COUNTY OF SACRAMENTO RETIREE MEDICAL, DENTAL AND VISION POLICY
Effective January 1, 2023

I. INTRODUCTION

This policy sets forth the guidelines for the administration of the Retiree Medical, Dental and Vision Insurance Program. The program includes medical, dental and vision insurance as authorized by the County Board of Supervisors.

II. DISCLOSURE

This policy is not intended to, and does not, create any contractual, regulatory, or other vested entitlement to present or future retirees, their spouses, registered domestic partners, or dependents for medical, dental and/or vision benefits, at any particular level, or at all. The County reserves the right, in its sole discretion, to amend or terminate, in whole or in part, this by Resolution of the County Board of Supervisors.

III. MEDICAL/DENTAL/VISION INSURANCE

This policy offers medical/dental and vision insurance through contracted insurance carriers, as negotiated between the County and its recognized employee organizations. The County will endeavor to maintain a variety of insurance coverage options for Annuitants but does not guarantee that any particular insurance carrier, type, or level of coverage will be available to Annuitants, or that any coverage at all will be available to Annuitants.

Medical, dental and/or vision insurance options for Annuitants living outside of the geographic boundaries of the service areas of the insurance plans offered to County Annuitants will be provided only to the extent that any such option is available and offered by the insurance carriers providing coverage to the County's employees and Annuitants.

IV. ELIGIBILITY TO PURCHASE MEDICAL, DENTAL AND/OR VISION COVERAGE

Annuitants as defined in Section XI are eligible to enroll in a retiree medical, vision and/or dental insurance plan.

An Annuitant must enroll in a medical, vision and/or dental insurance plan within 30 days of notification of eligibility or from the Annuitant's retirement date, which ever date provides the longest election period. He or she will be deemed to have waived coverage. A beneficiary who is a spouse or a registered domestic partner or an eligible minor child or a Survivor receiving

a pension payment, may elect to purchase a retiree medical, dental and/or vision plan whether or not they were enrolled in the program at the time of the enrolled retiree's or active member's death.

Medicare Coverage

As a condition of participation in the County-sponsored plan, all Annuitants or Dependents that are eligible for Medicare Part A and/or B, or who subsequently become eligible to purchase Medicare Part A and/or B, must enroll in one of the County-sponsored medical plans that provides for assignment of Medicare benefits. Annuitants or Dependents who are eligible for Medicare must enroll in and/or purchase Medicare Part A and B (even if such purchase is subject to a penalty under applicable federal law) in order to participate in the County Sponsored plan. Annuitants not eligible for Medicare Part A and/or B under Centers for Medicare and Medicaid Services ("CMS") guidelines may participate in the plan only to the extent that they remain ineligible for Medicare and are responsible for any penalties assessed by the carrier.

For Annuitants who are eligible for Medicare, failure to purchase or maintain Medicare Part A or B when eligible, or to enroll in a non-County plan that requires assignment of Medicare shall be considered a waiver of County-sponsored coverage and coverage will terminate. Should the annuitant seek to return to a County sponsored Medicare Advantage plan, they must be able to demonstrate continuous Medicare Supplement and Part D coverage for the prior 12 month period. Annuitants that are able to satisfactorily meet that requirement may return to the County's Medicare Advantage plan at any eligibility period, including Open Enrollment, Loss of Coverage or a Qualified Status Change Event. This enrollment may apply to Dependents that meet the same eligibility standard.

For Dependents that are eligible for Medicare, failure to purchase or maintain Medicare Part A or B when eligible, or to enroll in a non-County plan that requires assignment of Medicare shall result in loss of eligibility and the Dependent shall be dropped from coverage. It is the participant's responsibility to notify the Benefits Office of their eligibility and/or enrollment in Medicare. Any Medicare Part B late enrollment penalties, as determined by CMS, are the Annuitant's responsibility.

Annuitants and Dependents with Medicare eligibility that are enrolled in County-sponsored medical plans shall keep their Part D benefits available for enrollment in County-sponsored Medicare Part D coverage. **An Annuitant or Dependent who is enrolled in a non-County prescription drug plan under Part D of Medicare may not be enrolled in any County-**

sponsored Medicare health benefit plan. Any Medicare Part D late enrollment penalties as determined by CMS are the Annuitant's responsibility.

The Centers for Medicare and Medicaid Services requires that all participants must provide a physical address and social security number for themselves and covered dependents.

(Note: Section V applies only to Annuitants who are receiving a benefit based upon County employment. Eligibility for Annuitants that were last employed with a Special District or other SCERS employer shall be determined by separate agreement between the County and District or other employer.)

V. DEPENDENT ELIGIBILITY

Annuitants (including Survivors) may add newly acquired Dependents to their medical, dental and/or vision insurance coverage within 30 days of a Qualified Status Change Event (e.g. marriage, adoption, domestic partner registration, loss of other coverage, etc.) or during any enrollment period specified in the sole discretion of the County.

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.

Dependent Documentation:

Please refer to the Retiree MyBenefits Summary for specific details on dependent eligibility and acceptable documentation. Dependents will not be enrolled if Annuitant do not submit dependent documentation with election form.

VI. ELECTION PERIOD

An Annuitant who is eligible to enroll in a medical, dental and/or vision insurance plan as provided in this policy must do so within 30 days from the date of notification or from the Annuitant's retirement date, which ever date provides the longest election period. An otherwise eligible Annuitant who waives, or is deemed to have waived (by failing to return any documentation) medical, dental and/or vision coverage under the program may enroll within

30 days of a Qualified Status Change Event, or during any enrollment period specified in the sole discretion of the County.

Such enrollment shall be contingent upon the Annuitant presenting proof that is satisfactory to the County that the Annuitant (and any dependents to the extent they are also to be enrolled) has been continuously covered by another group health insurance plan or individual Medicare Advantage Plan, or Medicare Supplement plan with a simultaneous Part D plan for a period of not less than 12 months with no break in coverage exceeding 63 calendar days immediately prior to the requested enrollment in a County-sponsored plan. The 12 month requirement will be deemed to be met if the coverage satisfies the requirements for creditable coverage under the Health Insurance Portability and Accountability Act of 1996.

Upon the death of an Annuitant or active employee, a beneficiary who is a spouse or registered domestic partner or eligible minor child or a Survivor, will have 30 days to enroll in a medical, vision and/or dental insurance plan. Failure to do so shall constitute a waiver of medical, vision and/or dental insurance coverage.

VII. EFFECTIVE DATE OF COVERAGE

Upon retirement:

i. The first day of the month following the loss of active coverage providing that retiree medical, vision and/or dental forms are submitted within 30 days of the loss of active coverage. Failure to submit medical and/or dental forms within 30 days of the loss of active coverage shall constitute a waiver of medical, dental and/or vision coverage.

ii. Premium balances if owed by an Annuitant for the initial period of Retiree coverage must be paid within 30 days of the coverage effective date, or coverage will be dropped retroactively to the last date of paid coverage.

Upon activation of deferred retirement:

i. The first day of the month following the activation of the retiree's Pension benefit providing that retiree medical, vision and/or dental forms are submitted within 30 days of the activation. Failure to submit medical, vision and/or dental forms within 30 days of the activation of the pension benefit shall constitute a waiver of the insurance coverage.

Upon the occurrence of a Qualified Status Change Event:

ii. The first day of the month coincident with or next following the event and submission of medical, vision and/ or dental enrollment forms. Forms must be submitted within 30 days of the Qualified Status Change Event.

Upon Open Enrollment:

i. 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 Annuitants do not change coverage during Open Enrollment current benefits generally will automatically continue the following next year. Unless otherwise instructed, Annuitants do not need to re-enroll if they are keeping the same plan or coverage.**

Note: Final effective dates and enrollment in Medicare plans are determined by the Centers for Medicare and Medicaid Services and may not necessarily coincide with initial retirement enrollment dates, or Qualified Status Change Events.

If an Annuitant enrolls during an open enrollment period, the effective date of medical, vision and/or dental coverage shall be the date specified by the County in connection with that open enrollment period.

VIII. PREMIUM PAYMENTS

Payments for all benefits will be deducted from the Annuitant's pension check. Deductions are taken one month in advance of the coverage. Depending on the timing of the Annuitant's retirement and first pension check, the Annuitant may have multiple deductions for benefits taken from his/her initial pension check.

Benefit Premiums That Exceed Monthly Retirement Allowance:

i. If an Annuitant's (or survivor's) medical, dental and/or vision insurance premium is greater than the sum of the monthly retirement allowance, the Annuitant/Survivor shall be responsible for keeping premium payments current by remitting a check directly to the County of Sacramento. Premium balances owed by an Annuitant/Survivor must be paid within 30 days of the coverage effective date, or coverage will be dropped retroactively to the last date of paid coverage. An Annuitant that

is dropped from coverage for non-payment of premium shall not be permitted back into the program at a later date.

IX. WAIVER OF COVERAGE

An Annuitant may waive medical, dental and/or vision coverage under the Retiree Health Insurance Program at any time by submitting a completed County election form waiving coverage and the appropriate Medicare plan disenrollment form where applicable. Waiver of coverage will be processed only on prospective basis, beginning with the month following receipt of the Waiver form. Requests for retroactive waiver of coverage will be reviewed by the County of Sacramento. However, at no point will retroactive waiver of coverage request extend beyond 2 months prior to the date of the waiver application and MUST be approved by the medical/dental and/or vision carrier. .

Note: Final disenrollment dates from Medicare plans are determined by the Centers for Medicare and Medicaid Services and may not necessarily be effective with the first of the month following the submission of disenrollment forms. It is the Annuitants responsibility to pay for any additional premiums owed under County Medicare plans based on Centers for Medicare and Medicaid Services regulations.

Annuitants who waive medical, dental and/or vision coverage in this manner, or who are deemed to have waived medical, dental and/or vision coverage for any reason (except for non-payment of premium as set forth in Section IX above), shall be permitted to enroll in County-sponsored retiree medical, dental and/or vision coverage within 30 days of a Qualified Status Change Event or during any enrollment period specified in the sole discretion of the County, subject to all terms and conditions set forth in this policy (including proof of continuous coverage as described in Section VII), provided such coverage is being offered to similarly situated Annuitants by the County at the time coverage under the re-enrollment request is to become effective.

X. DEFINITIONS

Annuitant is a retiree, as defined; or is a survivor, or beneficiary who receives a monthly retirement allowance from SCERS. An individual receiving a monthly retirement allowance from SCERS solely as the result of a divorce settlement is not an Annuitant for purposes of this policy or eligibility for participation in the Retiree Health Insurance Program.

Beneficiary is an individual named as a beneficiary receiving a monthly retirement allowance as a result of the death of a Retiree. For purposes of this policy, a beneficiary is a spouse or a registered domestic partner or minor child.

Deferred Member is a SCERS participant who leaves County or member district employment and leaves their retirement contributions on deposit with SCERS as permitted by SCERS rules and regulations.

Dependent for purposes of this policy shall be an Annuitant's spouse or registered domestic partner and children (natural, step, adopted, legal guardianship and/or foster) including children of a registered domestic partner, who meet the required age limits, and you or your spouse's unmarried children of any age who are medically certified as disabled and are dependent upon you. Note: an ex-spouse/Domestic Partners is not an eligible dependent for purposes of this policy.

Qualified Status Change Event shall have the same meaning as defined in Section §125 of the Internal Revenue Code and shall also include events affecting the coverage or eligibility of a registered domestic partner or the dependent(s) of a registered domestic partner. Examples of qualified status change events include: marriage or divorce, registration or dissolution of a domestic partnership, birth, adoption, change of residence affecting health plan eligibility, or a dependent ceasing to be a dependent due to age limitations. This list is intended to be illustrative and is not exhaustive.

Registered Domestic Partner shall have the same meaning as set forth in Section §297 of the California Family Code.

Retiree is a SCERS member who has met eligibility requirements and has received a service retirement or disability retirement.

Retiree MyBenefits Summary is a booklet produced annually, in preparation for Open Enrollment that provided detail descriptions of all medical, dental and vision plans as well as the rates, enrollment process, dependent eligibility and vendor/carrier information. The plans described in this booklet are governed by insurance contracts and plan documents. Should there be a discrepancy between this booklet and the provisions of the Evidence of Coverage (EOC), insurance contracts or plan documents, the provisions of the applicable EOC, insurance contracts or plan documents will govern.

Survivor is a spouse, registered domestic partner, or minor child of an employee who died during active service and is receiving a monthly retirement allowance as a result of the death of the active member.

(Note: For purposes of this policy and these definitions, a retiree of, or an employee (including their subsequent Survivor) retiring from a SCERS member district or other SCERS-participating employer shall be an Annuitant only if so provided by separate agreement between the County and such district or other employer.)