

2009

Summary Of Benefits



COUNTY OF SACRAMENTO
Internal Services Agency
Department of Personnel Services
Employee Benefits Office

Effective:
January 1, 2009
For Special District
Employees



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OVERVIEW

As an employee of a Special District participating in the County of Sacramento benefit plans, you have a wide variety of benefits available. These benefits include: medical, dental, and life insurance.

For some benefits the District may pay the entire cost of your coverage. For others, you may contribute all or just a portion of the cost of coverage. Your premiums will vary according to the plan and number of dependents you enroll, and/or the level of coverage you select.

These benefit programs bring considerable value to you as a Special District employee. We encourage you to thoroughly review this Employee Benefit Summary (Summary) and contact the Department of Personnel Services Employee Benefits Office with any questions you might have.

USING THIS SUMMARY

This Summary provides an overview of:

- Medical Plan options
- Dental coverage
- Life insurance
- Coverage for your dependents
- COBRA Continuation Coverage

This Summary may not address all of your specific questions. The County Department of Personnel Services Employee Benefits Office has additional, comprehensive benefit information for all of the benefit programs, which you may review at 700 H Street, Room 6750 (6th Floor), in the County Administration Center from 8:00 a.m. until 5:00 p.m., Monday through Friday, or you may call your benefit specialist at **(916) 874-2020**.

OPEN ENROLLMENT INFORMATION

Our health plan contracts allow one opportunity each year during "Open Enrollment" for all eligible employees to change health insurance plans. Employees may also add or delete dependents at this time. (See the Dependent Coverage Overview section for additional information). During Open Enrollment you may make changes in person at one of the enrollment events or via fax (874-4621) or in person at the Department of Personnel Services Employee Benefits Office, Monday through Friday, 8:00 am to 5:00 pm. Changes made during Open Enrollment are effective on January 1st of the following year.

DEPARTMENT OF PERSONNEL SERVICES

EMPLOYEE BENEFITS OFFICE WEBSITE

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

<http://www.hra.saccounty.net/employ/ben/content.htm>



GENERAL INFORMATION

There are five (5) medical insurance plans from which you may choose. Details about the different types of plans available to you are contained in this Summary.

COVERAGE EFFECTIVE DATE

Medical and dental insurance are effective on the first day of the month following enrollment and receipt of the enrollment forms. Basic life insurance is effective on the first day of the month following employment upon which you are active at work on that day. Optional life insurance is effective on the first day of the month following enrollment upon which you are active at work on that day. In order to enroll in the benefit plans of your choice, enrollment forms must be submitted to the Employee Benefits Office within the first 30 days of becoming an eligible employee. If you do not enroll at the time of your initial eligibility, you will be enrolled in the "default plan." For additional information about the default plan, please contact your District.

Changes made to your health plan during Open Enrollment are effective on January 1st of the following year. For enrollment changes made due to a birth or adoption the coverage becomes effective on the date of birth or adoption. For marriage or a registered domestic partnership, the coverage is effective the first day of the month following enrollment. Refer to the particular benefit section for any special rules and coverage effective dates for dependents.

All mid-year enrollment change forms must be submitted to the Employee Benefits Office within 30 days of the event (see page 4)

ELIGIBILITY

An "Eligible Employee" is defined as:

- 1) full-time and part-time employees of Special Districts, as approved by the County Board of Supervisors.
- 2) any regular employee who temporarily transfers to a temporary position;
- 3) an elected official and his or her exempt deputy or assistant; or
- 4) a regular employee who is working full-time or part-time for the County;

A part-time employee is defined as working at least twenty (20) hours per week or forty (40) hours in a bi-weekly pay period. A full-time employee is defined as working at least forty (40) hours per week or eighty (80) hours in a bi-weekly pay period. An "eligible employee" is not an employee of a temporary agency, a contractor, or any other person who does not occupy a permanent position.

WAIVER OF COVERAGE

If you have other group health coverage, you may wish to waive the County sponsored medical benefit. The County requires you to provide documentation you have other group medical coverage.

You may waive coverage during your initial eligibility period, or within 30 days of a "change of status" event of gaining other group coverage. If you choose to waive coverage, you will be allowed to enroll in a County sponsored medical plan only if you enroll within 30 days of a mid year "change of status" event of the loss of other group coverage. Documentation of the loss of other group coverage will be required to enroll in the County provided medical benefit.

DEPENDENT COVERAGE

Medical, dental and life insurance coverage is available for your eligible dependents.

If you enroll a domestic partner, same sex spouse or children of a domestic partner or same sex spouse who are not your IRS-defined dependents, and/or other children who do not meet the IRS requirements for a dependent child, you will be required to pay applicable federal taxes on the value of the benefit (imputed income). Any dependent life insurance benefit in excess of \$2,000 is also subject to taxes based upon imputed income.

DEFINITION OF “ELIGIBLE DEPENDENT”

Eligible dependents are an employee’s lawful spouse or registered domestic partner, and unmarried children (natural, step, adopted, legal guardianship, and/or foster) of the employee or domestic partner who are under 19 years of age. Dependents attending school as full-time students in an accredited secondary school, college, or university, who are unmarried and have not attained 24 years of age are also eligible. Generally, 12 units represent full-time student status. Special rules apply for disabled dependents. Contact the Employee Benefits Office for details. Verification of full-time-student status must be submitted to the Employee Benefits Office each semester or quarter. Medical and dental eligibility will be extended through a summer break if the student was enrolled full time, completed the preceding school term, and will be attending school again in the next available term.

The term “domestic partner” as an “eligible dependent” has the same meaning as defined by Section 297 of the California Family Code.

ADDING DEPENDENTS

To add newly eligible dependents you must contact the Department of Personnel Services Employee Benefits Office within 30 days of the date of birth, adoption, adoptive placement, placement for foster

care or guardianship, return to student status, loss of other group coverage, marriage, or registration of a domestic partnership. Failure to add newly eligible dependents or present required documents within the 30-day time frame will result in your inability to add your dependents until the next Open Enrollment period.

To enroll your dependents, the following documents are required:

Spouse—a copy of your marriage certificate and your spouse’s social security number.

Domestic Partner—proof of partnership registration from the Secretary of State and your partner’s social security number.

Newborn or newly adopted/placed child—a copy of the birth certificate. The arm band, crib card, or hospital certificate of birth for a newborn up to 30 days old will also be accepted. Adoption or legal guardianship papers will satisfy the requirement for newly adopted/placed children.

Children (including the children of a domestic partner)—copies of the child’s birth certificate, the child’s social security number, and (for children ages 19 to 24 years of age) evidence of full-time-student status at an accredited secondary school, college, or university. Legal documents for guardianship, adoption, or foster placement as needed.

When you are first hired, and during Open Enrollment, if you do not have these documents, you may sign a “Dependent Certification Affidavit” that certifies that all dependents enrolled in your plan are eligible under the plan requirements. This form is available through the Employee Benefits Office.

DELETING DEPENDENTS

Except for a “change in status” event, you may only delete dependents from your medical and dental coverage during Open Enrollment. The effective date of any Open Enrollment change will be January 1st of the following year. Contact the Department of Personnel Services Employee Benefits Office to find out if you have a qualified change in status event.

For purposes of this section, a “change in status” event includes the loss of eligibility due to a dependent reaching maximum age, loss of student status, divorce, termination of a domestic partnership, or gaining other group coverage.

To maintain eligibility beyond 19 years of age, dependent children must be unmarried and meet the full-time student status requirements.

Remember that verification of full-time student status must be submitted to the Department of Personnel Services Employee Benefits Office each semester/quarter.

CONTINUATION COVERAGE PROVISIONS

While you must delete your ineligible dependent within 30 days of the loss of eligibility in order to change your medical plan premium, failure to delete your ineligible dependent within 60 days of loss of eligibility will result in a loss of continuation coverage rights (COBRA) for your dependent (see page 19 for more information).

COVERAGE FOR DEPENDENTS LIVING OUT-OF-AREA

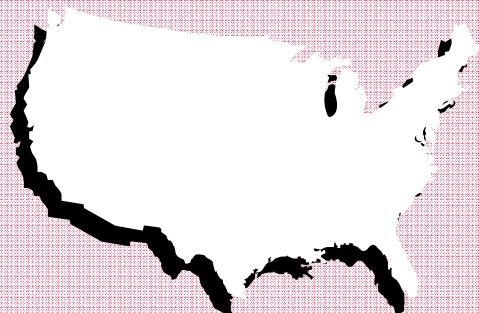
Medical

All of the County’s health insurance carriers provide a plan of benefits for dependents that live outside of the carrier’s local HMO service areas and/or in states other than California. However, in some cases, only emergency services may be available. We refer to this as “Out-of-Area” coverage. Eligibility and access through each of the health plans is different. It is very important that you choose a plan that will provide Out-of-Area coverage to meet the needs of your particular situation. Your best source of information is the toll-free customer service number for the specific plan(s). You may also obtain more details by contacting the Department of Personnel Services Employee Benefits Office.

Please refer to the benefit plan design materials for benefit comparisons, eligibility, and access. We encourage you to call the toll-free customer service number listed on page 20 of this booklet.

Dental

Dependents living out of the area may seek services from any licensed dentist. It may be necessary to pay for the dental services and submit an itemized bill along with a claim form (available from the Employee Benefits Office) to our dental plan. (See page 15 for more information about the Dental Benefits.)



MEDICARE WHILE WORKING

If you are eligible to participate in the County medical plans as an Active employee (page 3) and wish to continue working after reaching age 65, you have important options to consider when approaching Medicare eligibility. While you are still an active benefited employee under a County active medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your County active medical plan remains primary to Medicare while you are working.

MEDICARE

Medicare coverage consists of the following options:

Part A - Hospital Insurance - covers inpatient hospital stays and related services, skill nursing facilities, home health care, and hospice services. Part A entitlement is based on age, disability or End Stage Renal Disease (ESRD). For most people entitlement based on age occurs at age 65. Entitlement is automatic if you have reached age 65 and are receiving Social Security benefits. There is usually no premium cost for Part A.

However, if you are not receiving Social Security benefits you may apply for Part A benefits separately. It is recommended that you contact your local Social Security office at least 3 months before age 65 for more information.

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

Important: if you decline Part B coverage when first eligible, and you do not remain covered under a group medical plan sponsored by an employer or union, you may incur a Part B late enrollment penalty.

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

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

If you are within three (3) months of retirement, please contact the Employee Benefits Office for information on Retiree medical benefits. Retiree medical benefits have different rules associated with Medicare. Please be aware that The Department of Personnel Services Employee Benefits Office does not enroll you in any Medicare benefit.

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

MEDICAL PLANS

The County offers five (5) medical plan options designed to provide choices for employees. You may choose from three (3) traditional Health Maintenance Organization (HMO) plans, or two (2) High Deductible Health Plans (HDHP), one of which is an HMO plan, and the other is a Preferred Provider Organization (PPO) plan.

An overview of the benefit plan options offered by the County of Sacramento is included in this Summary. For detailed or specific plan information, you may call the plan's toll-free number listed on page 20 of this Summary, or you may refer to the full Evidence of Coverage booklet that is maintained in the Employee Benefits Office.

Note: Employees and all family members must be eligible for, and enrolled in, the same plan option.

HEALTH MAINTENANCE ORGANIZATION (HMO)

One of the medical plan options available to employees is called a Health Maintenance Organization or HMO. Under an HMO plan, a Primary Care Physician (PCP) generally directs all medical care and specialty referrals for members.

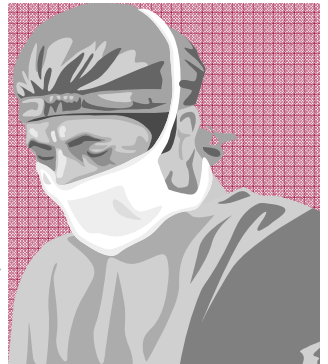
You and each of your enrolled family members select a PCP and/or Primary Medical Group (PMG). Each family member may choose his or her own PCP or PMG. Except for emergencies as defined by your medical plan, you must contact your PCP first in order for your health care to be covered. Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization.

PREFERRED PROVIDER ORGANIZATION (PPO)

The County also offers employees a medical plan called a Preferred Provider Organization (PPO). A PPO plan allows you freedom to choose your doctor without using a Primary Care Physician (PCP) and you may self-refer to specialists.

PPO plans have a calendar-year deductible, which is the amount that must be paid before benefits will be paid. After the deductible is satisfied, you must pay the coinsurance or co-payments, plus the cost of any non-covered services to the provider.

The PPO plan offered has a list of contracted providers called preferred providers. You also have the choice of using a doctor who is not under contract, or a non-preferred provider. Employees may go to any licensed physician or hospital, in or out of network, but members will receive a higher benefit when utilizing a preferred provider.



Out of network benefits are based on “usual, customary, and reasonable” (UCR) benefit schedules. Deductibles and co-pays apply to out of network benefits. You will be financially responsible for your share of non-preferred provider allowable charges. In addition, if the non-preferred provider charges more than the allowable fee or provides non-covered services, you must pay the balance of any charges that are over the allowable amount. These charges can increase your cost of care.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

A High Deductible Health Plan (HDHP) is defined by Internal Revenue Code 223(c)(2). To qualify as an HDHP, both medical (except for certain types of preventative care) and prescription expenses must apply to the deductible.

For 2008, the County offers two HDHP options to choose from; Kaiser High Deductible HMO, and Blue Shield High Deductible PPO. Please review the benefit summaries on pages 11 and 12 for more details. You will notice that the Kaiser High Deductible HMO does not provide chiropractic benefits nor does it provide lenses or frames as a vision benefit.

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

HEALTH SAVINGS ACCOUNTS

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

An HSA is not a medical plan with a carrier. It is an individual account established for your contributions and expenses.

Among the benefits of an HSA are:

- Contributions are exempt from Federal (not State) taxes;
- Interest and earnings are exempt from Federal taxes;
- Distributions are tax free when used for qualified medical expenses as listed under IRS Code 213 (d) such as co-pays, deductibles, dental and vision expenses and more (similar to the expenses you can claim in the Medical Reimbursement Account);
- Assets roll over from year to year—no “use it or lose it”;

- You can change the contribution at any time;
- The HSA is portable, so you can use the assets even if you leave County employment.

In order to be eligible to contribute to an HSA, you must:

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

*You cannot be covered as a dependent on another plan that is not also an HDHP. Also, you cannot create or contribute to an HSA account if you also have a balance in a Flexible Spending Account Medical Reimbursement Account. For more details, please contact the Department of Personnel Services Employee Benefits Office.

Even if you are no longer eligible to contribute to an HSA, whether you switch from a HDHP or leave Special District employment, your HSA account remains active for the reimbursement of qualified medical expenses until it is depleted. Non medical withdrawals are considered taxable income, and a 10% penalty for non medical withdrawals will also apply if you are under 65.

Contribution maximums are set by the IRS. For 2009, the maximums are:

<u>Coverage</u>	<u>Under Age 55</u>	<u>Age 55+</u>
Individual	\$3000.00	\$4000.00
Family	\$5950.00	\$6950.00

You are not required to have an HSA if you enroll in HDHP coverage. However, if you decide that you wish to have an HSA, you may select the institution of your choice on a post-tax basis taking a deduction when filing your itemized Federal income tax return.

Health Savings Accounts may be established at the financial institution of your choice (e.g. bank or credit union). Separate enrollment forms are required to establish an HSA.

HEALTH SAVINGS ACCOUNTS

Can my spouse and I both contribute to an HSA if we have the *same* insurance coverage?

Yes. If both you and your spouse individually meet the criteria for making an HSA contribution, you can both make HSA contributions. However, if both you and your spouse are covered by the same family coverage, you will need to allocate the HSA contribution limit between the two of you.

Can my spouse and I both establish an HSA if we have *separate* insurance coverage?

If you and your spouse have separate insurance coverage, then each of you will need to determine if you are eligible for an HSA contribution and the amount of that contribution based upon when you each enrolled in medical coverage and your age. Separate insurance coverage means that your insurance doesn't cover your spouse and your spouse's insurance doesn't cover you.

What are qualified health care expenses?

Qualified health care expenses include co-payments and deductibles at doctors, pharmacies, medical labs, dentists and orthodontists, medical supply stores, chiropractors, hospitals, vision centers, podiatrists and more. You can also use HSA funds tax-free for eyeglasses and contact lenses, mail order prescriptions, online prescriptions and eligible over-the-counter (OTC) medications.

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

Yes. However, you will be required to pay Federal income tax and a 10% penalty on the amount used for a non-medical expense (the 10% penalty does not apply if you are disabled or age 65 or older).

Can I use the money in my HSA to pay medical insurance premiums?

Generally, you cannot use your HSA to pay premiums for health insurance coverage. Exceptions include COBRA premiums, long-term care premiums or premium payments that allow you to retain health coverage while you are receiving unemployment compensation.

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

No. Health care expenses can be for yourself, your spouse or your dependent children. Your spouse and dependents do not need to be covered by the same high-deductible health plan.

How much can I contribute if my HDHP coverage starts in the middle of the year?

If you become newly eligible to contribute to an HSA during the year, you have two choices. You can prorate your contribution by dividing your maximum contribution amount by the number of months remaining in the year. Or, you can decide on the maximum full-year HSA contribution for that year (without incurring taxes or a penalty on the amount of the contribution), provided that you continue to remain eligible for a period beginning December 1 of the year in which you become eligible and ending on December 31 of the following year.

Can I change my contribution amounts during the year if I have payroll deduction?

You can change your contribution amount at any time during the year.

MONTHLY MEDICAL PLAN PREMIUMS

Kaiser Permanente HMO	Single Family	\$459.44 \$1174.92
Health Net HMO	Single Family	\$533.08 \$1363.22
Blue Shield HMO	Single Family	\$686.96 \$1758.62
Kaiser Permanente High Deductible HMO	Single Family	\$362.08 \$925.98
Blue Shield High Deductible PPO	Single Family	\$542.36 \$1301.66

MONTHLY DENTAL PLAN PREMIUM

Delta Dental of California	Single or Family	\$97.62
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HMO MEDICAL PLANS

	Blue Shield HMO Plan (#H30839)	Health Net HMO Plan (#66047)
General Plan Information		
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductibles	None	None
Annual Out-of-Pocket Limit	\$1,000 Indiv / \$2,000 Family	\$1,500 Indiv / \$4,500 Family
Office Visit/Exam	\$15 copay	\$15 copay
Outpatient Specialist Visit	\$15 copay	\$15 copay
Outpatient Services (Preventive)		
Adult Periodic Exams with Preventive Tests	100% covered	\$15 copay
Well-Child Care	100% covered	\$15 copay
Immunizations	100% covered	100% covered (80% covered occupational purposes/foreign travel)
Well Woman Exams	100% covered	\$15 copay
Mammograms	100% covered	100% covered
Diagnostic X-Ray and Lab Tests	100% covered	100% covered
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal)	100% covered	\$15 copay
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board)	100% covered (Semi-Private Room & Board)
Outpatient Facility Charge	\$50 copay	100% covered
Emergency Services		
Emergency Room	\$50 copay (waived if admitted)	\$35 copay (waived if admitted)
Mental Health Benefits		
Inpatient Care	100% covered	100% covered; limited to 30 days/ calendar year (non-severe) combined with Inpatient Substance Abuse
Outpatient Care	\$25 copay; limited to 20 visits/calendar year (non-severe) combined with Outpatient Substance Abuse. \$15 copay for severe mental health, no visit limit	\$30 copay (non-severe); limited to 20 visits/calendar year combined with Outpatient Substance Abuse; \$15 copay (severe), no visit limit
Substance Abuse		
Inpatient Hospitalization	100% covered after \$50 copay/day; limited to 30 days/ calendar year combined inpatient & partial hospitalization (residential care not covered)	100% covered; Limited to 30 days/calendar year combined with Inpatient Mental Health
Inpatient Detoxification Services	100% covered	100% covered
Outpatient Services	\$25 copay; limited to 20 visits/calendar year combined with Outpatient non-severe mental health	\$30 copay; Limited to 20 visits/calendar year combined with Outpatient Non-Severe Mental Health
Prescription Drugs		
Retail		
	30-Day Supply Limit	30-Day Supply Limit
Generic	\$10 copay	\$10 copay
Brand (Formulary/Preferred)	\$20 copay	\$20 copay
Brand (Non-Formulary/Non-preferred)	\$35 copay ²	\$35 copay
Mail Order		
	90-Day Supply Limit	90-Day Supply Limit
Generic	\$15 copay	\$15 copay
Brand (Formulary/Preferred)	\$30 copay	\$30 copay
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$50 copay
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	80% covered of allowable charges (Prosthetic Devices are 100% covered)	100% covered
Home Health Care	\$15 copay; limited to 100 visits/calendar year	\$15 copay; copay starts 31st calendar day after 1st visit
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days/calendar year	100% covered; Limited to 100 days/calendar year
Chiropractic Services	Not covered	\$5 copay; Limited to 40 visits/calendar year; \$50 annual allowance for chiro appliances
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	\$15 copay	100% covered if significant improvement is expected

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

NOTES:

² Brand Copay for Non-Formulary/Non-preferred drugs does not accrue to annual out-of-pocket maximum. If a generic drug is available and a brand drug is requested, member is responsible for the generic copay plus the difference between cost of generic and brand drug.

HMO MEDICAL PLANS

Kaiser HMO Traditional Plan (#600644)

Kaiser HMO High Deductible Plan (HDHP) (#600644)

General Plan Information		
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductibles	None	\$1,500 Indiv / \$3,000 Family ¹
Annual Out-of-Pocket Limit	\$1,500 Indiv / \$3,000 Family	\$1,500 Indiv / \$3,000 Family
Deductible Included In Out-of-pocket Limits?	N/A	Yes
Office Visit/Exam	\$15 copay	100% covered after calendar year deductible
Outpatient Specialist Visit	\$15 copay	100% covered after calendar year deductible
Outpatient Services (Preventive)		
Adult Periodic Exams with Preventive Tests	\$15 copay	100% covered, calendar yr deductible does not apply
Well-Child Care	\$15 copay for birth thru 23 months	100% covered birth thru 23 months; calendar year deductible does not apply
Immunizations	100% covered	100% covered
Well Woman Exams	\$15 copay	100% covered ; calendar yr deductible does not apply
Mammograms	100% covered	100% covered ; calendar yr deductible does not apply
Diagnostic X-Ray and Lab Tests	100% covered	100% covered after calendar year deductible
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal)	\$15 copay	100% covered ; calendar yr deductible does not apply
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board)	100% covered after calendar year deductible
Outpatient Facility Charge	\$50 copay	100% covered after calendar year deductible
Emergency Services		
Emergency Room	\$35 copay (waived if admitted)	100% covered after calendar year deductible
Mental Health Benefits		
Inpatient Care	100% covered; limited to 45 days/calendar year	100% covered after calendar year deductible; limited to 30 days/calendar year
Outpatient Care	\$15 copay/individual therapy visit; \$7 group therapy visit; limited to 20 individual & group therapy visits/calendar year. Up to additional 20 group visits that meet Medical Group criteria during same calendar year	100% covered after calendar year deductible; limited to 20 individual & group therapy visits/calendar year. Up to additional 20 group visits that meet Medical Group criteria during same calendar year
Substance Abuse		
Inpatient Hospitalization	100% covered (detox only)	100% covered (detox only) after calendar yr deductible
Inpatient Detoxification Services	100% covered	100% covered after calendar year deductible
Outpatient Services	\$15 copay/individual therapy visit; \$5 group therapy visit	100% covered after calendar year deductible
Prescription Drugs		
Retail	100-Day Supply Limit	100-Day Supply Limit
Generic	\$10 copay	100% covered after calendar year deductible
Brand (Formulary/Preferred)	\$20 copay	100% covered after calendar year deductible
Brand (Non-Formulary/Non-preferred)	N/A	N/A
Mail Order	100-Day Supply Limit	100-Day Supply Limit
Generic	\$10 copay	100% covered after calendar year deductible
Brand (Formulary/Preferred)	\$20 copay	100% covered after calendar year deductible
Brand (Non-Formulary/Non-preferred)	N/A	N/A
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	100% covered; formulary applicable	100% covered after calendar year deductible; limited to \$2,500 benefit max/calendar year; formulary applicable
Home Health Care	100% covered; limited to 100 two-hour visits/calendar year	100% covered after calendar year deductible; limited to 100 two-hour visits/calendar year
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days/calendar year	100% covered; limited to 100 days/calendar year
Chiropractic Services	\$10 copay; limited to 30 visits/calendar year	Not covered
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	\$15 copay	100% covered after calendar year deductible

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

NOTES:

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

PPO MEDICAL PLAN

Blue Shield PPO - High Deductible Health Plan (HDHP) (#975834)

General Plan Information	In-Network Schedule of Benefits	Out-of-Network Schedule of Benefits
Lifetime Plan Maximum	\$6,000,000 combined in/out of network	\$6,000,000 combined in/out of network
Annual Deductible	\$1,500 Indiv/\$3,000 Fam ¹ (combined in/out of network)	\$1,500 Indiv/\$3,000 Fam (combined in/out of network)
Annual Out-of-Pocket Limit	\$4,500 Indiv/\$9,000 Fam (combined in/out of network)	\$4,500 Indiv/\$9,000 Fam (combined in/out of network)
Deductible Included In Out-of-pocket Limits?	Yes	Yes
Coinsurance	80%	60%
Office Visit/Exam	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Specialist Visit	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Services (Preventive)		
Adult Periodic Exams with Preventive Tests	100% covered; calendar year deductible does not apply	Not covered
Well-Child Care	100% covered - birth-36 months; deduct does not apply	Not covered
Immunizations	100% covered; calendar year deductible does not apply	Not covered
Well Woman Exams	100% covered; calendar year deductible does not apply	Not covered
Mammograms	100% covered; calendar year deductible does not apply	Not covered
Diagnostic X-Ray and Lab Tests	80% covered after calendar year deductible	60% covered after calendar year deductible
Maternity Care		
Pregnancy and Maternity Care (Pre-Natal)	80% covered after calendar year deductible	60% covered after calendar year deductible
Inpatient Hospital/Surgical Services		
Inpatient Hospitalization	80% covered after calendar year deductible	60% covered after calendar year deductible
Outpatient Facility Charge	80% covered after calendar year deductible	60% covered after calendar year deductible
Emergency Services		
Emergency Room	80% covered after calendar year deductible	80% covered after calendar year deductible
Mental Health Benefits		
Inpatient Care	80% covered after calendar year deductible, combined inpatient & partial hospitalization	60% covered (severe mental health only) after calendar year deductible up to \$600 benefit max/day
Outpatient Care	50% covered after cal yr deductible (non-severe) limits apply*, 80%covered after cal yr deductible (severe)	Not covered (non-severe), 60%covered after cal yr deductible (severe)
Substance Abuse		
Inpatient Hospitalization	80% covered (for detox only) after cal yr deductible, 30 days/cal yr combined in/out network (non-detox)	60% covered (detox only) after cal yr deductible; 30 days/cal yr combined in/out of network; \$175 benefit max/day
Outpatient Services	50% covered after cal yr deductible, 20 visits/cal yr combined O/P non-severe mental health	Not covered
Prescription Drugs		
Retail		
	30-Day Supply Limit	
Generic	\$10 copay	25% + \$10 copay
Brand (Formulary/Preferred)	\$25 copay	25% + \$25 copay
Brand (Non-Formulary/Non-preferred)	\$40 copay ²	25% + \$40 copay ²
Mail Order		
	90-Day Supply Limit	
Generic	\$20 copay	Not covered
Brand (Formulary/Preferred)	\$50 copay	Not covered
Brand (Non-Formulary/Non-preferred)	\$80 copay ²	Not covered
Other Services and Supplies		
Durable Medical Equipment & Prosthetics	80% covered after cal yr deductible; \$2,000 benefit max /cal yr in & out of network (no max on prosthetics)	60% covered after cal yr deductible; \$2,000 benefit max / cal yr in & out of network (no max on prosthetics)
Home Health Care	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network
Skilled Nursing or Extended Care Facility	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network	80% covered after cal year deductible; limited to 100 preauthorized visits/cal yr combined in & out of network
Chiropractic Services	80% covered after calendar year deductible; limited 20 visits/calendar year combined in & out of network	60% covered after calendar year deductible; limited 20 visits/calendar year combined in & out of network
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	80% covered after calendar year deductible	60% covered after calendar year deductible

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

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

² Brand Copay for Non-Formulary/Non-preferred drugs does not accrue to the annual out of pocket maximum. If a generic drug is available and a brand drug is requested, member is responsible for the generic copay plus the difference between the cost of the generic and brand drug.

VISION BENEFITS

If you are enrolled in a County sponsored medical plan you also have vision benefits. The table below is a summary of the benefits provided by each plan. These benefits are provided through in network providers only.

	Blue Shield HMO Plan (#H30839)	Health Net HMO Plan (#66047)	Kaiser HMO Traditional Plan (#600644)	Kaiser HMO High Deductible Health Plan (HDHP) (#600644)	Blue Shield High Deductible PPO (#975834)
Vision Benefits					
Allowance Amount	\$100 every 24 months for frames	\$60 every 24 months for frames	\$175 every 24 months for frames & lenses combined	Not covered	\$100 every 24 months for Frames
Examination	100% covered	\$15 copay (through medical PCP referral)	\$15 copay	100% covered after calendar year deductible	100% covered
Benefit Frequency					
Examination	12 months	12 months	24 months	24 months	12 months
Lenses	24 months	24 months	24 months	Not covered	24 months
Frames	24 months	24 months	24 months	Not covered	24 months
Contacts	24 months	24 months	24 months	Not covered	24 months
PCP referral required?	No	Yes (from medical group for exam)	No	No	No
Access	Medical Eye Services (800) 877-6372	EyeMed (866) 392-6058	Kaiser Permanente (800) 464-4000	Kaiser Permanente (800) 464-4000	Medical Eye Services (800) 877-6372

¹ Vision benefits are limited to "In-Network" providers only. Refer to Plan Certificate for further details.

IMPORTANT INFORMATION ABOUT YOUR GROUP INSURANCE COVERAGE:

Your benefits are subject to the schedule of covered services as described in the applicable Evidence of Coverage (EOC) which is available through the Department of Personnel Services Employee Benefits Office. The Plan summaries on the previous pages are for comparison purposes only. Unless otherwise noted, all dollar and percentage amounts reflect your responsibility.

MEDICARE PART D

The Medicare Prescription Drug Improvement and Modernization Act of 2003 became effective on January 1, 2006. This legislation requires all employers to determine if their group prescription drug program is as good as or better than the benefit provided by the Medicare Part D prescription drug program. This is called "creditable coverage." Each participant will receive a notice indicating if the plan they have enrolled in is "creditable" or "non-creditable." This is important for individuals eligible for Medicare coverage. If you are eligible for Medicare coverage and do not have creditable coverage under a group health plan, you will be subject to penalties when you do elect Medicare Part D. **ALL COUNTY SPONSORED MEDICAL PLANS ARE "CREDITABLE."**

DENTAL BENEFITS



The County provides a comprehensive dental plan through Delta Dental of California for eligible full-time and part-time employees and their enrolled dependents. Dental benefits are effective on the first day of the month following your employment

and the receipt of your completed enrollment application by the Department of Personnel Services Employee Benefits Office. General information about your dental benefits is included in this Summary. An Evidence of Coverage booklet, that contains details about the plan, is distributed to all employees upon hire. They are also available from the Employee Benefits Office.

** As required by Federal tax law, federal axes must be paid if you enroll a dependent that does not meet the IRS definition of a dependent. These taxes are based upon the value of the benefit (imputed income).*

What if I already have dental insurance?

Even if you have other group dental coverage, you still must enroll in the Sacramento County Employee Dental plan as your primary dental plan. "Coordination of Benefits" rules will be applied in determining how benefits will be paid. You may find that many dental services will be paid in full between your two dental plans.

What if both my spouse/domestic partner and I are eligible for this benefit?

You are encouraged to evaluate the benefits of you both enrolling all members of your family in the County's Dental Plan since the Plan will provide full coordination of benefits for married couples and domestic partners who are both eligible to participate in this plan.

How does the plan pay?

This plan provides three levels of benefit:

If you receive services from a Delta PPO dentist (formerly called Delta Preferred Option), the plan will pay 100% of the preventative and diagnostic services; 90% for basic services; and 80% for major services.

If you receive services from a non-PPO Delta dentist, the plan will pay 80% of preventative and diagnostic services; 80% for basic services; and 80% for major services.

If you receive services from a non-Delta dentist, the plan will pay 80% of covered services based upon the Maximum Plan Allowance as defined by Delta Dental. Any amount over the amount paid by Delta Dental is your financial responsibility.

Is there a deductible?

There is a \$25 per person calendar-year deductible. The maximum family deductible is \$75 per policyholder per calendar year. The deductible will be waived in the third year of coverage for any member who has had two (2) preventive cleanings in each of the two (2) previous calendar years, provided there is not a break in coverage under this plan. The deductible will continue to be waived as long as you receive two cleanings per plan year.

How much will the plan pay each year?

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

LIFE INSURANCE

Your District provides a Basic life insurance benefit to all eligible employees. This coverage is effective on the first day of the month following your employment provided that you are active at work on that day. You may also purchase additional coverage through payroll deduction.

AMOUNT OF LIFE INSURANCE

Your District provides a Basic life insurance benefit at no premium cost to you. The Basic life insurance includes the dependent coverage for enrolled dependents. The Basic benefit paid by your District is either \$15,000, \$18,000 or \$50,000, depending upon your classification.

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

*Must pay taxes on imputed income

**Domestic Partner/Same sex spouse and dependents of a domestic partner/Same sex spouse must be enrolled.

All Special District employees covered under the Basic life benefit have Accidental Death & Dismemberment (AD&D) benefits equal to the amount of District paid life insurance. Please refer to "Your Group Life Insurance Plan" booklet for details.

OPTIONAL LIFE INSURANCE OPTONS

The choices in the optional life insurance program are:

Option A - 1 times your annualized salary, up to \$50,000 (This Option includes your Basic Coverage).

Option B - 1 times your annualized salary, up to \$500,000, plus your Basic Coverage.

Option C - 2 times your annualized salary, up to \$500,000, plus your Basic Coverage.

Option D - 3 times your annualized salary, up to \$500,000, plus your Basic Coverage.

Premiums for any optional life coverage you select will be deducted post-tax from your paycheck and are determined by your age and your annualized salary. For newly eligible employees, there is no medical underwriting if you enroll within 30 days of eligibility.

COST OF OPTIONAL INSURANCE

The cost of the optional life coverage is based upon your annualized salary and your age. You can determine the cost of the optional coverage utilizing the following table (the premium listed is the cost per thousand (\$1,000) of employee-paid life insurance per month):

AGE	PREMIUM
Under 30	\$0.038
30—34	\$0.050
35—39	\$0.076
40—44	\$0.088
45—49	\$0.146
50—54	\$0.223
55—59	\$0.379
60—64	\$0.595
65—69	\$1.151
70 or older	\$1.859

Example:

Non-management employee is age 43 on January 1, 2009.

Employee's annualized salary is \$43,257.

Employee chooses Option C (2 times annualized salary).

\$15,000 Basic life insurance is provided by the County – at no cost to employee.

Calculation:

Two times employee's salary is \$86,514.

Salary rounded up to nearest \$1,000 is \$87,000.

Monthly premium for a 43-year-old employee is \$7.66/month. (\$0.088 [from the rate table] times 87 (the number of \$1,000 of coverage) equals \$7.66).

Employee's premium is \$3.83 per payday. A deduction of \$3.83 will be taken the first two paydays in each month.

The employee's total life insurance coverage would be \$102,000 (\$87,000 optional + \$15,000 basic).

“AGE-RATED” PREMIUMS

Your premium for the same amount of life insurance will stay the same only as long as you remain within the same age bracket. It will change when you age into a new age bracket. If the employee in the example has no salary change, in two years the employee will be age 45 and move into the next age bracket. At that time the employee's life insurance premium would increase from \$7.66/month to \$12.70/month (from \$3.83/pay day to \$6.35/pay day). (Calculation: \$0.146 times 87 equals \$12.70).

PREMIUMS BASED UPON SALARY

If the employee in the example above at age 43 receives a 3% salary increase, the annualized salary would be \$44,554.71. Two times \$44,554.71 is \$89,109.42; rounded up to the nearest \$1,000 would be \$90,000. The premium would increase to \$7.92 month or \$3.96/pay day. (Calculation: \$0.088 times 90 equals \$7.92.)

CHANGING COVERAGE AMOUNTS

You may decrease the optional life insurance coverage at any time. To increase coverage, you must complete an application for additional coverage and submit the application to the insurance company. The effective date of coverage is the date ING/ReliaStar Life approves your application, provided that you are active at work on that day. Requests for changes must be made in person at the Department of Personnel Services Employee Benefits Office. You must provide picture ID at the time you make the change.

DEPENDENT COVERAGE

Employees covered under the Basic life insurance are eligible to receive a dependent coverage benefit of \$2,000 or \$5,000 for their spouse/domestic partner and dependent children (including the dependents of a domestic partner) age six months to age 19. Dependents attending school as full-time students in an accredited secondary school, college, or university, who are not yet 24 years of age and are unmarried, are also covered. For infants less than six months of age, the benefit is reduced. Please refer to “Your Group Life Insurance Plan” booklet for details.

Although there is no direct cost to cover a dependent, the Internal Revenue Code requires that federal taxes be paid on the value (imputed income) of the total benefit if the benefit exceeds \$2,000, or when the coverage applies to a same sex spouse, domestic partner or the dependents of same sex spouse or domestic partners that are not your IRS defined dependents. In these situations dependents must be enrolled in the life insurance plan to be covered under this plan and in order to calculate the taxes and receive the benefit.

Where enrollment is required, new spouses, domestic partners, and dependent children must be enrolled within 30 days of initial employment and/or a “change in status” event. Dependents may also be enrolled during Open Enrollment. Spouses, domestic partners, and dependent children may be deleted from coverage at any time.

For example:

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

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

AGE	VALUE PER PAY PERIOD FOR \$5,000 OF LIFE INSURANCE
Under 25	\$.13
25—29	\$.15
30—34	\$.20
35—39	\$.23
40—44	\$.25
45—49	\$.38
50—54	\$.58
55—59	\$1.08
60—64	\$1.65
65—69	\$3.18
70 or older	\$5.15

Based upon 24 pay periods with “rounding”

The value of the spouse’s benefit each pay period is \$.25.

The value of the child’s benefit each pay period is \$.13.

Federal taxes must be withheld on the \$.38 each pay period (\$.25 for the spouse’s benefit and \$.13 for the child’s benefit).

ACCELERATED DEATH BENEFIT

The life insurance program includes an accelerated death benefit, that allows terminally ill participants to withdraw up to one-half (1/2) of their total benefit amount, to a maximum of \$100,000, to assist with medical or living expenses. Please refer to the “Your Group Life Insurance Plan” booklet for further details. This booklet is available in the Department of Personnel Services Employee Benefits Office.

WAIVER OF PREMIUM

If you become disabled while you are covered under this plan, you may apply for a waiver of premium. That is, your benefit may continue while you are disabled without having to continue to pay the premium.

BENEFICIARIES

You may change your beneficiary at any time. You may obtain a change of beneficiary from on line at the County Employee Benefits Website, or by coming into the Employee Benefits Office at 700 H Street, 6th Floor, Room 6750.

CONVERSION / PORTABILITY

When your employment ends, your life insurance coverage will terminate at the end of the month in which you terminate employment. You may be eligible to convert to an individual life insurance policy. The Employee Benefits Office will provide you with information regarding requests for life insurance conversion information with your COBRA notification.



CONTINUATION COVERAGE

What is Continuation of Coverage?

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

Who is eligible for Continuation Coverage?

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

Generally, each person losing their health and/or dental, coverage has an independent right to this coverage.

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

What benefit plans can be continued?

Subject to certain limitations you may elect to continue your Medical and/or Dental plan at your own expense. You will receive a notice that explains the benefits you may continue, the election time frames, the cost, and the length of time that you may continue your coverage.

What should I do when there is a qualifying event?

Your department will notify the Department of Personnel Services Employee Benefits Office of your termination or reduction in hours. You must notify our office within 60 days of the date of the qualifying event for your dependent to be eligible to continue coverage. It is the responsibility of each employee or covered family member to inform the Employee Benefits Office within 60 days of a qualifying event (a dependent's loss of dependent status, divorce, death) to be eligible to continue coverage.

How long can benefits continue under Continuation Coverage?

Coverage may generally be continued for up to 36 months under a combination of Federal and State (CalCOBRA) benefits continuation laws. For information on CalCOBRA, you should contact the insurance carrier directly.

What if I have questions about Continuation of Coverage?

Direct your questions about your Continuation of Coverage rights to:

Department of Personnel Services
Employee Benefits Office
Continuation of Coverage
700 H Street, 6th Floor, Room 6750
Sacramento, CA 95814
Phone: (916) 874-5480
PSDbenefits@saccounty.net

CONTACTS

Contact

Phone

E-mail or Web Site

County Employee Benefits Office.....(916) 874-2020
COBRA (County COBRA Coordinator).....(916) 874-5480

PSDbenefits@saccounty.net
PSDbenefits@saccounty.net

Dental Plan

Delta Dental (800) 765-6003

www.deltadentalca.org

Health Plans

Blue Shield HMO.....(800) 642-6155
Blue Shield PPO (800) 642-6155
Blue Shield PPO Pre-Certification
(Radiology) (888) 642-2583
Blue Shield PPO Mental Health and
Substance Abuse Pre-Certification (877) 263-7178
Blue Shield HMO Mental Health and
Substance Abuse Pre-Certification (877) 263-8827

www.blueshieldca.com
www.blueshieldca.com

Health Net HMO (800) 522-0088
Health Net's Mental Health & Substance Abuse..(888) 426-0030

www.healthnet.com

Kaiser Permanente HMO (800) 464-4000

www.kaiserpermanente.org

Life Insurance

Prudential (800) 524-0542

www.prudential.com

**DEPARTMENT OF PERSONNEL SERVICES
EMPLOYEE BENEFITS OFFICE
700 H Street, Room 6750
Sacramento, CA 95814
<http://hra.co.sacramento.ca.us/employ/ben/content.htm>
(916) 874-2020**