2018 MyBenefits Summary

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

Special District

SACRAMENTO COUNTY

INTRODUCTION

The County of Sacramento is committed to your overall health and well-being, and we're pleased to offer a quality, competitive benefits program that provides valuable health care for you and your family.

But remember, it is your responsibility to make sure you understand your benefits and use them wisely. This Handbook is designed to assist you in doing just that. We encourage you to refer to it throughout the year so you can make benefit choices that help you and your family members live and play well.

Your benefits are subject to the schedule of covered services as described in the Evidence of Coverage (EOC) which is available in the Employee Benefits Office or online at http://www.personnel.saccounty.net/Benefits. The Plan summaries contained in this book are for comparison purposes only. The Summary of Benefit Coverage (SBC) is also available on the Employee Benefits Office website.

DISCLAIMER

This information is only a summary of the benefit options, responsibilities, and/or the 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, and 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 have effect regardless of whether any particular notice is received.

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

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

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OVERVIEW

As an employee of a Special District participating in the County of Sacramento benefit plans, you have a variety of benefits available to you depending on your Districts participation. This handbook provides and overview of the following benefits, which may or may not apply to you based upon your Districts participation:

- Medical Plans
- Dental Coverage
- Vision Benefits
- Life Insurance
- Making Changes to Coverage
- Coverage for your Dependents
- COBRA Continuation Coverage
- Leave of Absence

COVERAGE OPTIONS

The options available to you through the County's benefit program vary from District to District. You will have different benefits available to you based upon your District's participation. Contact your District Administration office directly for information on the benefits available to you

COST OF COVERAGE

Each Special District has a unique benefit and contribution package. For some benefits your District pays the entire cost of your coverage. For others, you may contribute all or just a portion of the cost of coverage. Your premiums will vary according to your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select. Contact your District's Administration office for more information on the cost of your benefits.

2018 MEDICAL PREMIUM COSTS

Plan	Single/Family	Total Monthly Premium
Kaiser $15 HMO	**S**	**$757.90**
	F	**$1,938.12**
Kaiser HD HMO	**S**	**$592.18**
	F	**$1,514.32**
Sutter $15 HMO	**S**	**$726.52**
	F	**$1,857.42**
Sutter HD HMO	**S**	**$534.42**
	F	**$1,365.02**
WHA $15 HMO	**S**	**$709.60**
	F	**$1,816.60**
WHA HD HMO	**S**	**$539.80**
	F	**$1,381.90**

ELIGIBILITY FOR BENEFITS

These rules are only applicable for the benefits your District is participating in through the County's benefit program. For eligibility regarding benefits your District has contracted with another entity, please contact your District Administration office directly.

EMPLOYEE

An "Eligible Employee" is defined as:
1) full-time and part-time employees of Special Districts;
2) an elected official and his or her exempt deputy or assistant;
3) any regular employee who temporarily transfers to a benefited temporary position.

An eligible employee is not an employee of a temporary agency, a contractor, or any other person who does not occupy a permanent position in accordance with the annual salary ordinance.

DEPENDENTS

Eligible dependents include:

- **Your spouse**-lawfully married;
- **Your domestic partner**-registered with the Secretary of State;
- **Children**-natural, step, adopted, and legal guardian (all up to age 26), and/or foster children (up to age 19) of the employee or spouse/domestic partner. Children over age 26 with a certified mental or physical disability are also eligible regardless of age. Diagnosis of the disability must occur prior to the child reaching the respective age limit.

NOTE: Your grandchild is not eligible for coverage unless you or your spouse/domestic partner has legal custody of that child.

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

INELIGIBLE DEPENDENTS

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

CHANGES TO COVERAGE

NEW HIRES

In order to enroll in the benefit plans of your choice, benefit elections must be made within the first 30 days of becoming eligible. Any required supporting documentation must be submitted to your District Office or the County's Employee Benefits Office for final approval within 7 days of your benefit elections. Coverage is effective the 1st day of the month following the enrollment. If you do not enroll within the first 30 days of becoming eligible or provide the required documentation timely you will be enrolled in the default plans as described in the contract.

MID-YEAR LIFE EVENTS

During the year, you may experience a "qualifying event" such as marriage, divorce, domestic partnership, birth, loss or gain of group coverage, etc. The change must be on account of and consistent with the event, and must be made within 30 days of the event. Documentation to verify the event is also required within 7 days of submitting your enrollment. A Social Security number is required for dependents. For mid-year events such as a birth or adoption, the coverage becomes effective on the date of birth or adoption in accordance with HIPAA regulations, as long as you enroll and provide any required documentation timely. For all other midyear qualifying events, the coverage is effective the first day of the month following the event, your enrollment, **and** timely submission of required documentation. **If you do not have the supporting documentation or social security number, you still need to complete the enrollment within 30 days and request additional time for documents.**

Failure to complete your enrollment within 30 days or provide supporting documentation will result in your inability to make changes until the next qualifying event or Open Enrollment.

OPEN ENROLLMENT

All employees are provided an opportunity each year during "Open Enrollment" to change health insurance plans, and add or delete dependents without a qualifying event. Open Enrollment is usually held in the fall (October) and coverage is effective on January 1st of the following year.

If you add dependents or waive medical coverage you are required to submit supporting documents with your change form. If your District Office or the County's Employee Benefits Office doesn't receive this documentation prior to the deadline your changes will not go into effect.

WAIVER OF COVERAGE

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

MEDICARE WHILE WORKING

If you are eligible to participate in the County medical plans and wish to continue working after reaching age 65, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your County medical plan remains primary to Medicare while you are working. That is, the County plan will pay claims first. If you decline Part B when first eligible and you do not remain covered under a group medical plan sponsored by an employer or union, you may incur a late enrollment penalty.

Medicare coverage consists of the following options:

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

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

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

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

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

MEDICARE WHILE WORKING (cont'd)

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

Yes

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

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

No

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

Decide how you want to get your coverage:

Original Medicare or Medicare Advantage Plan

Part A Hospital Insurance	Part B Medical Insurance

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

Step 2: Decide if you need to add drug coverage

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

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

Step 3: Decide if you need to add supplemental coverage

Medicare Supplemental Insurance (Medigap) Policy

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

MEDICAL PLANS

For employees of Special Districts participating in the medical program, you may choose from three (3) traditional Health Maintenance Organization (HMO) plans or three (3) High Deductible Health Plans (HDHP). Employees and dependents must be enrolled in the same plan. Your District may pay all or a portion of the cost for medical coverage.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A primary care physician (PCP) directs all medical care and specialist referrals. Each family member may choose his or her own PCP and may have a different medical group. The PCP and/or medical group can be changed at any time by calling your plan's customer service number. Except for emergencies, you must contact your PCP first in order for your health care to be covered. You may have a higher paycheck deduction in exchange for a fixed co-payment under an HMO.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

High Deductible plans are still HMO plans that require PCP direction. In a HDHP both medical (except for certain prevent care) and prescription expenses apply to the deductible. HDHP's are lower in monthly premiums than traditional HMO plans but have a larger out of pocket expense for services which you pay for at the time of care. Once you reach the deductible under the family plan, most services are covered at 100%. For individual coverage you only have Rx co-payments once you reach your deductible up to the out of pocket maximum.

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

MEDICAL PLANS (cont'd)

COST DIFFERENCE BETWEEN HMO VS HDHP

Although there can be substantial savings under an HDHP over a traditional HMO, there are some important factors to consider.

- With an HMO you will have a larger paycheck deduction; with the HDHP you will have a larger out of pocket cost at the time of care.
- Since you pay the cost for services at the time of care under the HDHP, you could face early out of pocket expenses at the beginning of the calendar year.
- The entire deductible must be met ($2,700) before services are covered at 100% for family coverage, which may be less than the annual HMO premium.

	HMO	HDHP
Choice of Dr	Network PCP selection required; PCP coordinates all care	Network PCP selection required; PCP coordinates all care
Specialist	Requires PCP referral	Requires PCP referral
Wellness	Preventive and well-care services are provided at no additional cost	Preventive and well-care services are provided at no additional cost
Paycheck cost	Higher cost per paycheck	Lower cost per paycheck
Cost for visits	Set co-pay, $15 for most services; lower cost at time of care	You pay up to annual deductible, then plan pays 100% (family only)
Vision	Included	Not included, option to purchase
Chiropractic	Covered	Not covered
Acupuncture	Covered	Not covered
Overall Cost	Annual cost likely higher	Annual cost likely lower

HOW TO CALCULATE HMO VS HDHP DIFFERENCE

Take the paycheck cost for your HMO plan and multiply it by the number of paychecks in the year; next subtract the HDHP cost from the HMO cost to find the potential savings.

EXAMPLE: Sutter Health family plan HMO vs HDHP

	Sutter HMO	Sutter HDHP
Paycheck Deduction	$894.26 x 12 =$10,731.12	$524.42 x 12 = $6,293.04
Add any cost of services	$15 for each visit, up to $2,700	Co-pays up to $2,700
Total Annual Cost	**$10,731.12 + services**	**$6,293.04 + services**
Annual premium difference is $4,438.08		

Since the maximum deductible cost under the HDHP is $2,700 and services are covered at 100% after that limit, the annual HMO premium deduction of $10,731.12 is **more** than the HDHP premium and maximum deductible. And, if you do not use $2,700 in HDHP services, your savings is even greater! Your premiums will vary according to your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select. Contact your District's Administration office for more information on the cost of your benefits.

HMO PLAN COMPARISONS

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

HIGH DEDUCTIBLE HMO PLAN COMPARISONS

	Kaiser Permanente	Sutter Health Plus	Western Health Advantage
General Plan Information			
Lifetime Plan Maximum	None		
Annual Deductibles	$1,350 Individual / $2,700 Family		
Annual Out-of-Pocket Limit	$2,700 Individual / $2,700 Family		
Deductible Included in out-of-pocket limits?	Yes		
Office Visit / Exam/Outpatient Specialist	100% covered after deductible		
Outpatient Services (Preventive)			
Adult Periodic Exams with Preventive Tests	100% covered, Deductible Waived		
Well-Child Care, Immunizations			
Well Woman Exams, Mammograms			
Diagnostic X-Ray and Lab Tests	100% covered after deductible; deductible waived for preventative screens		
Maternity Care			
Pregnancy and Maternity Care (Pre-Natal)	Deductible Waived		
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization	100% covered after deductible		
Outpatient Facility Charge			
Emergency Services			
Emergency Room, Ambulance	100% covered after deductible		
Mental Health Benefits			
Inpatient / Outpatient Care	100% covered after deductible		
Substance Abuse			
Inpatient Hospitalization	100% covered after deductible		
Outpatient Services			
Prescription Drugs			
Retail	100 Day Supply	30 Day Supply	
Generic	$10 after deductible-Individual	100% covered after deductible-Family	
Brand (Formulary/Preferred)	$20 after deductible-Individual	100% after deductible-Family	
Brand (Non-Formulary/Non-preferred)	N/A	$35 after deductible-Individual 100% after deductible-Family	
Mail Order	100 Day Supply	90 Day Supply	
Generic	$10 after deductible-Individual	$20 after deductible-Individual	
Brand (Formulary/Preferred)	100% covered after deductible-Family $20 after deductible-Individual	100% covered after deductible-Family $40 after deductible-Individual	
Brand (Non-Formulary/Non-preferred)	100% covered after deductible-Family N/A	$70 after deductible-Individual 100% covered after deductible-Family	
Other Services and Supplies			
Durable Medical Equipment & Prosthetics Annual limits	100% covered after deductible $2,500		100% covered after deductible
Home Health Care (limited to 100 visits/yr)	100% covered after deductible (3 visits per day)	100% covered after deductible	
Skilled Nursing or Extended Care Facility--limited to 100 days per cal year	100% covered after deductible		
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	100% covered after deductible		
Chiropractic Services; Calendar year limit	Not covered		
Acupuncture Services; Calendar year limit	Not covered		

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a voluntary savings account that you contribute to and is used for payment or reimbursement of qualified health expenses. An HSA is not a medical plan. You must be enrolled in an HDHP and have no other coverage to be eligible to contribute to an HSA. Eligible expenses are the same category as a Medical Reimbursement Account, including medical, dental vision and Rx expenses; however the amount available is limited to your account balance.

Some of the benefits of an HSA are:

- Contributions, earnings and interest are exempt from Federal (not State) taxes;
- Distributions are tax free when used for qualified medical expenses;
- Assets roll over from year to year;
- The HSA is portable, so you can use the assets even if you leave your District job;
- You can contribute significantly more than your HDHP deductible.

In order to contribute to an HSA, you must:

- Be enrolled in an HDHP;
- Have no other non-HDHP health coverage*;
- Not be enrolled in Medicare;
- Have not received VA medical benefits over the past three months;
- Not be able to be claimed as a dependent on someone else's tax return.

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

Contribution maximums are set by the IRS. For 2018, the maximums are:

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

If you switch from an HDHP, or turn 65, you are no longer eligible to contribute to an HSA, but you can continue to use the account until it is depleted.

What are qualified health care expenses?

Qualified health care expenses include co-payments and deductibles at doctors' offices, pharmacies, medical labs, dentists and orthodontists, medical supply stores, chiropractors, hospitals, vision centers, podiatrists and more. You can also use HSA funds tax-free for eyeglasses and contact lenses, mail order prescriptions, and online prescriptions. Over-the-counter (OTC) medications are not reimbursable without a doctor's prescription.

Can I use funds from my HSA for non-medical expenses?

Yes. However, you will be required to pay Federal income tax and a 20% penalty on the amount used for a non-medical expense (20% penalty does not apply if you are disabled or over age 65).

Can I use my HSA to pay medical insurance premiums?

Generally, no if you are under 65. Limited exceptions include COBRA premiums, long-term care premiums, or health premium payments while you are receiving unemployment compensation. If you are over 65: Retiree medical and Medicare Part B premiums are reimbursable.

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

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

DENTAL BENEFITS

A comprehensive dental plan is available through Delta Dental of California for benefit eligible employees and their enrolled dependents.

BENEFIT LEVELS

This plan provides three levels of benefit:

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

You can visit Delta Dental's website to determine if your dentist is a Delta PPO dentist.

DEDUCTIBLE

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

COVERAGE AMOUNT

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

ACCESSING COVERAGE

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

2018 DENTAL PREMIUM COSTS

Plan	Single/Family	Total Monthly Premium
Delta Dental	**S**	**$125.00**
	F	**$125.00**

Your premiums will vary according to your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select.

VISION BENEFITS

For Special District participating in medical coverage, vision benefits are also available to benefit eligible employees and enrolled dependents; it is either bundled with your HMO medical plan or you have the option to purchase it if you have waived medical coverage or are enrolled in one of the high deductible plans.

BUNDLED PLANS

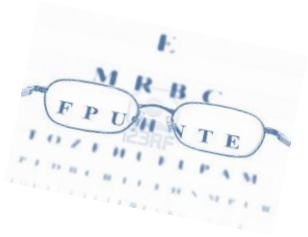
If you are enrolled in an HMO medical plan the cost and coverage for vision benefits is included with your HMO; no separate enrollment for vision is required. Any dependent also enrolled in your HMO medical plan has vision coverage.

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

OPTION TO PURCHASE

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

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



2018 VOLUNTARY VISION PREMIUM COSTS

Plan	Single/Family	Total Monthly Premium
VSP	S	$5.20
	F	$13.30

Your premiums will vary according to your District's contribution structure, the plan and number of dependents you enroll, and/or the level of coverage you select.

LIFE INSURANCE

Your District provides a Basic life insurance benefit to all benefit eligible employees. This coverage is effective on the first day of the month following employment upon which you are active at work.

BASIC LIFE INSURANCE

Your District provides a Basic life insurance benefit at no premium cost to you. The Basic benefit ranges from $15,000, $18,000 or $50,000, depending upon your District and classification. All employees have Accidental Death & Dismemberment (AD&D) benefits equal to the amount of District paid Basic life insurance.

OPTIONAL LIFE INSURANCE

You can purchase additional coverage for yourself in amounts equal to your base annual salary.

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

INCREASING COVERAGE

Life insurance changes can be made at any time. Newly eligible employees can enroll in any level of optional coverage without medical underwriting if the enrollment is within 30 days of hire.

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

- If you have experienced a life event within 30 days (such as getting married or having a baby), simply elect the new option on your enrollment form. (No underwriting needed if you have not been declined in the past).
- If no life event has occurred, then you must *apply* for the increase. You need to complete Prudential's short form health questionnaire AND the County's life insurance change form; return both forms to the County Employee Benefits Office. Prudential may require additional information, and the increase is not guaranteed.

COST OF COVERAGE

The cost of optional coverage is based on your annualized salary and your age, along with the coverage you select. Use the chart below to calculate the premium.

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

Formula: Multiply your base annual salary by the option you are requesting, round up to the nearest thousand. Find the cost for your age band then multiply that number by the requested coverage amount.

LIFE INSURANCE (cont'd)

Example-Employee with annualized salary of $43,257. Employee requests Option 2; two times salary is $86,514, rounded up is $87,000. Employee is 43; cost per thousand is $.080.
($0.080 times 87 equals $6.96). Monthly premium is $6.96/month post-tax; or $3.48 per payday if paid bi-weekly.

DECREASING COVERAGE

Decreasing or waiving optional coverage can be done anytime by completing a life insurance change form. The change is effective the first day of the next month.

PREMIUM CHANGES

The cost of your life insurance coverage may change due to a couple of factors:

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

BENEFICIARY INFORMATION

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

ACCELERATED DEATH BENEFIT

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

LEAVE OF ABSENCE

If you are placed on unpaid leave of absence, your coverage will terminate on the last day of the month of which you are in paid status. You may continue your coverage by paying the premiums on a self-pay basis. A notice will be provided to you when your leave of absence commences.

WAIVER OF PREMIUM

If you become disabled while under age 60 and covered under this plan, you may apply for a waiver of premium. If approved the policy remains in force and you do not have to pay the premiums for as long as you remain disabled, even temporarily. The life insurance carrier will periodically request proof of your continued disability. Failure to provide proof of disability will result in the cancellation of the premium waiver.

CONVERSION / PORTABILITY

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

DEPENDENT LIFE INSURANCE

DEPENDENT LIFE INSURANCE-Basic Coverage

Dependent coverage for your spouse/domestic partner and dependent children is either $2,000 or $5,000, depending on your District and classification. For infants less than six months of age the benefit is $200; there is no coverage for newborns from birth to 14 days.

Basic Life Coverage	Dependent Life Coverage	Dependent Enrollment Required?
$15,000	$5,000*	**Yes**
$18,000 or $50,000	$2,000	No*

*Although there is no direct cost to cover a dependent, the Internal Revenue Code requires that federal taxes be paid on the value (imputed income) of the total benefit if the benefit exceeds $2,000, or when the coverage applies to a domestic partner or the dependents of domestic partners that are not your IRS dependents. You must enroll your domestic partner and/or their children in the life insurance plan in order to calculate the taxes and receive the benefit.

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

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

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

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

DEPENDENT LIFE INSURANCE (cont'd)

DEPENDENT LIFE INSURANCE-Voluntary Term Coverage

In addition to the basic life insurance benefit for your dependents you may also elect optional voluntary term coverage for them. You must be enrolled in optional coverage in order to elect dependent optional coverage.

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

SPOUSE/DOMESTIC PARTNER

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

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

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

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

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

EXAMPLE 1:	EXAMPLE 2:
Your spouse is 31, you make $46,000 per year and have Option 2 ($92,000 coverage), you can elect up to $90,000 in $10,000 increments for your spouse. For $90,000 the cost is $3.96 per month, or $1.98 per pay period. (.044 x 90)	Your spouse is 56 and you make $63,000 per year, you are enrolled in Option 5 ($315,000). You can elect up to $250,000 (maximum) for your spouse, but you only want $100,000. The cost is $34.60 per month, or $17.30 per pay period. (.346 x 100)

CHILDREN

You can elect optional life insurance coverage for your children up to age 26 if you are enrolled in optional coverage. The child benefit is $15,000 and costs $0.90 per month, which is $0.45 per pay period post-tax. This rate is $0.90 per month no matter how many children are enrolled.

Number of children enrolled	Coverage amount	Monthly deduction
1	$15,000	$0.90
2 or more	$15,000 each child	$0.90

LEAVE OF ABSENCE

There are times during your employment where you may need to take a leave of absence from work. There are many types of leaves and some leaves may cover all of your benefits, while other leaves types require you to pay all or a portion of the cost to maintain coverage. Leave of absence situations vary vastly and are based on individual circumstances, so contact your District Administrator or the County Employee Benefits Office staff if you have questions on how your leave impacts your benefits.

COMMENCEMENT OF LEAVE

Regardless of when your leave begins, your benefits will terminate the last day of the month you are in paid status. You will receive a notice regarding your responsibilities and options to continue coverage. The type of leave you take will determine if you must pay the full cost of coverage or only a portion of the cost if you wish to continue benefit coverage. Your notice will contain specific details on the cost, deadline, and how to continue coverage.

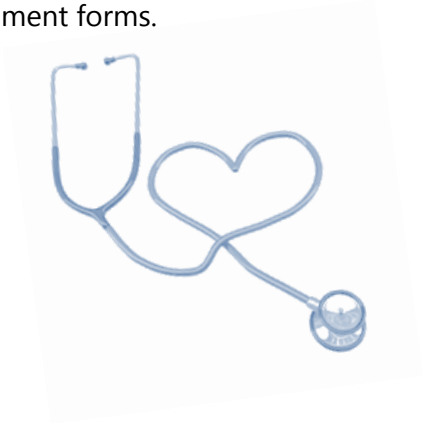
LIFE EVENTS WHILE ON LEAVE

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

RETURNING TO WORK

Depending on the length and type of your leave, you will either need to take action to enroll in benefits, or coverage will be reinstated automatically. You should contact your District Administrator or the County Employee Benefits Office prior to your return to work to determine which applies to your situation.

Where enrollment is required, coverage is effective the first day of the month following your return from leave AND submission of your completed enrollment forms.



CONTINUATION COVERAGE (COBRA)

What is Continuation Coverage?

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

Who is eligible for COBRA?

Any employee or family member, who loses County-sponsored group coverage due to a Qualifying Event, is eligible to elect continuation coverage. A Qualifying Event is the loss of group coverage due to the reduction in hours, termination of employment (except for gross misconduct), death, spouse's enrollment in Medicare Part A and/or B, divorce, or legal separation, or loss of dependent status.

Generally, each person losing their health and/or dental coverage has an independent right to this coverage as a Qualified Beneficiary (QB).

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

What benefits can be continued?

Subject to certain limitations you may elect to continue your medical, dental, and vision benefits at your own expense.

What should I do when there is a qualifying event?

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

How long can benefits continue under Continuation Coverage?

For employees who terminate employment COBRA can generally be continued for 18 months. Dependents who have lost eligibility can continue for up to 36 months.

What if I have questions about Continuation Coverage?

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

CONTACTS

COUNTY OFFICE	PHONE	WEBSITE
Employee Benefits Office	916-874-2020	http://www.personnel.saccounty.net/Benefits
DISTRICT OFFICES		
Carmichael Park	916-485-5322	www.carmichaelpark.com
Elk Grove Cemetery	916-686-6030	www.egccd.com
Mission Oaks	916-488-2810	www.morpd.com
Orangevale Park	916-988-4373	www.ovparks.com
SACOG	916-340-6243	www.sacog.org
Sac Metro Cable	916-874-7319	www.sacmetrocable.tv
SETA	916-263-3800	www.seta.net
Sunrise Park	916-725-1585	www.sunriseparks.com
MEDICAL CARRIERS		
Kaiser Permanente	800-464-4000	www.kp.org
Sutter Health Plus	855-315-5800	www.sutterhealthplus.com
Western Health Advantage	888-563-2250	www.mywha.org/personalaccess
OTHER VENDORS		
Delta Dental	800-765-6003	www.deltadentalins.com/cos
Prudential (Life Insurance)	800-524-0542	www.prudential.com
Prudential (Critical Illness)	877-920-4778	www.myprubenefits.com
SCERS	916-874-9119	www.retirement.saccounty.net
VSP	800-877-7195	www.vsp.com

NOTES

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