SACRAMENTO COUNTY

BENEFITS HANDBOOK

FOR NEW EMPLOYEES

2016

Dear New Employee,

Welcome to the County of Sacramento! This handbook is designed to explain your coverage options and assist you in enrolling in benefits as a new hire.

Understanding your benefit options and obligations can be overwhelming, we hope you find this resource helpful.

The Benefits Office staff can be reached Monday through Friday, 8am to 5pm

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	HMO	HDHP
PAY PERIOD COST-SINGLE	$67.83	$0
PAY PERIOD COST-FAMILY	$173.35	$0
VISION	Included	Not included*
HSA Eligibility	Not eligible	Eligible
MRA Eligibility	General or Limited	Limited only

*Vision coverage is not included in the benefit plan, but can be purchased on a voluntary basis separately.

KAISER PERMANENTE TRADITIONAL HMO

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible	None
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$35 per visit
Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$20 for up to a 100-day supply
Durable Medical Equipment	**You Pay**
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge

(continues)

Disclosure Form *(continued)*

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$15 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

KAISER PERMANENTE HIGH DEDUCTIBLE HMO

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, visiting Member care, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

"Kaiser Permanente HSA-Qualified Deductible HMO Plan" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *EOC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

Annual Out-of-Pocket Maximum	
You will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay, and your payments toward the Plan Deductible, add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible for Most Services	
For Services subject to the Plan Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Plan Deductible amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.	
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, evaluations, and treatment	No charge after Plan Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling	No charge after Plan Deductible
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Eye exams for refraction	No charge after Plan Deductible
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, exams, and treatment	No charge after Plan Deductible
Most physical, occupational, and speech therapy	No charge after Plan Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	No charge after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	No charge after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Health education:	
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge after Plan Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	No charge after Plan Deductible
Ambulance Services	**You Pay**
Ambulance Services	No charge after Plan Deductible
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service	No charge for up to a 100-day supply after Plan Deductible

(continues)

Disclosure Form *(continued)*

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines up to a $2,500 calendar-year benefit limit as described in the *EOC*	No charge after Plan Deductible

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	No charge after Plan Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	No charge after Plan Deductible
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	No charge after Plan Deductible
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *EOC*.	

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	No charge after Plan Deductible
Group outpatient chemical dependency treatment	No charge after Plan Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	No charge after Plan Deductible

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge after Plan Deductible

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Plan Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge after Plan Deductible
Hospice care	No charge after Plan Deductible

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

KAISER HDHP HMO ESTIMATED CHARGES

Kaiser Permanente Estimated Charges Northern California

SERVICE	ESTIMATED CHARGE
Office Visits	
New patient visit, level 1 (low severity)	$55
New patient visit, level 2	$95
New patient visit, level 3	$140
New patient visit, level 4	$210
New patient visit, level 5 (high severity)	$260
Established patient visit, level 1 (low severity)	$25
Established patient visit, level 2	$55
Established patient visit, level 3	$95
Established patient visit, level 4	$135
Established patient visit, level 5 (high severity)	$185
Office Visits (Preventive)	
Well-baby office visit, new patient (under 1 year)*	$145
Well-child office visit, new patient (1–4 years)*	$150
Well-child office visit, new patient (5–11 years)*	$155
Well-child office visit, new patient (12–17 years)*	$175
Well-adult office visit, new patient (18–39 years)*	$170
Well-adult office visit, new patient (40–64 years)*	$195
Well-adult office visit, new patient (65 and older)*	$210
Well-baby office visit, established patient (under 1 year)*	$125
Well-child office visit, established patient (1–4 years)*	$135
Well-child office visit, established patient (5–11 years)*	$135
Well-child office visit, established patient (12–17 years)*	$145
Well-adult office visit, established patient (18–39 years)*	$150
Well-adult office visit, established patient (40–64 years)*	$160
Well-adult office visit, established patient (65 and older)*	$175
Emergency Care by a Physician (excluding other fees such as X-rays, lab tests, or additional procedures)	
Emergency care by a physician, level 1 (low severity)	$120
Emergency care by a physician, level 2	$175
Emergency care by a physician, level 3	$255
Emergency care by a physician, level 4 (high severity)	$385

Kaiser Permanente Estimated Charges Northern California

SERVICE	ESTIMATED CHARGE
Psychotherapy Visits	
Group psychological therapy	$55
Managing mental health drugs	$105
Therapy	$143
Eye Examinations	
Eye exam, routine visit, new patient	$115
Eye exam and treatment, new patient	$210
Eye exam, routine visit, established patient	$120
Eye exam and treatment, established patient	$175
Vision screening test*	$6
Hearing Services	
Comprehensive audiometry evaluation	$71
Ear cleaning	$85
Eardrum test	$27
Hearing screening test (pure tone, air only)*	$23
Physical Therapy Services	
Electric stimulation therapy, treatment only	$28
Physical therapy evaluation	$133
Physical therapy exercises, treatment only	$55
Physical therapy, hot and cold application, treatment only	$11
Physical therapy, ultrasound, treatment only	$22
Vaccines and Other Injections	
Allergy shot	$20
Chickenpox vaccine*	$101
Diphtheria, tetanus booster vaccine*	$28
Diphtheria, tetanus, pertussis vaccine*	$37
Flu shot, children (3 years and older)*	$22
Flu shot, infants*	$11
Hepatitis B vaccine*	$97
Measles, mumps, and rubella vaccine*	$69
Pneumococcal vaccine*	$156
Polio vaccine*	$39

(continues)

SERVICE	ESTIMATED CHARGE
Vaccines and Other Injections *(continued)*	
Rubella vaccine*	$37
Therapeutic prophylactic or diagnostic injection (administration only, does not include medication)*	$46
Therapeutic prophylactic or diagnostic intra-arterial injection (administration only, does not include medication)*	$37
Tests and Procedures	
Breathing capacity test	$70
Breathing treatment	$35
Colonoscopy and removal of abnormal tissue using cautery	$794
Colonoscopy and removal of abnormal tissue using snare technique	$901
Colonoscopy and removal of colon tissue for examination	$805
Diagnostic colonoscopy	$675
Diagnostic proctosigmoidoscopy	$207
Diagnostic sigmoidoscopy	$244
Draining fluid from around swollen joint	$115
Electrocardiogram (EKG)	$35
Fetal monitoring	$78
Removal of abnormal areas of skin	$12
Sigmoidoscopy and removal of tissue for examination	$292
Skin biopsy	$176
Stress test	$167
Surgically destroying an abnormal area of skin	$138
Ultrasound test of heart	$250
X-rays, CT Scans, and Other Imaging Studies	
CT scan of chest, including dye	$652
CT scan of pelvis, including dye	$617
CT scan of pelvis, without dye	$506
CT scan of sinus and nasal passages	$571
CT scan of stomach area with dye	$706
CT scan of stomach area, without dye	$515
Mammogram	$245
Mammogram (one side)	$191
Mammogram (screening)*	$176
Pregnancy ultrasound	$318

(continues)

SERVICE	ESTIMATED CHARGE
X-rays, CT Scans, and Other Imaging Studies *(continued)*	
Review of CT scan of the head or brain	$410
Ultrasound of breast	$196
Ultrasound of pelvis	$282
Ultrasound of stomach area	$299
Vaginal ultrasound	$285
X-ray for osteoporosis	$127
X-ray of abdomen (complete)	$108
X-ray of ankle	$65
X-ray of ankle (complete)	$75
X-ray of both knees	$80
X-ray of chest	$67
X-ray of chest (one view interpretation)	$50
X-ray of finger	$75
X-ray of foot	$61
X-ray of foot (complete)	$71
X-ray of hand	$63
X-ray of hand (complete)	$73
X-ray of hip	$88
X-ray of knee	$69
X-ray of knee (complete)	$98
X-ray of lower back bones	$82
X-ray of neck	$119
X-ray of neck bones	$88
X-ray of shoulder	$69
X-ray of stomach area (one view)	$55
X-ray of wrist (complete)	$84
X-ray of wrist (two views)	$70
Laboratory Tests	
Albumin test	$12
Alkaline phosphatase test	$13
Allergy test	$13
ALT test	$13
Amylase test	$16
AST test	$13
Bilirubin test (total)	$12

(continues)

SERVICE	ESTIMATED CHARGE
Laboratory Tests *(continued)*	
Blood antibody test	$10
Blood clotting test	$10
Blood sugar test, diagnostic	$10
Blood sugar test, monitoring	$24
Calcium test (total)	$13
Cholesterol level test*	$11
Complete blood count	$19
Creatinine test	$13
Hepatitis B surface antigen test	$25
Hepatitis C test	$35
Kidney function test	$10
Laboratory chemistry test for creatine kinase	$16
Lipid panel test*	$33
Magnesium test	$16
Pap test, cervical cancer screening*	$26
Phosphorus test	$12
Potassium test	$11
Pregnancy test	$18
Prostate test*	$45
Sodium test	$12
Strep–A–Swab test	$49
Test for blood in stool	$8
Test for genital warts	$86
Thyroid stimulating hormone test	$41
Urine bacteria colony count	$20
Urine test (complete)	$8
Urine test (dipstick only)	$6
Urine test (microanalysis only)	$7

Health Savings Account (HSA)

Accountholder frequently asked questions (FAQs)

You can use your HSA to pay for current and future qualified medical expenses — tax free.[1] The Wells Fargo HSA consists of a Federal Deposit Insurance Corporation (FDIC)-insured, interest-bearing deposit account and an investment account.[2] It comes with access to *Wells Fargo Online*® for easy account management, and is tied to the Wells Fargo Visa® HSA debit card, making it a convenient way to pay for qualified medical expenses.

If you have questions not covered in this FAQ document, please call Wells Fargo HSA Customer Service at **1-866-884-7374**, Monday through Friday, from 7:00 a.m. to 8:00 p.m. Central Time. More resources are available online at wellsfargo.com/hsaresources. We are here to help you get the most out of your HSA.

Your HSA deposit account

What is the HSA deposit account?

Your HSA deposit account consists of an FDIC-insured, interest-bearing cash account, similar to a checking account.

What is the available balance?

The available balance is the cash amount in your HSA deposit account. This is the amount available for making withdrawals and purchases with your HSA. The HSA deposit account is protected by FDIC insurance and earns interest.

Do I earn interest on the cash in my HSA?

Yes, you may earn interest on the cash in the deposit account component of your HSA. Interest rates are subject to change. Current rates are posted at wellsfargo.com/hsa under Managing your HSA.

How much can I contribute to my HSA?

For 2015, the annual IRS contribution limits are $3,350 for individuals or $6,650 for families. Individuals age 55 and over may also contribute an additional $1,000 per year in catch-up contributions. If you were eligible to make HSA contributions in the prior tax year, you may make prior-year contributions to your HSA up until the deadline for filing your federal income tax return, which is typically April 15.[3]

Your personal contribution limit may be lower than Internal Revenue Code maximums. Individuals are responsible for calculating and monitoring their contribution limits — Wells Fargo does not calculate or monitor your contribution limit. **Information about how to make contributions to your account is covered on page two of this document.**

Your HSA investment account[2]

When can I start to invest with my HSA?

You can start to invest in the available HSA mutual funds when you have reached the minimum balance of $2,000 in the FDIC-insured deposit account.[4] You may preselect investment elections for contributions exceeding the $2,000 minimum deposit account balance requirement. Your contributions will be automatically directed into the investments you've selected once the minimum balance is met.[5]

What investment options are available?

Wells Fargo offers a wide array of no-load HSA mutual funds to meet a variety of investing goals and objectives. An overview of the HSA mutual fund options is available at wellsfargo.com/hsainvesting. **Information about activating your investment account and managing your investment portfolio are covered on page three of this document.**

Accessing and managing your HSA

Where can I get information about my account activity?

You will receive a monthly account statement that lists your HSA deposit account balance, investment details, and all transactions, including your HSA debit card transaction details. It also includes a year-to-date contribution summary. Your monthly transaction activity is also available online through *Wells Fargo Online*. See the following questions for more information.

How do I access and manage my HSA online?

Wells Fargo Online makes it fast and easy for you to manage your Wells Fargo HSA anytime.

- View your available balance.
- Review detailed account activity, including your HSA debit card transactions.
- Maintain your account profile.
- Make a one-time or recurring contribution to your HSA (current or prior year).

Together we'll go far

- Create an automatic transfer to investments. You can turn auto transfer on or off at any time.
- View online tax documents and monthly statements.
- Use online distributions to make transfers into your Wells Fargo bank account — a great way to reimburse yourself for out-of-pocket expenses, and much more.

How do access Wells Fargo Online?

If you are a new user, you will need to follow these steps to sign on:

1. Visit wellsfargo.com and select "Sign Up" at the top of the page.
2. Follow the steps to create a personal username and password. You will need your Health Savings Account number or your Wells Fargo HSA debit card number and Personal Identification Number (PIN) for online registration.
3. Once you are signed on, select your account from the Account Summary screen.

Are you already a *Wells Fargo Online* customer? Just select your account from the Account Summary screen.

What account information can I access by calling the automated phone line?

The automated phone line will allow you to:

- Obtain your deposit account balance
- Hear recent account activity
- Report a lost or stolen HSA debit card
- Customize your HSA debit card PIN
- Locate Wells Fargo retail banking stores or ATMs

You can access the automated phone line by calling Wells Fargo HSA Customer Service at 1-866-884-7374, Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time. In order to access your account information, you will be prompted to enter your account number or HSA debit card number and PIN. If you have changed your PIN from the one that was initially assigned to you, please enter the most recent PIN.

Making contributions to your account

How do I contribute money to my HSA?

You can contribute money directly to your HSA anytime through *Wells Fargo Online*.

To make a one-time contribution or schedule recurring contributions to your HSA, follow these steps:

1. Access your account by signing on to *Wells Fargo Online* at wellsfargo.com
2. From the Account Summary screen, select your account
3. Under **Manage Your HSA**, select **Deposit to HSA**

Note: *You will need to have your bank account information for the checking or savings account from which you are requesting the funds to be debited.*

Additionally, you can either use the coupon that's included with your monthly HSA statement or make contributions to your account in a Wells Fargo retail banking store using a standard account deposit slip.

If your HSA is through your employer benefits, you may also be able to make contributions through automated payroll deductions. Check with your employer to find out if they offer this service.

Regardless of how you contribute, it's important not to exceed the maximum annual contribution limit set by the IRS. If you have questions on how this limit applies to you, please consult your tax advisor. Wells Fargo does not calculate or monitor your contribution limits. Individuals are responsible for calculating and monitoring their contribution limits.

Can contribution amounts be changed during the year?

Yes. You may make changes to the recurring contributions that you have set up anytime during the year through *Wells Fargo Online*. If you have automatic payroll deductions through your employer, you should contact your employer directly to make changes.

What if I change jobs, enroll in Medicare, or simply work for an employer whose benefits renew midyear?

IRS rules state that contribution limits must generally be prorated by the number of months you participate in an HSA-qualified health plan without additional, disqualifying coverage.[6]

If you change coverage to or from a health plan that is HSA-qualified, you will need to recalculate your eligible HSA contribution limit.

Eligibility is based on your coverage on the first day of the month.

To calculate your contribution limit, take the total annual contribution you can make, multiply it by the number of months you qualify, and then divide that amount by 12.

If you are joining an HSA-qualified plan midyear, there is a provision which may allow you to contribute up to the maximum annual limit, even though you did not have qualifying coverage all year. To qualify, the IRS requires that you be HSA-eligible on December 1 and maintain HSA-qualified coverage through December 31 of the following year (this is referred to as the testing period).[6]

If you enroll in disqualifying coverage (including Medicare) midyear, you will need to prorate your HSA contribution limit.[6]

If a husband and wife have a family HSA-qualified health plan and one spouse has no other coverage and the other spouse is enrolled in Medicare, then the spouse with Medicare is not eligible to contribute to an HSA. The spouse with no other coverage may contribute up to the 2014 maximum of $6,550 to an HSA.[1]

Contribution rules are complex. Please consult IRS Publication 969 and your tax advisor with questions.

Investment account set-up and transactions

How do I activate my investment account?

1. Access your account by signing on to *Wells Fargo Online* at wellsfargo.com
2. From the Account Summary screen, select your account
3. Select the **HSA Investments** tab at the top of the page
4. Select the **Activate HSA Investment Account** button

After your account is activated, you can sign on to set up the HSA mutual funds you want to invest in.

Please note: *Once an investment account is opened and the automatic transfer feature is activated, balances in your FDIC-insured deposit account that exceed the $2,000 minimum[4] threshold will be automatically transferred to your preset investment elections.[5]*

How do I set up or change my investment elections?

You can set up or change your investments anytime through *Wells Fargo Online*. It's a good idea to set up your investment elections before you reach the $2,000 minimum deposit account balance[4] so your contributions will be automatically directed into the investments you've selected:

1. Access your account by signing on to *Wells Fargo Online* at wellsfargo.com
2. From the Account Summary screen, select your account
3. Select the **HSA Investment** tab at the top of the page and then click on the **Manage HSA Investments** button to be taken to the investment website
4. Select **Change Investments and Elections** under the **Actions & Investments** tab

How do I transfer money from my investments to my deposit account?

If you need to transfer money from your HSA investments to your HSA deposit account to pay for qualified medical expenses, you can liquidate a portion or all of your mutual fund holdings and transfer the proceeds to your HSA deposit account.

1. Access your account by signing on to *Wells Fargo Online* at wellsfargo.com
2. From the Account Summary screen select your account
3. Select the **HSA Investment** tab at the top of the page and then click on the **Manage HSA Investments** button to be taken to the investment website
4. Select **Change Investments and Elections** under the **Actions & Investments** tab and follow the instructions

What is the cutoff time for an investment transfer to be processed by the end of the business day?

In order for your investment transfer to be processed by the end of the business day, the request must be submitted before 3:00 p.m. Central Time.

Using your HSA

What are qualified medical expenses?

To help you determine whether an expense qualifies for tax-free[1] reimbursement under your HSA, Internal Revenue Code Section 213(d) states that eligible expenses must be made for "medical care." This is defined as amounts paid for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

Examples of common qualified medical expenses include:

- Acupuncture
- Ambulance services
- Artificial limb or prosthesis
- Dental treatment
- Contact lenses
- Doctor's fees
- Hearing aids and hearing aid batteries
- Hospital services
- Laboratory fees
- Prescription medicines or drugs
- Nursing home
- Nursing services
- X-rays

Expenses for over-the-counter (OTC) drugs are not eligible for payment or reimbursement from an HSA without a doctor's prescription. A few examples of OTC medicines that require a doctor's prescription for payment or reimbursement from an HSA are:

- Cold, cough, and flu medications
- Allergy and sinus medications
- Pain relief medications
- Acid controllers
- Sleep aids and sedatives

Insulin and prescribed drugs are eligible for payment or reimbursement from an HSA. You should save your receipts and doctor's prescriptions for OTC medicines for tax purposes.

Qualified medical expenses are eligible for reimbursement through your HSA, as long as they are not reimbursed through insurance or other sources. Although insurance premiums are generally not considered qualified medical expenses, the following types of insurance premiums typically do qualify:

- Health care continuation coverage (such as COBRA)
- Qualified long-term care insurance
- Any health care coverage maintained while receiving unemployment compensation under federal or state law
- For accountholders age 65 and over (those eligible for Medicare), premiums for any health insurance (including

Medicare and Medicare Part D premiums) other than a Medicare supplemental policy

As the HSA owner, you are ultimately responsible for determining whether a healthcare expense is eligible for reimbursement from your HSA. Wells Fargo does not determine whether claims qualify for tax-free[1] reimbursement. Consult a tax advisor for personalized tax advice.

For more information about qualified medical expenses, please visit wellsfargo.com/hsaqualifiedexpenses or call Wells Fargo HSA Customer Service at 1-866-884-7374, Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time.

Can I use funds from an HSA for nonqualified medical expenses?

Yes, but you'll be required to pay income tax and a 20% tax penalty on the amount you use for nonqualified medical expenses. (The 20% penalty doesn't apply to distributions made after your death or disability, or after you've reached age 65.)

How can I use the funds in my HSA?

There are several ways to access your HSA funds:

- Use your HSA debit card to pay any merchant that accepts Visa debit cards.
- Visit more than 6,000 Wells Fargo retail banking stores to make deposits, withdrawals, and transfers.
- Make withdrawals at any ATM displaying the Visa or Plus® logos worldwide.
- Use HSA checks to pay merchants for qualified medical expenses. (To order checks for your HSA, please call Wells Fargo HSA Customer Service at 1-866-884-7374, Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time.)
- You can also pay for qualified medical expenses using cash or your personal credit or debit card. Then, reimburse yourself by making a withdrawal from your HSA at an ATM or at a Wells Fargo retail banking store using your HSA debit card. You can also send in a reimbursement request to pay yourself back by check or electronic deposit.
  - To make an online distribution to another Wells Fargo account:
    1. Access your account by signing on to *Wells Fargo Online* at wellsfargo.com
    2. From the Account Summary screen, select your account
    3. Under **Manage Your HSA**, select **Withdraw from HSA** and choose the Wells Fargo account that you want to transfer your HSA funds to

Can an HSA be overdrawn? Do fees incur as a result?

Yes, an HSA can be overdrawn. There is no overdraft fee, but an HSA can be overdrawn for a variety of reasons. If your HSA does become overdrawn, it is important to resolve it quickly or your account may be closed.

Here are some examples of transactions that could cause an HSA to become overdrawn:

- The available balance (the cash balance) in your HSA deposit account was insufficient to cover the monthly service fee or other account fees.
- A contribution (or deposit) to your HSA could not be processed and those funds were removed from your account.
- A transaction on your HSA debit card was approved at the time of purchase, but the available balance in your HSA deposit account was insufficient to cover the transaction when processed.
- While waiting for an approved transaction(s) on your Wells Fargo HSA debit card to be processed to your account, other transactions on your debit card were processed and your deposit account was left with insufficient funds to cover the initial, approved transaction(s).
- You may have requested direct reimbursement from your Wells Fargo HSA for an out-of-pocket expense. While that request was in process, another transaction was processed first, leaving an insufficient balance in the account to cover the direct reimbursement request.

Understanding your Wells Fargo Visa HSA debit card

When will I receive my HSA debit card?

You will receive your HSA debit card and your personal identification number (PIN) within 10 business days of enrolling in the Wells Fargo HSA. For security, the HSA debit card and PIN will arrive in separate mailings.

How does the HSA debit card work with the HSA?

Your HSA debit card is tied to the available deposit account balance in your HSA. The HSA debit card can be used to pay for qualified medical expenses billed from an insurance company, at a doctor's office or pharmacy, or at any merchant that accepts the Visa debit card. You can also use the card to make withdrawals from your HSA at an ATM.

Can I order HSA debit cards for my spouse or dependents?

Yes, you can order HSA debit cards for your spouse or dependents by following these instructions:

1. Access your account by signing on to *Wells Fargo Online* at wellsfargo.com
2. From the Account Summary screen, select your account
3. Under **Manage Your HSA**, select **Order HSA dependent card**

Please have your dependent's name, mailing and physical address, Social Security Number, date of birth, phone number, and residency information when you begin.

If I order a debit card for my dependents, what do my dependents and I need to know about the debit card?

- Your dependents will have access to your HSA funds with the dependent debit card. Dependents do not have any HSA

ownership rights and cannot request any changes to the HSA.

- The dependent HSA debit card can be used to pay for goods and services that are qualified medical expenses, or for reimbursing qualified medical expenses paid out-of-pocket by withdrawing cash at an ATM.
- The card can be used at any merchant that accepts Visa debit cards for payment or to withdraw cash at Wells Fargo ATMs or any other ATM with a Visa or Plus® logo. If given the option when making a purchase, select "credit" for payment and sign for the purchase.
- Dependents should keep all of their receipts and provide them to the HSA account owner.
- There is a daily spending limit on the dependent debit card. The amounts are listed with the card when it is initially mailed. Dependents cannot change this amount; only the HSA owner can request a change to the spending amount.
- Dependents can access your balance and transaction history, as well as the transaction history of all dependents, by telephone, ATM, or at any Wells Fargo retail banking store.
- You are responsible for any transaction initiated by your dependent(s).
- You may be required to pay taxes and penalties for distributions if your dependent(s) use the dependent debit card for nonqualified medical expenses.
- Dependents have no authority to manage any portion of your HSA, including ordering or writing of checks, maintenance of your account, or buying or selling of investment funds.
- For more information on dependents' responsibilities and rights, please read the Card Terms of Use, which are mailed with each HSA debit card.
- For service questions, call Wells Fargo HSA Customer Service at 1-866-884-7374, Monday through Friday, 7:00 a.m. to 8:00 p.m. Central Time. You can:
  - Obtain the balance on the HSA by following the prompts when you call the service center; you will need to enter your card number and your PIN.
  - Call immediately if your card is lost or stolen; we will close your card and order you a card with a new card number.
  - Change your address or update your personal information; be sure to inform the HSA owner of your changes.

If I am at the ATM and it asks me to indicate what type of account I have, what do I choose?

Choose checking.

Do I choose debit or credit on the signature pad when I make a purchase using my HSA debit card?

Choose credit. Also, it's important to note that you cannot get cash back from your HSA debit card when you make a purchase at a merchant.

I received my new HSA debit card, but did not receive the PIN. How do I get the PIN?

For security reasons, your PIN will be mailed separately from your debit card. However, you can also visit a Wells Fargo retail banking store to get your HSA debit card PIN. If you are not near a Wells Fargo retail banking location, you can call Wells Fargo HSA Customer Service at 1-866-884-7374. To ensure your security, we require that the accountholder contact Customer Service to get a PIN, rather than your spouse or dependent.

How do I change my HSA debit card PIN?

You can change your PIN at any Wells Fargo ATM or Wells Fargo retail banking store, or by calling the automated phone line at 1-866-884-7374. If using the automated system, enter your HSA deposit account number or HSA debit card number and follow the prompts. If you plan to change your PIN at a Wells Fargo ATM, you will need to know your current PIN in order to make the change.

Who do I contact if I think there have been unauthorized transactions on my HSA debit card?

If you think there are unauthorized transactions on your HSA debit card, please call Customer Service immediately at 1-866-884-7374 and choose option #4.

Taxes and your HSA

What tax reporting does Wells Fargo provide as part of the HSA administration?

Wells Fargo provides IRS Form 1099-SA and IRS Form 5498-SA for accountholders. IRS Form 1099-SA reports the distributions you took from your HSA. It is mailed in January of each year. IRS Form 5498-SA is mailed in May so it reflects all contribution activity in your Wells Fargo HSA during the previous tax year, which can be made up until the deadline for filing the federal income tax return for the current year. Additionally, accountholders may access the two most recent annual tax forms online through *Wells Fargo Online*.

Do I need to file any special forms with my federal tax return to report contributions to my HSA?

Yes. You will need to file IRS Form 8889-Health Savings Accounts with your federal tax return. Please consult a tax advisor if you have specific questions.

Will I have to pay tax penalties on the monthly fees that Wells Fargo deducts from an HSA?

No. The IRS has stated that administration and account maintenance fees withdrawn directly from the HSA are allowable withdrawals and, therefore, not subject to taxes or penalties.

What are the HSA guidelines for domestic partners?

The federal tax rules governing HSAs and domestic partners vary depending on whether the domestic partner is a tax dependent. Consult your tax advisor whether your domestic partner is a tax dependent.

If your domestic partner is a tax dependent, HSA disbursements from your account for your domestic partner's qualified medical expenses are tax-free.[1]

Your domestic partner cannot contribute to his or her own HSA. Individuals who can be claimed as dependents on a tax return are not eligible to open their own HSA.

If your domestic partner is not a tax dependent, HSA disbursements from your account for your domestic partner's medical expenses will be taxable, and will also be subject to the 20% penalty tax (the 20% penalty doesn't apply to distributions made after death or disability, or after the accountholder reaches age 65). However, your domestic partner may open his or her own HSA and contribute up to the annual family IRS maximum amount if he or she is covered under an HSA-qualified health plan. An HSA for your domestic partner can be opened as long as the domestic partner is in a qualifying high-deductible health plan.

Please note: *This assumes that you have family medical coverage under your qualifying health plan, cover your domestic partner as a dependent, and that your domestic partner has no disqualifying coverage and is otherwise HSA-eligible.*

Life changes and your HSA

What happens if I change jobs or health plans?

HSAs are owned by the individual, so if you change jobs or health plans, you may elect to keep your HSA at Wells Fargo or roll the funds into an HSA at another qualified institution. Your eligibility to continue to contribute to the HSA will depend, in part, on the type of health insurance you have.

Can I use money in my HSA to pay expenses for my adult children?[1]

U.S. healthcare reform legislation extended coverage for adult children for family health plans until they turn age 26. The "age 26" change did not extend to the use of the HSA because HSAs are covered under a different section of the tax code. If you list your adult child as a tax dependent on your federal income tax return, you may typically use the money in your HSA for eligible expenses for that adult child, regardless of age.

If your adult child is not listed as a tax dependent on your federal income tax return, you may not use the money in your HSA for that adult child — even if they are covered by your qualified high-deductible medical plan. If your adult child does not qualify as a tax dependent, any HSA distributions for the adult child may be subject to income tax and a penalty tax. If your adult child is covered under your qualified high-deductible medical plan and is not your tax dependent, your adult child may be able to open his/her own HSA and contribute up to the allowable family maximum.

What happens to the money in my HSA upon death?

Upon death, if your spouse is the designated beneficiary, he or she will become the owner of the HSA without tax consequences. If you designate another person as the beneficiary of your HSA, the HSA ceases to be an HSA on the date of death and the value of the HSA at death is taxable to the nonspouse beneficiary in the year in which you die. If your estate is your beneficiary, the value of your HSA at death is includible on your final tax return.

What happens to HSA funds upon divorce?

Your divorce decree should specify if and how the HSA balance should be split between the spouses. Transfers incident to divorce must be done as trustee-to-trustee transfers. Please contact Wells Fargo HSA Customer Service for any questions.

Questions?

For more information please visit wellsfargo.com/hsa, or contact Wells Fargo HSA Customer Service at 1-866-884-7374, Monday through Friday, from 7:00 a.m. to 8:00 p.m. Central Time.

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[1] All tax references are at the federal level. State taxes vary. Please consult a tax advisor.

[2] INVESTMENT PRODUCTS: NOT FDIC INSURED • NO BANK GUARANTEE • MAY LOSE VALUE

[3] Individual contribution limits may be lower than IRS maximums. Individuals are responsible for monitoring their contribution limits. Consult your tax advisor with questions about how limits apply to your situation.

[4] The minimum transfer amount to investments from the FDIC-insured deposit account is $20.00.

[5] If you activate the automatic transfer feature and do not preselect investments, funds will be invested in the default fund — *Wells Fargo Advantage Cash Investment Money Market* (S) – NWIXX until you make other investment elections.

[6] Contact your insurance provider if you have questions on whether your health coverage is HSA-qualified. If you are enrolled in or your spouse is enrolled in a Flexible Spending Arrangement (FSA) it may disqualify you from making HSA contributions. Other HSA-eligibility criteria apply including: cannot be enrolled in Medicare, cannot be covered in a health plan that is not an HSA-qualifying plan, with limited exceptions, cannot have received VA medical benefits in the past three months, cannot be eligible to be claimed as a dependent on someone else's tax return.

Wells Fargo reserves the right to add or remove funds at any time.

Health Savings Account (HSA)

Qualified medical expenses and your HSA

Paying for qualified medical expenses such as doctor's visits and prescription medications is simple and tax-free with your Wells Fargo HSA.[1] The money you contribute to your HSA is tax-deductible and can be used to pay for qualified medical expenses not only for yourself, but also for your spouse and tax dependents.

What expenses qualify for tax-free reimbursement from my HSA?

To help you determine whether an expense qualifies for tax-free reimbursement under your HSA, Internal Revenue Code Section 213(d) states that eligible expenses must be made for "medical care." This is defined as amounts paid for the "diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body."

Qualified medical expenses are eligible for reimbursement through your HSA as long as they are not reimbursed through insurance or other sources. The examples and requirements stated in this flyer are subject to change by the IRS.

Examples of qualified medical expenses

This list includes some examples of qualified medical expenses:

- Acupuncture
- Alcoholism treatment
- Ambulance services
- Artificial limb or prosthesis
- Artificial teeth
- Birth control pills
- Braille books/magazines (portion of costs)
- Car adaptations (for a person with a disability)
- Chiropractors
- Christian Science practitioners
- Contact lenses (including saline solution and cleaner)
- Crutches
- Dental treatment (x-rays, fillings, extractions, dentures, braces, etc.)
- Diagnostic devices (such as a blood sugar test kit)
- Doctor's fees
- Drug addiction treatment
- Eyeglasses (including eye examinations)
- Eye surgery (including laser eye surgery)
- Fertility enhancement (including in-vitro fertilization)
- Guide dog (for visually-impaired or hearing-impaired)
- Hearing aids and hearing aid batteries
- Hospital services (including meals and lodging)
- Insulin
- Laboratory fees
- Lactation assistance supplies
- Prescription medicines or drugs
- Nursing home
- Nursing services
- Operations or surgery
- Psychiatric care
- Psychologist
- Telephone equipment for hearing-impaired
- Telephone equipment for visually-impaired
- Therapy or counseling
- Transplants
- Transportation for medical care
- Vasectomy
- Wheelchair
- X-rays

Together we'll go far

Changes to over-the-counter medical expenses in 2011

As of January 1, 2011, expenses for over-the-counter (OTC) drugs are no longer eligible for payment or reimbursement from an HSA without a doctor's prescription. This change is a result of the 2010 healthcare reform legislation. A few examples of OTC medicines that will require a doctor's prescription for payment or reimbursement from an HSA are:

- Acid controllers
- Allergy and sinus medications
- Cold, cough, and flu medications
- Pain relief medications
- Sleep aids and sedatives

Examples of other expenses that DO NOT qualify for reimbursement through an HSA

- Babysitting, childcare, and nursing services for a normal, healthy baby
- Controlled substances obtained in violation of federal law
- Cosmetic surgery
- Dancing lessons
- Diaper service
- Electrolysis or hair removal
- Funeral expenses
- Hair transplant
- Health club dues
- Household help
- Illegal operations and treatments
- Maternity clothes
- OTC medications (without a doctor's prescription)
- Personal use items
- Swimming lessons
- Teeth whitening
- Vacation or travel
- Veterinary fees
- Weight loss programs for improvement of appearance, general health, or sense of well-being

A special note on insurance premiums

Insurance premiums are generally not considered qualified medical expenses. However, the following types of insurance premiums typically do qualify:

- Continuation coverage under federal law (i.e., COBRA)
- Qualified long-term care insurance contract
- Any health plan maintained while an individual is receiving unemployment compensation under federal or state law
- For accountholders age 65 and over (i.e., those eligible for Medicare), premiums for any health insurance (including Medicare and Medicare Part D premiums) other than a Medicare supplemental policy

Important reminders about qualified medical expenses

- Items that are merely beneficial to an individual's general good health, such as vitamins or dietary supplements, are not qualified medical expenses.
- Drugs must be purchased legally.
- Remember to save your receipts and your doctor's prescriptions for OTC medicines for tax purposes.
- There may be situations when your doctor recommends a treatment that will be good for your health, but it still may be considered ineligible, such as a vacation.
- As the HSA owner, you are ultimately responsible for determining whether a healthcare expense is eligible for reimbursement from your HSA.
- Wells Fargo does not determine whether claims qualify for tax-free reimbursement.
- If an HSA expenditure is not used for a qualified medical expense, you will be required to pay income tax and a 20 percent penalty on the amount used. (The 20 percent penalty tax does not apply to payments made after your death or disability, or after you reach age 65.)

[1] Tax references are at the federal level. State taxes may vary. Please consult a tax advisor.

[2] The maximum IRS contribution limit for 2014 is $3,300 for individual coverage and $6,550 for families. Accountholders age 55 or older can make additional $1,000 catch-up contributions annually. Individual contribution limits may be lower than IRS maximums. Individuals are responsible for monitoring their contribution limits. Consult your tax advisor with questions about how limits apply to your situation.

	HMO	HDHP
PAY PERIOD COST-SINGLE	$78.38	$0
PAY PERIOD COST-FAMILY	$201.30	$0
VISION	Included	Not included*
HSA Eligibility	Not eligible	Eligible
MRA Eligibility	General or Limited	Limited only

*Vision coverage is not included in the benefit plan, but can be purchased on a voluntary basis separately.

Western Health Advantage

PREMIER 15A MHP

COPAYMENT SUMMARY a uniform health plan benefit and coverage matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE/DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

cost to member	DEDUCTIBLE
none	Deductible amount

ANNUAL OUT-OF-POCKET MAXIMUM

The maximum out-of-pocket expense for a Member per calendar year is limited to either the Individual amount or Family amount, whichever is met first:

$1,500	Self-only coverage
$1,500	Individual with Family coverage
$3,000	Family coverage
none	Lifetime maximum

Preventive Care Services

none — Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF

- Annual physical examinations and well baby care
- Immunizations, adult and pediatric
- Women's preventive services
- Routine prenatal care and lab tests, and first post-natal visit
- Breast, cervical, prostate, colorectal and other generally accepted cancer screenings

Note: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

Professional Services

$15 per visit	Office visits, primary care physician (PCP)
$15 per visit	Office visits, specialist
$15 per visit**	Vision and hearing examinations
$15 per visit	Family planning services

Outpatient Services

Outpatient surgery

$15 per visit	• Performed in office setting
$15 per visit	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests, X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
$5 per visit	Therapeutic injections, including allergy shots

Hospitalization Services

none — Facility fees — semi-private room and board and hospital services for acute care or intensive care, including:

- Newborn delivery (private room when determined medically necessary by a participating provider)
- Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy, blood transfusion services, rehabilitative services, and nursery care for newborn babies

none — Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services

cost to member	
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area
$15 per visit	• Physician's office
$15 per visit	• Urgent care center
$35 per visit	• Emergency room — facility fees (waived if admitted)
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Outpatient prescription medications are excluded on the medical plan and covered under the prescription rider plan (see your Prescription Copayment Summary).
	Durable Medical Equipment (DME)
none	Durable medical equipment (excluding orthotic and prosthetic devices) when determined by a participating physician to be medically necessary and when authorized in advance by WHA
none	Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA
	Behavioral Health Services
	Mental Health Disorders and Substance Abuse
$15 per visit	• Office visit
none	• Outpatient services
none	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
none	• Inpatient hospital services — provided at residential treatment center
none	• Inpatient physician services
	Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).
	Other Health Services
none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
none	Skilled nursing facility, semi-private room and board, when medically necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days per calendar year
none	Hospice services
$15 per visit	Habilitation services
$15 per visit	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement
none	Inpatient rehabilitation
20%*	Home self-injectable medication, up to $100 maximum copay per 30-day supply, may be limited to a 30-day supply; insulin is covered under the prescription benefit
	Acupuncture and chiropractic services, provided through Landmark Healthplan of California, Inc., when determined to be medically necessary, no PCP referral required
$15 per visit	• Acupuncture, up to 20 visits per year
$15 per visit**	• Chiropractic care, up to 20 visits per year

* Percentage copayment are based upon WHA's contracted rates with the provider of service.
** Copayments do not contribute to the out-of-pocket maximum.

WESTERN 1500MHP

COPAYMENT SUMMARY a uniform health plan benefit and coverage matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE/DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

member responsibility	DEDUCTIBLE
$1,500*	Self-only coverage
$3,000*	Family coverage

The annual deductible is the amount of money a member or family must pay for covered services before WHA will cover those services. After the deductible is met the applicable copayments will apply. The deductible applies to both medical and pharmacy expenses. The deductible does not apply to Preventive Care Services as noted below. The deductible is applied each calendar year. If you have family coverage, there is no single deductible amount for each family member; rather, the entire Family deductible must be met before WHA becomes responsible for providing covered services for any individual member in the family. Amounts paid for non-covered services do not count toward a member's deductible.

ANNUAL OUT-OF-POCKET MAXIMUM

$1,500	Self-only coverage
$3,000	Family coverage

The out-of-pocket maximum is the maximum total amount of copayments and deductibles that a member or the family must pay for covered services during any calendar year. If you have family coverage, there is no single out-of-pocket maximum for each family member; rather, the entire Family out-of-pocket maximum must be met before you do not have to pay any more copayments for that calendar year. Amounts paid for non-covered services do not count toward a member's out-of-pocket maximum.

none	Lifetime maximum

cost to member	SERVICES NOT SUBJECT TO DEDUCTIBLE

Preventive Care Services

none	Preventive care services, including laboratory tests, as outlined under the Preventive Services Covered without Cost-Sharing section of the EOC/DF

- Annual physical examinations and well baby care
- Immunizations, adult and pediatric
- Women's preventive services
- Routine prenatal care and lab tests, and first post-natal visit
- Breast, cervical, prostate, colorectal and other generally accepted cancer screenings

Note: Procedures resulting from screenings are not considered preventive care. In order for a service to be considered "preventive," the service must have been provided or ordered by your PCP or OB/GYN, and the primary purpose of the visit must have been to obtain the preventive service. Otherwise, you will be responsible for the cost of the office visit as described in this copayment summary.

none	Vision examination
none	Hearing examination

IMPORTANT: **Health savings accounts (HSAs) are complex financial products.** This plan is a high-deductible health care plan. While there is no obligation to have an HSA, WHA recommends that you consult your tax or financial advisor to discuss the benefits and determine whether this plan and HSAs are a good choice for you.

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE
	Professional Services
none	Office visits, primary care physician (PCP)
none	Office visits, specialist
none	Family planning services
	Outpatient Services
	Outpatient surgery
none	• Performed in office setting
none	• Performed in facility — facility fees
none	• Performed in facility — professional services
none	Dialysis, infusion therapy and radiation therapy
none	Laboratory tests, X-ray and diagnostic imaging
none	Imaging (CT/PET scans and MRIs)
none	Therapeutic injections, including allergy shots
	Hospitalization Services
none	Facility fees — semi-private room and board and hospital services for acute care or intensive care, including: • Newborn delivery (private room when determined medically necessary by a participating provider) • Use of operating and recovery room, anesthesia, inpatient drugs, X-ray, laboratory, radiation therapy, blood transfusion services, rehabilitative services, and nursery care for newborn babies
none	Professional inpatient services, including physician, surgeon, anesthesiologist and consultant services
	Urgent and Emergency Services
	Outpatient care to treat an injury or sudden onset of an acute illness within or outside the WHA Service Area
none	• Physician's office
none	• Urgent care center
none	• Emergency room — facility fees
none	• Emergency room — professional services
none	• Ambulance service as medically necessary or in a life-threatening emergency (including 911)
	Prescription Coverage
	Walk-in pharmacy (30-day supply)
none	• Tier 1 - Preferred generic medication
none	• Tier 2 - Preferred brand name medication[1]
none	• Tier 3 - Non-preferred medication[1]
	Mail order (up to 90-day supply)
none	• Tier 1 - Preferred generic medication
none	• Tier 2 - Preferred brand name medication[1]
none	• Tier 3 - Non-preferred medication[1]

The following prescription medications are covered at no cost to the member (generic required if available): aspirin, prenatal vitamins, folic acid, fluoride for preschool age children, tobacco cessation medication and women's contraceptives.

At walk-in pharmacies if the actual cost of the prescription is less than the applicable copayment, the member will only be responsible for paying the actual cost of the medication.

[1]Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment.

cost to member after deductible is met	SERVICES SUBJECT TO DEDUCTIBLE
	Durable Medical Equipment (DME)
none	Durable medical equipment (excluding orthotic and prosthetic devices) when determined by a participating physician to be medically necessary and when authorized in advance by WHA
none	Orthotics and prosthetics when determined by a participating physician to be medically necessary and when authorized in advance by WHA
	Behavioral Health Services
	Mental Health Disorders and Substance Abuse
none	• Office visit
none	• Outpatient services
none	• Inpatient hospital services, including detoxification — provided at a participating acute care facility
none	• Inpatient hospital services — provided at residential treatment center
none	• Inpatient physician services
	Mental health disorders means disturbances or disorders of mental, emotional or behavioral functioning, including Severe Mental Illness and Serious Emotional Disturbance of Children (SED).
	Other Health Services
none	Home health care when prescribed by a participating physician and determined to be medically necessary, up to 100 visits in a calendar year
none	Skilled nursing facility, semi-private room and board, when medically necessary and arranged by a primary care physician, including drugs and prescribed ancillary services, up to 100 days per calendar year
none	Hospice services
none	Habilitation services
none	Outpatient rehabilitative services, including: • Physical therapy, speech therapy and occupational therapy, when authorized in advance by WHA and determined to be medically necessary • Respiratory therapy, cardiac therapy and pulmonary therapy, when authorized in advance by WHA and determined to be medically necessary and to lead to continued improvement
none	Inpatient rehabilitation
none	Home self-injectable medication, may be limited to a 30-day supply; insulin is covered under the prescription benefit

* Deductibles or percentage copayments are based upon WHA's contracted rates with the provider of service.

MANAGING YOUR HIGH-DEDUCTIBLE PLAN

The deductible and annual out-of-pocket maximum apply only to the covered services described in this Copayment Summary. Copayments and deductibles for any benefits purchased separately as a rider, including but not limited to infertility benefits, do not apply to this deductible or annual out-of-pocket maximum.

When your copayments and deductible payments for the services described in this Copayment Summary have reached the annual out-of-pocket maximum, WHA will automatically provide you a document to show that you do not have to pay any more copayments or deductibles for covered services through the end of the calendar year.

To review amounts applied to your annual deductible and out-of-pocket maximum, simply access your accumulator through MyWHA at westernhealth.com.

If you have any questions about how much has been applied to your deductible or annual out-of-pocket maximum, or whether certain payments you have made apply to the annual out-of-pocket maximum, please call WHA Member Services.

WHA HSA-COMPATIBLE PLAN
DEDUCTIBLE FEE SCHEDULE

Each cost listed below assumes the service is received from a network provider, and does not include facility charges (if applicable). Please note that several CPT codes may be used for one visit, in which case your responsibility will be the sum of the costs for all codes used.

For information about services covered with no cost-sharing, please consult the Copayment Summary and Appendix A of the Combined Evidence of Coverage and Disclosure Form (EOC/DF) for your plan.

Members of Hill Physicians Medical Group (HPMG): Please contact HPMG or your provider for relevant costs.

CPT Code	Description	Cost Under Deductible *for One Unit*
Office Visits		
99201	New patient - 10 minutes	$30
99202	New patient - 20 minutes	$51
99203	New patient - 30 minutes	$74
99204	New patient - 45 minutes	$112
99205	New patient - 60 minutes	$139
99211	Established patient - 5 minutes	$14
99212	Established patient - 10 minutes	$30
99213	Established patient - 15 minutes	$50
99214	Established patient - 25 minutes	$73
99215	Established patient - 40 minutes	$98
99241	Routine specialist care - 15 minutes	50% of billed charges*
99242	Routine specialist care - 30 minutes	50% of billed charges*
99243	Routine specialist care - 40 minutes	50% of billed charges*
99244	Routine specialist care - 60 minutes	50% of billed charges*
99245	Routine specialist care - 80 minutes	50% of billed charges*
Emergency Care by a Physician		
99281	Emergency care by a physician	$14
99282	Emergency care by a physician, routine	$27
99283	Emergency care by a physician, complex	$40
99284	Emergency care by a physician, severe/urgent	$76
99285	Emergency care by a physician, extensive	$112
Psychotherapy Visits - *Please contact Magellan Behavioral Health*		
Other Eye Services - *You may incur additional Professional and Technical Component Fees*		
92018	Ophthalmological examination & evaluation	$98
92019	Ophthalmological examination & evaluation, limited	$47
92020	Gonioscopy	$19
92025	Computerized corneal topography	$27
92060	Sensorimotor examination	$46
92065	Orthoptic and/or pleoptic training	$39
92070	Fitting of contact lens for treatment of disease/ supply of lens	50% of billed charges*
92081	Visual field examination	$29
92082	Visual field examination, intermediate	$46
92083	Visual field examination, extended	$45
92100	Serial tonometry	$58
92120	Tonography with interpretation and report	50% of billed charges*

CPT Code	Description	Cost Under Deductible *for One Unit*
92130	Tonography with water provocation	50% of billed charges*
92132	Scanning computerized ophthalmic diagnosis imaging	$25
92136	Ophthalmic biometry	$66
92140	Provocative tests for glaucoma	$46
92225	Extended ophthalmoscopy, initial	$19
92226	Extended ophthalmoscopy, subsequent	$17
92230	Fluorescein angioscopy	$42
92235	Fluorescein angiography [includes multiframe imaging]	$90
92240	Indocyanine-green angiography	$189
92250	Fundus photography	$58
92260	Ophthalmodynamometry	$14
92265	Needle oculoelectromyography	$57
92270	Electro-oculography	$66
92275	Electroretinography	$116
92283	Color vision examination, extended	$41
92284	Dark adaptation examination	$45
92285	External ocular photography	$15
92286	Special anterior segment photography	$25
92287	Special anterior segment photography [with flourescein angiography]	$92
92311	Prescription contact lens for aphakia, one eye	$73
92312	Prescription contact lens for aphakia, both eyes	$83
92313	Prescription corneoscleral lens	$73
92315	Prescription contact lens for aphakia, one eye	$60
92316	Prescription contact lens for aphakia, both eyes	$79
92317	Prescription corneoscleral lens	$56
92325	Modification of contact lens	$31
92326	Replacement of contact lens	$26
Other Hearing Services		
92616	Flexible fiberoptic endoscopic evaluation of swallowing & laryngeal sensory testing by cine or video recording	$148
92617	Flexible fiberoptic endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video; physician interpretation & report only	$28
92620	Evaluation of central auditory function - initial 60 minutes	$63
92621	Evaluation of central auditory function - each additional 15 minutes	$15
92625	Assessment of tinnitus	$47
92626	Evaluation of auditory rehabilitation status - initial 60 minutes	$61
92627	Evaluation of auditory rehabilitation status - each additional 15 minutes	$15
Physical Therapy Services		
97001	Physical therapy evaluation	$51
97002	Physical therapy re-evaluation	$29
97003	Occupational therapy evaluation	$59
97004	Occupational therapy re-evaluation	$37
97012	Mechanical traction	$11
97016	Vasopneumatic device	$14
97018	Paraffin bath	$8

CPT Code	Description	Cost Under Deductible *for One Unit*
97022	Whirlpool	$17
97024	Diathermy	$4
97026	Infrared	$4
97028	Ultraviolet	$5
97032	Electrical stimulation - each 15 minutes	$13
97033	Iontophoresis - each 15 minutes	$23
97034	Contrast bath - each 15 minutes	$13
97035	Ultrasound - each 15 minutes	$9
97036	Hubbard tank - each 15 minutes	$23
97110	Therapeutic procedure & exercises - each 15 minutes	$22
97112	Neuromuscular reeducation of movement, balance & coordination for sitting & standing activities	$23
97113	Aquatic therapy with therapeutic exercises	$31
97116	Gait training [includes stair climbing]	$20
97124	Massage therapy	$18
97140	Manual therapy techniques - each 15 minutes	$21
97150	Therapeutic procedure(s), group	$11
97530	Therapeutic activities - each 15 minutes	$24
97532	Development of cognitive skills - each 15 minutes	$18
97533	Sensory integrative techniques - each 15 minutes	$20
97535	Self care/home management training - each 15 minutes	$24
97537	Community/ work reintegration training - each 15 minutes	$21
97542	Wheelchair management training - each 15 minutes	$21
Allergy Shots, including Therapeutic Injections		
96372	Therapeutic, prophylactic or diagnostic injection	$18
96373	Therapeutic, prophylactic or diagnostic injection - intra-arterial	$14
96374	Therapeutic, prophylactic or diagnostic injection - intravenous push, single or initial substance/drug	$41
95115	Allergy shot - single injection	$7
95117	Allergy shot - two or more injections	$8
95144	Antigens for allergen immunotherapy - single dose vial	$9
95145	Antigens for allergen immunotherapy - single stinging insect venom	$16
95146	Antigens for allergen immunotherapy - two single stinging insect venoms	$29
95147	Antigens for allergen immunotherapy - three single stinging insect venoms	$26
95148	Antigens for allergen immunotherapy - four single stinging insect venoms	$39
95149	Antigens for allergen immunotherapy - five single stinging insect venoms	$53
95165	Antigens for allergen immunotherapy, single or multiple antigens	$9
95170	Antigens for allergen immunotherapy, whole body extract of biting insect or other arthropod	$7
95180	Rapid desensitization procedure - each hour	$91

Allergy Testing

CPT Code	Description	Cost Under Deductible *for One Unit*
95004	Percutaneous tests with allergenic extracts - each test	$5
95010	Percutaneous tests sequential and incremental - each test	50% of billed charges*
95015	Intracutaneous tests with drugs, biologicals, or venoms - each test	50% of billed charges*
95024	Intracutaneous tests with allergenic extracts, immediate type reaction - each test	$6
95027	Intracutaneous tests with allergenic extracts for airborne allergens, immediate type reaction - each test	$4
95028	Intracutaneous tests with allergenic extracts, delayed type reaction - each test	$10
95044	Patch or application tests - each test	$4
95052	Photo patch tests - each test	$5
95056	Photo tests - each test	$34
95060	Ophthalmic mucous membrane tests	$25
95065	Direct nasal mucous membrane test	$20
95070	Inhalation bronchial challenge testing	$23
95071	Inhalation bronchial challenge testing with antigens or gases	$26
95075	Ingestion challenge test	50% of billed charges*

Tests and Procedures - *Please contact your medical group*

X-rays, CT Scans and Other Imaging Studies - *Please contact your medical group*

Laboratory Tests - *Please contact your medical group*

* The WHA rate for these services is not a flat dollar amount. Members will pay the percentage amount under the deductible.

A benefit of
Western Health Advantage

HealthEquity®
Building Health Savings™

A Hassle-Free HealthEquity® HSA: A Healthy Choice for Saving

As a benefit of your HSA-compatible health plan with Western Health Advantage, you have access to an easy, hassle-free health savings account (HSA) from HealthEquity. Discover the best way to save for health care, and a great way to save on taxes.

What Is an HSA?

An HSA is a tax-free savings account that works with a qualified health plan to help you pay your insurance deductible and qualified out-of-pocket medical expenses.

You take the money you would have paid for higher health insurance premiums and use it to pay qualified medical expenses or save it and let it grow from year to year. What's more:

- Your HSA—including all the money you and your employer (if applicable) contribute—is yours.
  - You won't lose it if you don't spend it, change jobs, retire, or leave the health plan.
- You never pay taxes on withdrawals for qualified medical expenses[1].
- Your money earns interest and you don't pay taxes on the interest earned[1].
- Your contributions are tax-free and reduce your overall taxable income.

Who's Eligible for an HSA?

Anyone meeting the following requirements is eligible for an HSA.

- Be enrolled in a qualified health plan.
- Have no other health coverage except what's permitted by the IRS (see IRS Publication 969).
- Not be enrolled in Medicare.
- Not be claimed as a dependent on someone else's tax return.

Benefits of Your HealthEquity HSA

Your HealthEquity HSA includes:

- **Easy-to-use online access to claims and payments**—access claims[2], pay bills, get reimbursements, and more—all from a single, easy-to-use online portal.
- **Live service 24/7/365**—get the same service at 2 a.m. or 2 p.m. from knowledgeable, US-based HealthEquity Member Services specialists.
- **Remarkable education and support**—Rely on HealthEquity Member Services and online resources to get the most from your HSA.
- **Knowledge of your Western Health Advantage claims data** to "bridge the gap" between your responsibility under insurance, and your payments from your HSA.
- **Everything you get from a typical HSA and more**—including:
  - FDIC-insured cash deposits that earn competitive interest rates
  - Free mutual fund investment options with no transaction fees[3]
  - Free HealthEquity Visa® health account card*

A benefit of Western Health Advantage

HealthEquity® Building Health Savings™

Why an HSA Might Be Right for You

Seventy percent of people have less than $1,000 of medical expense a year (including what both the insured and the health plan pay[4]). Why not invest the money you'd pay for premiums in an interest-bearing, tax-advantaged HSA and lower-premium health plan?

Even if you have higher medical expenses, an HSA often costs less than a traditional plan when you combine what you save on premiums and your out-of-pocket maximum. See the health plan comparison tool in the resource center at www.healthequity.com and see the savings for yourself.

Frequently Asked Questions

To learn even more, visit www.healthequity.com or contact HealthEquity Member Services by phone or at memberservices@healthequity.com.

Q. HOW MUCH CAN CONTRIBUTING TO AN HSA SAVE ME ON TAXES?

A. If you're in the 25% tax bracket and contribute $1,500, you save $375 in taxes*! In addition your $1,500 grows tax-free in your HSA. And when you incur costs, you have money you can withdraw with no tax penalty for qualified medical expenses.

Sample Tax Savings
Your contribution: **$1,500**
Annual medical expenses: **$500**

	5 years	10 years	20 years
Saving with interest at year's end*	$5,101	$10,462	$22,019
Cumulative tax savings*	$2,295	$4,670	$9,671

*Examples based on a 1% interest rate on HSA compounded over time, a 5% state tax rate, and a 25% federal tax bracket. Individual results will vary based on the amount contributed to the HSA, medical expenses, and tax bracket.

Calculate your own savings at http://healthequity135.vtoolkit.com/appToolkit/app/login/loginGlobal.cfm.

Q. WHAT'S A QUALIFIED MEDICAL EXPENSE?

A. Qualified medical expenses are those that generally qualify for the income tax deduction outlined in IRS Publication 502. See www.irs.gov/pub/irs-pdf/p502.pdf for a complete list or visit the resource center on www.healthequity.com.

Q. WHO CAN PUT MONEY IN MY HSA?

A. Anyone can contribute to your HSA. Only you (and your employer, if a contributor) receive tax deductions on monies contributed. And your contribution is tax-free.

Q. HOW MUCH MONEY CAN I CONTRIBUTE TO MY HSA?

A. In 2014, the maximum contribution set by the IRS for an individual is $3,300 and $6,550 for family coverage (up from $3,250 and $6,450 in 2013). People 55 and older can make an additional $1,000 "catch-up" contribution. Limits are the same regardless of the source.

Q. CAN I TAKE THE MONEY OUT OF MY HSA ANY TIME I WANT?

A. Yes. You can take money out anytime tax-free and without penalty as long as it's to pay for qualified medical expenses. If you take money out for other purposes, you'll pay income taxes plus a 20% penalty.

Q. CAN I USE THE MONEY IN MY HSA TO PAY FOR MY CHILDREN'S MEDICAL EXPENSES?

A. Yes. Your HSA can be used to pay the qualified medical expenses of any family member who qualifies as a dependent on your tax return. If the dependent isn't on your health plan, his/her expenses won't apply to your deductible.

Q. CAN I ACCESS MY HSA ONLINE?

A. Yes. Simply visit your member portal or www.myhealthequity.com.

Health Savings Account (HSA) FAQs

Q: DO I HAVE TO HAVE HEALTH INSURANCE TO HAVE A HEALTH SAVINGS ACCOUNT (HSA)?

A: Yes. To be eligible to open and contribute to an HSA, you need to be enrolled in a qualified high-deductible health plan (HDHP)—one with a minimum annual deductible of $1,250 for self-only coverage or $2,500 for family coverage.

Q: WHO OWNS THE HSA?

A: You do.

Q: DOES THE MONEY IN MY HSA EARN INTEREST?

A: Yes, and tax-free. HealthEquity calculates, compounds, and credits interest monthly based on the applicable rate for different tiers of the account balance. For current rates see the interest rate page in the HealthEquity online resource center.

Q: CAN I INVEST THE MONEY IN MY HSA?

A: Yes. Similar to an IRA, many HSAs let you choose to invest your account balance in stocks/bonds, mutual funds, CDs, and/or annuities. With your HealthEquity® HSA, you can typically invest in pre-selected mutual funds after you reach a $2,000 balance in your account. (Note: Your account may have a different minimum balance. Check your plan details or call your dedicated HealthEquity Member Services line or 866.346.5800 for more information.)

Q: IS MY HSA FDIC-INSURED?

A: Yes. However, eligible monies in investments are not FDIC-insured.

Q: CAN I ROLL THE MONEY FROM MY IRA INTO MY HSA?

A: Yes. You can make a one-time rollover from your IRA into your HSA. You can't, however roll money into your IRA from your HSA. Note that a rollover will count against annual contribution amounts. For more information, call your dedicated HealthEquity Member Services line or 866.346.5800.

Q: WHO CAN PUT MONEY IN MY HSA?

A: Anyone can contribute to your HSA. However, only the account holder and the employer receive tax deductions on monies contributed. Only your contribution is tax-free.

Q: DO I HAVE TO CLAIM CONTRIBUTIONS FROM OTHERS ON MY INCOME TAXES?

A: You don't have to claim contributions you receive from others, whether your employer or your family, as gross income on your annual tax return.

Q: HOW MUCH MONEY CAN I CONTRIBUTE TO MY HSA?

A: In 2013, the maximum contribution as set by the IRS for an individual account is $3,250 and the maximum contribution for family coverage is $6,450. In 2014, those limits increase to $3,300 and $6,550, respectively. People over the age of 55 can make an additional "catch-up" contribution of $1,000. These limits are the same regardless of the source of the contribution.

Q: WHAT HAPPENS TO THE MONEY IN MY HSA IF I LEAVE MY JOB OR RETIRE?

A: You take that money with you wherever you go. The HSA is in your name. It's your account. If you're on Medicare or go to another employer that doesn't have a qualified HDHP, you can still use your HSA money to pay for co-pays and qualified medical expenses, but won't be able to continue to make contributions to your HSA.

Q: DOES THE MONEY I HAVE IN MY HSA ROLL OVER FROM YEAR TO YEAR OR DO I LOSE THE MONEY AT THE END OF THE YEAR?

A: The money rolls over from year to year. You don't lose the money left in your HSA or the interest it's earned. It's your money.

Q: CAN I TAKE THE MONEY OUT OF MY HSA ANY TIME I WANT?

A: Yes. You can take money out anytime tax-free and without penalty as long as it's to pay for qualified medical expenses. If you take money out for other purposes, however, you'll have to pay income taxes on the withdrawal plus a 20% penalty.

Q: WHAT IS A QUALIFIED MEDICAL EXPENSE?

A: Qualified medical expenses are those that would generally qualify for the medical and dental expenses income tax deduction as outlined in *IRS Publication 502–Medical and Dental Expenses*. See www.irs.gov/publications/p502/index.html for a current complete list.

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Q: DO I PAY CO-PAYMENTS IF I HAVE AN HSA?

A: If your health insurance plan requires a co-payment, you will pay the co-payment as part of the full amount your insurance has contracted to pay for the visit, which you'll pay in full until meeting your deductible. Whether you continue to pay co-payments after meeting your deductible depends on the specifics of your health plan. You can always use your HSA to pay your co-payments.

Q: I AM A PARENT ON AN HSA-BASED PLAN, BUT DIDN'T COVER MY CHILDREN UNDER THIS PLAN. CAN I USE THE MONEY IN MY HSA TO PAY FOR MY CHILDREN'S MEDICAL EXPENSES, CO-PAYS, AND DEDUCTIBLES?

A: Yes. The money in your HSA can be used to pay for qualified medical expenses of any family member who qualifies as a dependent on your tax return. However, if the dependent isn't covered under your plan, his/her expenses won't be applied toward your deductible.

Q: MY DOMESTIC PARTNER IS COVERED ON MY INSURANCE PLAN. CAN I USE MY HSA FOR MY DOMESTIC PARTNER'S MEDICAL EXPENSES?

A: If your domestic partner meets the IRS qualifications of a tax dependent, you can legally use your HSA funds for his/her medical expenses.

Q: DO I PAY FOR THE FULL DOCTOR'S OFFICE VISIT WHEN I GO TO THE DOCTOR?

A: You're responsible to pay the amount your insurance has contracted to pay your doctor, typically a discounted rate, until your deductible is met. You can use your HSA for this expense.

It's best to have your doctor's office put the charge through to your insurance, so that you receive credit toward your deductible and know exactly what to pay. Some doctors may require that you pay up front, but most bill your insurance, and then bill you only once the claim has been processed. Make sure you don't pay more than your portion shown on the explanation of benefits you receive from your insurance carrier.

Q: I'M RETIRED. CAN I STILL CONTRIBUTE TO MY HSA?

A: Yes, provided you're covered by a qualified HDHP and aren't on Medicare.

Q: IF MY SPOUSE IS ON MEDICARE, CAN I CONTRIBUTE TO AN HSA?

A: Yes. As long as you're not enrolled in Medicare yourself and are still enrolled in a qualified HDHP, you can contribute to your HSA.

Q: CAN I USE THE MONEY IN MY HSA FOR NON-MEDICAL EXPENSES?

A: Yes. If you do though, and are under 65, you'll be taxed on the money you use and assessed a 20% penalty. Once you're 65, you'll be taxed for moneys used for non-medical expenses, but won't pay a penalty.

Q: CAN I USE MY HSA FOR EYE GLASSES, CONTACTS, OR LASIK SURGERY?

A: Yes. These expenses may not apply to your insurance deductible though.

Q: CAN I USE MY HSA TO PAY FOR DENTAL EXPENSES AND ORTHODONTICS?

A: Yes. These expenses may not apply to your insurance deductible though.

Q: CAN I USE MY HSA TO PAY FOR VOLUNTARY COSMETIC SURGERY?

A: The HSA can be used for cosmetic surgery if prescribed by a physician and deemed being medically necessary.

Q: CAN I ACCESS MY HSA ONLINE?

A: Yes. You can see your account balances, HSA debit card balance, claim transactions, and more online. You can also pay providers, request reimbursements, and manage your personal information. Simply visit www.myhealthequity.com or your specific member portal.

Q: HOW DO I CONTACT HEALTHEQUITY?

A: You can call HealthEquity Member Services 24/7/365 at your dedicated service line.

	HMO	HDHP
PAY PERIOD COST-SINGLE	$65.46	$0
PAY PERIOD COST-FAMILY	$167.42	$0
VISION	Included	Not included*
HSA Eligibility	Not eligible	Eligible
MRA Eligibility	General or Limited	Limited only

*Vision coverage is not included in the benefit plan, but can be purchased on a voluntary basis separately.

County of Sacramento

Plan Name	Sutter Health Plus HMO	Sutter Health Plus HMO HDHP (HSA Eligible)[10]
Plan ID	**ML33**	**HL05 / HL55**
Overall Deductible		
Single	$0	$1,500
Family	$0	$3,000
Deductible for Certain Medical Services[1]		
Single	$0	$0
Family	$0	$0
Deductible for Prescription Drugs[1]		
Generic	$0	$0
Brand (Preferred and Non-Preferred)	$0	$0
Annual Out-of-Pocket Maximum for Certain Services[2]		
Single	$1,500	$1,500
Family	$3,000	$3,000
Professional and Outpatient Services		
Preventive Care[3]	No Charge	No Charge
Primary Care Office Visit	$15 per visit	No charge after deductible
Specialist Office Visit	$15 per visit	No charge after deductible
Prenatal and Postnatal Care[4]	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	$15 per visit	No charge after deductible
Non-Preventive Diagnostic Tests (X-ray, blood work)	No Charge	No charge after deductible
Outpatient Surgery Facility Fees	$15 per visit	No charge after deductible
Outpatient Surgery Physician/Surgeon Fees	No Charge	No charge after deductible
Hospitalization Services		
Hospitalization Facility Fees	No Charge	No charge after deductible
Hospitalization Physician/Surgeon Fees	No Charge	No charge after deductible
Emergency and Urgent Care Services		
Emergency Room Services (Waived if Admitted)	$35 per visit	No charge after deductible
Emergency Medical Transportation	No Charge	No charge after deductible
Urgent Care	$15 per visit	No charge after deductible
Prescription Drugs[5]		
Generic Drugs	$10 copay	No charge after deductible
Preferred Brand Name Drugs[6]	$20 copay	No charge after deductible
Non-Preferred Brand Name Drugs[6]	$35 copay	No charge after deductible
Specialty Drugs[6]	20% coinsurance	No charge after deductible
Behavioral Health[7]		
Mental/Behavioral Health Outpatient Services	$15 Individual/ $7 Group	No charge after deductible
Mental/Behavioral Health Inpatient Services	No Charge	No charge after deductible
Other Services		
Home Health Care[8]	No Charge	No charge after deductible
Durable Medical Equipment	No Charge	No charge after deductible
Hospice Services	No Charge	No Charge
Skilled Nursing Care[8]	No Charge	No charge after deductible
Rehabilitation Services	$15 per visit	No charge after deductible
Eye Exam[9]	Not Covered	Not Covered

Medical Plan Footnotes

Large Group	
1	Medical or prescription services are subject to a deductible as indicated within each benefit plan's services listing. The member must pay for these services when services are rendered until the deductible or coinsurance is met in that plan year. Charges for services subject to a deductible are based on SHP's contracted rate with the provider of service.
2	Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum. (See #5 regarding prescription drug cost sharing.)
3	Including, but not limited to: annual physical examinations, immunizations (adult and pediatric), maternity care (after initial diagnosis and pre- and post natal visits), well baby care up to age two; breast, cervical, prostate and colorectal cancer screenings. Preventive care services are available at no cost. For a complete list of preventive services please refer to the Combined Disclosure Form and Evidence of Coverage.
4	Scheduled prenatal visits and the first postpartum visit.
5	Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 90-day supply is available, at twice the 30-day copay price, through the mail-order form. Prescription drug deductibles or copays do not contribute toward the plan year medical deductible or plan year medical out-of-pocket maximum unless the plan is a high deductible health plan.
6	Subject to prior authorization in accordance with SHP formulary guidelines.
7	Mental and behavioral health services include substance abuse and chemical dependency services.
8	Up to 100 visits per year for home health care and 100 days per benefit period for skilled nursing care.
9	Annual preventive refractive eye exam.
10	The deductible and annual out-of-pocket maximum amounts are aggregate, i.e. the family amount must be met before benefits will apply for any member of the family.

Health Savings Account Q&A

WHAT ARE HSAs AND WHO CAN HAVE THEM?

1. What is an HSA and how does it work?

An HSA is a tax-advantaged account established to pay for qualified medical expenses for those who are covered under a High Deductible Health Plan. With money from this account, you pay for healthcare expenses until your deductible is met. Then, in accordance with the terms of your healthcare plan, your insurance company pays for covered expenses in excess of your deductible. Any unused funds are yours to retain in your HSA and accumulate toward your future healthcare expenses or your retirement.

2. What are the general features and tax benefits of an HSA?

- Your contributions are pre-tax or tax-deductible*
- Interest earned is tax-free
- Tax-free withdrawals may be made for qualified medical expenses
- Unused funds and interest are carried over, without limit, from year to year
- You own the HSA and it is yours to keep - even when you change jobs, health plans, or retire

*Contributions are tax-deductible on your Federal tax return. Some states do not recognize HSA contributions as a deductions. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). See IRS Publication 969. Consult a qualified tax adviser for advice.

3. Who qualifies for an HSA?

An eligible individual is anyone who:

- is covered under a High Deductible Health Plan (HDHP)
- is not covered by any other health plan that is not an HDHP
- is not currently enrolled in Medicare or TRICARE
- has not received medical benefits through the Department of Veterans Affairs (VA) during the preceding three months
- may not be claimed as a dependent on another person's tax return

4. Who qualifies as a dependent?

A person generally qualifies as your dependent for HSA purposes if you claim them as an exemption on your Federal tax return. Please see IRS Publication 502 for exceptions. www.irs.gov/pub/irs-pdf/p502.pdf.

5. What is a "High Deductible Health Plan" (HDHP)?

An HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. In 2014, for self-only coverage, an HDHP has an annual deductible of at least $1,250 and annual out-of-pocket expenses (deductibles, co-payments and other amounts, but not premiums) not exceeding $6,350 (as indexed). For family coverage in 2014, an HDHP has an annual deductible of at least $2,500 and annual out-of-pocket expenses not exceeding $12,700. HDHP qualifying deductibles and annual out-of-pocket-expenses are indexed for inflation on an annual basis. Visit www.treas.gov and click on "Health Savings Accounts" for updates.

6. What kind of other health coverage makes an individual ineligible for an HSA?

Generally, an individual is ineligible for an HSA if the individual, while covered under an HDHP, is also covered under a health plan (whether as an individual, spouse, or dependent) that is not an HDHP.

7. What can I use the HSA for?

The HSA can be used:

- to pay for qualified medical, dental, vision and prescription drug expenses, including over-the counter drugs that have been prescribed by a doctor, as defined in IRS Publication 502
- as supplemental income, but money withdrawn is taxable and if you are under age 65, it will be subject to a 20% penalty

8. Can I invest my HSA dollars?

Yes, you can invest your HSA dollars into a variety of mutual fund options* to help build your HSA dollars to use for future medical expenses or save for retirement. For additional information on HSA investments, please review our HSA Investment FAQs on our website.

*Please read the **Important Information** section on the last page.

9. What other kinds of health coverage may an individual maintain without losing eligibility for an HSA?

An individual does not fail to be eligible for an HSA merely because, in addition to an HDHP, the individual has coverage for any benefit provided by "permitted insurance." Permitted insurance is insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., automobile insurance), insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization.

In addition to permitted insurance, an individual does not fail to be eligible for an HSA merely because, in addition to an HDHP, the individual has coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

10. Can I use my HSA to pay for medical expenses for a spouse or dependent?

Yes, you may use your HSA funds without penalty to pay for qualified medical expenses for yourself, your spouse, or dependent even if they are covered under another health plan. Consult a qualified tax adviser for advice.

CONTRIBUTIONS TO HSAs

14. Who may contribute to an HSA?

Anyone may contribute to the HSA of an eligible individual. If an employee establishes an HSA, for example, the employee, their employer, or both may contribute to the employee's HSA in a given year. If a self-employed or unemployed individual establishes an HSA, that individual may contribute to the HSA. Family members may also make contributions to an HSA on behalf of another family member as long as that other family member is an eligible individual.

15. Can I enroll in both an HSA and a health Flexible Spending Account (FSA)?

If you enroll in both an HSA and an FSA or Health Reimbursement Arrangement (HRA), you cannot make deductible contributions to the HSA for that coverage period if the FSA or HRA are "general purpose" arrangements that pay or reimburse for qualified medical expenses. However, you still may be able to make deductible contributions to an HSA even if you are also covered under an FSA or HRA if those arrangements are "limited purpose" FSAs or HRAs that restrict reimbursements to certain "permitted benefits" such as vision, dental or preventive care benefits. Other permissible combinations include "suspended HRAs" and "post-deductible" FSAs or HRAs. Contact your legal or tax adviser to review these situations.

16. How much can I contribute to my HSA?

In 2014, your annual HSA contribution may not exceed IRS limits of $3,300 for individual coverage or $6,550 for family coverage. IRS limits are indexed for inflation on an annual basis. Visit www.treas.gov and click on "Health Savings Accounts" for updates.

11. What if I use my HSA to pay for something other than a qualified medical expense?

If HSA funds are used for other than qualified medical expenses, the expenditures are subject to applicable income tax and, for individuals who are not disabled or over age 65, subject to a 20% tax penalty.

12. Are health insurance premiums qualified medical expenses?

Generally, health insurance premiums are not qualified medical expenses. Exceptions include qualified long-term care insurance, COBRA healthcare continuation coverage, any health plan maintained while receiving unemployment compensation under federal or state law, and for those age 65 or over (whether or not they are entitled to Medicare) any employer-sponsored retiree medical coverage premiums for Medicare Part A or B, or Medicare HMO. Conversely, premiums for Medigap policies are not qualified medical expenses.

13. What happens to the money in my HSA if I no longer have HDHP coverage?

Once you discontinue coverage under an HDHP and/or get coverage under another health plan that disqualifies you from an HSA, you can no longer make contributions to your HSA, but since you own the HSA, you can continue to use the remaining funds for future medical expenses.

17. If I enrolled in an HDHP and HSA mid-year, what is my permitted contribution amount for that year?

As outlined in IRS Publication 969, under the "last month rule," if you have HDHP coverage on the first day of the last month of your tax year (December 1 for most taxpayers), you are considered an eligible individual for the entire year. The maximum annual HSA contribution can be made for that tax year, regardless of when, during that year, the HSA was opened. For example, if an individual opens an HSA on June 1, the full contribution allowable by law can be made for that year. Penalties may apply if HDHP coverage does not continue for 12 months during the testing period. For the last-month rule, the testing period begins with the last month of your tax year (usually December 31) and ends on the last day on the 12th month following that month. If you fail to remain an eligible individual during the testing period, you may be subject to penalties. Please see IRS Publication 969 for details. www.irs.gov/pub/irs-pdf/p969.pdf.

18. Can I change my contributions to my HSA during the year?

Generally, if you make contributions through an employer's cafeteria plan, you will not be subject to the "change in status" rules applicable to other qualified benefits. If this is the case, you will be able to make changes in your contributions by providing the applicable notice of change provided by your employer. If you do not contribute to your HSA through a cafeteria plan, you are free to start, stop, or modify your contributions at any time.

19. How do I make contributions?

Contributions can be made:

- through payroll deduction with your employer
- on-line by making a contribution from your personal checking account
- mailing a personal check with the on-line HSA Contribution Form

20. My HSA deduction is shown in Box 12 of my W-2 as Code W. Why is it designated as an employer contribution when I have contributed the money to the account?

Consistent with applicable IRS guidelines, HSA deductions reported on your W-2 in Box 12 includes contributions made by the employer and employee contributions made through a section 125 cafeteria plan as a pre-tax salary deferral. When you prepare your taxes at year-end, you are required to complete an additional tax form. Form 8889 and instructions are available at www.irs.gov.

21. Will HSA contributions that I made via lockbox deposit or on-line show up on my W-2?

No. Contributions made by either of these methods are considered after-tax contributions for purposes of W-2 reporting. In order to receive the tax benefit of after-tax contributions, you must claim them on your tax return.

22. When can HSA contributions be made? Is there a deadline for contributions to an HSA for a taxable year?

For an established HSA, contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, this is April 15 of the year following the year for which contributions are made.

23. What happens when HSA contributions exceed the maximum amount that can be deducted or excluded from gross income in a taxable year?

Contributions by individuals to an HSA, or if made on behalf of an individual to an HSA, are not deductible when they exceed the limits. Contributions by an employer to an HSA for an employee are included in the gross income of the employee if they exceed the limits or if they are made on behalf of an employee who is not an eligible individual. In addition, if not withdrawn in a timely manner, an annually assessed excise tax of 6% is imposed on the accountholder for excess individual and employer contributions.

24. What are catch-up contributions for individuals age 55 or older?

For individuals age 55 and older, the HSA contribution limit is increased by $1,000 in calendar year 2009 and after.

25. If my spouse is age 55 or older, am I eligible to make the catch-up contribution?

No. The primary accountholder must be age 55 or older in order to make the catch-up contribution.

26. What happens to my remaining account balance at the end of the year?

Any remaining balance automatically rolls over year after year.

27. Can I contribute funds from my Individual Retirement Arrangement (IRA) to my HSA?

During your lifetime, you are allowed a one-time contribution from one of your IRA(s) to one of your HSA(s). The contribution must be made in a direct trustee-to-trustee transfer. The IRA transfer will not be included in income or subject to additional tax due to early withdrawal. The transfer is limited to the maximum HSA contribution for the year and the amount contributed is not allowed as a deduction. Penalties may apply if HDHP coverage does not continue for 12 months.

28. Are rollover contributions from Archer MSAs and other HSAs permitted?

Yes. Rollover contributions from Archer MSAs and other HSAs are permitted. Qualifying rollover contributions must be made in cash and are not subject to annual contribution limits.

DISTRIBUTIONS & ACCOUNTHOLDER RESPONSIBILITIES

29. How are distributions from an HSA taxed?

Distributions from an HSA used exclusively to pay for qualified medical expenses of the accountholder, his or her spouse, or dependents are tax exempt and not included in gross income.

In general, amounts retained in an HSA can be used for qualified medical expenses and will be excludable from gross income even if the individual is not currently eligible to make contributions to the HSA.

30. When can I initiate distributions from an HSA?

Once your account is funded and activated, you can initiate distributions from the HSA at any time.

31. What are the "qualified medical expenses" that are eligible for tax-free distributions?

Qualified medical expenses are expenses paid by the accountholder for diagnosis, cure, mitigation, treatment, or prevention of disease.

Examples of these expenses are prescription drugs, including over-the-counter drugs that have been prescribed by a doctor, transportation to care providers, qualified long-term care expenses, and certain health insurance premiums (see question 12). Such expenses are "qualified medical expenses" only if they are ineligible for insurance or any other type of coverage. For more information, visit www.irs.gov/pub/irs-pdf/p502.pdf.

32. Can I use my HSA to pay for non-health related expenses?

Yes, however, any amount of a distribution not used exclusively to pay for qualified medical expenses of the accountholder, spouse or dependents is includable in gross income of the accountholder. Such distributions are subject to an additional 20% tax on the amount includable, except in the case of distributions made after the accountholder's death, disability, or attaining age 65.

33. How do I pay for medical services?

Medical services can be paid for with your U.S. Bank Payment Card, on-line Bill Pay, or distributing funds from the HSA to your personal bank account.

34. Is there a PIN associated with the U.S. Bank Payment Card?

No PIN is required–at check-out, select "Credit" and sign for your purchase. If you would like to use the card for making purchases where entering a PIN is allowed, you can obtain a PIN by calling the number on the back of your card. The PIN cannot be used to obtain cash at ATMs or get cash back at merchants.

35. Is there a daily transaction limit on my card?

For your protection, there is a $3,000 daily transaction limit on your card, regardless of your account balance. It can temporarily be increased, upon request, by calling U.S. Bank Consumer Services.

36. What happens if the HSA has insufficient funds for payment?

Payment card transactions will not be authorized if funds are not available.

37. Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

38. What are the tax rules of an HSA?

An HSA provides you triple tax savings by allowing:

- tax deductions from gross income when you contribute to your HSA;
- tax-free earnings through interest and investments; and
- tax-free withdrawals for qualified medical expenses.

39. How are distributions taxed after the accountholder is no longer an eligible individual?

Distributions used exclusively to pay for qualified medical expenses are not taxed, whether or not the accountholder is eligible to contribute to an HSA at the time of distribution.

www.mycdh.usbank.com
877-470-1771

40. What happens to the HSA if I die?

If you are married and your spouse is a named beneficiary, s/he becomes the owner of the account and assumes it as his/her own HSA. If you are unmarried, your account will cease to be an HSA. It will pass to beneficiaries or become a part of your estate, and be subject to applicable taxes.

41. What are the income tax consequences for the beneficiary after the HSA accountholder's death?

Upon death, any balance remaining in the accountholder's HSA becomes the property of the individual named in the HSA as the beneficiary of the account. If the accountholder's surviving spouse is the named beneficiary of the HSA, the HSA is treated as though the surviving spouse were the accountholder, and distributions used for qualified medical expenses are not subject to income tax.

If, by reason of the death of the accountholder, the HSA passes to a person other than the accountholder's surviving spouse, the HSA ceases to be an HSA as of the date of the accountholder's death, and the person is required to include in gross income the fair market value of the HSA assets as of the date of death.

42. Who is responsible for determining whether HSA distributions are used exclusively for qualified medical expenses?

As the HSA accountholder, you must ensure that distributions are used for qualified medical expenses. Records of medical expenses should be maintained as evidence that distributions have been made for these purposes. You are responsible for ensuring contributions to the HSA do not exceed IRS limits.

43. If I change employers, what happens to my HSA?

Since you are the owner of the HSA, you may continue to maintain the account if you change employers.

44. How will HSA summaries be delivered and how frequently?

Periodic HSA summaries itemizing deposits and withdrawals will be available on-line or you may opt to receive paper statements at an additional fee. A monthly summary is provided for any month in which a transaction (other than interest) is made.

45. Can I reimburse myself with HSA funds for qualified medical expenses incurred prior to my enrollment in an HSA?

No. Qualified medical expenses may only be reimbursed, tax-free, if the expenses are incurred after the date your HSA was established.

Your vision coverage depends on which medical plan you enroll in.

1. **Enroll in a traditional HMO plan**

   If you enroll in a traditional HMO plan though Kaiser, Western Health Advantage or Sutter Health Plus, your medical plan includes vision.

   **Kaiser HMO enrollees have vision benefits through Kaiser.*

   WHA and Sutter HMO enrollees have vision benefits through VSP.

2. **Enroll in a high deductible plan or waive medical**

   If you waive County medical coverage or enroll in a High Deductible HMO plan, you do not have vision benefits. You can purchase vision coverage separately. Benefits are through VSP.

2016 PAY PERIOD COST FOR OPTIONAL VISION

Single $2.52

Family $6.46

VSP
Vision care for life

Your Vision Benefit Summary

Keep your eyes healthy with COUNTY OF SACRAMENTO and VSP® Vision Care.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** You can choose to see any eyecare provider—your local VSP doctor, a retail chain affiliate, or any other provider. To find a VSP doctor or retail chain affiliate, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor or retail chain affiliate.

Diabetic EyeCare

Annual eye exams can help prevent diabetes-related blindness. If you have type 1 or type 2 diabetes, you can get both your routine and diabetic eyecare from your VSP doctor—the one who knows your eyes best. Ask your VSP doctor for details.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, ck Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more. Visit **vsp.com** to find a doctor who carries these brands.

Plan Information

VSP Coverage Effective Date: 01/01/2014
VSP Doctor Network: VSP Choice

Diabetic EyeCare Copay: $20

New for 2014, you automatically get an extra $20 to spend when you choose a featured frame brand like bebe®, ck Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more. Visit vsp.com for more information.

Benefit	Description	Copay
Your Coverage with VSP Doctors and Affiliate Providers*		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$15 for exam and glasses
Prescription Glasses		
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands (see below) • 20% off amount over your allowance • $70 allowance at Costco® Optical • Every other calendar year	Combined with exam
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Combined with exam
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options • Every calendar year	$55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation) • Every calendar year	$0
Additional Coverage	• Diabetic Eyecare Plus Program	
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. **Retinal Screening** • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $45	Lined Trifocal Lenses.....up to $65
Frame.....up to $70	Progressive Lenses.....up to $50
Single Vision Lenses.....up to $30	Contacts.....up to $105
Lined Bifocal Lenses.....up to $50	

***Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details.**
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

All employees automatically have employee-only dental coverage through Delta Dental.

- You have 30 days from your date of hire or rehire to enroll your spouse, domestic partner or children.

- You must submit documentation that indicates your dependents legal relationship to you within 7 days of enrolling.

The County pays the full cost of the monthly premium for you and any enrolled family members.

There is no paycheck deduction for dental coverage.

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age **26**.		
Deductibles Deductibles waived for D & P?	**$25** per person / **$75** per family each calendar year **Yes**		
Maximums	In-network: **$2,500** per person each calendar year Out-of-network: **$2,000** per person each calendar year		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	**100 %**	**80 %**
Basic Services Fillings, simple tooth extractions, sealants	**90 %**	**80 %**
Endodontics (root canals) Covered Under Basic Services	**90 %**	**80 %**
Periodontics (gum treatment) Covered Under Basic Services	**90 %**	**80 %**
Oral Surgery Covered Under Basic Services	**90 %**	**80 %**
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, implants	**80 %**	**80 %**
Orthodontic Benefits Adults and dependent children	**50 %**	**50 %**
Orthodontic Maximums	**$ 1,500** Lifetime per person	**$ 1,500** Lifetime per person

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This is a retirement savings plan designed to supplement your County Retirement income.

- You can enroll anytime by contacting Fidelity at 800-343-0860.

You designate the amount deducted from your paycheck. The deduction amount can be changed at any time.

Invest some of what you earn today for what you plan to accomplish tomorrow.

It is our pleasure to offer you the opportunity to enroll in the Deferred Compensation Plan. Your retirement savings plan offers a convenient, tax-advantaged way to save for retirement.

Benefit from:

Convenience. Your contributions are automatically deducted regularly from your paycheck.

Tax savings now. Your pretax contributions are deducted from your pay before income taxes are taken out. This means that you can actually lower the amount of current income taxes you pay each period. It could mean more money in your take-home pay versus saving money in a taxable account.

Investment options. You have the flexibility to select from investment options that range from more conservative to more aggressive, making it easy for you to develop a well-diversified investment portfolio.

Online beneficiary. With Fidelity's Online Beneficiaries Service, you can designate your beneficiaries, receive instant online confirmation, and check your beneficiary information virtually any time.

Catch-up contributions. If you make the maximum contribution to your plan account, and you are 50 years of age or older during the calendar year, you can make an additional "catch-up" contribution of $5,500 in 2014. In addition, during one or more of the last 3 years before normal retirement age, you may be limited to using the greater of the 457 "last-3-years" catch-up or the age 50 catch-up.

Frequently asked questions about your plan.

Here are answers to questions you may have about the key features, benefits, and rules of your plan.

When can I enroll in the Plan?

There is no waiting period. You can enroll in the Plan at any time.

How do I enroll in the Plan?

Log on to Fidelity NetBenefits® at http://plan.fidelity.com/saccounty or call the Fidelity Retirement Benefits Line at 1-800-343-0860 to enroll in the Plan.

How much can I contribute?

Through automatic payroll deduction, you may contribute up to 99% of your eligible pay on a pretax basis, up to the annual IRS dollar limits.

What is the IRS contribution limit?

You may defer $17,000, the maximum IRS limit in 2012, which applies to all employee and employer contributions in all 457 plans in which you participate.

When is my enrollment effective?

Your enrollment becomes effective once you elect a dollar amount, which initiates deduction of your contributions from your pay. These salary deductions will generally begin with your next pay period after we receive your enrollment information, or as soon as administratively possible.

How do I designate my beneficiary?

If you have not already selected your beneficiaries, or if you have experienced a life-changing event such as a marriage, divorce, birth of a child, or a death in the family, it's time to consider your beneficiary designations. Fidelity's Online Beneficiaries Service, available through Fidelity NetBenefits®, offers a straightforward, convenient process that takes just minutes. Simply log on to NetBenefits® at http://plan.fidelity.com/saccounty and click on "Beneficiaries" in the About You section of Your Profile. If you do not have access to the Internet or prefer to complete your beneficiary information by paper form, please contact 1-800-343-0860.

What are my investment options?

To help you meet your investment goals, the Plan offers you a range of options. You can select a mix of investment options that best suits your goals, time horizon, and risk tolerance. The 33 investment options available through the Plan include conservative, moderately conservative, and aggressive funds. A complete description of the Plan's investment options and their performance, as well as planning tools to help you choose an appropriate mix, are available online at Fidelity NetBenefits.®

Fidelity Freedom K® Funds. The Plan also offers the Fidelity Freedom K® Funds that offer a blend of stocks, bonds and short-term investments within a single fund. Each Freedom K® Fund's asset allocation is based on the number of years until the fund's target retirement date. The Freedom K® Funds are designed for investors who want a simple approach to investing for retirement. Lifecycle funds are designed for investors expecting to retire around the year indicated in each fund's name. The investment risk of each lifecycle fund changes over time as each fund's asset allocation changes. The funds are subject to the volatility of the financial markets, including equity and fixed income investments in the U.S. and abroad and may be subject to risks

associated with investing in high yield, small cap, commodity-linked and foreign securities. Principal invested is not guaranteed at any time, including at or after the fund's target date.

Fidelity BrokerageLink.® For those desiring the most investment flexibility and choice, the Plan offers a self-directed brokerage option, which gives you access to individual stocks and bonds as well as many other mutual funds. A complete description of the Plan's investment options and their performance, as well as planning tools to help you choose an appropriate mix, are available online at Fidelity NetBenefits.®

What if I don't make an investment election?

We encourage you to take an active role in the the Deferred Compensation Plan and choose investment options that best suit your goals, time horizon, and risk tolerance. If you do not select specific investment options in the Plan, your contributions will be invested in the Fidelity Freedom K Fund with the target retirement date closest to the year you might retire, based on your current age and assuming a retirement age of 65, at the direction of Sacramento County. Please refer to the chart in the Investment Options section for more detail.

If no date of birth or an invalid date of birth is on file at Fidelity your contributions may be invested in the Fidelity Freedom K® Income Fund. For more information about the Fidelity Freedom K® Fund options, log into http://plan.fidelity.com/saccounty.

What "catch-up" contribution can I make?

A 457(b) plan participant may be eligible during one or more of the last 3 years before normal retirement age. You can only use the 457 "last 3 years" catch-up. The otherwise applicable contribution limit may be increased to up to twice that amount. Eligibility is dependent upon your underutilized amount and will be calculated by the plan administrator.

When am I vested?

You are always 100% vested in your own contributions to the the Deferred Compensation Plan.

Can I take a loan from my account?

Although your plan account is intended for the future, you may borrow from your account for any reason. Generally, the Deferred Compensation Plan allows you to borrow up to 50% of your vested account balance. The minimum loan amount is $1,000, and a loan must not exceed $50,000. You then pay the money back into your account, plus interest, through the Automated Clearing House (ACH) Service in monthly equal installments. Any outstanding loan balances over the previous 12 months may reduce the amount you have available to borrow. You may have two loans outstanding at a time. The cost to initiate a loan is $35.00, and there is a quarterly maintenance fee of $3.75. The initiation and maintenance fees will be deducted directly from your individual plan account. If you fail to repay your loan (based on the original terms of the loan), it will be considered in "default" and treated as a distribution, making it subject to income tax and possibly to a 10% early withdrawal penalty. Defaulted loans may also impact your eligibility to request additional loans. Be sure you understand the plan guidelines and impact of taking a loan before initiating a loan from your plan account.

To learn more about or request a loan, log on to http://plan.fidelity.com/saccounty or call the Fidelity Retirement Benefits Line at 1-800-343-0860.

Fees

The County will deduct an administrative fee of $4.55 from your account each quarter. The County may declare a "fee holiday" wherein this fee is not collected.

Can I make withdrawals from my account?

Withdrawals from the Plan are generally permitted when you terminate your employment, attain age 70½, have a unforeseeable emergency or the Plan is terminated.

Any assets distributed from your governmental 457(b) plan will be taxed as ordinary income in the year withdrawn; if you are under age 59½ at the time of the distribution, a 10% early withdrawal penalty may apply to any amounts which were rolled into the plan from an IRA or a plan other than another governmental 457(b) plan. If the distribution is eligible to be rolled over, but is not directly rolled over to an eligible plan or IRA, 20% mandatory withholding of federal income tax applies. Federal income tax will not be withheld if an eligible plan-to-plan transfer is made to another employer's 457(b) plan that accepts the transfer. Be sure you understand the federal and state tax consequences of any distribution before you initiate one. You may want to consult your tax adviser about your situation. To learn more about and/or to request a withdrawal, log on to Fidelity NetBenefits® at http://plan.fidelity.com/saccounty or call the Fidelity Retirement Benefits Line at 1-800-343-0860.

Can I move money from another retirement plan into my account in the Deferred Compensation Plan?

You are permitted to roll over eligible pretax contributions from another 401(k) plan, 401(a) plan, 403(b) plan or a governmental 457(b) retirement plan account or eligible pretax contributions from conduit individual retirement accounts (IRAs). A conduit IRA is one that contains only money rolled over from an employer-sponsored retirement plan that has not been mixed with regular IRA contributions. Call the Fidelity Retirement Benefits Line at 1-800-343-0860 or log on to Fidelity NetBenefits®at http://plan.fidelity.com/saccounty for details. You should consult your tax adviser and carefully consider the impact of making a rollover contribution to your employer's plan because it could affect your eligibility for future special tax treatments.

How do I access my account?

You can access your account online through Fidelity NetBenefits® at http://plan.fidelity.com/saccounty or call the Fidelity Retirement Benefits Line at 1-800-343-0860 to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week.

Where can I find information about exchanges and other plan features?

You can learn about loans, exchanges, and more, online through Fidelity NetBenefits® at http://plan.fidelity.com/saccounty. In particular, you can access loan modeling tools that illustrate the potential impact of a loan on the long-term growth of your account. You will also find a withdrawal modeling tool, which shows the amount of federal income taxes and early withdrawal penalties you might pay, along with the amount of earnings you could potentially lose by taking a withdrawal. You can also obtain more information about loans, withdrawals, and other plan features, by calling the Fidelity Retirement Benefits Line at 1-800-343-0860 to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week.

How do I obtain additional investment option and account information?

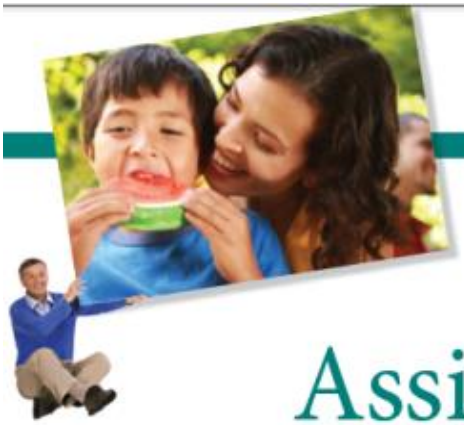
The Employer has appointed Fidelity to provide additional information on the investment options available through the Plan. Also, a statement of your account may be requested by phone at 1-800-343-0860 or reviewed online at http://plan.fidelity.com/saccounty.

Your Employee Assistance Program (EAP) benefits are provided through Managed Health Network (MHN). This program offers free counseling sessions for a variety of life's challenges.

- All employees automatically have EAP coverage through MHN.
- There is no enrollment to complete for this benefit. Eligibility is verified at the time of services for you and your family members.
- Your dependents are eligible for coverage even if they are not enrolled in any of your other benefits.

The County pays the full cost of the monthly premium for you and your family members.

There is no paycheck deduction for EAP coverage.



MHN
A Health Net Company℠

Your Employee Assistance Program

Michael McClusky, RPh, Health Net
We help MHN members get the most from their benefits and services.

How can we help?

Life can be complicated. With MHN, getting help is easy.

Your EAP is here to help with life's many challenges. MHN provides the following services, paid for by your employer.

Problem-solving support

Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about your use of alcohol or drugs.

When you call, you can speak with a clinician immediately. Or, you can make an appointment that works for you:

- **Face-to-face sessions** – Meet with a provider from our network (for example, a counselor, marriage and family therapist or psychologist) in his or her office. We can provide a referral when you call us. You can also search for a provider on our member website.
- **Phone or web-video consultations** – Private, easy-access support by phone or web-video, provided by one of our highly qualified staff clinicians or network providers.

Remember that EAP services are not medical care or mental health treatment of any kind. If, in the course of a consultation, clinical problems are suspected, including drug or alcohol problems, we will offer a referral to appropriate medical or mental health services.

Work and life services

Our experts can help you balance your work with your life! Call us for:

- **Childcare and eldercare assistance** – We'll find out what kind of help you need caring for children or elders in your life. Then we'll give you names and numbers of providers in your area.
- **Financial services** – Talk to an advisor over the phone about:
  - Budgeting
  - Credit and financial questions (investment advice, loans and bill payments not included)
  - Retirement planning

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