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COUNTY OF SACRAMENTO RETIREE MEDICAL, DENTAL AND VISION INSURANCE PROGRAM ADMINISTRATIVE POLICY Effective January 1, 2019

I. INTRODUCTION

This policy sets forth the guidelines for the administration of the Retiree Medical, Vision and Dental Insurance Program. The program includes medical, vision and dental 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, vision and/or dental 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/VISION INSURANCE

This Policy offers medical/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/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. DENTAL INSURANCE

The dental insurance offered to Retirees/Annuitants is separate and apart from the dental insurance offered to active employees. The County does not guarantee that any particular dental insurance carrier, type, or level of coverage will be available to Annuitants, or that any coverage at all will be available to Annuitants.

Eligible Annuitants and their dependents who enroll in or are currently participating in the Dental Plan must remain in the Dental Plan for a minimum of 12 consecutive months before being allowed to change coverage levels (by reducing dependent coverage) or waive dental coverage.

Newly eligible Annuitants must enroll within 30 days of notification of eligibility or he or she will be deemed to have waived coverage. Annuitants that waive participation in the Dental Plan upon initial eligibility or waive coverage after 12 months of continuous enrollment will be eligible to re-enroll in the Dental Plan at the next open enrollment

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opportunity after a minimum 24 month period following the effective date of their termination from the Dental Plan.

If an eligible dependent is added to the Dental plan in the middle of a plan year as the result of a Qualified Status Change Event, both the Annuitant and the dependent must remain in the Dental Plan for a minimum of 12 consecutive months beginning on January 1 of the following plan year before any change in coverage is allowed.

A Qualified Status Change Event will not allow for a change out of the Dental Plan for the Annuitant unless the Annuitant has participated in the Dental plan for a minimum of 12 consecutive months. A Qualified Status Change Event that causes a loss of dependent eligibility (i.e. divorce) will allow for a reduction in the Annuitant's dependent coverage under the Dental Plan without the 12 consecutive months requirement for the dependent.

V. ELIGIBILITY TO PURCHASE MEDICAL, VISION AND/OR DENTAL 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 he or she will be deemed to have waived coverage. A continuing beneficiary who is a spouse or a registered domestic partner or an eligible minor child or a Survivor may elect to purchase a retiree medical, vision and/or dental plan whether or not they were enrolled in the program at the time of the enrolled retiree's or active member's death.

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. 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, or coordination with, 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.)

VI. 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.

VII. 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 of program eligibility. An otherwise eligible Annuitant who waives, or is deemed to have waived medical 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 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. Separate enrollment requirements apply for dental coverage (See section IV).

Upon the death of an Annuitant or active employee, a continuing 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.

VIII. EFFECTIVE DATE OF COVERAGE

Upon retirement:

i. The first day of the first 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 and/or dental coverage.

ii. Premium balances if owed by an Annuitant for the initial period of Retiree coverage must be paid within 60 days of the coverage effective date, or coverage will be dropped retroactively to the last date of paid coverage.

Upon activation of deferred retirement:

The first day of the first 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:

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.

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.

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IX. PREMIUM BALANCE PAYABLE

If an Annuitant's medical, vision or dental insurance premium is greater than the sum of the Annuitant's monthly retirement allowance, the Annuitant shall be responsible for keeping premium payments current. Premium balances owed by an Annuitant must be paid within 60 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.

X. WAIVER OF COVERAGE

An Annuitant may waive medical and/or vision coverage under the Retiree Health Insurance Program at any time submitting a completed County election form waiving coverage and the appropriate Medicare plan disenrollment form where applicable. Separate waiver requirements apply for dental coverage (See section IV).

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 and/or vision coverage in this manner, or who are deemed to have waived medical 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 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.

Annuitants who waive dental coverage in this manner, or who are deemed to have waived dental 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 dental coverage within 30 days of a Qualified Status Change Event, or during any enrollment period specified in the sole discretion of the County, provided they have not been a participant in the Dental plan for a minimum of 24 consecutive months.

XI. 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

agreement 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 are under 26 years of age 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.

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.)