2018 MyBenefits Summary

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

Retiree

SACRAMENTO COUNTY

INTRODUCTION

The County of Sacramento is committed to your overall health and well-being, and we're pleased to offer a comprehensive retiree benefits program that provides valuable health care 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 handbook 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 benefits and the application of policies that pertain to your specific situation should be addressed to the Employee Benefits Office staff.

CONTACT US

(916) 874-2020

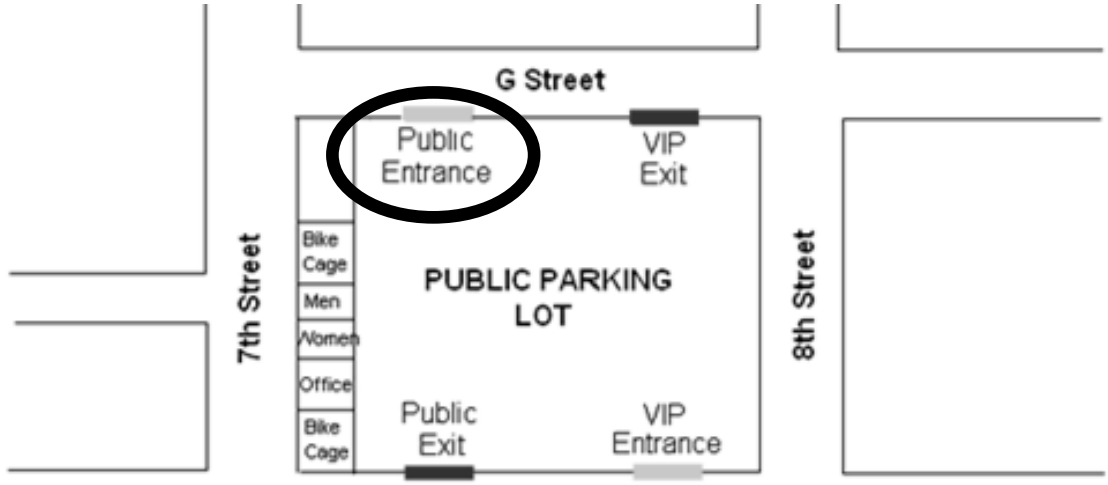
700 H Street Room 4650, Sacramento, CA 95814

MyBenefits@saccounty.net

www.personnel.saccounty.net/benefits

8:00 a.m. to 5:00 p.m., Monday – Friday

Visitor parking is available in the 2-story parking lot across the street from the Administration Building. Entrance to the parking garage is on G Street, at 7th Street. Parking rates are charged in 30 minute increments.



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USING THIS HANDBOOK

PROGRAM OVERVIEW

These benefit programs bring considerable value to you as a Sacramento County annuitant. We encourage you to thoroughly review this Benefit Handbook and contact the Department of Personnel Services Employee Benefits Office with any questions you might have. This Handbook is only a summary and may not address all of your specific questions. The Department of Personnel Services Employee Benefits Office has additional, comprehensive benefit information for all of the benefit programs, which you may review at 700 H Street, Room 4650 (4th Floor), in the County Administration Center from 8:00 a.m. until 5:00 p.m., Monday through Friday, or you may reach our staff by calling (916) 874-2020, or send an email to MyBenefits@saccounty.net.

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 comparisons contained in this handbook 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 available online and in paper upon request.

LOCATING INFORMATION

The individual sections of this guide provide you with the information you need to understand each of your plans. As you dig deeper into a section, you will find more and more details about that plan. If you can't find what you're looking for, refer to the last section of this handbook titled "How to Contact Us". There you will find contact information for vendor phone numbers and websites. We appreciate your service to the County of Sacramento and look forward to providing service to you.

GENERAL INFORMATION

PREMIUM PAYMENTS

Health plan premiums will be deducted from your monthly pension payment while you are participating in the benefits program. If your premiums are greater than your annuity, you will be required to make monthly payments to SCERS to continue coverage. If you are required to make direct payments to SCERS for your coverage and the payment is not made within 60 days of the date due, your County-sponsored coverage will be cancelled retroactively to the last day of paid coverage, and you will not be permitted to re-enroll in the plan at a later date.

ADDRESS CHANGES

You must keep your address current with SCERS in order to receive information from the Benefits Office after you retire. Your physical address is required if you are enrolled in a medical plan.

MEDICARE ELIGIBILITY

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 (Part B) without incurring a late enrollment penalty at a later date. You can activate Part B immediately once you retire.

If you or your covered dependent(s) becomes eligible for Medicare once you are retired, you must enroll in Medicare parts A & B in order to continue in the retiree health program. Failure to enroll in Medicare parts A & B when eligible will result in cancellation of your County sponsored coverage without the opportunity to enroll at a later date.

OPEN ENROLLMENT

Open Enrollment is generally held in the Fall. This is the once a year opportunity to change plans or add dependents without a qualifying event. Enrollment or coverage changes made during Open Enrollment become effective on January 1st of the following year. If you do not change your coverage during Open Enrollment your current benefits will automatically continue next year. Unless otherwise instructed, you do not need to re-enroll if you are keeping the same coverage.

NEW RETIREES

WHAT HAPPENS TO MY BENEFITS WHEN I RETIRE?

The County offers retiree medical, dental, and vision coverage for eligible retirees and their eligible dependents. Each benefit can be elected independently. If you are enrolled in a County plan, your coverage as an active eligible employee stops at the end of the month in which you terminate your employment.

You should elect your retiree medical, dental, and vision coverage at least one month before you retire to ensure you do not have a break in coverage. You can elect any of the coverages independently from the other (e.g., Single medical, Family dental, Waive vision). You are responsible for all or a portion of the cost of your retiree medical, dental and vision coverage. You are responsible for future increases to the cost of coverage. Retiree benefits are effective the first day of the month following your retirement date and the submission of your benefit election form(s).

MEDICAL, DENTAL & VISION COVERAGE

When you retire, you have three options for medical, dental and vision coverage enrollment:

1. Enroll in a County sponsored retiree plan
   - Read through this book and complete the enrollment form selecting the benefits for yourself and any eligible dependent(s) you wish to enroll. Deductions for coverage(s) are taken automatically from your pension check in most cases.
2. Continue your medical, dental and vision coverage under COBRA for 18 months
   - COBRA packet is mailed at retirement, sign election form in packet and return to the Employee Benefits Office by the election deadline. COBRA deductions are not taken from pension check. Separate payment arrangements apply.
3. Look for coverage on the marketplace through Covered California or elsewhere
   - Waive County options and find coverage on your own

NEW RETIREES (cont'd)

WAIVING COVERAGE

If you do not enroll within your first 30 days of retirement, you will be deemed to have waived your medical, vision and dental coverage. You can also sign a waiver.

Medical-If you waive medical coverage, you can only enroll at a later date provided you

1) have been continuously covered by another group health plan or individual Medicare Advantage plan for at least 12 months,
2) have not had a break in coverage exceeding 63 calendar days immediately prior to your request to enroll, and
3) request the enrollment within 30 days of losing your group or Medicare coverage.

Dental-If you waive dental coverage, you will not be allowed into the dental plan until the first day of the calendar year after 24 consecutive months have passed.
Vision- If you waive vision coverage at the time of retirement you can only enroll at a later date provided you have a life event or at Open Enrollment.

LIFE INSURANCE

Your life insurance coverage will terminate the last day of the month in which you are in paid status. You are able to continue your basic and/or optional coverage for yourself or your dependents directly through the life insurance carrier and have the opportunity to select lower amounts if desired. You must submit the conversion application direct to the life insurance carrier within 31 days of the coverage terminating. Contact the Benefits Office for more information.

NEW RETIREES (cont'd)

HEALTH SAVINGS ACCOUNT

If you contributed to a Health Savings Account (HSA) via payroll deduction while working, your payroll contributions will end on your last month of employment. Currently there is no retiree option for HSA payroll contributions. You may continue to contribute to an HSA by making post-tax contributions directly to the account, as long as you maintain enrollment in a high deductible health plan, are under 65, and have exhausted your funds in the Retiree Health Savings Plan.

DEPENDENT COVERAGE

If you are enrolling dependents in your medical, vision, or dental plan, you will need to provide documentation to show their relationship to you, even if they were enrolled in your benefits while you were working.

Dependent:	Document required:
Spouse	Marriage certificate
Domestic Partner	Registration from Secretary of State
Child	Birth certificate

Depending on your situation, additional documentation may be required.

FLEXIBLE SPENDING

Enrollment in Flexible Spending Accounts will end on the last day of the month of your employment. For claim expenses incurred during your eligibility in the plan year, you have until April 30 of the following year to submit your request for reimbursement. Expenses must be incurred before your coverage ends. If you were enrolled in the Medical Reimbursement Account you might be able to continue coverage past your retirement date by electing COBRA coverage.

NEW RETIREES (cont'd)

PENSION DEDUCTIONS

Deductions for benefits are taken one month in advance of the coverage. Depending on the timing of your retirement and first pension check, you may have a double deduction for your benefits. If your pension check is not enough to cover your premiums, you will be required to send in monthly payments.

MEDICARE ELIGIBILITY

If you (or any covered dependent) are age 65 at the time of your retirement you must elect Medicare Parts A & B to participate in retiree medical. If you were eligible for Medicare while working but declined enrollment due to having a County medical plan, you must now contact the Social Security office to enroll in Medicare Parts A & B under the Medicare Special Enrollment Period. You should contact the Social Security office a couple months ahead of your retirement so that you can transition immediately into a retiree Medicare plan under.

Failure to enroll in Medicare when you are eligible will result in cancellation of your County sponsored medical plan. You may also incur a Medicare late enrollment penalty if you do not follow Medicare's enrollment requirements and sign up at a later date.

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.

ELIGIBILITY FOR COVERAGE

All Retirees-You are eligible for health insurance coverage under the retiree group plans if you are a County retiree, a survivor, or beneficiary receiving a monthly retirement allowance as defined by the County of Sacramento Retiree Medical, Dental and Vision Insurance Program Administrative Policy. You may not be enrolled in a medical, vision, or dental plan as a retiree and as a beneficiary or as a spouse of another retiree.

New Retirees-Initial enrollment must take place within 30 days of eligibility. However, in order to prevent a break in coverage when transitioning from an active employee to a retiree, please contact the Employee Benefits Office at least 30 days before retirement to discuss your enrollment options.

Current Retirees-If you do not enroll within the first 30 days of retirement, you may be able to enroll within 30 days of a life event or during the next Open Enrollment if you meet the eligibility criteria. Proof of continuous, comparable group coverage will be required.

RETIREES LIVING OUT-OF-AREA

If you are a non-Medicare retiree and you live outside of the HMO service area, your only option for coverage is the non-Medicare PPO plan. Please note this plan is only available if you have no other County sponsored HMO coverage available to you in your residential area. To enroll in a Kaiser plan outside of the Sacramento area you must reside in another Kaiser Permanente service region, which is limited to a few states. Medicare retirees living out of the area may enroll in the UnitedHealthcare NPPO.

DEPENDENTS-You may elect to enroll your eligible dependents in the same coverages that you select. A dependent must be enrolled in the same medical plan as the Annuitant if there is no Medicare entitlement for any participant. In situations where one or more participant(s) has Medicare entitlement and one or more participant(s) has no Medicare entitlement, all Medicare enrollment must be in the same Medicare plan and all non-Medicare enrollment must be in the same non-Medicare plan.

ELIGIBILITY FOR COVERAGE (cont'd)

Who can be enrolled?

Spouse	*Legally married*
Domestic Partner	*Registered with Secretary of State*
Child-Under 21	*Foster/ Legal Guardianship*
Child-Under 26	*Natural/ Step/ Adopted*
Child-Over 26	*Disabled*

Grandchildren are not eligible for coverage unless the retiree, spouse, or domestic partner has legal guardianship of the child.

- Coverage may be available for dependents that live outside of the carrier's local HMO service areas and/or in states other than California. However, in some cases only emergency services may be available.
- You may not enroll a dependent who is also a County of Sacramento retiree covered under our group health plans.
- Dependents must normally be enrolled in the same coverage as the retiree. However, split enrollments for mixed Medicare and non-Medicare coverage situations are available.

SURVIVING SPOUSE OR DOMESTIC PARTNER COVERAGE

In the event of the death of a retiree, the surviving spouse, domestic partner or minor child beneficiary who will receive a continuing SCERS pension benefit may be eligible to continue medical, dental, or vision insurance benefits. Please contact SCERS at (916) 874-9119 **within 30 days of the date of death** to determine if retirement benefits can be continued.

A surviving spouse or domestic partner beneficiary who is receiving a continuing SCERS pension benefit may add a newly acquired dependent to any plan within 30 days of a qualified life event or at Open Enrollment. You must contact the Employee Benefits Office to enroll in the medical, dental, and vision insurance plans.

CHANGING COVERAGE

When you need to make a change to your medical, dental, or vision coverage, contact the Employee Benefits Office. Some changes are time sensitive and need to be completed within 30 days, and some changes require documentation to support the change. All changes are completed on paper forms that require your signature. The Benefits Office staff can provide you with the correct forms to complete, and inform you if your change requires any additional steps or paperwork.

LIFE EVENTS-If you experience a life event, you have 30 days from the date of the event to make the corresponding change to your coverage. Examples include getting married or losing other group medical coverage. Changes in coverage due to a life event are generally effective the first day of the month following your request.

OPEN ENROLLMENT-If you miss the 30 day window to make a change from a life event, or you want to add dependents or change medical plan carriers, you may do so during Open Enrollment, which is generally in the Fall. Changes made during Open Enrollment are effective the following January 1st.

Outside of Open Enrollment, you may waive your medical, vision and dental coverage, or cancel coverage for your dependents at any time.

ADDING DEPENDENTS

- You must add eligible dependents to coverage within 30 days of the life event. (*Examples include birth, adoption, placement for foster care or guardianship, marriage, registration of domestic partnership, or loss of eligibility of other group coverage*).
- Coverage is effective the first day of the month following the event and submission of all required forms.

CHANGING COVERAGE (cont'd)

- You must present documents which verify the identity of the dependent, their relationship to you, and the date of the event.
- Failure to add dependents and present required documents within the time frame will result in your inability to add your dependent(s) until the next Open Enrollment period.

REMOVING DEPENDENTS

There are two types of dependents, those eligible for coverage, and those not eligible for coverage. If your dependent is not eligible for coverage, he/she MUST be removed from the plan(s).

Eligible Dependents

- You may remove an eligible dependent from your medical and/or vision plan at any time.
- You may remove dependents from the dental plan only after they have been enrolled for 12 consecutive months.
- Coverage will terminate on the last day of the month that the appropriate forms are received by the Employee Benefits Office.
- Eligible dependents that are removed from coverage may only be re-enrolled during Open Enrollment, unless there is a life event. **Proof of continuous, comparable group coverage will be required if re-enrolling in a medical plan** in accordance with the Retiree Health Insurance Program Administrative Policy. A copy of this policy is available through the Department of Personnel Services Employee Benefits Office or on the website.

CHANGING COVERAGE (cont'd)

Ineligible Dependents

- If your dependent is no longer eligible for coverage due to divorce, termination of a domestic partnership, or a child exceeding age limitations it is your responsibility to remove him/her at the time s/he loses eligibility.
- Under no circumstance can an ex-spouse continue to be covered under your plan, even if the divorce settlement indicates you are responsible to maintain health coverage. Generally you would pay for COBRA or private insurance to comply with the court order.

IMPORTANT: In situations where it is determined that the dependent lost eligibility more than 30 days in the past, the Employee Benefits Office will terminate coverage under administrative guidelines on a retroactive basis.

- Retroactive premiums will be refunded where possible in accordance with the terms of the contract with the carrier.
- Failure to remove ineligible dependents within 60 days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependent(s).
- You may become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.
- You and/or the dependent may be subject to any sanctions or actions taken by the carrier.

MEDICAL PLANS AT A GLANCE

You have a variety of medical plan options available to you as a County retiree. In most cases you will pay the full monthly cost of the coverage for yourself and any eligible dependents that you enroll. A basic explanation of the plan types offered through the County's benefit program is described below.

Plan Type	HMO	HDHP	PPO*
Choice of Dr	Network Primary Care Physician (PCP) selection required	Network Primary Care Physician (PCP) selection required	You see any doctor
Specialist	Requires PCP referral	Requires PCP referral	No referral needed
Monthly cost	Median cost	Lower cost	Median-High cost
Cost for visits	Set co-pay, $15 for most services	You pay annual deductible, then plan pays 100%	Set co-pay or percentage
Vision	Option to purchase	Option to purchase	Option to purchase

***Limited availability in non-Medicare situations-only available if no other County HMO coverage in the area.**

HEALTH MAINTENANCE ORGANIZATION (HMO)

Under an HMO plan, a Primary Care Physician (PCP) directs all of your medical care and specialty referrals. You and each of your enrolled family members may select a PCP, and if you do not, one will be assigned to you and each family member. Each enrolled member of the plan may choose a different PCP. You may change your PCP at any time by calling the carrier's customer service number. You will generally pay a fixed copayment at the time you seek care.

Some points to consider in making this choice:

- The doctor you choose becomes your Primary Care Physician and all medical care, including routine care, hospitalization, and referral to other health professionals must be coordinated under the direction of your Primary Care Physician.
- Preventive and well-care services are provided at no additional cost.
- Copayments apply to doctor's office visits and prescriptions.
- HMOs generally do not require you to submit claim forms, except in cases when emergency care takes place outside of your coverage area.

MEDICAL PLANS AT A GLANCE (cont'd)

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

High Deductible plans are still HMO plans requiring in-network services and a PCP. However, in a HDHP both medical (except for certain types of preventive care) and prescription expenses must apply to the deductible. These plans are lower in monthly premiums than traditional HMO plans but have a larger initial out of pocket expense. You pay for services at the time of care. Once you reach the deductible, most services are covered at 100%. If you choose to enroll in one of the HDHP plans, you may also be eligible to establish a Health Savings Account (HSA).

Some points to consider in making this choice:

- With the HDHP the doctor you choose becomes your PCP and all medical care, including routine care, hospitalization, and referral to other health professionals must be coordinated under the direction of your PCP.
- Preventive care and routine physicals are provided at no additional cost.
- Expenses for doctor's office visits **and prescriptions** apply to the deductible.
- Coverage for chiropractic and acupuncture is generally not included.

PREFERRED PROVIDER ORGANIZATION (PPO)-Limited Availability For Non-Medicare Participants – Cannot have any County HMO coverage available in your service area.

A PPO plan allows you to choose your doctor without using a Primary Care Physician (PCP) and you may self-refer to specialists. You have the option to utilize in-network preferred providers or out-of-network providers. You may go to any licensed physician or hospital.

Some points to consider in making this choice:

- With the PPO, you have the flexibility to choose any provider, in or out-of-network, and still receive benefits. Your cost will be greater for out-of-network services.
- Can be very expensive.

HMO PLANS NON-MEDICARE

Monthly Cost

PLAN CARRIER	RETIREE	RETIREE +1	RETIREE +2/More
Kaiser Permanente	$757.90	$1,515.80	$2,144.86
Sutter Health Plus	$721.32	$1,414.30	$2,004.30
WHA	$704.40	$1,408.80	$1,993.50

Coverage

HMO MEDICAL PLAN COVERAGE			
COVERAGE CATEGORY	**KAISER**	**SUTTER**	**WHA**
Annual Deductible	$0		
Annual Out-of-Pocket Limit	$1,500 Individual/$3,000 Family		
Annual Wellness Exam	$0		
Inpatient Care (Hospitalization, Mental Health, Substance Abuse)	$0		
Diagnostic X-Ray/Lab Tests	$0		
Primary Care Office Visit	$15		
Outpatient Care (Hospitalization, Mental Health, Substance Abuse)	$15		
Specialist Visit	$15		
Short Term Therapy (Physical, Occupational, Speech)	$15		
Home Health Care (100 visits/year)	$0		
Skilled Nursing Facility (100 days/year)	$0		
Durable Medical Equipment	$0		
Generic Rx	$10		
Brand Name Rx	$20		
Mail Order Rx (G/B/Non Preferred)	$10/$20	$20/$40/$70	
Chiropractic/annual visit limit (v)	$10/ 30v	$15/ 20v	
Acupuncture /annual visit limit (v)	$15	$10/ 30v	$15/ 20v
Emergency Room Visit	$35 (waived if admitted)		

See the appropriate plan EOC booklet for more details on coverage and exclusions

HIGH DEDUCTIBLE PLANS NON-MEDICARE

Monthly Cost

PLAN CARRIER	RETIREE	RETIREE +1	RETIREE +2/More
Kaiser Permanente	$592.18	$1,184.36	$1,675.88
Sutter Health Plus	$534.42	$1,046.20	$1,481.92
WHA	$539.80	$1,079.60	$1,527.80

Coverage

HIGH DEDUCTIBLE MEDICAL PLAN COVERAGE			
COVERAGE CATEGORY	**KAISER**	**SUTTER**	**WHA**
Annual Deductible	$1,350 Individual/$2,700 Family		
Annual Out-of-Pocket Limit (OOP)	$2,700 Individual/$2,700 Family		
Annual Wellness Exam Preventive Exams/Lab Tests	$0 (deductible waived)		
Primary Care Office Visit Skilled Nursing Facility (100 visits/year) Short Term Therapy (Phys, Speech, Occupational) Inpatient Care (Hospitalization, Mental Health, Substance Abuse) Outpatient Care (Hospitalization, Mental Health, Substance Abuse) Specialist Visit Emergency Room Visit Ambulance Home Health Care (100 visits/year) Generic/Brand Name RX	100% covered after deductible **<u>Important Note:</u>** Single subscribers on a HDHP have an upfront annual deductible of $1,350 (excluding Wellness and Preventive exams and tests) and co-pays for prescription drugs up to $2,700 maximum OOP.		

See the appropriate plan EOC booklet for more details on coverage and exclusions

MEDICARE ENTITLEMENT

If you are enrolled in a County sponsored medical plan when you become eligible for Medicare, you must enroll in Medicare Parts A & B in order to continue participation in the County-sponsored retiree medical plans.

MEDICARE PARTS A & B

- Contact the Employee Benefits Office 30-60 days before your Medicare takes effect to enroll in a Medicare Advantage plan. You must complete additional forms and we will require a copy of your Medicare card or verification letter from the Social Security office.
- If you and/or your dependent are eligible for Medicare and do not enroll in or keep Medicare Parts A & B, your County-sponsored medical coverage will be cancelled.

MEDICARE PART D

The County sponsored plans provide prescription drug coverage that is comparable to Medicare Part D coverage or better.

Under the Medicare Part D rules from the Center for Medicare and Medicaid Services (CMS), if you purchase Medicare Part D from another non-County-sponsored plan, your medical coverage with the County-sponsored plan will be cancelled. You can only be covered under one Medicare Part D policy at a time.

SPLIT ENROLLMENTS

If you have dependent medical coverage and one of you has Medicare and the other does not, you will be considered a "split" enrollment. Normally your dependents must be enrolled in the same medical plan that you have, but special rules apply to Medicare.

MEDICARE ENTITLEMENT (cont'd)

MEDICARE ADVANTAGE PLANS

Under a Medicare Advantage Plan, you must have Medicare Parts A & B. You assign your Medicare benefits directly to the Medicare Advantage Plan. You cannot enroll in two Medicare Advantage Plans at the same time since your individual Medicare benefits are assigned to the Medicare Advantage Plan you select.

Coverage for services outside of your plan may be limited or subject to additional requirements or costs. For further details, please refer to the plan's Evidence of Coverage (EOC).

The County currently has four Medicare Advantage plans available:

- Two through UnitedHealthcare-UHC Advantage HMO and NPPO
- Two through Kaiser Permanente-Silver and Gold

Participants in these County Medicare Advantage plans are also enrolled in Medicare Part D automatically. You should not enroll in any other no County Part D plan separately. Enrolling in any other Part D plan will terminate your County medical plan, since you cannot have two Part D plans at the same time.

REMEMBER: If you or your dependent is eligible for Medicare, you must enroll in and keep Medicare Parts A and B in order to participate in the County Sponsored retiree Medical Plans. If you drop Part A and/or Part B, your county coverage will be cancelled.

MEDICARE ADVANTAGE PLAN PREMIUMS

Monthly Cost

ONE MEMBER HAS MEDICARE			
PLAN CARRIER	**RETIREE**	**RETIREE +1**	**RETIREE +2/More**
UnitedHealthcare HMO	$260.69	N/A*	N/A*
UnitedHealthcare NPPO	$397.15	N/A*	N/A*
Kaiser Sr Advantage GOLD	$321.95	$1,079.85	$1,708.91
Kaiser Sr Advantage SILVER	$216.16	$974.06	$1,603.12

TWO MEMBERS HAVE MEDICARE		
PLAN CARRIER	**RETIREE +1**	**RETIREE +2/More**
UnitedHealthcare HMO	$521.38	N/A*
UnitedHealthcare NPPO	$794.30	N/A*
Kaiser Sr Advantage GOLD	$643.90	$1,272.96
Kaiser Sr Advantage SILVER	$432.32	$1,061.38

*Contact the Benefits Office for information on coverage options

UNITEDHEALTHCARE MEDICARE PLANS

MEDICARE ADVANTAGE PLAN COVERAGE		
COVERAGE CATEGORY	**UHC HMO**	**UHC NPPO**
Annual Deductible	$0	
Annual Out-of-Pocket Limit/Individual	$3,400	
Preventive Exam	$0	
Inpatient Care (Hospitalization, Mental Health, Substance Abuse)	$0	
Home Health Care	$0	
Skilled Nursing Facility (100 days/year)	$0	
Durable Medical Equipment	$0	
Short Term Therapy (Physical, Occupational, Speech)	$0	
Primary Care Office Visit	$15	
Specialist Visit	$15	
Diagnostic X-Ray/Lab Tests	$0	
Outpatient Care (Mental Health, Substance Abuse)	$15	
Generic Rx	$10	
Brand Rx	$20	
Chiropractic Services	$15	
Emergency Room	$20 (waived if admitted)	
Hearing Screening	$0	
Hearing Aid(s)	$500 allowance (every 36 months)	

See the appropriate plan EOC booklet for more details on coverage and exclusions

KAISER PERMANENTE-Senior Advantage

MEDICARE ADVANTAGE PLAN COVERAGE		
COVERAGE CATEGORY	**Kaiser Gold Plan**	**Kaiser Silver Plan**
Annual Deductible	$0	
Annual Out-of-Pocket Limit/Individual	$1,500 Ind. / $3,000 Family	
Preventive Exam	$0	
Home Health Care	$0	
Diagnostic X-Ray/Lab Tests	$0	
Chiropractic Services (30 visit limit/year)	$15	
Generic Rx (30 day supply)	$10	
Brand Rx (30 day supply)	$20	$25
Durable Medical Equipment	$0	20% co-pay
Emergency Room (waived if admitted)	$35	$50
Inpatient Care (Hospitalization, Mental Health, Substance Abuse)	$0	$500
Primary Care Office Visit	$15	$25
Specialist Visit	$15	$25
Short Term Therapy (Physical, Occupational, Speech)	$15	$25
Skilled Nursing Facility (Limited to 100 days/year)	$0	$0 (first 20 days) $75 (days 21-100)
Mental Health Outpatient Care	$15 Ind $7 Group	$25 Ind $12 Group
Substance Abuse Outpatient Care	$15 Ind $5 Group	$25 Ind $5 Group
Hearing Screening	$15	$25
Hearing Aid(s)	Not covered	

See the appropriate plan EOC booklet for more details on coverage and exclusions

HEALTH SAVINGS ACCOUNT (HSA)

You are not required to have an HSA if you enroll in HDHP coverage. However, if you do choose to enroll in an HDHP before you reach Medicare eligibility, you have the option to continue to set aside funds in an HSA for reimbursement of qualified expenses.

If you have HDHP coverage and elect to have an HSA, you cannot make any contributions until you have exhausted the funds set aside for you in the Retiree Health Savings Account (see page 33). Once you have exhausted your RHSP funds, you are eligible to begin contributing to an HSA again. When you do make contributions they will be to the financial institution of your choice on a post-tax basis and you will take a deduction when filing your itemized Federal income tax return.

ELIGIBLE EXPENSES

In addition to medical expenses, you can use the funds in your HSA account to pay for qualified dental, vision, and hearing expenses as well.

Even if you are no longer eligible to contribute to an HSA, whether you switch from an HDHP, gain other coverage, or become entitled to Medicare, you can continue to use your HSA account for qualified health expenses until it is depleted. Non-medical withdrawals are considered taxable income, and a 20% penalty for those withdrawals will also apply if you are under 65.

DENTAL COVERAGE

Retirees have the option to enroll in the retiree dental plan. You will pay the full cost of the plan, and enrollment is completely separate from medical and vision. You may also enroll any eligible dependents.

COST

You pay the full monthly cost for yourself, your covered spouse, domestic partner, and/or dependent children's coverage.

DENTAL CARRIER	RETIREE	RETIREE +1	RETIREE +2/More
Principal Financial	$39.74	$72.67	$108.75

ENROLLMENT

- Eligible retirees, survivors, or beneficiaries, as defined by the Sacramento County Retiree Medical, Vision and Dental Insurance Program, may participate in the retiree dental insurance program.
- You may not be enrolled in a dental plan as a retiree and as a beneficiary or as a spouse of another County retiree.
- Retirees may elect to enroll their spouse, registered domestic partner, and/or dependent children at the time of retirement or during Open Enrollment.
- Spouses, domestic partners, and/or dependent children may also be added within 30 days of a life event provided the 12/24 month lock has been satisfied (see later in this section).
- Children may only be enrolled as dependents of one County retiree.
- Once you have enrolled in the dental plan coverage will continue year to year until you make a change.

DENTAL COVERAGE (cont'd)

LOCK PERIOD

- If you enroll yourself or dependents in the dental plan, you must remain in the plan for a minimum of 12 consecutive months before you can waive coverage or drop dependents.
- If your dependent is no longer eligible for coverage you will be allowed to remove the ineligible dependent without fulfilling the 12 consecutive month's requirement.
- If you drop coverage for yourself or a dependent, you must wait until January 1st after 24 months has passed to re-enroll.

COVERAGE

Review the Group Voluntary Dental Insurance booklet for detailed information about what is covered under the dental plan. Booklets are available from the Employee Benefits Office or on the website.

- Annual maximum payment limit is $1,500 per calendar year.
- A $25 calendar year deductible applies to Basic and Major services.

  The dental plan will pay the percentages listed below:

	EPO	PPO	Non-network
Preventative	80%	80%	60%
Basic Services	60%	60%	60%
Major Services	55%	55%	50%

- Please review the dental booklet for coverage resulting from dental accidents and limitations on coverage.
- Consultants are available to assist you with getting the best use out of your dental plan, such as the benefits of a specific procedure and types of services offered by dentists; call 800-247-4695 for assistance.

VISION COVERAGE

Vision coverage is available as an independent coverage election to all retirees who are eligible for benefits. You can purchase vision coverage separately from medical or dental on an optional voluntary basis, although it is already included in the Kaiser $15 HMO and Kaiser Medicare Advantage plans. You may only enroll in optional vision during Open Enrollment or within 30 days of a qualified life event.

Voluntary vision coverage is through Vision Services Plan (VSP).

OPTION TO PURCHASE-The monthly cost and coverage is listed below.

VISION CARRIER	RETIREE	RETIREE +1	RETIREE +2/More
Vision Services Plan (VSP)	$5.20	$10.38	$14.70

If you purchase vision…	Then your coverage is…		
	Exam	Frame Allowance	Provider
	$15	$130/24 months	VSP

See the appropriate plan EOC for more details on coverage and exclusions.

Kaiser $15 HMO and Medicare Advantage participants have vision include in the medical plan. You can buy VSP in addition to your already include vision benefit, but there is no coordination of benefits.

If your plan is…	Then your coverage is…		
	Exam	Frame Allowance	Provider
Kaiser HMO/Advantage Gold	$15	$175/24 months	Kaiser
Kaiser HMO/Advantage Silver	$25	$150/24 months	Kaiser

See the appropriate plan EOC for more details on coverage and exclusions.

LIFE INSURANCE

When you retire from active employment your life insurance generally ends at that time. There are two ways to continue life insurance:

1. Conversion-You must complete the conversion application within 31 days from the date your life insurance coverage ends and pay the required premiums.
2. Waiver of Premium-If you are under age 60 and disabled you can apply for a waiver of premium. The application must be made while your life insurance coverage is in force.

WAIVER OF PREMIUM

As a retiree, if you have continued your life insurance by Waiver of Premium, you should contact the Employee Benefits Office to maintain your beneficiary. Contact our office to obtain a beneficiary form if you need to make any updates. As a reminder, the life insurance company will generally require you to provide proof of your continued disability each year to remain eligible for the waiver. Failure to provide the proof of disability will result in termination of your life insurance policy. If the retiree passes away the beneficiary should contact the Employee Benefits Office to file the life insurance claim.

CONVERSION

If you have converted your life insurance policy to an individual contract, beneficiary updates will be maintained by the life insurance company directly, as the County will have no knowledge of this conversion. If the retiree passes away the beneficiary should contact the life insurance carrier directly to file the life insurance claim.

CONTINUATION COVERAGE (COBRA)

What is Continuation of Coverage?

COBRA* is a continuation of health coverage under the plan when coverage would otherwise end because of a "qualifying event." After a qualifying event, COBRA must be offered to each person who is a "qualified beneficiary." The covered retiree, his/her covered spouse, and his/her dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA pay the full cost of the benefits at group rates.

Who is eligible for Continuation Coverage?

Each family member who loses County-sponsored group coverage due to a qualifying event is eligible to elect continuation coverage. A COBRA notice will be mailed to the last address we have on file if the below event triggers a loss of coverage:

Retirees

- When you terminate active employment

Spouse

- Upon the retirees death
- Divorce/Legal separation
- Retiree gains Medicare and waives coverage

Child

- Upon the retirees death
- Divorce
- Child no longer meets age requirements
- Retiree gains Medicare and waives coverage

Domestic partners of retirees and the children of domestic partners are not eligible to independently elect to continue coverage after a loss of eligibility. Domestic partners may continue coverage as a dependent of a retiree who elects continuation coverage.

CONTINUATION COVERAGE (cont'd)

What should I do when there is a qualifying event?
Our office must be notified within 60 days of the date of the qualifying event for your dependent to be eligible to continue coverage. It is the responsibility of each retiree or covered family member to inform the Employee Benefits Office within 60 days of a qualifying event to be eligible to continue coverage.

What benefits can be continued?
Medical, vision, dental, EAP and Medical Reimbursement plans may be continued. You will receive a notice that explains the benefits that may be continued, the election time frames, cost, and the length of time that coverage may be continued.

How long can benefits continue under Continuation Coverage?
Coverage may be continued for 18 to 36 months.

What if I have questions about Continuation Coverage?
Direct your questions about your Continuation Coverage rights to:

Department of Personnel Services, Employee Benefits Office
700 H Street, Room 4650, Sacramento, CA 95814
Phone: (916) 874-2020
MyBenefits@saccounty.net

*Consolidated Omnibus Budget Reconciliation Act of 1985

DEFERRED COMPENSATION

Once you have separated employment from the County of Sacramento, you are eligible to receive distributions from your deferred compensation account(s). Your options include:

- Keep your account balance in the County of Sacramento 457(b) and /or 401(a) Plan(s);
- Request a distribution of a lump sum, partial lump sum, monthly/quarterly/annual distribution or stop a distribution arrangement at any time;
- Rollover to another retirement plan such as an IRA, 401(k), etc.

As a reminder, you should carefully consider the impact to your account balances and overall fund costs in rolling over to another retirement plan as you will be leaving a large governmental plan with preferential pricing.

Distributions can be made as soon as Fidelity is notified of your separation. Taxes are paid as ordinary income. The default tax amount for any distribution from your 457(b) Plan is 20% Federal and 2% State. You must take a Required Minimum Distribution no later than March of the year you turn 70 ½ years old.

If you were in Recognized Employee Organization (REO) 020, 021, 024, 029, 032, 033, Unrepresented Management (050) or Elected Officials, you may have been eligible for the 401(a) Plan. At the time of distribution your default tax amount is 20% Federal, 2% State and if you are under age 59 ½ you may be assessed an extra 10%.

More information about the impact of taxes on your distributions is available in IRS form 402(f) which is available at www.irs.gov. You may also contact Fidelity at (800)-343-0860 or www.Netbenefits.com/saccounty for more information, or the Deferred Compensation Office at (916) 874-2020 or MyBenefits@saccounty.net.

Important: Always keep your beneficiary Information updated with any new life event (marriage, divorce, death, etc.) and your address current!

RETIREE HEALTH SAVINGS PLAN (RHSP)

During your employment the County may have been contributing $25 per pay period into this account for you to use after you separate from service. You should receive a packet in the mail from Meritain Health a few weeks after you retire that explains the plan.

This employer-sponsored health savings account allows you to be reimbursed on a tax-free basis for qualifying health expenses for you, your spouse and/or your dependents after you leave County employment.

Expenses eligible for reimbursement consist of all medical expenses eligible under the Internal Revenue Code Section 213 (IRS Publication 502). Examples of eligible expenses include most medical insurance premiums, medical out-of-pocket expenses, Medicare Part B and D insurance premiums, dental insurance premiums, dental out-of-pocket expenses, vision insurance premiums, vision out-of-pocket expenses, qualified Long Term Care insurance premiums, non-prescription medications when allowed under IRS guidelines, and other qualifying health expenses.

There is a $7.50 claims administration charge to your account each quarter after you leave County service. Claims for medical expenses are submitted for reimbursement on *VantageCare Retirement Health Savings Plan Benefits Reimbursement Request Form*. This form is available at:

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

or directly from Meritain Health, (888) 587-9441.

Upon your death, any remaining assets will be transferred to an account for continuing tax-free use by your surviving IRS eligible spouse and/or dependents for their own qualifying health expenses. Please contact ICMA-RC or Meritain Health, Inc. if you have any questions.

HOW TO CONTACT US

COUNTY OF SACRAMENTO		
Benefits Office	916.874.2020	www.personnel.saccounty.net/benefits
DEFERRED COMPENSATION		
County of Sacramento	916.874.2020	www.personnel.saccounty.net/benefits
Fidelity Investments	800.343.0860	www.Netbenefits.com/saccounty
DENTAL PLAN		
Principal Financial	800.247.4695	www.principal.com/providers
MEDICAL PLANS		
Kaiser Permanente	800.464.4000	www.kp.org
Sutter Health Plus	855.315.5800	www.sutterhealthplus.org
Western Health Advantage	888.563.2250	www.westernhealth.com
UnitedHealthcare	877.714.0178	www.UHCRetiree.com
BEHAVIORAL HEALTH		
Optum Behavioral (Sutter)	855.202.0984	www.liveandworkwell.com
Magellan Health (WHA)	800.424.1778	www.magellanhealth.com
CHIROPRACTIC		
ASH (Kaiser)	800.678.9133	https://www.ashlink.com/ash/ashco.aspx?hp=KaiserCA
Landmark (WHA)	800.298.4875	www.lhp-ca.com
RETIREE HEALTH SAVINGS		
Meritain	888.587.9441	www.meritain.com
ICMA-RC	800.669.7400	www.icmarc.org
RX		
MedImpact –For Sutter	844.282.5330	https://mp.medimpact.com
Express Scripts-For WHA	800.903.8664	www.express-scripts.com
COUNTY RETIREMENT		
SCERS	916.874.9119	www.retirement.saccounty.net
VISION		
VSP	800.877.7195	www.vsp.com

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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