SACRAMENTO COUNTY

RETIREE SUMMARY OF BENEFITS

2015

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DEPARTMENT OF PERSONNEL SERVICES EMPLOYEE BENEFITS OFFICE WEBSITE

You will be able to find this Summary of Benefits, forms, and links to carriers on the Employee Benefits Office website:

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

You may also reach us via e-mail at: MyBenefits@saccounty.net or by telephone at (916) 874-2020.

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 at http://www.personnel.saccounty.net/Benefits. The Plan summaries contained in this book are for comparison purposes only.
Summary of Benefit Coverage (SBC) is also available on the Employee Benefits website.

OVERVIEW

USING THIS SUMMARY

This Summary provides information about the insurance plans currently offered to eligible retirees. It includes side-by-side comparisons highlighting common medical services, information regarding dependent coverage, premium rates, and eligibility.

Your premiums will vary according to the plan and number of dependents you have enrolled. Each Special District determines whether or not a premium offset will be provided to their retirees for health, dental, and/or vision premiums.

PLEASE NOTE: This Summary is not a plan document and does not provide comprehensive information. The Employee Benefits Office has benefit plan enrollment and information packets, copies of the contracts, and Evidence of Coverage documents for all of the benefit programs which you may review at any time at 700 H Street, Room 4667, in the County Administration Center.

PARTICIPATION

If you are a County retiree, or a survivor, or beneficiary receiving a monthly retirement allowance as defined by the Sacramento County Employee Retirement System (SCERS) you may be eligible to participate in the Sacramento County Retiree Medical and Dental Insurance Program. You cannot be enrolled in a medical, dental, or vision plan as a retiree and as a beneficiary or as a spouse/dependent of another retiree.

OPEN ENROLLMENT

Open Enrollment for medical, dental, and vision insurance is held each year in the Fall (normally during the month of October). This is the one time each year that participants in the County's health, dental, and vision insurance benefit programs may change plans or add dependents without a qualifying event, such as marriage, losing benefits from other coverage, etc.

Outside of Open Enrollment, a retiree may waive coverage or cancel coverage for their dependents at any time but may only add coverage if other comparable coverage is lost during the year. For more information, please refer to the **Sacramento County Retiree Medical and Dental Insurance Program.** Special rules apply to the dental benefit (see page 17 for more information).

MEDICARE ENROLLMENT

If you are eligible for Medicare, you **MUST ENROLL IN AND KEEP Medicare parts A & B** in order to participate in the County-sponsored retiree medical plans. Medicare A & B information may be obtained from your local Social Security Office. **You must also contact the Employee Benefits Office to enroll in a Medicare plan otherwise your coverage will be cancelled.** The County sponsored plans provide prescription drug coverage that is comparable to Medicare Part D coverage or better. **Do not sign up for any other Medicare Part D coverage or you will lose your County sponsored medical coverage!**

IMPORTANT NOTICE

Legal instruments under which the Sacramento County Retiree Medical and Dental Insurance Program is created provide that the plan does not create any contractual, regulatory, or other vested right or entitlement to either present or future retirees, their spouses, domestic partners, or dependents to any particular level of subsidization cost, or subsidization at all. Whether health plan offerings continue is vested within the sole discretion of the Sacramento County Board of Supervisors. Whether or not subsidization continues, and if so, the level of the subsidy, or whether or not a participating employer continues participation in the County Retiree Medical and Dental Insurance Program is vested within the sole discretion of each eligible, participating employer through agreement with the County of Sacramento.

ELIGIBILITY

Retiree

All County annuitants (and annuitants of Special Districts that have elected to participate) may be eligible to participate in the Retiree Medical, Dental, and Vision Insurance Programs. Annuitants may elect to enroll their eligible dependents in the same coverages that they select. 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.

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 the details of your situation.

If you do not enroll during the initial eligibility period, you may enroll within 30 days (*See note page 5) of a Qualified Status Change Event or during the next Open Enrollment period as defined by the County of Sacramento. **Proof of continuous, comparable group coverage will be required.**

IMPORTANT NOTE: If you or your dependent become eligible for Medicare, under the terms of the Sacramento County Retiree Medical and Dental Insurance Program you must contact the Department of Personnel Services Employee Benefits Office immediately to enroll in a County Medicare plan or your coverage will be cancelled.

Dependents

Eligible dependents include:

- the retiree's lawful spouse or domestic partner;
- natural, step, adopted, and those that you have legal guardianship of (up to age 26)

Dependents of minor dependents or of adult dependents of the retiree or spouse or domestic partner are not covered unless there is legal guardian or foster child status with the retiree, spouse or domestic partner.

The term "domestic partner" as an "eligible dependent" 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 or same sex marriage is established outside of California.

Special rules apply for disabled dependents. Contact the County Employee Benefits Office for details. The Employee Benefits Office or the carrier may request verification of dependent status at any time.

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. Contact the Department of Personnel Services, Employee Benefits Office for more information.

Surviving Spouse or Domestic Partner Continuation 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 Status Change Event" or at Open Enrollment. You must contact the Employee Benefits Office to enroll in the medical, dental, and vision insurance plans.

Adding Dependents

You must add newly eligible dependents to the medical, dental, and/or vision plan within 30 days of the date of birth, adoption, placement for foster care or guardianship, marriage, registration of partnership, or loss of eligibility for other group coverage. Failure to add dependents and present required documents within this time frame will result in your inability to add your dependents until the next Open Enrollment period.

To enroll dependents you are required to present documents which verify the identity of the dependent, the relationship to the retiree, and the date of the event.

Examples include the following documents:

- Legal spouse/domestic partner - a copy of your marriage certificate/Declaration of Domestic Partnership and your spouse or partner's social security number.
- Newborn or newly adopted/placed child - a copy of the birth certificate, the armband, or crib card for a newborn up to 30 days old is accepted. Adoption or legal guardianship papers will satisfy the requirement for newly adopted/placed children. A Social Security number is required within 30 days but is not necessary at the time of enrollment.
- Children - a copy of the child's birth certificate, legal documents for guardianship, adoption, or foster placement are required. A Social Security Number is required within 30 days but is not necessary for initial enrollment.
- Loss or gain of other group coverage- verification of the date of the event and of the individuals that lost/gained other group coverage such as a HIPPA Certificate, COBRA notice, or other employer documentation indicating a loss/gain of eligibility for other group coverage.

Deleting Dependents From Coverage

You may delete an otherwise eligible dependent from your medical and/or vision plan at any time. The coverage will cease at the end of the month that the appropriate forms are received in the Department of Personnel Services Employee Benefits Office.

You will not be allowed to drop an otherwise eligible dependent from the retiree dental plan unless they have been covered for 12 consecutive months, even if they have gained other coverage. If you drop a dependent from the dental plan, you cannot add them back onto the plan until the first day of the calendar year following 24 consecutive months.

Qualified Status Change Events

A qualified status change event is a birth, death, divorce, marriage, adoption, placement for foster care or guardianship, registration of partnership, or gaining or losing other group coverage.

*__NOTE__: You have __60__ days to enroll in or waive County coverage if you gain or lose either Medi-Cal or CHIP coverage under certain conditions. Coverage will be effective the first of the month following receipt of the forms in the Employee Benefits Office. See pages 7 and 17 for special rules about dental coverage.

DELETION OF COVERAGE

It is the retiree's responsibility to delete a dependent that loses eligibility for coverage due to divorce/end of a domestic partnership, and/or for children exceeding age limitations. If you need to delete dependents, contact the Employee Benefits Office.

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 delete ineligible dependents within 60 days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependent(s).

In addition, you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility. The carrier will be notified of the date of ineligibility and the dependent and/or the retiree may be liable for any claims paid during the period of ineligibility. The retiree and/or dependent may also be subject to any sanctions or actions taken by the carrier.

TERMINATION OF COVERAGE

If you and/or your dependent are eligible for Medicare and do not maintain Medicare A & B, your County-sponsored medical coverage will be cancelled.

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

If you wish to continue medical, dental, and/or vision coverage but your SCERS benefit is not large enough to make the payment, you will be required to make payments directly to SCERS. If you are required to make direct payments to SCERS for your medical, dental, and/or vision coverage and the payment is not paid within 60 days of the date due, your County-sponsored coverage will be cancelled retroactively to the last day of paid coverage.

If your coverage is terminated for non-payment of premium, you will not be permitted to re-enroll in the plan at a later date.

COVERAGE EFFECTIVE DATES

MEDICAL AND/OR VISION PLAN EFFECTIVE DATE

Initial medical and/or vision enrollment takes place at the time of retirement and coverage becomes effective the first of the month following your retirement date and the completion of the required enrollment forms. If you do not enroll in the medical plan within your first 30 days of retirement, it is considered a waiver of coverage.

Enrollment or coverage changes made during Open Enrollment become effective on January 1st of the following year. You may also add dependents **within thirty (30) days** of a "Qualified Status Change Event." (Some examples of a "Qualified Status Change Event" are found on page 5). The coverage change is effective the first of the month following the event and the completion of the forms. You may delete dependents at any time; however, you may not re-enroll them until the next Open Enrollment unless there is a "Qualified Status Change Event." **Proof of continuous, comparable group coverage will be required** 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 their website.

DENTAL PLAN EFFECTIVE DATE

Initial enrollment for dental coverage takes place at the time of retirement. The coverage is effective the first of the month following the retirement date and the completion of the required enrollment forms. If you do not enroll in the dental plan within your first 30 days of retirement, it is considered a waiver of coverage. You may decline coverage at the time of retirement but you will not be allowed into the plan until the first day of the calendar year after 24 consecutive months. Newly eligible dependents must be added within 30 days of eligibility if you are currently enrolled. You may waive coverage for yourself or your dependents during Open Enrollment if there has been 12 consecutive months of coverage. However you will not be allowed to re-enroll until the first day of the calendar year following 24 consecutive months. Dependents must be deleted if they become ineligible without regard to the 12 month participation requirement.

NON-MEDICARE PLANS

HEALTH MAINTENANCE ORGANIZATION (HMO)

One of the medical plan options available to retirees who are not Medicare eligible is a Health Maintenance Organization or HMO. Under an HMO plan, a primary care physician (PCP) directs all medical care and specialty referrals for its members. You and each of your enrolled family members select a PCP and a primary medical group (PMG). Each enrolled member of the plan may choose a different PCP and PMG. If you do not choose a PCP, one will be assigned to you and each family member. You may change your PCP at any time by calling the carrier's 800 number.

Except for emergencies as defined by your medical plan, you must first go to your PCP for your health care to be covered. Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization.

PREFERRED PROVIDER ORGANIZATION (PPO)

A PPO plan allows you the freedom to choose your doctor without using a Primary Care Physician (PCP) and you may self-refer to specialists. PPO plans have a calendar year deductible. You have the option to utilize in-network preferred providers, or out-of-network non-preferred providers. You may go to any licensed physician or hospital; however, you will receive a higher benefit when utilizing a preferred provider. If a non-preferred provider charges more than the allowable fee or provides non-covered services, you must pay the balance of any charges that are over the allowable amount. These charges can substantially increase your out-of-pocket costs.

Please note this plan is only available if you have no other County sponsored HMO coverage available to you in your residential area.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

High Deductible plans are still HMO plans requiring in-network services and a PCP. However, in a High Deductible Health Plan (HDHP) both medical (except for certain types of preventive care) and prescription expenses must apply to the deductible. High Deductible Health Plans are not available once you or an enrolled dependent become entitled to Medicare.

These plans are lower in monthly premium than traditional 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.

If you choose to enroll in one of the HDHP medical plans, you may also be eligible to establish a Health Savings Account (HSA).

HEALTH SAVINGS ACCOUNTS

HEALTH SAVINGS ACCOUNTS

A Health Savings Account (HSA) is a voluntary savings account that permits reimbursement of qualified medical expenses. HSAs were created by the Medicare Prescription Drug Improvement and Modernization Act of 2003 to provide individuals with a tax saving benefit for certain medical expenses when covered under an HDHP.

An HSA is not a medical plan with a carrier. It is an individual account established for your contributions and expenses. Among the benefits of an HSA are:

- Contributions are exempt from Federal taxes;*
- Investment earnings are exempt from Federal taxes;*
- Distributions are tax free when used for qualified medical expenses as listed under IRS Code 213(d) such as co-pays, deductibles, dental and vision expenses and more;*
- Assets roll over from year to year - no “use it or lose it”;
- The HSA can still be used after becoming entitled to Medicare (but contributions must cease).

** State tax exemption varies by state – not exempt in California.*

In order to be eligible 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 at any time over the past three months; and
- Not be able to be claimed as a dependent on someone else’s tax return.

†You cannot be covered as a dependent on another plan that is not also an HDHP.

Even if you are no longer eligible to contribute to an HSA, whether you switch from an HDHP, gain coverage under another employer, or become entitled to Medicare, your HSA account remains active for the reimbursement of qualified medical 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.

Contribution maximums are set by the IRS. For 2015, the maximums are:

Coverage	Under Age 55	Age 55+
Individual	$3,350.00	$4,350.00
Family	$6,650.00	$7,650.00

You are not required to have an HSA if you enroll in HDHP coverage. If you elect to have an HSA, you may make contributions to the financial institution of your choice on a post-tax basis and take a deduction when filing your itemized Federal income tax return.

MEDICARE ADVANTAGE PLANS

Under a Medicare Advantage Plan, also known as a "Risk" plan, the member assigns his/her Medicare benefits to the Health Maintenance Organization (HMO). With a Risk plan, the carrier contracts with Centers for Medicare and Medicaid Services (CMS) to provide the enrollee with all the benefits they are entitled to under Medicare and more. CMS pays a fixed monthly amount for each person who enrolls in the plan, whether or not they use medical services. In exchange for payment, the carrier will provide all of the services. The member agrees to receive all routine medical services through a participating physician group, and pay the co-payment. The member will not have to coordinate paperwork between plans. This type of plan typically has the lowest premium.

However, please note: In an Advantage HMO plan, since the member's Medicare benefits are assigned to the HMO, Medicare will not consider any claim payments for a member seeking services outside of the HMO. All medical care, except out-of-area emergency services, must be provided or referred by the member's PCP.

The County offers four Advantage Plans; two through UnitedHealthcare and two through Kaiser. These plans are designed for retirees who have enrolled in Medicare Parts A and B. Participants in this plan are also enrolled in Part D through this plan. Participants may not enroll in any other Part D plan through any other carrier or their County coverage will be cancelled.

If you are eligible to enroll in an Advantage plan through the County and another employer or trust fund, CMS restricts a member from enrolling in two Advantage plans at the same time.

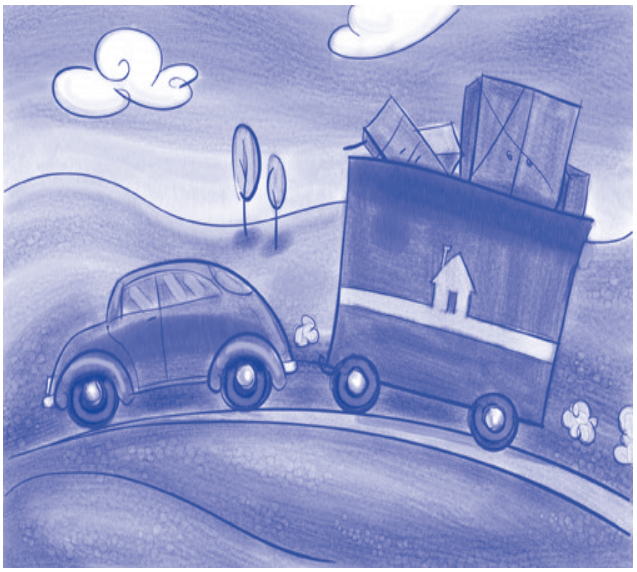
REMEMBER: If you or your dependent are eligible for Medicare, <u>you must enroll in and keep Medicare Parts A and B</u> in order to participate in the County Sponsored retiree Medical Plans. If you drop Part A and/or Part B, your county cov-

OUT OF AREA COVERAGE

If you are a non-Medicare retiree and you live outside of the HMO service areas for the County HMO plans, your option for out-of-area coverage would be to enroll in the Out Of Area PPO plan. Kaiser enrollment outside of the Sacramento area is only possible in other Kaiser Permanente service regions.

If you move out of the area during the calendar year, you should notify the Benefits Office to confirm what coverage is available or to change plans.

Please note this plan <u>is only available if you have no other County sponsored HMO coverage available to you</u> in your residential area



NON-MEDICARE HMO PLANS

	Kaiser HMO Traditional Plan (#600644-0001)	Sutter Health Plus HMO Plan (#001001)	Western Health Advantage HMO Plan (#107282)
General Plan Information			
Lifetime Plan Maximum	None	None	None
Annual Deductibles	None	None	None
Annual Out-of-Pocket Limit	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family
Deductible Included In Out-of-pocket Limits	N/A	N/A	N/A
Office Visit/Exam	$15 copay	$15 copay	$15 copay
Outpatient Specialist Visit	$15 copay	$15 copay	$15 copay
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests	100% covered	100% covered	100% covered
Well-Child Care	100% covered	100% covered	100% covered
Immunizations	100% covered	100% covered	100% covered
Well Woman Exams	100% covered	100% covered	100% covered
Mammograms	100% covered	100% covered	100% covered
Diagnostic X-Ray and Lab Tests	100% covered	100% covered	100% covered
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal)	$15 copay	100% covered	100% covered
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization	100% covered	100% covered	100% covered
Outpatient Facility Charge	$15 copay	$15 copay	$15 copay
Emergency Services			
Emergency Room	$35 copay (waived if admitted)	$35 copay (waived if admitted)	$35 copay (waived if admitted)
Air or Ground Ambulance	100% covered	100% covered	100% covered
Mental Health Benefits			
Inpatient Care	100% covered	100% covered	100% covered
Outpatient Care	$15 copay individual therapy visit $7 copay group therapy visit	$15 copay	$15 copay
Substance Abuse			
Inpatient Hospitalization	100% covered (detox only)	100% covered	100% covered
Outpatient Services	$15 copay individual therapy visit $5 copay group therapy visit	$15 copay	$15 copay
Prescription Drugs			
Retail	100 Day Supply	30 Day Supply	30 Day Supply
Generic	$10 copay	$10 copay	$10 copay
Brand (Formulary/Preferred)	$20 copay	$20 copay	$20 copay
Brand (Non-Formulary/Non-preferred)	N/A	$35 copay	$35 copay
Mail Order	100 Day Supply	90 Day Supply	90 Day Supply
Generic	$10 copay	$20 copay	$20 copay
Brand (Formulary/Preferred)	$20 copay	$40 copay	$40 copay
Brand (Non-Formulary/Non-preferred)	N/A	$70 copay	$70 copay
Other Services and Supplies			
Durable Medical Equipment & Prosthetics	100% covered	100% covered	100% covered
Home Health Care (limited to 100 visits per calendar year)	100% covered (limited to 3 visits per day)	100% covered	100% covered
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days per calendar year	100% covered; limited to 100 days per calendar year	100% covered; limited to 100 days per calendar year
Chiropractic Services	$15 copay; limited to 30 visits per calendar year	$10 copay; limited to 30 visits per calendar year	$15 copay; limited to 20 medically necessary visits per calendar year
Acupuncture Services	N/A	$10 copay; limited to 30 visits per calendar year	$15 copay; limited to 20 medically necessary visits per calendar year
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	$15 copay	$15 copay	$15 copay

** The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.*

NOTES:

[1] **For family coverage, the full family deductible amount must be met before benefits will be paid for any covered member.**

NON-MEDICARE HIGH DEDUCTIBLE HMO PLANS

	Kaiser High Deductible Plan (HDHP) (#600644-0001)	Sutter Health Plus High Deductible Plan (HDHP) (#001001)	Western Health Advantage High Deductible Plan (HDHP) (#107282)
General Plan Information			
Lifetime Plan Maximum	None	None	None
Annual Deductibles	$1,500 Individual / $3,000 Family[1]	$1,500 Individual / $3,000 Family[1]	$1,500 Individual / $3,000 Family[1]
Annual Out-of-Pocket Limit	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family
Deductible Included In Out-of-pocket Limits	Yes	Yes	Yes
Office Visit / Exam	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Outpatient Specialist Visit	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests	100% covered (deductible waived)	100% covered (deductible waived)	100% covered (deductible waived)
Well-Child Care	100% covered (deductible waived)	100% covered (deductible waived)	100% covered (deductible waived)
Immunizations	100% covered (deductible waived)	100% covered (deductible waived)	100% covered (deductible waived)
Well Woman Exams	100% covered (deductible waived)	100% covered (deductible waived)	100% covered (deductible waived)
Mammograms	100% covered (deductible waived)	100% covered (deductible waived)	100% covered (deductible waived)
Diagnostic X-Ray and Lab Tests	100% covered after cal yr deductible (deductible waived for preventive screenings)	100% covered after cal yr deductible (deductible waived for preventive screenings)	100% covered after cal yr deductible (deductible waived for preventive screenings)
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal)	100% covered (deductible waived)	100% covered (deductible waived)	100% covered (deductible waived)
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Outpatient Facility Charge	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Emergency Services			
Emergency Room	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Air or Ground Ambulance	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Mental Health Benefits			
Inpatient Care	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Outpatient Care	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Substance Abuse			
Inpatient Hospitalization	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Outpatient Services	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Prescription Drugs			
Retail	30 Day Supply	30 Day Supply	30 Day Supply
Generic	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Brand (Formulary/Preferred)	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Brand (Non-Formulary/Non-preferred)	N/A	100% covered after cal yr deductible	100% covered after cal yr deductible
Mail Order	100 Day Supply	90 Day Supply	90 Day Supply
Generic	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Brand (Formulary/Preferred)	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible
Brand (Non-Formulary/Non-preferred)	N/A	100% covered after cal yr deductible	100% covered after cal yr deductible
Other Services and Supplies			
Durable Medical Equipment & Prosthetics	100% covered after cal yr deductible; limited to $2,500 maximum per year	100% covered after cal yr deductible; limited to $2,500 maximum per year	100% covered after cal yr deductible
Home Health Care (limited to 100 visits per calendar year)	100% covered after cal yr ded (limited to 3 visits per day)	100% covered after cal yr deductible	100% covered after cal yr deductible
Skilled Nursing or Extended Care Facility	100% covered after cal yr deductible; limited to 100 days per cal yr	100% covered after cal yr deductible; limited to 100 days per cal yr	100% covered after cal yr deductible; limited to 100 days per cal yr
Chiropractic Services	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	100% covered after cal yr deductible	100% covered after cal yr deductible	100% covered after cal yr deductible

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NOTES:

[1] **For family coverage, the full family deductible amount must be met before benefits will be paid for any covered member.**

OUT OF AREA NON-MEDICARE PPO PLAN

	In-Network Benefits	Out-of-Network Benefits
General Plan Information		
Annual Deductibles	$2,000 Indiv/$4,000 Fam (combined in/out of network)	$2,000 Indiv/$4,000 Fam (combined in/out of network)
Annual Out-of-Pocket Limit	$4,000 Indiv/$8,000 Fam (combined in/out of network)	$8,000 Indiv/$16,000 Fam (combined in/out of network)
Coinsurance	80%	60%
Office Visit/Exam	$20 copay; covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Specialist Visit	$20 copay; covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Services (Preventive)		
Adult Periodic Exams w/ Preventive Tests	100% covered; calendar year deductible does not apply	60% covered after calendar year deductible
Well-Child Care	100% covered; calendar year deductible does not apply	60% covered after calendar year deductible
Immunizations	100% covered; calendar year deductible does not apply	60% covered after calendar year deductible
Well Woman Exams	100% covered; calendar year deductible does not apply	60% covered after calendar year deductible
Mammograms	100% covered; calendar year deductible does not apply	60% covered after calendar year deductible
Diagnostic X-Ray and Lab Tests	100% covered; calendar year deductible does not apply	60% covered after calendar year deductible
Maternity Care		
Pregnancy & Maternity Care (Pre-Natal)	100% covered; deductible waived	60% covered after calendar year deductible
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization (Pre-Auth Req'd)	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Facility Charge	80% covered after calendar year deductible	60% covered after calendar year deductible
Emergency Services		
Emergency Room	80% covered after $100 copay (waived on admit)	80% covered after $100 copay (waived on admit)
Urgent Care		
Urgent Care Facility	$50 copay; covered after calendar year deductible	$50 copay, covered after calendar year deductible
Mental Health Benefits		
Inpatient Care	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Care	$20 copay; covered after calendar year deductible	60% covered after calendar year deductible
Substance Abuse		
Inpatient Hospitalization	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Services	$20 copay; covered after calendar year deductible	60% covered after calendar year deductible
Prescription Drugs	**(All Rx Subject to Calendar Year Deductible)**	**(All Rx Subject to Calendar Year Deductible)**
Retail	34-Day Supply Limit	34-Day Supply Limit
Generic	$10 copay only after calendar year deductible	Network Allowed Reimbursement + $10 copay after deduct.
Brand (Formulary/Preferred)	$30 copay only after calendar year deductible	Network Allowed Reimbursement + $30 copay after deduct.
Brand (Non-Formulary/Non-preferred)	$50 copay only after calendar year deductible[2]	Network Allowed Reimbursement + $50 copay after deduct.
Mail Order	90-Day Supply Limit	
Generic	$25 copay only after calendar year deductible	Not covered
Brand (Formulary/Preferred)	$75 copay only after calendar year deductible	Not covered
Brand (Non-Formulary/Non-preferred)	$125 copay only after calendar year deductible	Not covered
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	80% covered after calendar year deductible	60% covered after cal. year deductible
Home Health Care	80% covered after cal. year deductible; limited to 100 visits/calendar year combined in & out of network	60% covered after cal. year deductible; limited to 100 visits/calendar year. combined in & out of network
Skilled Nursing or Extended Care Facility	80% covered after cal. year deductible; limited to 100 visits/calendar year combined in & out of network	60% covered after cal. year deductible; limited to 100 visits/calendar year. combined in & out of network
Chiropractic/Acupuncture Services	80% covered after cal. year deductible; limited to $1000 maximum/calendar year combined in & out of network	60% covered after cal. year deductible; limited to $1000 maximum/calendar year. combined in & out of network
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	$20 copay, covered after calendar year deductible	60% covered after calendar year deductible

** The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.*

KAISER MEDICARE ADVANTAGE PLANS

	Kaiser HMO Senior Advantage Gold Plan (#600644)	Kaiser HMO Senior Advantage Silver Plan (#600644)
General Plan Information		
Lifetime Plan Maximum	None	None
Annual Deductibles	None	None
Annual Out-of-Pocket Limit	$1,500 Individual / $3,000 Family	$1,500 Individual / $3,000 Family
Office Visit/Exam	$15 copay	$25 copay
Outpatient Specialist Visit	$15 copay	$25 copay
Outpatient Services (Preventive)		
Adult Periodic Exams/Preventive Tests	100% covered	100% covered
Diagnostic X-Ray and Lab Tests	100% covered	100% covered
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	100% covered	$500 copay per admission
Outpatient Surgery	$15 copay per procedure	$150 copay per procedure
Emergency Services		
Emergency Room	$35 copay (waived if admitted)	$50 copay (waived if admitted)
Air and Ground Ambulance	100% covered	$125 copay per trip
Mental Health Benefits		
Inpatient Care	100% covered	$500 copay per admission
Outpatient Care	$15 copay individual therapy visit $7 copay group therapy visit	$25 copay individual therapy visit $12 copay group therapy visit
Substance Abuse		
Inpatient Hospitalization	100% covered	$500 copay per admission
Outpatient Services	$15 copay individual therapy visit $5 copay group therapy visit	$25 copay individual therapy visit $5 copay group therapy visit
Prescription Drugs		
Retail	30 Day Supply	30 Day Supply
Generic	$10 copay	$10 copay
Brand (Formulary/Preferred)	$20 copay	$25 copay
Brand (Non-Formulary/Non-preferred)	N/A	N/A
Mail Order	100 Day Supply	100 Day Supply
Generic	$20 copay	$20 copay
Brand (Formulary/Preferred)	$40 copay	$50 copay
Brand (Non-Formulary/Non-preferred)	N/A	N/A
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	100% covered; formulary guidelines apply	80% covered; formulary guidelines apply
Home Health Care	100% covered; (part time; intermittent)	100% covered; (part time; intermittent)
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days per benefit period	100% covered first 20 days, $75 copay days 21-100; limited to 100 days per benefit period
Chiropractic Services	$15 copay; limited to 30 visits per calendar year	$15 copay; limited to 30 visits per calendar year
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	$15 copay	$25 copay
Hearing Screening Hearing Aid(s)	$15 copay Not covered	$25 copay Not covered

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UNITEDHEALTHCARE MEDICARE ADVANTAGE PLANS

	UnitedHealthcare HMO Medicare Advantage Plan	UnitedHealthcare National PPO Medicare Advantage Plan	
General Plan Information		**In Network**	**Out of Network**
Lifetime Plan Maximum	None	None	None
Annual Deductibles	None	None	None
Annual Out-of-Pocket Limit / Individual	$3,400	$3,400	$3,400
Office Visit / Exam	$15 copay	$15 copay	$15 copay
Outpatient Specialist Visit	$15 copay	$15 copay	$15 copay
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests	100% covered	100% covered	100% covered
Diagnostic X-Ray and Lab Tests	100% covered	100% covered	100% covered
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization	100% covered	100% covered	100% covered
Outpatient Surgery	100% covered	100% covered	100% covered
Emergency Services			
Emergency Room	$20 copay (waived if admitted)	$20 copay (waived if admitted)	$20 copay (waived if admitted)
Air and Ground Ambulance	$20 copay	$20 copay	$20 copay
Mental Health Benefits			
Inpatient Care	100% covered; 190 day lifetime limit	100% covered; 190 day lifetime limit	100% covered; 190 day lifetime limit
Outpatient Care	$15 copay	$15 copay	$15 copay
Substance Abuse			
Inpatient Hospitalization	100% covered	100% covered	100% covered
Outpatient Services	$15 copay	$15 copay	$15 copay
Prescription Drugs			
Retail *	30 Day Supply	30 Day Supply	30 Day Supply
Generic	$10 copay	$10 copay	$10 copay
Brand (Preferred)	$20 copay	$20 copay	$20 copay
Brand (Non-preferred)	$35 copay	$35 copay	$35 copay
Mail Order *	90 Day Supply	90 Day Supply	90 Day Supply
Generic	$20 copay	$20 copay	$20 copay
Brand (Preferred)	$40 copay	$40 copay	$40 copay
Brand (Non-preferred)	$70 copay	$70 copay	$70 copay
Other Services and Supplies			
Durable Medical Equipment & Prosthetics	100% covered	100% covered	100% covered
Home Health Care	100% covered	100% covered	100% covered
Skilled Nursing Facility	100% covered for 100 days per benefit period	100% covered for 100 days per benefit period	100% covered for 100 days per benefit period
Chiropractic Services	$15 copay	$15 copay	$15 copay
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	100% covered	100% covered	100% covered
Hearing Screening	100% covered	100% covered	100% covered
Aid(s)	$500 allowance every 36 months + Hi Health Innovation discount program	$500 allowance every 36 months + Hi Health Innovation discount program	$500 allowance every 36 months + Hi Health Innovation discount program

**** Non Formulary drugs are not covered. Once members reach the Part D Catastrophic stage, they pay the greater of $2.65 copay for generic, $6.60 copay for brand name, or 5% coinsurance***

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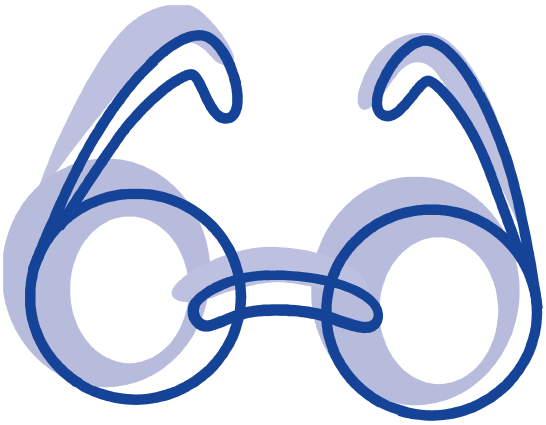
VISION COVERAGE

Vision benefits are available to all retirees. If you enroll in a Kaiser Traditional HMO or Senior Advantage plan your vision benefits are provided through Kaiser. If you enroll in a Western Health Advantage, Sutter Health Plus, or UnitedHealthcare plan your vision benefits are managed through Vision Service Plan (VSP). If you enroll in any of the High Deductible plans or you waive medical coverage you may enroll separately to have vision benefits available through Vision Service Plan (VSP).

	VSP Western Health Advantage, Sutter Health Plus, UnitedHealthcare or Separate Coverage	**Kaiser HMO Traditional Plan**	**Kaiser HMO High Deductible Health Plan (HDHP)**	**Kaiser Senior Advantage Gold Plan**	**Kaiser Senior Advantage Silver Plan**
Vision Benefits					
Allowance Amount	$130 every 24 months for frames	$175 every 24 months for frames & lenses combined	Not covered*	$175 every 24 months for frames & lenses combined	$150 every 24 months for frames & lenses combined
Examination	$15 copay (exam and materials)	$15 copay	100% covered after calendar year deductible	$15 copay	$25 copay
Benefit Frequency					
Examination	12 months	24 months	24 months	24 months	24 months
Lenses	12 months	24 months	Not covered*	24 months	24 months
Frames	24 months	24 months	Not covered*	24 months	24 months
Contacts	12 months	24 months	Not covered*	24 months	24 months

*NOTE: The Kaiser High Deductible HMO does NOT include vision coverage for frames, lenses or contact lenses.



DENTAL PLAN

VOLUNTARY DENTAL PLAN

Retirees pay all of the cost for themselves, their spouse, domestic partner, and/or dependent children coverage.

DENTAL COVERAGE

Eligible retirees, survivors, or beneficiaries as defined by the Sacramento County Retiree Medical 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 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 "Qualified Status Change Event" provided the 12/24 month lock has been satisfied. Children may only be enrolled as dependents of one retiree. Once you have enrolled in a dental plan, that coverage will continue year to year until you make a change.

*You have **60** days to enroll in or waive County coverage if you gain or lose either Medi-Cal or CHIP coverage under certain conditions.

12/24 MONTH LOCK

If you select the dental plan, you must remain in the plan for a minimum of 12 consecutive months before you can waive coverage. If you add a dependent mid year, both you and the dependent must remain in the plan for a minimum of 12 consecutive months before you can waive coverage, or drop dependents. Only a "Qualified Status Change Event" causing a loss of dependent status will allow for a reduction in dependent coverage without fulfilling the 12 consecutive months requirement.

If you drop coverage for yourself or a dependent, coverage under the dental plan will not be available until the beginning of the calendar year after 24 consecutive months have passed.

Evidence of Coverage booklets that contain details about the dental plan are available from the Employee Benefits Office or on their website.

The retiree dental plan has three benefit levels depending on where you go for services. You can choose services from a Principal EPO dentist (Highest reimbursement benefit, lowest patient cost), a Principal PPO dentist (normal reimbursement benefit, low patient cost) or a non network dentist (payments are capped, you may be balance billed).

	Payment % to EPO Dentist	Payment % to PPO Dentist	Payment % to Non Network Dentist (at 80th Percentile UCR)
Preventative Services	**80%**	**80%**	**60%**
Basic Services	**60%**	**60%**	**60%**
Major Services	**55%**	**55%**	**50%**

PLAN COSTS

MONTHLY DENTAL AND VISION PREMIUMS

Coverage	Retiree Only	Retiree With 1 Dependent	Retiree With Two or More Dependents
Dental	$35.80	$65.74	$97.97
Vision	$5.14	$10.28	$14.58

NON-MEDICARE HMO PLAN MONTHLY PREMIUMS

	Western Health Advantage HMO	Sutter Health Plus HMO	Kaiser Permanente HMO
Retiree Only	$649.74	$631.22	$626.38
Retiree With 1 Dependent	$1,299.48	$1,238.69	$1,252.70
Retiree With 2 or more Dependents	$1,838.88	$1,752.78	$1,772.64

NON-MEDICARE HIGH DEDUCTIBLE HMO & PPO PLAN MONTHLY PREMIUMS

	Western Health Advantage HDHP HMO	Sutter Health Plus HDHP HMO	Kaiser Permanente HDHP HMO	HDHP PPO
Retiree Only	$496.30	$491.64	$493.74	$966.90
Retiree With 1 Dependent	$992.60	$964.55	$987.48	$1,933.70
Retiree With 2 or more Dependents	$1,404.60	$1,364.82	$1,397.34	$2,736.20

MEDICARE ADVANTAGE PLAN MONTHLY PREMIUMS

Medicare Advantage HMO Plan

The enrolled member assigns his/her Medicare Parts A & B benefits to the HMO. The member chooses a Primary Care Physician (PCP). All medical care except for emergency services must be provided or referred by the member's PCP. All plans include Medicare Part D.

One Member (Retiree OR Spouse/Domestic Partner) With Medicare A & B

(One Member enrolled in Advantage Plan, one or more enrolled in non-Medicare Plan)

	United-Healthcare HMO	United-Healthcare NPPO	Kaiser Permanente Senior Advantage GOLD	Kaiser Permanente Senior Advantage SILVER
Retiree Only	$186.20	$272.85	$313.14	$198.33
Retiree With 1 Dependent	N/A*	N/A*	$939.46	$824.65
Retiree With 2+ Dependents	N/A*	N/A*	$1,459.40	$1,344.59

Retiree AND Spouse/Domestic Partner With Medicare A, B, & D

(Both enrolled in Advantage Plan)

	United-Healthcare HMO	United - Healthcare NPPO	Kaiser Permanente Senior Advantage GOLD	Kaiser Permanente Senior Advantage SILVER
Retiree With 1 Dependent	$372.40	$545.70	$626.28	$396.66
Retiree With 2+ Dependents	N/A*	N/A*	$1,146.22	$916.60

* ***Non-Medicare dependents may be eligible for another Sacramento County sponsored health plan. For more information contact the Sacramento County Employee Benefits Office.***

CONTINUATION COVERAGE

What is Continuation of Coverage?

Federal legislation requires most employer sponsored group health plans to offer 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 referred to as "COBRA."*

Who is eligible for Continuation Coverage?

Any family member who loses County-sponsored group coverage due to a qualifying event is eligible to elect continuation coverage. Generally, each person losing coverage has an independent right to this 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, however, may continue coverage as a dependent of a former employee who elects continuation coverage.

What should I do when there is a qualifying event?

You must notify our office 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 (a dependent's loss of dependent status, divorce, death) to be eligible to continue coverage.

What County benefit plans can be continued?

Medical and Dental coverage may be continued. If your dependent is eligible for this coverage, 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?

Subject to certain limitations you may elect to continue your Medical and/or Dental coverage at your own expense. Coverage may generally be continued for up to 36 months under a combination of Federal and State benefits continuation laws.

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, 4th Floor, Room 4650
Sacramento, CA 95814
Phone: (916) 874-2020

*Consolidated Omnibus Budget Reconciliation Act of 1985

COBRA

DEFERRED COMPENSATION / RETIREE HEALTH SAVINGS PLAN

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.

Note: You must take a Required Minimum Distribution no later than March of the year you turn 70 ½ years old.

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.

If you were in Recognized Employee Organization (REO) 020, 021, 024, 032, 033, or Unrepresented Management (050) after 7/1/2007, 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 http://plan.fidelity.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

The Retiree Health Savings Plan (RHSP) is an employer-sponsored health savings benefit account that allows you to be reimbursed on a tax-free basis for medical expenses for you, your spouse and/or your dependents when you leave County employment. The County contributions to your account at ICMA-RC during your employment can be used for your post employment medical benefit claims processing, which is handled by ICMA-RC's third-party claims administrator, Meritain Health, Inc.

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 medical expenses.

There is a $7.50 claims administration charge to your account each quarter after you leave County service. Claims for medical expenses that qualify under RHSP 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 surviving spouse and/or dependents for their own qualifying health expenses. Please contact ICMA-RC at (800) 669-7400 or Meritain Health, Inc. at (888) 587-9441 if you have any questions.

CONTACTS

Contact	Phone	Email or Web Site
County Employee Benefits Office	(916) 874-2020	MyBenefits@saccounty.net http://www.personnel.saccounty.net/Benefits
Deferred Compensation		
County of Sacramento	(916) 874-2020	MyBenefits@saccounty.net http://www.personnel.saccounty.net/ DeferredCompUnit
Fidelity Investments	(800) 343-0860	http://plan.fidelity.com/saccounty
Dental Plan		
Principal Financial Group	(800) 247-4695	www.principal.com
Health Plans		
Sutter Health Plus Member Services	(855) 315-5800	www.sutterhealthplus.org
Sutter Health Nurse Advice Line	(855) 836-3500	
Optum Behavioral Health	(855) 202-0984	
Optum RX	(888) 642-2583	www.optumrx.com
Pharmacy Help Desk	(800) 797-9791	
Western Health Advantage Member Services	(888) 563-2250	www.westernhealth.com
Nurse24 Advice Services	(877) 793-3655	www.mywha.org/healthsupport
Magellan Behavioral Health	(800) 424-1778	www.magellanhealth.com
Landmark Chiropractic and Acupuncture	(800) 298-4875	www.lhp-ca.com
Medco Pharmacy	(800) 903-8664	www.medco.com/westernhealth
Kaiser Permanente Member Services	(800) 464-4000	www.kp.org
Chiropractic	(800) 678-9133	www.ashcompanies.com/kp
UnitedHealthcare	(877) 714-0178	www.UHCRetiree.com
Retiree Health Savings Plan		
ICMA-RC	(800) 669-7400	www.icmarc.org
Meritain Health	(888) 587-9441	www.meritain.com
Sacramento County Employees Retirement System		
SCERS Office	(916) 874-9119	www.retirement.saccounty.net
Vision		
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com

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