2022 MyBenefits Summary

Helping you make informed choices so you and your family members live and play well.

Special District

SACRAMENTO COUNTY

INTRODUCTION

The County of Sacramento is committed to your overall health and well-being, and we're pleased to offer a comprehensive benefits program that provides valuable health care coverage for you and your family.

It is your responsibility to make sure you understand your benefits and use them wisely. This Handbook is designed to assist you in doing just that. We encourage you to refer to it throughout the year so you can make benefit choices that help you and your family members live and play well.

Your benefits are subject to the schedule of covered services as described in the Evidence of Coverage (EOC) for your medical plan which is available in the Employee Benefits Office or online at http://www.personnel.saccounty.net/Benefits. The Plan summaries contained in this book are for comparison purposes only. The Summary of Benefits and Coverage (SBC) for each medical plan is also available on the Employee Benefits Office website.

DISCLAIMER

The County of Sacramento reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the applicable EOC, insurance contracts or plan documents, the provisions of the applicable EOC, insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Reasonable attempts will be made to inform you of any changes to the information in this booklet. However, it is your responsibility to read, understand, and comply with the County's policies, and stay informed of changes. Changes will take effect regardless of whether any particular notice is received.

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OVERVIEW

As an employee of a Special District participating in the County of Sacramento benefit plans, you have a variety of benefits available to you depending on your Districts participation. This handbook provides and overview of the following benefits, which may or may not apply to you based upon your Districts participation:

- Medical Plans
- Dental Coverage
- Vision Benefits
- Life Insurance
- Making Changes to Coverage
- Coverage for your Dependents
- COBRA Continuation Coverage
- Leave of Absence

COVERAGE OPTIONS

The options available to you through the County's benefit program vary from District to District. You will have different benefits available to you based upon your District's participation. Contact your District Administration office directly for information on the benefits available to you

COST OF COVERAGE

Each Special District has a unique benefit and contribution package. For some benefits your District 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 your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select. Contact your District's Administration office for more information on the cost of your benefits.

2022 MEDICAL PREMIUM COSTS

Plan	Single/Family	Total Monthly Premium
Kaiser $15 HMO	**S**	**$948.88**
	F	**$2,426.46**
Kaiser HD HMO	**S**	**$686.22**
	F	**$1,754.80**
Sutter $15 HMO	**S**	**$866.76**
	F	**$2,220.72**
Sutter HD HMO	**S**	**$638.70**
	F	**$1,635.10**
WHA $15 HMO	**S**	**$803.56**
	F	**$2,057.22**
WHA HD HMO	**S**	**$613.70**
	F	**$1,571.10**

ELIGIBILITY FOR BENEFITS

These rules are only applicable for the benefits your District is participating in through the County's benefit program. For eligibility regarding benefits your District has contracted with another entity, please contact your District Administration office directly.

EMPLOYEE

An "Eligible Employee" is defined as:
1) full-time and part-time employees of Special Districts;
2) an elected official and his or her exempt deputy or assistant;
3) any regular employee who temporarily transfers to a benefited temporary position.

An eligible employee is not an employee of a temporary agency, a contractor, or any other person who does not occupy a permanent position in accordance with the annual salary ordinance.

DEPENDENTS

Eligible dependents include:

- **Your spouse**-lawfully married;
- **Your domestic partner**-registered with the Secretary of State;
- **Children**-natural, step, adopted, and legal guardian (all up to age 26), and/or foster children (up to age 21) of the employee or spouse/domestic partner. Children over age 26 with a certified mental or physical disability are also eligible regardless of age. Diagnosis of the disability must occur prior to the child reaching the respective age limit.

NOTE: Your grandchild is not eligible for coverage unless you or your spouse/domestic partner has legal custody of that child.

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

INELIGIBLE DEPENDENTS

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

CHANGES TO COVERAGE

NEW HIRES

In order to enroll in the benefit plans of your choice, benefit elections must be made within the first 30 days of becoming eligible. Any required supporting documentation must be submitted to your District Office or the County's Employee Benefits Office for final approval within 7 days of your benefit elections. Coverage is effective the 1st day of the month following the enrollment. If you do not enroll within the first 30 days of becoming eligible or provide the required documentation timely you will be enrolled in the default plans as described in the contract.

MID-YEAR LIFE EVENTS

During the year, you may experience a "qualifying event" such as marriage, divorce, domestic partnership, birth, loss or gain of group coverage, etc. The change must be on account of and consistent with the event, and must be made within 30 days of the event. Documentation to verify the event is also required within 7 days of submitting your enrollment. A Social Security number is required for dependents. For mid-year events such as a birth or adoption, the medical coverage becomes effective on the date of birth or adoption in accordance with HIPAA regulations, as long as you enroll and provide any required documentation timely. For all other midyear qualifying events, the coverage is effective the first day of the month following the event, your enrollment, **and** timely submission of required documentation. **If you do not have the supporting documentation or social security number, you still need to complete the enrollment within 30 days and request additional time for documents.**

Failure to complete your enrollment within 30 days or provide supporting documentation will result in your inability to make changes until the next qualifying event or Open Enrollment.

OPEN ENROLLMENT

All employees are provided an opportunity each year during "Open Enrollment" to change health insurance plans, and add or delete dependents without a qualifying event. Open Enrollment is usually held in the fall (October) and coverage is effective on January 1st of the following year.

If you add dependents or waive medical coverage you are required to submit supporting documents with your change form. If your District Office or the County's Employee Benefits Office doesn't receive this documentation prior to the deadline your changes will not go into effect.

WAIVER OF COVERAGE

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

MEDICAL PLANS

For employees of Special Districts participating in the medical program, you may choose from three (3) traditional Health Maintenance Organization (HMO) plans or three (3) High Deductible Health Plans (HDHP). Employees and dependents must be enrolled in the same plan. Your District may pay all or a portion of the cost for medical coverage.

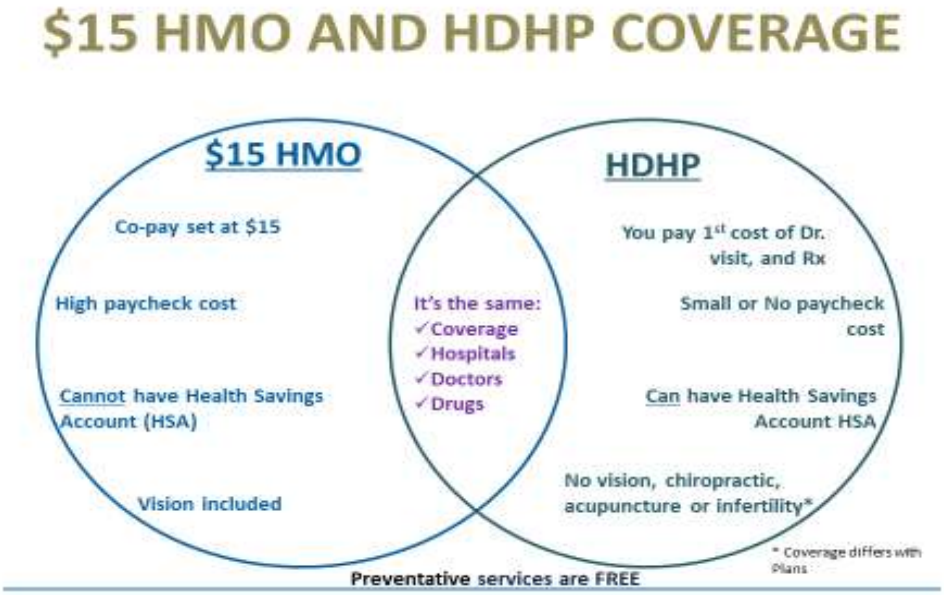
HEALTH MAINTENANCE ORGANIZATION (HMO)

A primary care physician (PCP) directs all medical care and specialist referrals. Each family member may choose his or her own PCP and may have a different medical group. The PCP and/or medical group can be changed at any time by calling your plan's customer service number. Except for emergencies, you must contact your PCP first in order for your health care to be covered. You may have a higher paycheck deduction in exchange for a fixed co-payment under an HMO.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

High Deductible plans are still HMO plans that require PCP direction. In a HDHP both medical (except for certain prevent care) and prescription expenses apply to the deductible. HDHP's are lower in monthly premiums than traditional HMO plans but have a larger out of pocket expense for services which you pay for at the time of care. Once you reach the deductible under the family plan, most services are covered at 100%. For individual coverage you only have Rx co-payments once you reach your deductible up to the out of pocket maximum.

The primary difference between the HMO and HDHP is how you pay the carrier for services. If you have questions, please contact the Employee Benefits Office at: 916-874-2020 or email at Mybenefits@saccounty.net.



MEDICAL PLANS (cont'd)

COST DIFFERENCE BETWEEN HMO VS HDHP

Although there can be substantial savings under an HDHP over a traditional HMO, there are some important factors to consider.

- With an HMO you may have a larger paycheck deduction; with the HDHP you will have a larger out of pocket cost at the time of care.
- Since you pay the cost for services at the time of care under the HDHP, you could face early out of pocket expenses at the beginning of the calendar year.
- The entire deductible for family coverage must be met ($2,800) before services are covered at 100%, but the deductible may be less than the annual payroll cost of the HMO premium.

	HMO	HDHP (HSA Qualified pg 11)
Choice of Dr	Network PCP selection required; PCP coordinates all care	Network PCP selection required; PCP coordinates all care
Specialist	Requires PCP referral	Requires PCP referral
Wellness	Preventive and well-care services are provided at no additional cost	Preventive and well-care services are provided at no additional cost
Paycheck cost	Higher cost per paycheck	Lower cost per paycheck
Cost for visits	Set co-pay, $15 for most services; lower cost at time of care	You pay up to annual deductible, then plan pays 100% (family only)
Vision	Included	Not included, option to purchase
Chiropractic	Covered	Not covered
Acupuncture	Covered	Not covered
Overall Cost	Annual cost likely higher	Annual cost likely lower

THINGS TO CONSIDER WHEN CHOOSING BETWEEN HMO VS HDHP

Your District may pay for most or all of your monthly premium, or only a portion of the extra dependent coverage. You may be able to stretch your employer provided dollars further with an HD plan. Even if your employer is paying the full cost of an HMO plan for you, choosing the HMO coverage prevents you from contributing to a Health Savings Account (HSA), which is a valuable long term savings account to offset medical, dental, vision, and RX costs, and potentially even health premiums after age 65.

You will also want to factor in your desired retirement date, because if you retire before age 65 when Medicare is available, you will be exposed to the higher non-Medicare County retiree premiums and the HSA funds can provide protection from excess deductible exposure until you reach Medicare age. For more information about an HSA, see Page 11.

HMO PLAN COMPARISONS

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

HIGH DEDUCTIBLE HMO PLAN COMPARISONS

	Kaiser Permanente	Sutter Health Plus	Western Health Advantage
General Plan Information			
Lifetime Plan Maximum	None		
Annual Deductibles	$1,400 Individual / $2,800 Family		
Annual Out-of-Pocket Limit	$2,800 Individual / $2,800 Family		
Deductible Included in out-of-pocket limits?	Yes		
Office Visit / Exam/Outpatient Specialist	100% covered after deductible		
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests	100% covered, Deductible Waived		
Well-Child Care, Immunizations			
Well Woman Exams, Mammograms			
Diagnostic X-Ray and Lab Tests	100% covered after deductible; deductible waived for preventative screens		
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal)	Deductible Waived		
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization	100% covered after deductible		
Outpatient Facility Charge			
Emergency Services			
Emergency Room, Ambulance	100% covered after deductible		
Mental Health Benefits			
Inpatient / Outpatient Care	100% covered after deductible		
Substance Abuse			
Inpatient Hospitalization	100% covered after deductible		
Outpatient Services			
Prescription Drugs			
Retail	100 Day Supply	30 Day Supply	
Generic	$10 after deductible-Individual	100% covered after deductible-Family	
Brand (Formulary/Preferred)	$20 after deductible-Individual	100% after deductible-Family	
Brand (Non-Formulary/Non-preferred)	N/A	$35 after deductible-Individual 100% after deductible-Family	
Mail Order	100 Day Supply	90 Day Supply	
Generic	$10 after deductible-Individual	$20 after deductible-Individual	
Brand (Formulary/Preferred)	100% covered after deductible-Family $20 after deductible-Individual	$40 after deductible-Individual	
Brand (Non-Formulary/Non-preferred)	100% covered after deductible-Family N/A	$70 after deductible-Individual 100% covered after deductible-Family	
Other Services and Supplies			
Durable Medical Equipment & Prosthetics Annual limits	100% covered after deductible $2,500		100% covered after deductible
Home Health Care (limited to 100 visits/yr)	100% covered after deductible (3 visits per day)	100% covered after deductible	
Skilled Nursing or Extended Care Facility--limited to 100 days per cal year	100% covered after deductible		
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	100% covered after deductible		
Chiropractic Services; Calendar year limit	Not covered		
Acupuncture Services; Calendar year limit	Not covered		

PLAN LIMITATIONS

Below is a summary of a few plan limitations associated with the County's medical benefits. If an alternate form of coverage may be available, you may want to explore that possibility:

Limitation	Explanation	Potential Alternative Coverage
Out of Area Coverage	Currently, our medical providers offer coverage only in the greater Sacramento and nearby areas.	Employees residing out of the health plan coverage area may find that their preferred coverage is unavailable. Please use the Zip Code locator option for your plan to ensure coverage is available in your actual residence area and refer to the plan's Evidence of Coverage documents for your preferred medical plan, available on the Employee Benefits Office website.
Childbirth related High Deductible Plan considerations	Change in coverage level may increase maximum annual deductible.	Newborns are covered under the mother's plan automatically for the entire month of birth. If the mother has elected employee only coverage, the birth of the child will convert the employee only HD plan to a family HD plan and the deductible will change from $1, 400 to $2800. Pre-natal refers to preventative care before the birth of a child. Childbirth is not considered preventative, and is subject to the deductible under the High Deductible plan.
Infertility Coverage	Currently, both the HMO and HDHP Plans do not offer complete infertility services (partial coverage options may be available)	n/a
NOTE: Always refer to the plan's Evidence of Coverage for complete details!		

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a voluntary savings account that you contribute to and is used for payment or reimbursement of qualified health expenses. An HSA is not a medical plan. You must be enrolled in an HDHP and have no other coverage to be eligible to contribute to an HSA. Eligible expenses are the same category as a Medical Reimbursement Account, including medical, dental vision and Rx expenses; however the amount available is limited to your account balance.

Some of the benefits of an HSA are:

- Contributions, earnings and interest are exempt from Federal (not State) taxes;
- Distributions are tax free when used for qualified medical expenses;
- Assets roll over from year to year;
- The HSA is portable, so you can use the assets even if you leave your District job;
- You can contribute significantly more than your HDHP deductible.

In order to contribute to an HSA, you must:

- Be enrolled in an HDHP, and have no other non-HDHP health coverage either as an employee or dependent;
- Not be enrolled in Medicare Part A and/or Part B;
- Have not received VA medical benefits over the past three months;
- Not be able to be claimed as a dependent on someone else's tax return.

Contribution maximums are set by the IRS. For 2022, the maximums are:

Coverage	Under Age 55	Age 55+
Individual	$3,650.00	$4,650.00
Family	$7,300.00	$8,300.00

If you switch from an HDHP, or turn 65, you are no longer eligible to contribute to an HSA, but you can continue to use the account until it is depleted.

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.

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

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

Can I use my HSA to pay medical insurance premiums?

Generally, no if you are under 65. Limited exceptions include COBRA premiums, long-term care premiums, or health premium payments while you are receiving unemployment compensation. Once the account holder reaches age 65, Retiree medical premiums and Medicare Part B premiums are reimbursable.

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

No. The expenses can be for yourself, your spouse or your dependent children you claim on your tax return up to age 24. Your spouse and dependents do not need to be covered by your HDHP.

MEDICARE WHILE WORKING

If you are eligible to participate in the County medical plans as an active employee and wish to continue working after reaching age 65, 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, before Medicare. If you decline to enroll in Medicare Part B when you are first eligible and you also do not remain covered under a group medical plan sponsored by an employer or union, you may incur a Medicare late enrollment penalty once you do enroll. Please see section on Health Savings Account for information regarding your HSA when you become Medicare eligible.

For additional information visit: www.Medicare.gov.

DENTAL BENEFITS

A comprehensive dental plan is available through Delta Dental of California for benefit eligible employees and their enrolled dependents.

Following is a chart outlining the dental benefits provided through Delta Dental.

Plan Benefit Highlights for:	County of Sacramento – Group Number 02476			
Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	$25 per person / $75 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P), Sealants and Orthodontics?	Yes			
Maximums	**Delta Dental PPO dentists:** $2,500 per person each calendar year **Non-Delta Dental PPO dentists:** $2,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Services None	Major Services None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO-dentists****	**Non-Delta Dental PPO**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	80 %
Basic Services Fillings, posterior composites and sealants	90 %	80 %
Endodontics (root canals) Covered Under Basic Services	90 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	90 %	80 %

Oral Surgery Covered Under Basic Services	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges, dentures and implants	80 %	80 %
Temporomandibular Joint (TMJ) Benefits	90 %	80 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$1,500	$1,500
Dental Accident Benefits	100 % (No Maximums)	100 % (No Maximums)

*Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

The 2022 costs for the dental plans are:

Employee Category	Cost
Employee Only	$118.50
Family +	

Your premiums will vary according to your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select.

Additional information, including coverage details and our FAQ document can be found at the Employee Benefits Office resource page:
https://personnel.saccounty.net/Benefits/Pages/Resources.aspx

VISION BENEFITS

For Special District participating in medical coverage, vision benefits are also available to benefit eligible employees and enrolled dependents; it is either bundled with your HMO medical plan or you have the option to purchase it if you have waived medical coverage or are enrolled in one of the high deductible plans.

Employees who have elected a High Deductible Health Plan and wish to have vision coverage will need to elect the voluntary vision plans.

The 2022 costs for the voluntary vision plans are:

Employee Category	Cost
Employee Only	$5.16
Family +	$13.22

Your premiums will vary according to your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select.

Following is a summary of your VSP Vision Benefits Summary plan.

VSP Coverage (Group No. 30015915)		**VSP Provider Network:** VSP Choice	
Benefit	**Description**	**Copay**	**Frequency**
Your Coverage with a VSP Provider			
WellVision Exam	Focuses on your eyes and overall wellness	$15 for exam and glasses	Every calendar year
Prescription Glasses			
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance	Combined with exam	Every other calendar year
Benefit	**Description**	**Copay**	**Frequency**
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. • 20% savings on additional glasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		

	Retinal Screening • No more than $39 copay on routine retinal screening as an enhancement to the WellVision Exam
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

Your Coverage with Out-of-Network Providers
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network details.
Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Additional information, including coverage details and our FAQ document can be found at the Employee Benefits Office resource page:
https://personnel.saccounty.net/Benefits/Pages/Resources.aspx

LIFE INSURANCE

Your District provides a Basic life insurance benefit to all benefit eligible employees. This coverage is effective on the first day of the month following employment upon which you are active at work.

BASIC LIFE INSURANCE

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

Basic dependent coverage for your spouse/domestic partner and dependent children up to age 26 is tied to your Basic coverage and is either $2,000 or $5,000, depending on your District. Dependents must be enrolled within 30 calendar days of initial employment, a "change in status" event, or Open Enrollment.

*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 cost of the coverage. You must enroll your domestic partner and/or their children in the life insurance plan in order to calculate the taxes and receive the benefit.

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

AGE	< 25	25—29	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70+
Value	$.05	$.06	$.08	$.09	$.10	$.15	$.23	$.43	$.66	$1.27	$2.06

OPTIONAL LIFE INSURANCE

You can purchase additional coverage for yourself in amounts equal to your base annual salary.

Option 1A - 1 times your annualized salary, up to $50,000, includes basic coverage
Option 1 - 1 times your annualized salary, up to $600,000, plus your basic coverage
Option 2 - 2 times your annualized salary, up to $600,000, plus your basic coverage
Option 3 - 3 times your annualized salary, up to $600,000, plus your basic coverage
Option 4 - 4 times your annualized salary, up to $600,000, plus your basic coverage
Option 5 - 5 times your annualized salary, up to $600,000, plus your basic coverage
Option 6 - 6 times your annualized salary, up to 1,000,000, plus your basic coverage
Option 7 - 7 times your annualized salary, up to 1,000,000, plus your basic coverage
Guaranteed Issued Level - 5 times your annualized salary or $600,000 (whichever is less)

Guaranteed issue is the maximum amount you can receive without providing proof of good health through underwriting or medical questionnaires. Proof of good health, also known as Evidence of Insurability (EOI) is required if you select more coverage than the guaranteed issue level for either yourself or your spouse/DP, or if you enroll as a late entrant after the initial eligibility period. This form can be requested through your payroll/service team and must be sent to the Employee Benefits Office so that VOYA can review for approval.

In addition to the basic life insurance benefit for your dependents you may also elect optional voluntary term coverage for them. You must be enrolled in optional coverage in order to elect dependent optional coverage.

SPOUSE/DOMESTIC PARTNER

Minimum Coverage	Maximum Coverage	Guaranteed Issue Level
$10,000	Lessor of $250,000 or 100% of employee amount	$30,000

Use the chart below to calculate the monthly premium for both the employee and spouse/domestic partner:

Employee and Spouse Optional Life Insurance Rates	
Employee or Spouse Age	**Monthly rate per $1,000 of coverage**
Under 30	$0.022
30-34	$0.033
35-39	$0.047
40-44	$0.056
45-49	$0.094
50-54	$0.140

Employee and Spouse Optional Life Insurance Rates	
Employee or Spouse Age	**Monthly rate per $1,000 of coverage**
55-59	$0.234
60-64	$0.374
65-69	$0.748
70 +	$1.169
These rates are per individual.	

Example-Employee with $15,000 basic and annualized salary $43,257. Employee is age 43; cost per thousand dollars of coverage is $0.056. Employee requests Option 2; two times salary is $86,514, rounded up is $87,000. Monthly premium is $4.88/month ($0.056 times 87 equals $4.88 with rounding); premium is $2.44 per pay check and will be taken the first two pay checks a month post-tax. The employee's total life insurance coverage would be $102,000 ($87,000 Optional + $15,000 Basic).

CHILDREN

You can elect optional life insurance coverage for your unmarried dependent child up to age 26 if you are enrolled in any level of optional coverage. The child benefit is a maximum of $15,000 and would cost $0.90 per month, which is $0.45 per pay period post-tax. This rate is $0.90 per month no matter how many children are enrolled.

Children Life Insurance Rates
Monthly cost for all eligible children
Monthly rate per $1,000 of coverage
$0.06

INCREASING COVERAGE

Your spouse/domestic partner can be enrolled within 30 calendar days of your employment for up to guaranteed issued with no underwriting.

Current employees can increase optional coverage two ways:

- If you have experienced a life event within 30 days (such as getting married or having a baby), simply elect the new option on your enrollment form. (No underwriting needed if you have not been declined in the past).
- If no life event has occurred, then you must *apply* for the increase. You need to complete the Voya short form health questionnaire AND the County's life insurance change form; return both forms to your District Human Resource Department. Voya

may require additional information, and the increase is not guaranteed.

Things to Remember:

- You must apply for an EOI on your current optional coverage if it exceeds the guaranteed issue amount of $600,000 if your salary increases due to a promotion, step increase, or cost of living.
- During Open Enrollment EOI is not required if you would like to increase 1 times your salary, not to exceed 5 times annual earnings or $600,000 whichever is less (if currently enrolled).

LEAVE OF ABSENCE

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

COMMENCEMENT OF LEAVE

Regardless of when your leave begins, your benefits will terminate the last day of the month you are in paid status. You will receive a notice regarding your responsibilities and options to continue coverage. The type of leave you take will determine if you must pay the full cost of coverage or only a portion of the cost if you wish to continue benefit coverage. Your notice will contain specific details on the cost, deadline, and how to continue coverage.

LIFE EVENTS WHILE ON LEAVE

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

RETURNING TO WORK

Depending on the length and type of your leave, you will either need to take action to enroll in benefits, or coverage will be reinstated automatically. You should contact your District Administrator or the County Employee Benefits Office prior to your return to work to determine which applies to your situation.

Where enrollment is required, coverage is effective the first day of the month following your return from leave AND submission of your completed enrollment forms.

CONTINUATION COVERAGE (COBRA)

What is Continuation Coverage?

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

Who is eligible for COBRA?

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 and/or dental coverage has an independent right to this coverage as a Qualified Beneficiary (QB).

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

What benefits can be continued?

Subject to certain limitations you may elect to continue your medical, dental, and vision benefits at your own expense.

What should I do when there is a qualifying event?

Your District will notify of your termination or reduction in hours. However, it is the responsibility of each employee and/or covered family member to notify the Employee Benefits Office within 30 calendar days of a divorce, legal separation, Medicare eligibility or a child ceasing to be a dependent in order to be eligible to continue coverage. You will receive a notice that explains the benefits you may continue, the election time frames, the cost, and the length of time that you may continue your coverage. Failure to provide proper notification will result in the loss of continuation rights.

How long can benefits continue under Continuation Coverage?

For employees who terminate employment COBRA can generally be continued for 18 months. Dependents who have lost eligibility can continue for up to 36 months. . You may be eligible for State (CalCOBRA) benefits continuation laws. For information on CalCOBRA, you should contact the insurance carrier directly.

What if I have questions about Continuation Coverage?

Direct your questions about your Continuation Coverage rights to:
Employee Benefits Office
700 H Street, Room 4650, Sacramento, CA 95814
(916) 874-2020, MyBenefits@saccounty.net

CONTACTS

COUNTY OFFICE	PHONE	WEBSITE
Employee Benefits Office	916-874-2020	http://www.personnel.saccounty.net/Benefits
DISTRICT OFFICES		
Carmichael Park	916-485-5322	www.carmichaelpark.com
Elk Grove Cemetery	916-686-6030	www.egccd.com
Mission Oaks	916-488-2810	www.morpd.com
Orangevale Park	916-988-4373	www.ovparks.com
SACOG	916-340-6243	www.sacog.org
Sac Metro Cable	916-874-7319	www.sacmetrocable.tv
SETA	916-263-3800	www.seta.net
Sunrise Park	916-725-1585	www.sunriseparks.com
MEDICAL CARRIERS		
Kaiser Permanente (HMO)	800-464-4000	www.kp.org
Kaiser Permanente (HDHP)	800-390-3507	www.kp.org
Sutter Health Plus	855-315-5800	www.sutterhealthplus.com
Western Health Advantage	888-563-2250	www.mywha.org/personalaccess
OTHER VENDORS		
Delta Dental	800-765-6003	www.deltadentalins.com/cos
SCERS	916-874-9119	www.retirement.saccounty.net
VSP	800-877-7195	www.vsp.com
Voya (Life Insurance)	(877) 236-7564	https://presents.voya.com/EBRC/saccounty
Optum Bank *(Kaiser & Sutter HDHP HSA)*	844-326-7967	www.optumbank.com
Health Equity *(WHA HDHP HSA)*	877-300-4987	www.myhealthequity.com

NOTES

COUNTY OF SACRAMENTO•DEPARTMENT OF PERSONNEL SERVICES•EMPLOYEE BENEFITS OFFICE
700 H Street, Room 4667, Sacramento, CA 95814
Phone (916) 874-2020 • Fax (916) 874-4621
Email: MyBenefits@saccounty.gov
http://www.personnel.saccounty.gov/Benefits