEAVE COUNTY EMPLOYMENT

HSAs are owned by the individual, so if you leave the County you still may keep the account. The HSA is portable, so you can use the assets even if you leave County employment.

The assets in your account roll over from year to year.

TAXATION OF DISTRIBUTIONS

Neither the distributions nor the earnings are taxable to you as long as the distribution was to reimburse yourself for a qualified medical expense. If the distribution was for non-medical expenses you will owe Federal income tax and incur a 20% penalty. (The penalty and tax don't apply after your death or if you are disabled or age 65 or older)

CASH BENEFIT FEATURE

The cash benefit feature has two components:

- Cash Back from subsidy
- Plan Selection Incentive (PSI)

This feature is only available to those employees who are in Tier A which is explained below.

Tier A - Employees who were in a benefit eligible position before January 1, 2007
Tier B - Employees who were hired into a benefit eligible position on or after January 1, 2007 or who were in Tier A and made a one-time election to move to Tier B

SPECIAL RULES

- You have a one-time opportunity to move from Tier A to Tier B. The results may be that you are able to reduce your portion of the medical plan premium.
- A change from Tier A to Tier B is not mandatory or required. It is a voluntary decision that is irrevocable once made. The change can only be made during Open Enrollment or during a "change in status" event.
- Employees in Tier A who are eligible for Cash Back or the Plan Selection Incentive (PSI) and move to Tier B forfeit all future rights to Cash Back or PSI.

CASH BACK FROM 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 – 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. Your bargaining agreement describes the eligibility for these programs and is available on the website at: http://www.laborrelations.saccounty.net/LaborAgreements/default.htm

If the plan you selected costs less than the subsidy, you may be eligible to receive that amount in your paycheck. Each REO has a "designated date" that determines eligibility for Cash Back. To determine the applicable designated date for your REO, see the chart on the following page.

Recognized Employee Organization (REO)	Eligible for Cash Back if hired on or before
005	December 27, 1997
027	January 18, 1998
001, 028, 029, 032, 033, 034, 050, 060, 070, 080	February 1, 1998
022, 023	April 12, 1998
019	July 19, 1998
010	August 2, 1998
007	August 30, 1998
006, 030	October 11, 1998
017	November 22, 1998
013, 014	December 6, 1998
020, 021, 026	June 20, 1999
016	July 18, 1999
008	August 15, 1999
003	October 24, 1999
018	November 7, 1999
002, 004, 025, 031	November 21, 1999

PLAN SELECTION INCENTIVE

If you were hired before January 1, 2007 and after the date above and your REO has negotiated with the County for this benefit, or you are an eligible unrepresented employee, a Plan Selection Incentive (PSI) payment of $150.00 per month will be made to you if you waive the County provided medical benefit. You may only waive this benefit if you have other group health coverage. The County requires you to provide documentation verifying the other coverage.

If you waive your coverage and later choose to enroll you may enroll during Open Enrollment or within 30 days of a mid-year "change in status" event.

If you were hired after December 31, 2006 you are not eligible for Cash Back or PSI.

Note: You have 60 days to enroll in or waive County coverage if you gain or lose either Medi-Cal or SCHIP coverage under certain conditions. Coverage changes will be effective the first of the month following receipt of the forms in the Employee Benefits Office.

GENERAL INFORMATION

PURPOSE OF THE PLAN

The purpose of the Plan is to allow eligible employees to elect benefits and use funds provided by the County through an employee Salary Reduction Agreement, to pay for one or more of the benefits offered through the Plan on a tax preferred basis.

HOW LONG THE PLAN WILL REMAIN IN EFFECT

Although the County expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan at any time. The Plan may be amended or terminated by a written resolution adopted by a majority of the County's Board of Supervisors. The Plan will also automatically terminate if the County;

- Is legally dissolved;
- Makes a general assignment for the benefit of its creditors;
- Files for liquidation under the Bankruptcy Code;
- Merges or consolidates with any other entity and it is not the surviving entity, or if it sells or transfers substantially all of its assets, or goes out of business, unless the County's successor in interest agrees to assume the liabilities under this Plan as to the participants and eligible dependents.

If the Plan is terminated, credits to your accounts will be used to provide benefits through the end of the Plan Year in which termination occurs. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

FIDUCIARY

The County of Sacramento is the Plan Administrator and named fiduciary, with respect to the Plan, for everything not delegated to another fiduciary. The County of Sacramento shall exercise all discretionary authority and control with respect to management of the Plan.

The County of Sacramento may delegate certain fiduciary responsibilities under the Plan to persons who are not named fiduciaries of the Plan. If fiduciary responsibilities are delegated to any other person, such delegation of responsibility should be made by written instrument executed by the County of Sacramento. A copy of the written instrument delegating the responsibility will be kept with the records of the Plan.

Each fiduciary under the Plan shall be solely responsible for its own acts or omissions.

PARTICIPANTS' KEY RESPONSIBILITIES

It is a participant's responsibility to: 1) ensure that benefits are provided to only the participant, spouse and eligible dependents as defined by the Plan; 2) provide accurate and reliable information to the Plan Administrator upon request; 3) provide documentation to verify the status of a spouse or dependent (such as marriage certificate, birth certificate, adoption or guardianship papers, etc.) or to establish the occurrence of a Change in Status event (such as a divorce decree or verification of a change in coverage from another employer); and 4) notify the Plan Administrator of any circumstance that may affect the before-tax status of benefits under the Plan. This includes immediately notifying the Plan Administrator if anyone for whom they have been obtaining benefits under the Plan is no longer a legal spouse or dependent as defined by the Plan.

PARTICIPANTS' RIGHTS

As a participant in the County's Flexible Benefit Plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U. S. Department of Labor, if any.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for copying these documents.
- In addition, the individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including the County, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit from the Plan, or from exercising your rights.

DENIAL OF A CLAIM

The Plan Administrator shall provide to every claimant who is denied a claim for benefits a written notice containing the following information and setting forth in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary, and
- An explanation of the Plan's claim review procedure.

Within sixty (60) days after the receipt by the claimant of written notification of the denial (in whole or in part) of his/her claim, the claimant or their duly authorized representative may:

- Make a written application to the Plan Administrator, in person or by certified mail, postage paid, to be afforded a review of such denial;
- Review pertinent documents; and
- Submit issues and comments in writing.

Upon receipt of a request for review, the Plan Administrator shall make a prompt decision on the review matter. The decision on such review shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent Plan or insurance policy provisions on which the decision was based. The decision upon review shall be made not later than sixty (60) days after the Plan Administrator's receipt of a request for a review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered not later than one hundred twenty (120) days after receipt of a request for review. If an extension is necessary, the claimant shall be given written notice of the extension prior to the expiration of the initial sixty (60) day period. If notice of the decision on the review is not furnished in accordance with these timelines, the claim shall be deemed denied and the claimant shall be permitted to exercise their right to legal remedy.

After exhaustion of the claims procedure as provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy.

WHEN AN EMPLOYEE IS A PARTICIPANT

Each eligible employee shall become a participant on the later of:

- The effective date;
- The first day of the month following the day on which the eligible employee meets the requirements for participation;
- The first day of the month following the day on which the eligible employee has completed the enrollment process and filed the appropriate forms and documents.

FUNDS

The County holds any money you set aside for your Flexible Spending Account.

Your Premium Conversion Option funds are sent monthly to each health plan provider.

Your Health Savings Account (HSA) funds, if you enrolled with the County's preferred provider, are sent bi-weekly as they are deducted from your paycheck.

SOCIAL SECURITY AND TAXES

Since the Plan is intended to meet certain requirement of the Internal Revenue Code, eligible benefits you receive under the Plan are not taxable to you. However, the County, the Plan Administrator, or the Plan's Claims Administrator cannot guarantee the net tax treatment to any given participant, as individual circumstances may produce differing results. Questions should be directed to your tax advisor.

Because these contributions are deducted before Social Security taxes are calculated, your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

COVERAGE PERIOD

The coverage period is the Plan Year during which period the benefits provided by this Plan shall be available to a participant. The Plan Year is January 1st thru December 31st.

HIPAA PRIVACY PRACTICES

The County of Sacramento protects the privacy of your protected health information (PHI). PHI is health information that includes your name, Social Security number, or other information that identifies you and pertains to health care. 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.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, member-identifiable medical information is shared with Employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your personal representative's) written authorization, except as described in our ***Notice of Privacy Practices***. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our ***Notice of Privacy Practices*** describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available either by accessing the County of Sacramento web site located at http://www.compliance.saccounty.net/Pages/default.aspx or by calling the Employee Benefits Office at (916) 874-2020, 8 a.m. to 5 p.m., Monday through Friday.

GRANDFATHER PLAN

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 Car 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.

GLOSSARY

The following words and phrases are used throughout this document:

After-tax: The amount of money left in your paycheck after state and federal taxes are withheld

Annual Benefit: The total amount you elected to contribute to your Medical Reimbursement Account for the Plan Year

Automatic Reimbursement: Recurring reimbursements that you can sign up for if you sign an Orthodontia Contract or a Dependent Care Contract. You will never be reimbursed for more than the amount that is in your Dependent Care Reimbursement Account.

Before-tax: This is the term used to describe monies that come out of your paycheck before Social Security and State and Federal Income Taxes. The taxes are calculated on the remaining balance.

Change in Status Event: Includes:

A change in an eligible employee's legal marital status: marriage, death of a spouse, divorce, legal separation, and annulment;

A change in an eligible employee's number of dependents, either gaining or losing a dependent, including a child placed for adoption, step-children, gain of a dependent through legal guardianship, and/or a foster child;

A change in employment status of an eligible employee, spouse, or dependent that affects eligibility including a strike or lockout, commencement or return from an unpaid leave of absence of more than thirty (30) days, change in worksite, and certain changes in the eligibility of the spouse's employer's Section 125 plan;

An event causing an eligible employee's dependent to satisfy or cease to satisfy eligibility requirements, such as: a change in age, change in legal custody, or similar circumstances. (A dependent's loss of eligibility due to non-payment of contributions is not a qualifying event.);

A change in residence of an eligible employee, spouse, or dependent that triggers a gain or loss of eligibility, including moving in or out of a health plan's service area.

A commencement or termination of adoption proceedings;

An FMLA Leave;

A gain or loss of eligibility for Medicare, Medi-Cal, or Medicaid;

A Qualified Medical Child Support Order;

A cost change with automatic increase/decrease in elective contributions of a benefit package including changes in administration costs or premium changes;

A significant cost increase/decrease of a benefit package option;

A significant coverage curtailment of a benefit package option;

An addition, significant improvement, or elimination of a benefit package option;

A change in coverage of spouse or dependent under another employer's cafeteria plan including during the other employer's open or annual enrollment election period;

A loss of coverage under a group health plan of a government or an educational institution (A gain in coverage under a group health plan of a government or an educational institution is not a change in status event);

A HIPAA special enrollment event;

A significant cost change imposed by a dependent care provider who is not a relative of the employee.

Note: You have 60 days to enroll in or waive County coverage if you gain or lose either Medi-Cal or SCHIP coverage under certain conditions. Coverage changes will be effective the first of the month following receipt of the forms in the Employee Benefits Office.

Claims Administrator: The company that processes and pays your claims. Your Plan has different Claims Administrators based on the type of claim (Medical/Dependent Reimbursement Account or Health Savings Account). The Claims Administrator for each type of claim is responsible for claims processing within the time periods listed for initial claims determination.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1986 that requires group health plans to provide employees and eligible family members the opportunity to continue health care coverage at their own expense.

County: The County of Sacramento as the employer, or successor thereof that subsequently adopts this Plan.

Distribution: The reimbursement amount paid to you from your Medical Reimbursement Account once your claims are processed.

Eligible Employee: An eligible employee is defined as 1) a regular employee who is working full time or part time for the County; or 2) any regular employee who temporarily transfers to a temporary position. A regular employee for purposes of this Plan 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 a class which is intended for permanent or career-type employment;

An eligible employee includes elected officials.

For the purposes of this Plan, part time is defined as working at least twenty (20) hours per week or forty (40) hours in a bi-weekly pay period. Full time 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.

Fiduciary: Is any person who has discretionary authority with respect to administration of the Plan, handling of the Plan's assets, or acts as a professional investment advisor or fund manager with respect to the Plan's assets.

Grace Period: Is the two (2) month plus fifteen (15) day period following the end of a Plan Year during which a participant can be reimbursed with funds carried over from the prior Plan Year for eligible expenses incurred within that specified period.

High Deductible Health Plan: Is a health plan with a high deductible that applies to both medical and prescription expenses. There is an exception for some preventative care. The deductible and out of pocket limits are set annually by the IRS. The County offers two (2) High Deductible Health Plans.

Open Enrollment: The County has identified Open Enrollment as a time each Fall during which you may change health plans and/or add or delete dependents.

Participant: Is an eligible employee enrolled in a benefit plan that is part of the Flexible Benefit Plan.

Plan Year: Is the annual accounting period of the Plan, which shall begin January 1st and end on December 31st of each year.

Plan Administrator: Is the person appointed by the County with authority and responsibility to manage and direct the operation and administration of the Plan. If no such person is appointed, the Plan Administrator shall be the County.

Salary Reduction: Is the amount of salary you elect to pay for benefits under the Plan on a before-tax basis.

Salary Reduction Agreement: Is the written agreement by which you agree to reduce your salary on a before-tax basis to pay the benefits under the Plan.

Spouse: Is an individual who is legally married to a participant, but shall not include an individual separated from the participant under a legal separation decree.

Subsidy: Is the amount the County pays towards the total cost of your health, dental and vision elections.

ADMINISTRATIVE INFORMATION

PLAN NAME

County of Sacramento Flexible Benefit Plan

EFFECTIVE DATE OF THE PLAN

The Plan became effective October 1, 1984. It was amended and restated January 1, 2005 and was amended October 26, 2010. It has most recently been restated and amended effective January 1, 2013.

TYPE OF PLAN

A cafeteria plan intended to qualify under Section 125 of the Internal Revenue Code

PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS

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(916) 874-2020
Identification Number: 94-6000529
Plan Number: 502

DEPARTMENT OF PERSONNEL SERVICES
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