2018 MyBenefits Summary

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

Active Employee

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) 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 Benefit Coverage (SBC) is also available on the Employee Benefits Office website.

DISCLAIMER

This information is only a summary of the benefit options, responsibilities, and/or opportunities to change the benefits that are available to you as a participant in the benefit programs offered by the County of Sacramento. It is not intended to be exhaustive in detail or address all of the possible regulations that govern the administration of our benefit programs. The County of Sacramento reserves the right to revise, supplement, or rescind any segment or portion of the information provided as it deems appropriate.

The benefits and the policies governing those benefits may change as legislation is revised or contract provisions are modified. Reasonable attempts will be made to inform you of those changes. 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.

If there is a conflict between the laws, regulations, contracts and policies governing our benefit programs and this information, the applicable provision of law or policy will take precedence. The Employee Benefits Office reserves the right to request additional documentation at any time to support requests for changes in benefits or coverage adjustments.

Questions concerning your particular benefits and the application of policies that pertain to your specific situation should be addressed to the Employee Benefits Office staff.

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OVERVIEW

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

- Medical
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- Life Insurance
- Critical Illness
- Health Savings Accounts (HSA)
- Flexible Spending Accounts (FSA)
- Retiree Health Savings Plan
- Deferred Compensation
- Employee Assistance Program
- Leave of Absence
- COBRA Continuation Coverage

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

BENEFITS AND BARGAINING

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

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

USING THIS SUMMARY

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

YOUR GROUP INSURANCE COVERAGE

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

ELIGIBILITY FOR BENEFITS

EMPLOYEE

An "Eligible Employee" is defined as:

1) a regular employee who is working full-time or part-time for the County;
2) an elected official and his or her exempt deputy or assistant;
3) any regular employee who temporarily transfers to a benefited temporary position; or
4) full-time and part-time employees of Special Districts

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

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

DEPENDENTS

Eligible dependents include:

- **Your spouse**-lawfully wedded;
- **Your domestic partner**-registered with the Secretary of State;
- **Children**-natural, step, adopted (up to age 26), a child that you have legal guardianship of, and/or foster minor children of the employee or spouse/domestic partner (up to age 21). Children over age 26 with a certified medical disability are also eligible.
  - ➢ Dependents of your children are not eligible unless you or your spouse/domestic partner has legal guardianship of that child.

COVERAGE AVAILABLE FOR DEPENDENTS

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

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

COVERAGE EFFECTIVE DATES

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

NEW HIRES

In order to enroll in the benefit plans of your choice, benefit elections must be made within the first 30 days of becoming an eligible participant. You may enroll online, either at home or at work, by using BenefitBridge, our online enrollment system. Additional information for new hires can be found on our website at: http://www.personnel.saccounty.net/Benefits. Any required supporting documentation must be submitted to the 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 described in your labor agreement.

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. For mid-year enrollment changes associated with a birth or adoption, the coverage becomes effective on the date of birth or adoption in accordance with HIPAA regulations, as long as you enroll and provide any required documentation in a timely manner. For all other midyear qualifying events, the coverage is effective the first day of the month following eligibility **and** enrollment, provided there has been timely submission of required documentation.

OPEN ENROLLMENT

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

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

WAIVER OF COVERAGE

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

CHANGES TO COVERAGE

After your initial enrollment you can generally only make changes to coverage during qualified "life events" and/or Open Enrollment. The change must be on account of and consistent with the event, and must be made online within 30 days of the event using BenefitBridge. Documentation to verify the event is also required within 7 days of the enrollment request.

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

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

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

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

2. Submit your request within 30 days

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

3. Provide supporting documentation-(7 days) Examples of supporting documents include:

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

Documentation is required within 7 days of submitting your enrollment. A Social Security number is required for dependents, but if you do not have it at the time of enrollment, you should enroll the dependent and request additional time to provide the SSN.

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

INELIGIBLE DEPENDENTS

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

COMMON MISTAKES

New Baby Submitting your paperwork to your department HR to request FMLA or Parental Leave for the birth of a newborn does not add your new baby to coverage. We cannot assume your intentions for enrollment so you must take action to enroll your newborn, elect the benefits and complete the enrollment!	Divorced Spouse Ex-spouses must be removed within 30 days of the divorce; If family court orders continued benefits for an ex-spouse, you would need to elect COBRA continuation coverage or purchase coverage privately; divorced spouses cannot stay on County coverage.

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

Medicare coverage consists of the following options:

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

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

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

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

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

MEDICARE WHILE WORKING (cont'd)

Almost 65 or Medicare Eligible, Still Working And Covered Under The County Medical Plans?

Yes

Step 1: May Delay Enrollment in Part B and D penalty free

Part A Hospital Insurance	Part B Medical Insurance
Part C Combines Part A, Part B and usually Part D	Part D Prescription Drug Coverage

No

Step 1: Contact your local Social Security Office to enroll.

Decide how you want to get your coverage:

Original Medicare or Medicare Advantage Plan

Part A Hospital Insurance	Part B Medical Insurance

Part C Combines Part A, Part B and usually Part D

Step 2: Decide if you need to add drug coverage

Part D A separate Part D Prescription Drug Coverage plan is required. Costs and coverages vary.

Part D Prescription Drug Coverage generally included in most Advantage plans. Coverage and costs generally better than separate Part D plans.

Step 3: Decide if you need to add supplemental coverage

Medicare Supplemental Insurance (Medigap) Policy

If enrolled in any Medicare, you are not eligible to contribute to a Health Savings Account (HSA).

INSURANCE SUBSIDY

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

TIER A

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

CASHBACK

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

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

PLAN SELECTION INCENTIVE (PSI)

If you were hired before January 1, 2007, have not moved to Tier B, and your REO has negotiated with the County for PSI, or you are an eligible unrepresented employee, a PSI payment of $150/month will be made to you if you waive medical coverage.

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

TIER B

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

You can only change from Tier A to Tier B during Open Enrollment, or during a "change of status" event. It is a voluntary decision that can be made only once and is irrevocable once made, which means once you move from Tier A to Tier B, you cannot return to Tier A. Since the County contribution to family medical coverage is greater in Tier B, you may realize a significant savings under family coverage by moving to Tier B.

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

2018 MEDICAL PREMIUM COSTS

Definitions			Tier B Hired after 12/31/2006	Tier A (1) All Other Units		Tier A (2) Units 003, 006, 017, 019, 030	
Employer Contribution To Medical	Monthly Single Subsidy (S)		$567.68	$826.90		$1,148.80	
	Monthly Family Subsidy (F)		$1,453.28	$826.90		$1,148.80	
Cashback Maximum or PSI			N/A	Cashback	No Cashback (PSI)	Cashback	No Cashback
				$535.00	$150.00	$894.52	$0.00
Plan	Single/ Family	Total Monthly Premium	Employee Deduction Per Pay Period	Cashback or Deduction (-) per pay period		Cashback or Deduction (-) per pay period	
Kaiser $15 HMO	S	$757.90	($95.11)	$0.00	$0.00	$63.45	$0.00
	F	$1,938.12	($242.42)	($555.61)	($555.61)	($394.66)	($394.66)
Kaiser HD HMO	S	$592.18	($12.25)	$0.00	$0.00	$140.42	$0.00
	F	$1,514.32	($30.52)	($343.71)	($343.71)	($182.76)	($182.76)
Sutter $15 HMO	S	$726.52	($79.42)	$0.00	$0.00	$78.03	$0.00
	F	$1,857.42	($202.07)	($515.26)	($515.26)	($354.31)	($354.31)
Sutter HD HMO	S	$534.42	$0.00	$0.27	$0.00	$167.25	$0.00
	F	$1,365.02	$0.00	($269.06)	($269.06)	($108.11)	($108.11)
WHA $15 HMO	S	$709.60	($70.96)	$0.00	$0.00	$85.89	$0.00
	F	$1,816.60	($181.66)	($494.85)	($494.85)	($333.90)	($333.90)
WHA HD HMO	S	$539.80	$0.00	$0.00	$0.00	$164.75	$0.00
	F	$1,381.90	$0.00	($277.50)	($277.50)	($116.55)	($116.55)
Waivers			$0.00	$248.48	$75.00	$415.46	$0.00

Subsidy = the County contribution amount available for medical coverage according to labor agreements*
"$" = your net Cash Back amount after FICA reduction per paycheck
"($)" = the deduction that will come out of each paycheck (24 times a year)
***Refer to your specific labor agreement for details**

MEDICAL PLANS

The County offers three (3) traditional Health Maintenance Organization (HMO) plans and three (3) High Deductible Health Plans (HDHP). Employees and enrolled dependents must be enrolled in the same plan.

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.

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, and they do not include chiropractic, acupuncture or vision coverage. Once you reach the deductible under the family plan, most services are covered at 100%. For single coverage you only have Rx co-payments once you reach your deductible.

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 annual deductible applies in full no matter what time of year you enroll in the HDHP coverage, it is not pro-rated. Finally, for family coverage the entire deductible must be met before services are covered at 100%, there is no single deductible inside of the family deductible.

Single Coverage	Family Coverage
You pay the first $1,350 for all services and prescriptions. After you reach $1,350 in expenses, professional services are covered at 100%, but you pay your plans Rx copayments from $1,351-$2,700. Once you reach the single deductible professional services are covered at 100%. You are only responsible for prescription co-payments and not full cost after the deductible up to the out of pocket maximum.	You pay the first $2,700 for all services and prescriptions. After you reach $2,700 in expenses, prescriptions and professional services are covered at 100% for all enrolled family members for the remainder of the calendar year. Once you reach the family deductible, any additional services you incur have no out of pocket costs. All services and prescriptions are covered at 100% for all enrolled family members.

MEDICAL PLANS (cont'd)

HMO vs HDHP

Although there can be considerable annual savings under a HDHP over a traditional HMO, there are some important factors to consider. Since you pay costs at the time of care you could face early out of pocket expenses at the beginning of the calendar year when deductibles are reset. If you choose an HDHP, you may want to consider establishing a Health Savings Account (HSA) to assist with paying for or reimbursing your upfront medical costs (see page 15).

	HMO	HDHP
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

HOW TO CALCULATE HMO vs HDHP DIFFERENCE

Take the paycheck cost for your HMO plan and multiply it by 24 paychecks; next subtract the HDHP cost from the HMO cost to find the potential annual premium savings.

EXAMPLE: Sutter Health family Tier B plan HMO vs HDHP

	Sutter HMO	Sutter HDHP
Paycheck Deduction	$202.07 x 24 =$4,849.68	$0
Add any cost of services	$15 co-pays per visit, up to $2,700	Full cost of service up to $2,700
Total Annual Cost	**$4,849.68 + services**	**$0 + services**
Annual premium difference is $4,849.68		

Since the maximum deductible cost under the HDHP family plan is $2,700 and services are covered at 100% after that, the annual HMO premium deduction of $4,849.68 is **more** than the HDHP maximum deductible of $2,700. And, if you do not use $2,700 in HDHP services, your savings is even greater! Midyear HDHP enrollments mean less savings, but you can move to an HDHP plan every Open Enrollment for a January effective date. HDHP enrollment might also allow you to contribute to an HSA under certain conditions to protect you from the deductible costs (see page 15).

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	$10; 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	$1,350 Individual / $2,700 Family		
Annual Out-of-Pocket Limit	$2,700 Individual / $2,700 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 Well-Child Care, Immunizations Well Woman Exams, Mammograms	100% covered, Deductible Waived		
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 Outpatient Facility Charge	100% covered after deductible		
Emergency Services			
Emergency Room, Ambulance	100% covered after deductible		
Mental Health Benefits			
Inpatient / Outpatient Care	100% covered after deductible		
Substance Abuse			
Inpatient Hospitalization Outpatient Services	100% covered after deductible		
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	
	100% covered after deductible-Family		
Brand (Formulary/Preferred)	$20 after deductible-Individual	$40 after deductible-Individual	
	100% covered after deductible-Family		
Brand (Non-Formulary/Non-preferred)	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		

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. You may enroll, change, or stop your contributions to the HSA at any time throughout the year. Changes to your HSA are made online through BenefitBridge and are effective the following month. 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—no "use it or lose it";
- You can change the contribution at any time;
- The HSA is portable, so you can use the assets even if you leave the County.
- You can contribute significantly more than your HDHP deductible.

In order to contribute to an HSA, you must:

- Be enrolled in an HDHP;
- Have no other non-HDHP health coverage*;
- Not be enrolled in Medicare;
- Have not received VA medical benefits 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 2018, the maximums are:

Coverage	Under Age 55	Age 55+
Individual	$3,450.00	$4,450.00
Family	$6,900.00	$7,900.00

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

Also, you cannot immediately contribute to an HSA if you have a balance in your General Medical Reimbursement Account at the end of the calendar year. However, you can have a Limited Purpose Medical Reimbursement Account and contribute to an HSA (see page 19).

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. Non-qualified withdrawals are considered taxable income, and a 20% penalty will apply if you are under 65.

*You cannot be covered as a dependent on another plan that is not also an HDHP. For more details, please contact the Department of Personnel Services Employee Benefits Office.

HEALTH SAVINGS ACCOUNT (cont'd)

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

Yes. If both you and your spouse individually meet the criteria for making an HSA contribution, you can both make HSA contributions and you can allocate the HSA contribution limit between the two of you. You cannot exceed the family limit even if you both have double family coverage. However, if both you and your spouse are covered by a single County HDHP family plan, HSA payroll deductions will only be taken from the employee with the County HDHP family coverage. Remember, you can change your contributions amounts throughout the year at any time.

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

Separate insurance coverage means that your insurance doesn't cover your spouse and your spouse's insurance doesn't cover you, or your spouse has coverage through another employer plan. If your spouse covers you with any non-HDHP coverage, you are ineligible to contribute to an HSA. If your spouse does not cover you with non HDHP coverage and you have a County HDHP, you are eligible to contribute up to the limit of your coverage level; single or family. The family contribution limit applies even if you cover just your spouse with the non HDHP plan under the family coverage.

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. If you are over 65: Retiree medical and Medicare Part B premiums are reimbursable.

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

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

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

If you become newly eligible to contribute to an HSA during the year or want to start contributing midyear, your maximum is determined by following formula: Maximum (based on age and coverage level) divided by 12, then multiply by the number of months remaining in the year.

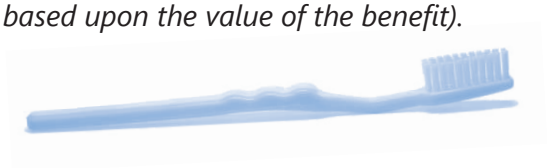
DENTAL BENEFITS

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

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

What if both my spouse/domestic partner and I are County employees?
You are encouraged to evaluate the benefits of you both enrolling all members of your family in the County's dental plan since the plan will provide full coordination of benefits for married couples and domestic partners who are both County employees. The County pays 100% of the dental plan premium cost. The **employer cost** for dental coverage is **$125 per month** or **$62.50 per pay period**. Premiums are pre-tax and deducted the first two paychecks of the month. (*As required by Federal tax law, federal taxes must be paid if you enroll a dependent that does not meet the IRS definition of a dependent. These taxes are based upon the value of the benefit).*

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



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

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

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

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

VISION BENEFITS

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

ENROLLMENT

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

BUNDLED PLANS

If you are enrolled in an HMO medical plan the cost and coverage for vision benefits is included with your HMO; no separate enrollment for vision is required. Any dependent also enrolled in your HMO medical plan has vision coverage.

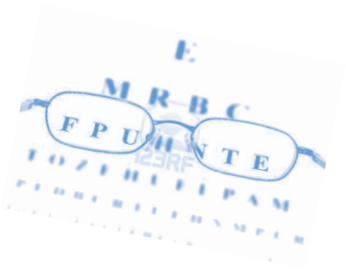
Schedule of benefits	Kaiser HMO	Sutter HMO & WHA HMO
Coverage is through	Kaiser Vision	VSP
Allowance amount	$175 frames/lenses	$130 frames
Exam frequency	24 months	12 months
Lenses frequency	24 months	12 months
Contacts frequency	24 months	12 months
Frames frequency	24 months	
Eye exam	$15 copay	

OPTION TO PURCHASE

Vision benefits are not included if you enroll in a high deductible plan or you waive medical coverage; you may elect to purchase vision coverage separately. If you are enrolled in Kaiser HMO, you may also elect to purchase additional coverage through VSP.

Premiums are pre-tax and deducted the first two paychecks of the month. The **employee cost** for single coverage is **$5.20 per month** or **$2.60 per pay period** and family coverage is **$13.30 per month** or **$6.65 per pay period**.

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



FLEXIBLE SPENDING ACCOUNTS

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

GENERAL PURPOSE MEDICAL REIMBURSEMENT ACCOUNT (MRA)

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

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

NOTE: IRS regulations do not permit you to participate in a General Purpose MRA account and contribute to a Health Savings Account at the same time or in the same calendar year even if you have exhausted your General Purpose MRA account balance. In addition, you are not eligible to contribute to an HSA until April 1 of the following calendar year if you have any funds left in your General Purpose MRA account that carry over into the "grace period".

LIMITED PURPOSE MEDICAL REIMBURSEMENT ACCOUNT (MRA)

This account functions exactly the same as the General Purpose MRA except that reimbursable expenses are limited to only dental and vision costs. The key benefit of a Limited Purpose MRA is that you can remain eligible to contribute to a Health Savings Account all year long (provided that you are also enrolled in a High Deductible Health Plan and have no other disqualifying coverage).

This provides you with an additional pre-tax reimbursement account for your dental and vision expenses and allows you to preserve more of your HSA funds over time to take with you after your employment ends.

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

You may set aside up to $2,500 per calendar year to pay for qualified unreimbursed health expenses in either the General Purpose or Limited Purpose MRA.

FLEXIBLE SPENDING ACCOUNTS (cont'd)

DEPENDENT CARE REIMBURSEMENT ACCOUNT (DCRA)

You may set aside pre-tax dollars to pay for qualified childcare or dependent care expenses that are necessary for you and your spouse (domestic partner is not included in this definition) to continue working or going to school full time. This is a separate election from the MRA and you do not need to enroll in the MRA to elect the DCRA.

You may elect up to $5,000 per Plan Year if you are married and file a joint return or are a single parent. You may elect up to $2,500 if you are married and file separate tax returns) for DCRA.

FOR BOTH MRA AND DCRA

When can I enroll?

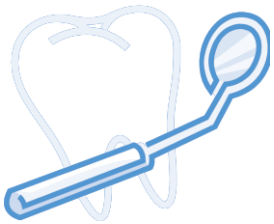
You may enroll within 30 days of your hire date or within 30 days of a "change in status" event. You may also enroll during Open Enrollment each year.

When can I change my election amount?

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

How do I request reimbursement?

Submit a reimbursement voucher with proof of the expenses that you incurred (e.g., itemized bills/proof of expenses). The administrator offers a direct deposit option so that reimbursement checks may be deposited directly into your bank account. Automatic reimbursements can also be set up for reoccurring expenses.
"Benny" cards are also issued and can be used in lieu of submitting reimbursement vouchers. Contact the FSA administrator-Navia Benefit Solutions-for more information.



LIFE INSURANCE

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

BASIC LIFE INSURANCE

The Basic benefit provided by the County is $15,000, $18,000 or $50,000, depending upon your classification and/or REO. All County employees have Accidental Death & Dismemberment (AD&D) benefits equal to the amount of County paid Basic life insurance.

Bargaining Unit	Basic Life Coverage
005, 008	$15,000
020, 021, 024, 027, 029, 032, 033, 050, Elected Officials	$50,000
All others	$18,000

OPTIONAL LIFE INSURANCE

In addition to County paid basic coverage, you can purchase additional coverage for yourself in multiples equal to your annual salary. This is a term policy with no cash value.

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

HOW DO I INCREASE MY COVERAGE?

Life insurance changes can be made at any time. New employees can enroll in any level of optional coverage without medical underwriting if enrolling within 30 days of hire.

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 online enrollment (no medical underwriting needed if you have not been declined in the past).
- If no life event has occurred, then you must *apply* for the increase using paper forms. You need to complete Prudential's short form health questionnaire AND the County's life insurance change form; return both forms to the Employee Benefits Office. Prudential may require additional information, and the increase is not guaranteed. You can *apply* at any time during the year.

HOW MUCH DOES THE OPTIONAL COVERAGE COST?

The cost of optional coverage is based on your annualized salary and your age. Premiums for optional life coverage will be deducted from your paycheck post-tax. Premiums will increase automatically if your salary increases or your age moves you into the next age band.

LIFE INSURANCE (cont'd)

Use the chart below to calculate the premium:

Age	< 30	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70+
Cost Per $1,000	$.034	$.044	$.068	$.080	$.132	$.204	$.346	$.542	$1.046	$1.72

Example-Employee in BG05, annualized salary is $43,257. Employee is age 43; cost per thousand dollars of coverage is $.080. Employee requests Option 2; two times salary is $86,514, rounded up is $87,000. Monthly premium is $6.96/month ($0.080 times 87 equals $6.96 with rounding); premium is $3.48 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).

HOW DO I DECREASE MY COVERAGE?

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

PREMIUM CHANGES

- Age Rated-Your premium will change when you age into a new age bracket.
- Salary changes-when your salary changes, your premiums will change accordingly.

BENEFICIARY INFORMATION

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

ACCELERATED DEATH BENEFIT

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

WAIVER OF PREMIUM

If you become disabled while under age 60 and covered under this plan, you may apply for a waiver of premium. That is, the policy remains in force and you do not have to pay the premiums upon approval for as long as you remain disabled, even temporarily. Contact the Employee Benefits Office for more information or to apply.

CONVERSION / PORTABILITY

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

DEPENDENT LIFE INSURANCE

DEPENDENT LIFE INSURANCE-Basic Coverage

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 BG unit. For infants less than six months of age, the benefit is $200; there is no coverage for newborns from birth to 14 days.

Employees in BG units 005 and 008 (UPE) have $5,000 in dependent coverage available and must enroll dependents for coverage (you may cancel this coverage anytime). Dependents must be enrolled within 30 days of initial employment, a "change in status" event, or Open Enrollment. Employees in all other units automatically have dependent coverage of $2,000, no enrollment is required and there is no cost.

Bargaining Unit	Dependent Life Coverage	Dependent Enrollment Required?
005, 008	$5,000*	**Yes**
All others	$2,000	No*

*Although there is no direct cost to cover a dependent, the Internal Revenue Code requires that federal taxes be paid on the value (imputed income) of the total benefit if the benefit exceeds $2,000, or when the coverage applies to a domestic partner or the dependents of domestic partners that are not your IRS dependents. 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.

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

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

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

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

DEPENDENT LIFE INSURANCE (cont'd)

DEPENDENT LIFE INSURANCE-Optional Coverage

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.

This is a term policy with no cash value, and you are the beneficiary in the event of an enrolled dependents' death. You have the option to convert this policy to an individual contract if you terminate employment or your dependent ceases to be eligible. Coverage can be cancelled at any time by making the request online at BenefitBridge.

SPOUSE/DOMESTIC PARTNER

Your spouse/domestic partner can be enrolled within 30 days of your employment for up to guaranteed issued with no underwriting. Current employees looking to increase coverage or enroll can make the request by the following:

- If you have experienced a life event within 30 days (such as getting married or having a baby), you may elect up to the guaranteed issue amount. Amounts over the guaranteed issue will require EOI approval. Log in to www.benefitbridge.com/saccounty.
- If no life event has occurred you are requesting coverage as a late entrant. You must complete Prudential's short form health questionnaire AND the County's life insurance change form; return both forms to the Employee Benefits Office. Prudential may require additional information, and the increase is not guaranteed. You can *apply* at any time.

Minimum Coverage	Maximum Coverage	Guaranteed Issue Level
$10,000	Lessor of $250,000 or 100% of employee amount	$20,000

The cost of coverage is determined by your spouse's age and the amount of coverage selected. It is deducted on a post-tax basis. Use the chart below to determine the cost.

AGE	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Cost per 1,000	.034	.044	.068	.080	.132	.204	.346	.542	1.046	1.720

EXAMPLE 1:	EXAMPLE 2:
Your spouse is 31, you make $46,000 per year and have Option 2 ($92,000 coverage), you can elect up to $90,000 in $10,000 increments for your spouse. For $90,000 the cost is $3.96 per month, or $1.98 per pay period. (.044 x 90)	Your spouse is 56 and you make $84,000 per year, you are enrolled in Option 3 ($252,000). You can elect up to $250,000 (maximum) for your spouse, but you only want $100,000. The cost is $34.60 per month, or $17.30 per pay period. (.346 x 100)

CHILDREN

You can elect optional life insurance coverage for your children up to age 26 if you are enrolled in optional coverage. The child benefit is $15,000 and costs $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.

Number of children enrolled	Coverage amount	Paycheck deduction
1	$15,000	$0.45
2 or more	$15,000 each child	$0.45

CRITICAL ILLNESS

The County provides an optional Critical Illness policy on a voluntary post tax deduction basis. This policy pays out a tax free lump sum payment upon the diagnosis of certain illnesses. These funds may be used in any way you choose.

WHAT DOES THE POLICY COVER?

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

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

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

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

Reoccurrence benefits may also be possible if more than 180 days has passed between a previous diagnosis and payment and a diagnosis of reoccurrence.

WHAT ARE THE COVERAGE AMOUNTS?

Critical Illness coverage is purchased in set increment levels. The levels vary depending on whether the coverage is for the employee, spouse/domestic partner or dependent child. Dependent coverage is only available if the employee is enrolled and cannot exceed a percentage of the employee's coverage amount. Employees who are married to another County employee cannot cover each other as dependents, and there is no double coverage for children.

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

Guaranteed issue is the maximum amount you can receive without providing proof of good health through underwriting or medical questionnaires. Proof of good health, also known as Evidence of Insurability (EOI) is required if you 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.

HOW DO I ENROLL?

You should elect coverage by using the online system at www.benefitbridge.com/saccounty.

CRITICAL ILLNESS (con't)

HOW MUCH DOES THE COVERAGE COST?

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

EMPLOYEE COST

Employee Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79
Cost Per $1,000	$.132	$.176	$.262	$.408	$.668	$1.068	$1.598	$2.300	$3.388	$4.792	$6.762	$8.932

SPOUSE/CHILD COST

Sp/DP Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
Cost Per $1,000	$.136	$.184	$.264	$.418	$.680	$1.096	$1.652	$2.384	$3.520	N/A

Dependent children are a flat rate of $.112 per $1000 of coverage.

Formula: To find the cost for your age band; multiply that number (age) by the number of $1000 increments. For example: Employee is age 43 and wants $30,000 in coverage; cost per thousand is $.668. Cost is calculated as follows: 30 x $.668 = $20.04 month.

HOW DO I CHANGE MY COVERAGE?

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

- If you have experienced a life event within 30 days (such as getting married or having a baby), you may elect up to the guaranteed issue amount. Amounts over the guaranteed issue will require EOI approval. Log in to www.benefitbridge.com/saccounty.
- If no life event has occurred you are requesting coverage as a late entrant. You must *apply* for the benefit online by submitting the application requiring EOI approval. Enroll online at www.benefitbridge.com/saccounty. You will be notified if your request was approved.
- You can decrease coverage anytime by logging into BenefitBridge at www.benefitbridge.com/saccounty.

HOW DO I FILE A CLAIM?

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

WHERE CAN I FIND MORE INFORMATION?

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

DEFERRED COMPENSATION

The County of Sacramento Deferred Compensation Plan (the Plan) is an Internal Revenue Code Section 457(b) non-qualified government deferred compensation plan that can provide retirement income for employees or their beneficiaries. In this plan, participants have an option to contribute on a pre or post tax basis. Fidelity Investments is the record-keeper of the plan.

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

ELIGIBILITY

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

401(a) Plan-County employees in Recognized Employee Organizations (REO) 020, 021, 024, 029, 032, 033, Unrepresented Management (050) and Elected Officials are eligible to participate. A participant in the 401(a) Plan must be contributing 1% or more of gross pay into the 457(b) Plan. Enrollment in this plan is automatic. If the contribution into the 457(b) Plan drops below 1% of gross pay, the 401(a) Plan match will stop for the remainder of the calendar year.

CONTRIBUTIONS

457(b) Plan (Pre-Tax and Post Tax ROTH)-You designate a percentage of your biweekly pay that you want deducted from your paycheck to contribute to the Plan. With pre-tax contributions you are deferring taxes on currently earned wages to a future time when the account distribution will be taxed as normal income. With post-tax contributions into a ROTH, your contributions can be withdrawn tax and penalty free at any time, and growth earnings can be withdrawn tax and penalty free after a 5 year waiting period and at age 59 ½ or older. For more information about the benefits of pre vs. post tax contributions, contact Fidelity.

The minimum contribution is 1% of gross pay and the maximum is set annually by the IRS:

- The 2018 maximum for participants under age 50 is $18,000 + COLA determined by the IRS.
- The 2018 maximum for participants age 50+ is $24,000 + COLA determined by the IRS.

Contribution amounts may be changed at any time by contacting Fidelity. Contribution changes made by the 18th of the month, will take effect on the first pay period of the following month **Note: The contribution on your very last check will be zero ($0) if you do not complete a Final Compensation Amendment at least one month prior to your separation date.**.

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

DEFERRED COMPENSATION (cont'd)

CATCH-UP OPTION- If you have not contributed the maximum into the program throughout your working career you may be eligible for the "3-Year Limited Catch-Up". The maximum for "Catch-Up" is up to twice the under age 50 limit, and restrictions apply. You must contact our office at 916-874-2020 fours year prior to your retirement date (not available the year you retire).

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

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

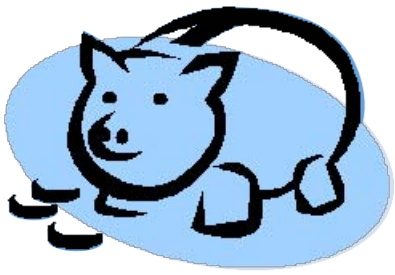
PURCHASING SERVICE CREDIT-Active Participants may use the 457 Plan funds to purchase service credits on a pre-tax basis. You should contact the Sacramento County Employees Retirement System (SCERS) about purchasing the service credits.

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

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

INVESTMENT ALLOCATION-Contributions to the 457(b) Plan (and 401(a) if eligible) will be deposited into a target dated or lifecycle fund based on your age that reallocates automatically as you get nearer to retirement unless you specify your deposits into other account funds. You may change the investment allocation at any time and the changes are effective immediately. You may also move assets between funds at any time and the changes will take place at the next market closure. These transactions may be accomplished by contacting Fidelity or going online.

DISTRIBUTIONS-Since both the 457(b) and the 401(a) Plans are long-term non-liquid retirement plans with IRS restrictions, distributions can only occur under limited circumstances. Distributions from pre-tax accounts will be taxed as normal income, as will growth earnings from the ROTH post-tax account if withdrawn within 5 tax years of establishing the ROTH. While distributions may be made after separation from service, both the 401(a) Plan and ROTH growth earnings have a 10% penalty if distribution takes place prior to age 59 ½. It is important to start planning early, so contact Fidelity to set up a financial plan for the future.



EMPLOYEE ASSISTANCE PROGRAM

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

Who is eligible?

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

What services does the EAP provide?

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

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

How do I access the Employee Assistance Program?

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

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

How are services provided?

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

RETIREE HEALTH SAVINGS PLAN

What is the Retiree Health Savings Plan (RHSP)?

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

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

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

Where will my RHSP assets be invested?

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

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

Who handles benefit claims?

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

What is the procedure for submitting a claim for reimbursement?

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

What happens to the account balance if I die?

Upon your death, remaining assets will be transferred to an account for continued tax-free use by your surviving spouse and/or eligible dependents for their own qualifying health expenses. If there are no eligible dependents at the time of your death, all funds are returned to the plan.

Whom should I contact with questions?

- For questions regarding your account balance or statement, contact:
  ICMA-RC at (800) 669-7400
- For all claim related issues once you separate from County employment, contact:
  Meritain Health, Inc. at (888) 587-9441

LEAVE OF ABSENCE (LOA)

There are times during your employment where you may need to take a leave of absence (LOA) from work. There are many types of leaves and some leaves may cover all of your benefits, while other leaves types require you to pay all or a portion of the cost to maintain coverage. Leave of absence situations vary vastly and are based on individual circumstances, so contact the 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 from our office regarding your responsibilities and options to continue coverage. As a general rule, if you have a payroll deduction for benefit coverage while working, you must continue to make those payments to keep coverage in effect while on leave of absence. Your notice will contain specific details on how to continue coverage.

LIFE EVENTS WHILE ON LEAVE

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

RETURNING TO WORK

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

CONTINUATION COVERAGE (COBRA)

What is Continuation Coverage?

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

Who is eligible for 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, dental, and/or EAP coverage has an independent right to this coverage as a Qualified Beneficiary (QB).

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

What County benefit plans can be continued?

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

What should I do when there is a qualifying event?

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

How long can benefits continue under Continuation Coverage?

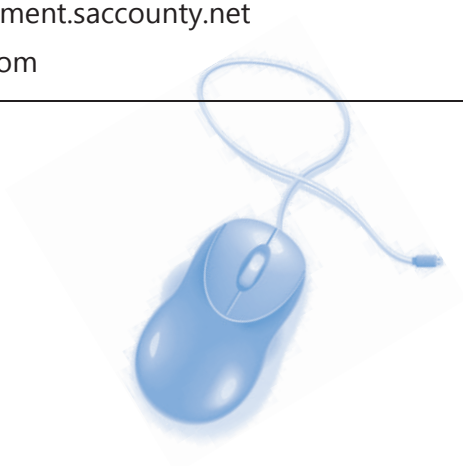
Coverage may generally be continued for up to 36 months (except for MRA) under a combination of Federal and State (CalCOBRA) benefits continuation laws. For information on CalCOBRA, you should contact the insurance carrier directly.

What if I have questions about Continuation Coverage?

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

CONTACTS

BENEFITS CONTACTS	PHONE	WEBSITE
Employee Benefits Office	916-874-2020	http://www.personnel.saccounty.net/Benefits
BenefitBridge	800-814-1862	www.benefitbridge.com/saccounty
MEDICAL CARRIERS		
Kaiser Permanente	800-464-4000	www.kp.org
Sutter Health Plus	855-315-5800	www.sutterhealthplus.com
Western Health Advantage	888-563-2250	www.mywha.org/personalaccess
HSA VENDORS		
Optum Bank (Kaiser & Sutter HDHP)	844-326-7967	www.optumbank.com
Health Equity (WHA HDHP)	877-300-4987	www.myhealthequity.com
OTHER VENDORS		
Delta Dental	800-765-6003	www.deltadentalins.com/cos
Fidelity Investments	800-343-0860	http://netbenefits.com/saccounty
Navia Benefit Solutions	800-669-3539	www.naviabenefits.com
ICMA-RC	800-669-7400	www.icmarc.org
Managed Health Network	800-227-1060	www.members.mhn.com
Meritain Health	888-587-9441	www.meritain.com
Prudential (Life Insurance)	800-524-0542	www.prudential.com
Prudential (Critical Illness)	877-920-4778	www.myprubenefits.com
SCERS	916-874-9119	www.retirement.saccounty.net
VSP	800-877-7195	www.vsp.com



REO INDEX

REO	REO Title	Cashback Cutoff Date	Basic Life Amount
001	General Supervisory Unit, Teamsters, Local 150	2/1/1998	$18,000
002, 004	Sacramento County Alliance of Law Enforcement (SCALE)	11/21/1999	$18,000
003	Sacramento County Deputy Sheriff's Association (DSA)	10/24/1999	$18,000
005	Office-Technical, United Public Employees (UPE)	12/27/1997	$15,000
006	Operations & Maintenance, Local 39	10/11/1998	$18,000
007	Health Services (AFSCME)	8/30/1998	$18,000
008	Welfare Non-Sup, United Public Employees (UPE)	8/15/1999	$15,000
010	Accountants, Non-Supervisory (SCPAA)	8/2/1998	$18,000
013, 014	Environmental Specialists (EMSSC)	12/6/1998	$18,000
016	Nurses, Non-Supervisory (CNA)	7/18/1999	$18,000
017	Water Quality/Stationary Engineers, Local 39	11/22/1998	$18,000
018	Building Trades	11/7/1999	$18,000
019	Probation, Non-Supervisory (SCPA)	7/19/1998	$18,000
020, 021	Attorneys (SCAA)	6/20/1999	$50,000
022, 023	Engineers & Architects (APECS)	4/12/1998	$18,000
024	Probation Supervisory	2/1/1998	$50,000
025	Welfare Supervisory (SEIU)	11/21/1999	$18,000
026	Engineering Technicians & Technical Inspectors (ETTI)	6/20/1999	$18,000
027	Physicians & Dentists	1/18/1998	$50,000
028	Data Processing	2/1/1998	$18,000
029	Law Enforcement Management (LEMA)	2/1/1998	$50,000
030	Firefighters	10/11/1998	$18,000
031	Peace Officers (SCALE)	11/21/1999	$18,000
032	Management (SCMA)	2/1/1998	$50,000
033	Attorney-Civil (SCMA)	2/1/1998	$50,000
034	Administrative Professionals Association (SCAPA)	2/1/1998	$18,000
050	Unrepresented Management	2/1/1998	$50,000
080	Unrepresented	2/1/1998	$18,000
E01	Elected Officials	2/1/1998	$50,000

Note: Dependent life bundled as follows: $15,000/$5,000, $18,000/$2,000, $50,000/$2,000

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.net
http://www.personnel.saccounty.net/Benefits