

# SACRAMENTO COUNTY



## **SUMMARY OF BENEFITS**

**Effective January 1, 2010**



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**IMPORTANT NOTICE**

Legal instruments under which the Sacramento County Retiree Medical and Dental Insurance Program for Plan Year 2010 is created provide that the plan does not create any contractual, regulatory, or other vested right or entitlement to either present or future retirees, their spouses, domestic partners, or dependents to any particular level of subsidization cost, or subsidization at all. Whether health plan offerings continue is vested within the sole discretion of the Sacramento County Board of Supervisors. Whether or not subsidization continues, and if so, the level of the subsidy, or whether or not a participating employer continues participation in the County Retiree Medical and Dental Insurance Program is vested within the sole discretion of each eligible, participating employer through agreement with the County of Sacramento.

# OVERVIEW

## USING THIS SUMMARY

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

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

**PLEASE NOTE:** This Summary is not a plan document and does not provide comprehensive information. The County Department of Personnel Services Employee Benefits Office has benefit plan enrollment and information packets, copies of the contracts, and Evidence of Coverage documents for all of the benefit programs. You may review this information at any time. The office is located at 700 H Street, 6th Floor, Room 6750, in the County Administration Center.

## OPEN ENROLLMENT

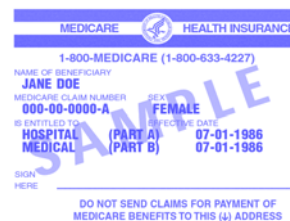
Open Enrollment for health and dental insurance is held each year in the fall (normally during the month of October). This is the one time of the year that participants in the County's health and dental insurance benefit programs may change plans or add dependents without a qualifying event, such as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

## PARTICIPATION

If you are a County retiree, or a survivor, or beneficiary receiving a monthly retirement allowance as defined by the Sacramento County Employee Retirement System (SCERS) you may participate in the retiree medical and dental insurance program whether or not you receive a subsidy/offset from the County. You may not be enrolled in a medical or dental plan as a retiree and as a beneficiary or as a spouse of another retiree.

## MEDICARE ENROLLMENT

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



## DEPARTMENT OF PERSONNEL SERVICES—EMPLOYEE BENEFITS OFFICE WEBSITE

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

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

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

# COVERAGE EFFECTIVE DATES

## MEDICAL PLAN EFFECTIVE DATE

Medical coverage becomes effective the first of the month following your retirement date and the completion of the required enrollment forms as long as you receive your first pension check within 60 days of your retirement date.

Medical plan or coverage changes made during Open Enrollment become effective on January 1st of the following year. You may also add dependents **within thirty (30) days** of a “Qualified Status Change Event.” (Some examples of a “Qualified Status Change Event” are marriage, birth, adoption, etc.) The coverage change is effective the first of the month following the completion of the forms. You may delete dependents at any time; however, you may not re-enroll them until the next Open Enrollment unless there is a “Qualified Status Change Event.” **Proof of continuous, comparable group coverage will be required** in accordance with the Retiree Health Insurance Program Administrative Policy. A copy of this policy is available through the Department of Personnel Services Employee Benefits Office.

**\*NOTE:** You have **60** days to enroll in or waive County coverage if you gain or lose either Medi-Cal or SCHIP/ Healthy Families coverage. Coverage changes will be effective first of the month following receipt of the forms in the Employee Benefits Office.

## DENTAL PLAN EFFECTIVE DATE

Enrollment for dental coverage takes place at the time of retirement. The coverage is effective the first of the month following the retirement date and the completion of the required enrollment forms as long

as you receive your first pension check within 60 days of your retirement date. You may decline enrollment at the time of retirement but you will not be allowed into the plan until the first day of the calendar year after 24 consecutive months have passed if you decide to enroll at a later date. Newly eligible dependents must be added within 30 days of eligibility if you are currently enrolled. You may waive coverage for yourself or your dependents during Open Enrollment if there has been 12 consecutive months of coverage, however you will not be allowed to re-enroll until 24 consecutive months have passed. Dependents must be deleted if they become ineligible without regard to the 12 month participation requirement.

## TERMINATION OF COVERAGE

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

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

If you are required to make direct payments for your medical and/or dental coverage and the payment is not paid within 60 days of the coverage effective date, your County-sponsored coverage will be cancelled, retroactively to the last day of paid coverage. If your coverage is terminated for non-payment of premium, you will not be permitted to re-enroll in the plan at a later date.

# ELIGIBILITY

## COVERAGE ELIGIBILITY

### Retiree

All County annuitants (and annuitants of Special Districts that have elected to participate) are eligible to participate in the Retiree Health and Dental Insurance Program. Annuitants may elect to enroll their eligible dependents in the medical and/or dental insurance plan. You may not be enrolled in a medical or dental plan as a retiree and as a beneficiary or as a spouse of another retiree.

Initial enrollment must take place within 30 days of eligibility, however, in order to prevent a break in coverage when transitioning from an active employee to a retiree, please contact the Employee Benefits Office at least 30 days before retirement to discuss the details of your situation. In addition, if your initial pension check is delayed more than 60 days from your retirement date, your retiree coverage will not go into effect until the receipt of new enrollment forms and the commencement of your pension check. This may also prevent retroactive reinstatement of coverage. If this situation occurs and you are not able to transition directly to retiree coverage without a break, you may have a separate opportunity to keep your County coverage under COBRA (page 25).

If coverage is not elected during the initial eligibility, an annuitant may enroll within 30\* days of a Qualified Status Change Event or during the next Open Enrollment Period as defined by the County of Sacramento. **Proof of continuous, comparable group coverage will be required.**

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

### Dependents

Eligible dependents are the retiree's lawful spouse or domestic partner, and unmarried children (natural, step, adopted, legal guardianship, and/or foster) of the retiree 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 County Employee Benefits Office for details. The Benefits Office or the carrier may request verification of full-time-student status at any time. 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 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.

### Surviving Spouse or Domestic Partner Continuation Coverage

In the event of the death of a retiree, the surviving spouse, domestic partner beneficiary or minor child who will receive a continuing SCERS pension benefit may be eligible to continue medical and/or dental insurance benefits. Please contact SCERS at (916) 874-9119 or (800) 336-1711 **within 30 days of the date of death** to determine if retirement benefits can

**\*NOTE:** You have **60** days to enroll in or waive County coverage if you gain or lose either Medi-Cal or SCHIP/ Healthy Families coverage under certain conditions. Coverage will be effective first of the month following receipt of the forms in the Employee Benefits Office. See page 4 for special rules about dental coverage.

be continued. A surviving spouse/domestic partner beneficiary who is receiving a continuing SCERS pension benefit may add a newly acquired dependent to any plan within 30\* days of a "Qualified Status Change Event" or at Open Enrollment. You must contact the Employee Benefits Office to enroll in the medical and/or dental insurance plans.

## Student Coverage During Illnesses

A student who is no longer able to maintain a full time schedule due to a "serious illness or injury" can remain covered under a County plan for up to 12 months before their coverage under student status ends. Verification of the need for a leave of absence from school from a medical provider must be submitted to the Department of Personnel Services Employee Benefits Office. At the end of the maximum 12 months of extended medical leave student coverage, an additional period of coverage may be available under COBRA (see page 25 for more information).

## Adding Dependents

You must add newly eligible dependents to the medical plan within 30 days\* of the date of birth, adoption, placement, return to student status, registration of partnership, or marriage. Failure to add dependents and present required documents within this time frame will result in your inability to add your dependents until the next Open Enrollment period.



To enroll dependents you are required to present the following documents:

- Legal spouse/domestic partner - a copy of your marriage certificate/Declaration of Domestic Partnership and your spouse's/partner's social security number.
- Newborn or newly adopted/placed child - a copy of the birth certificate, the armband, or crib card for a newborn up to 30 days old is accepted. Adoption or legal guardianship papers will satisfy the requirement for newly adopted/placed children. A Social Security Number is required within 30 days.

- Children - a copy of the child's birth certificate, and the child's social security number, legal documents for guardianship, adoption, or foster placement are required.



## Deleting Dependents From Coverage

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

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

### DELETION OF COVERAGE

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

**IMPORTANT:** In situations where it is determined that the dependent lost eligibility more than 30 days in the past, the Employee Benefits Office will terminate coverage under administrative guidelines on a retroactive basis. Retroactive premiums will be refunded where possible in accordance with the terms of the contract with the carrier. Failure to delete ineligible dependents within 60 days of a change in status may result in a loss of continuation coverage (COBRA) rights for your dependent(s), AND you may also become financially responsible for the cost of premiums and any services received by your dependent(s) after the loss of eligibility.

# NON-MEDICARE PLANS

## HMO - Health Maintenance Organization

One of the medical plan options available to retirees who are not Medicare eligible is a Health Maintenance Organization or HMO. Under an HMO plan, a primary care physician (PCP) directs all medical care and specialty referrals for its members. You and each of your enrolled family members select a PCP and a primary medical group (PMG). Each member may choose a different PCP and PMG.



Except for emergencies as defined by your medical plan, you must first go to your PCP for your health care to be covered. Any specialty care you need will be coordinated through your PCP and will generally require a referral or authorization. (Under the Kaiser Permanente plan, designating a PCP is optional, but if you do not choose one, one will be assigned.) The HMO benefit comparison chart, presented later in this Summary on pages 13, 14, 16 and 17 provides an overview of some of the common benefits offered by the various HMO plans available to you. For detailed or specific information, you may call the toll-free number for the plan listed at the end of this Summary on page 27, or you may review the full Evidence of Coverage booklet for the plan, which is maintained in the Department of Personnel Services Employee Benefits Office.

Blue Shield provides a "Guest Membership" option for member(s) traveling outside the plan's service area. The travel must be for a minimum of 90 consecutive days, but no more than 180 days before returning to your permanent residence and is also

available for dependents that live out-of-state within another Blue Shield HMO service area. You must call your plan's toll-free Membership Services number to set up a Guest Membership.

## PPO - Preferred Provider Organization

The County offers a plan option called a Preferred Provider Organization or PPO. A PPO plan allows you to choose a doctor or specialist without a referral from a primary care physician.

PPO plans have a calendar-year deductible, which is the amount that must be paid by the participant(s) before covered benefits will be paid by the plan. After the deductible is satisfied, you are obligated to pay the coinsurance or co-payments and any non-covered expenses.

The Blue Shield PPO has a list of contracted providers called Preferred Providers (in-network providers). Members will reduce their out-of-pocket expenses when utilizing these providers. You also have the freedom to use an out-of-network provider. When seeing an out-of-network provider, you will be financially responsible for stated percentages of allowable charges. If the out-of-network provider charges more than the allowable fee, you must also pay the balance of any charges that are over the allowable amount. These charges can substantially increase your out-of-pocket costs.

An overview of the benefits provided under the non Medicare PPO plan is shown on page 15 and the Medicare Coordinated PPO plan is shown on page 18. More details are available by calling the plan's toll-free number listed on page 27 of this Summary.

**There are two types of PPOs offered this year, the Blue Shield PPO for Medicare participants and the Blue Shield non-Medicare High Deductible PPO.**

# HIGH DEDUCTIBLE HEALTH PLANS - HEALTH SAVINGS ACCOUNTS

## 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. High Deductible Health Plans are not available once you or a participating dependent become entitled to Medicare.

For 2010, 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 14 and 15 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 an HDHP.

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

- Contributions are exempt from Federal taxes;\*
- Investment earnings are exempt from Federal taxes;\*
- Distributions are tax free when used for qualified medical expenses as listed under IRS Code 213 (d) such as co-pays, deductibles, dental and vi-

sion expenses and more;\*

- Assets roll over from year to year—no “use it or lose it”;
- The HSA can still be used after becoming entitled to Medicare (but contributions must cease).

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

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

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

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

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

Contribution maximums are set by the IRS. For 2010, the maximums are:

<u>Coverage</u>	<u>Under Age 55</u>	<u>Age 55+</u>
Individual	\$3,050.00	\$4,050.00
Family	\$6,150.00	\$7,150.00

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

# MEDICARE PLANS

## MEDICARE ADVANTAGE PLANS

Under a Medicare Advantage Plan, also known as a “Risk” plan, the member assigns his/her Medicare benefits to the Health Maintenance Organization (HMO). With a Risk plan, the carrier contracts with Centers for Medicare and Medicaid Services (CMS) to provide the enrollee with all benefits they are entitled to under Medicare and more. CMS pays a fixed monthly amount for each person who enrolls in the plan, whether or not they use medical services.

In exchange for payment, the carrier will provide all of the services. The member agrees to receive all routine medical services through a participating physician group, pays the co-payment, and does not have to coordinate paperwork between plans.

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

The County offers a Health Net and a Kaiser Medicare Advantage Plan. These plans are designed for retirees who have enrolled in Medicare Parts A and B. Participants in this plan must also enroll in Part D through this plan. Participants may not enroll in any other Part D plan through any other carrier. This type of plan typically has the lowest premium.

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

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

## MEDICARE COORDINATED PLANS

With a Medicare Coordinated Plan, or Medicare COB (Coordination of Benefits) plan, the member chooses an HMO or PPO plan and claims are billed by the carrier to Medicare. Any outstanding balances for covered services are then processed by the HMO or PPO plan. As long as the member is following Medicare and the HMO or PPO guidelines, the member pays the co-payment or co-insurance. Medicare Coordinated Plans are available to retirees who have enrolled in Medicare Parts A and B. Participants in this plan must also enroll in Part D through this plan. Participants may not enroll in any other Part D plan through another carrier, or their County coverage will be cancelled, since under CMS rules you can only be covered under one Medicare D plan at a time.

On a Medicare COB plan, members do not assign their Medicare benefits over to the carrier, preserving their portability of their basic Medicare benefits. However, Medicare deductibles and coinsurance are not covered by the carrier when utilizing out of network services. By not assigning your Medicare benefits to your carrier, you are able to access healthcare providers outside your provider network. If you access providers who contract with Medicare but are outside of your provider network, you will be responsible for any expense above Medicare allowances for the services provided.

**Special note:** Kaiser does not allow new enrollments into their Medicare Coordinated (Cost) Plan. Any newly eligible Medicare members wishing Kaiser coverage must enroll in the Kaiser Senior Advantage Plan.

**REMEMBER:** If you or your dependent are eligible for Medicare, you must enroll in and keep Medicare Parts A and B in order to participate in the County Sponsored retiree Medical Plans. If you drop Part A and/or Part B, your county coverage will be cancelled.

# OUT-OF-AREA MEDICAL PLANS

If you and your dependents live outside of the Sacramento area, or may be moving during the 2010 calendar year, you have access to two different “Out-of-Area” plan options; Kaiser HMO and Blue Shield PPO. Kaiser enrollment outside of the Sacramento area is only possible in other Kaiser Permanente service regions. The Blue Shield PPO is the only plan available in every state. In order to ensure that you and your dependent(s) have access to comprehensive health insurance coverage, review the Out-of-Area plan description and benefits comparison to determine which plan best meets your specific needs. Sometimes it is less expensive to purchase an individual plan or a plan sponsored by an association. Detailed information about how the Out-of-Area option works may be accessed for each plan by calling the plan’s toll-free Membership Services number (see page 27).

General information regarding Out-of-Area coverage for each of the health plans is included below. **Note: The dependent and retiree must be enrolled with the same carrier.**

## BLUE SHIELD

Retirees and dependents that are permanent out-of-state residents or are living outside of an HMO service area may enroll in the Blue Shield PPO Plan. The plan allows the choice of any health care provider without using a primary care physician (PCP).

If neither the retiree nor any dependents are entitled to Medicare, the Blue Shield PPO plan is a High Deductible plan, which qualifies the retiree to establish a HSA at the financial institution of their choice. If any member covered under the Blue Shield High Deductible PPO plan becomes entitled to Medicare, only the Medicare member moves to the Medicare Coordinated PPO plan. Deductibles amounts incurred during the calendar year under the High Deductible PPO Plan will carry over to the Medicare Coordinated PPO plan.

You must contact the Department of Personnel Services Employee Benefits Office before you or a covered dependent becoming entitled to Medicare to enroll in the Medicare Coordinated Plan and avoid unnecessary premium costs, deductible expenses, or a loss of coverage.

## KAISER PERMANENTE

**It is important to note that there are significant restrictions for Out-of-Area retirees accessing Kaiser Permanente coverage.**

As a general rule, Kaiser Permanente coverage is only available to retirees and dependents that live within the geographic boundaries of a Kaiser Permanente service area in California. For out-of-state members that live in other Kaiser Permanente service regions, Kaiser Permanente has established the Kaiser Permanente Multi-site Plan (KPMP).

**An additional enrollment form is required for the KPMP.** General eligibility guidelines for both in-state and out-of-state Kaiser Permanente members are presented on the next page. If the member moves out of California, out-of-state rules apply for continuing eligibility.

**ATTENTION KPMP MEMBERS: Plan benefits may vary by region. Office visit and pharmacy co-payments may also be different. Check with the Kaiser Permanente facility in your area, or call Kaiser Permanente’s toll-free member services number for coverage details for your particular Kaiser Permanente region.**

## Kaiser Permanente (In-State) Eligibility Guidelines

*These guidelines apply to both members and their dependents.*

Living in the state	Non-Medicare	Medicare
<b>In a Kaiser Permanente Service Area</b>	Coverage is continuous. When a member turns 65, they must enroll in the Senior Advantage Plan. <u>Members must enroll in the Senior Advantage Plan through the County's Benefits Office.</u>	Members must be enrolled in Medicare A & B and in a Medicare Plan (Senior Advantage or Cost). The County is subject to a surcharge (\$927.83) if a member is not enrolled in a Medicare plan. The retiree may have to pay this surcharge.
<b>Outside of a Kaiser Permanente Service Area</b>	Members may remain with Kaiser Permanente until they turn 65. At age 65, Kaiser Permanente coverage is no longer available, per Federal regulations.	Members enrolled in the Senior Advantage plan who are currently living inside of California, but outside of the Kaiser Permanente service area, may keep their Kaiser Permanente membership at the current time. If the member moves to a new address that is also outside of the Kaiser Permanente service area, even if the member remains in California, the member will lose Kaiser Permanente coverage, per Federal regulations.

Members enrolled in the Kaiser Permanente Cost plan who are currently living inside of California but outside of the Kaiser Permanente service area, may continue their Kaiser Permanente membership at this time. The Kaiser Permanente Cost plan will again be offered in 2010; however, no new enrollments are permitted.

If you live or move out of state, you must continuously reside within the geographic boundary of another Kaiser Permanente region in order to remain a Kaiser Permanente member. The "geographic boundary" is defined by zip codes and is determined by Kaiser Permanente. All out-of-state members must enroll in the KPMP plan. **A separate KPMP enrollment form is required, even if you are a continuing Kaiser Permanente member.** Out-of-state members who are 65 years of age or older must maintain both Medicare Parts A and B, and must be enrolled in the Senior Advantage Plan. Members who are over 65 and do not have both parts of Medicare **may not** remain Kaiser Permanente members. Members who are under 65 years of age must obtain both Parts A and B upon turning 65 and must enroll in the Senior Advantage Plan.

## Kaiser Permanente (Out-of-State) Eligibility Guidelines

*These guidelines apply equally to members and their dependents.*

Living out of state	Non-Medicare	Medicare
<b>In a Kaiser Permanente Service Area</b>	Member must be enrolled in KPMP. A separate form must be completed.	Member must enroll in KPMP Senior Advantage Plan and must be enrolled in Medicare Part A & B. A separate KPMP form and Senior Advantage application is required.
<b>Outside of a Kaiser Permanente Service Area</b>	Kaiser Permanente coverage is not available. Current Kaiser Permanente members who move out-of-state will lose coverage at the end of the month. Contact the Employee Benefits Office to determine coverage options in their new state of residence.	Kaiser Permanente coverage is not available. Current Kaiser Permanente members who move out-of-state will lose coverage at the end of the month. Contact the Employee Benefits Office to determine coverage options in their new state of residence.

# PREMIUM SUBSIDY/OFFSETS

## ELIGIBILITY

Annuitants who retired for any reason on or before May 31, 2007 and who were eligible to receive a subsidy/offset at that time, are eligible to receive a County-paid medical subsidy/offset payment during calendar year 2010.

Annuitants who have previously waived coverage, or who are deemed to have waived coverage for any reason (except for non-payment of premium), shall be permitted to enroll in County-sponsored retiree coverage within 30 days of a Qualified Status Change Event or during any enrollment period specified in the sole discretion of the County, subject to all terms and conditions set forth in the policy (including proof of continuous coverage), provided such coverage is being offered to similarly situated Annuitants by the County at the time coverage under the re-enrollment request is to become effective. Similarly, eligibility for a subsidy/offset payment shall be restored provided that the County is providing subsidy/offset payments to similarly situated Annuitants at the time of the re-enrollment request.

If you are not eligible for the subsidy/offset, you may elect to purchase coverage on a self-pay basis. If you are a retiree from a Special District, contact your district to determine if a subsidy/offset is available to you.

## MEDICAL PREMIUM SUBSIDY/OFFSET RATES

**Effective: January 1, 2010 – December 31, 2010 \***

Less Than 10 Years Of Service	Less Than 15 Years, But More Than 10 Years	Less Than 20 Years, But More Than 15 Years	Less Than 25 Years, But More Than 20 Years	25 Or More Years Of Service
<b>\$72</b>	<b>\$90</b>	<b>\$108</b>	<b>\$126</b>	<b>\$144</b>

**Note: the Dental Premium Subsidy/Offset for dental coverage has been eliminated for 2010.**

## IMPORTANT NOTICE

Legal instruments under which the Sacramento County Retiree Medical and Dental Insurance Program for Plan Year 2010 is created provide that the plan does not create any contractual, regulatory, or other vested right or entitlement to either present or future retirees, their spouses, domestic partners, or dependents to any particular level of subsidization cost, or subsidization at all. Whether health plan offerings continue is vested within the sole discretion of the Sacramento County Board of Supervisors. Whether or not subsidization continues, and if so, the level of the subsidy, or whether or not a participating employer continues participation in the County Retiree Medical and Dental Insurance Program is vested within the sole discretion of each eligible, participating employer through agreement with the County of Sacramento.

Your benefits are subject to the schedule of covered services as described in the Evidence of Coverage (EOC) which is available in the Employee Benefits Office. The Plan summaries contained in this book are for comparison purposes only. Unless otherwise noted, all dollar and percentage amounts shown in this book reflect your responsibility.

# NON-MEDICARE HMO PLANS

	Blue Shield HMO Plan (#H30839)	Health Net HMO Plan (#66047)
<b>General Plan Information</b>		
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, \$30 for self referred Access+ specialist	\$15 copay
<b>Outpatient Services (Preventive)</b>		
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
<b>Maternity Care</b>		
Pregnancy and Maternity Care (Pre-Natal)	100% covered	\$15 copay
<b>Inpatient Hospital/Surgical Services</b>		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board)	100% covered (Semi-Private Room & Board)
Outpatient Facility Charge	\$50 copay	100% covered
<b>Emergency Services</b>		
Emergency Room	\$50 copay (waived if admitted)	\$35 copay (waived if admitted)
<b>Mental Health Benefits</b>		
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
<b>Substance Abuse</b>		
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 Acute 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
<b>Prescription Drugs</b>		
<b>Retail</b>		
	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 <sup>2</sup>	\$35 copay
<b>Mail Order</b>		
	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 <sup>2</sup>	\$50 copay
<b>Other Services and Supplies</b>		
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	\$10 copay; 30 visits/calendar year	\$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:**

<sup>2</sup> 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.

# NON-MEDICARE KAISER PLANS

	Kaiser HMO Traditional Plan (#600644)	Kaiser HMO High Deductible Plan (HDHP) (#600644)
<b>General Plan Information</b>		
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductibles	None	\$1,500 Indiv / \$3,000 Family <sup>1</sup>
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
<b>Outpatient Services (Preventive)</b>		
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
<b>Maternity Care</b>		
Pregnancy and Maternity Care (Pre-Natal)	\$15 copay	100% covered ; calendar yr deductible does not apply
<b>Inpatient Hospital/Surgical Services</b>		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board)	100% covered after calendar year deductible
Outpatient Facility Charge	\$15 copay	100% covered after calendar year deductible
<b>Emergency Services</b>		
Emergency Room	\$35 copay (waived if admitted)	100% covered after calendar year deductible
<b>Mental Health Benefits</b>		
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
<b>Substance Abuse</b>		
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
<b>Prescription Drugs</b>		
<b>Retail</b>	30-Day Supply Limit	30-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
<b>Mail Order</b>	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
<b>Other Services and Supplies</b>		
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	\$15 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:**

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

# NON-MEDICARE HIGH DEDUCTIBLE PPO PLAN

<b>Blue Shield PPO - High Deductible Health Plan (HDHP) (#975834)</b>		
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 <sup>1</sup> (combined in/out of network)	\$1,500 Indiv/\$3,000 Fam <sup>1</sup> (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
<b>Outpatient Services (Preventive)</b>		
Adult Periodic Exams with Preventive Tests	100% covered; calendar year deductible does not apply	Not covered
Well-Child Care	100% covered to 36 months; cal yr 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
<b>Maternity Care</b>		
Pregnancy and Maternity Care (Pre-Natal)	80% covered after calendar year deductible	60% covered after calendar year deductible
<b>Inpatient Hospital/Surgical Services</b>		
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
<b>Emergency Services</b>		
Emergency Room	80% covered after calendar year deductible	80% covered after calendar year deductible
<b>Mental Health Benefits</b>		
Inpatient Care	80% covered after calendar year deductible, combined inpatient & partial hospitalization	60% covered (severe mental health only) after calendar year deductible. \$600/day maximum allowed
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 calendar year deductible (severe)
<b>Substance Abuse</b>		
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. deduct; 30 days/cal yr. combined in/out of network/\$175 max/day (non-detox)
Outpatient Services	50% covered after cal yr deductible, 20 visits/cal yr combined outpatient non-severe mental health	Not covered
<b>Prescription Drugs</b>		
<b>Retail</b>		
	30-Day Supply Limit	30-Day Supply Limit
Generic	\$10 copay only after calendar year deductible	25% + \$10 copay only after calendar year deductible
Brand (Formulary/Preferred)	\$25 copay only after calendar year deductible	25% + \$25 copay only after calendar year deductible
Brand (Non-Formulary/Non-preferred)	\$40 copay only after calendar year deductible <sup>2</sup>	25% + \$40 copay only after calendar year deductible <sup>2</sup>
<b>Mail Order</b>		
	90-Day Supply Limit	
Generic	\$20 copay only after calendar year deductible	Not covered
Brand (Formulary/Preferred)	\$50 copay only after calendar year deductible	Not covered
Brand (Non-Formulary/Non-preferred)	\$80 copay only after calendar year deductible <sup>2</sup>	Not covered
<b>Other Services and Supplies</b>		
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. year 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 (if authorized) after cal. year deductible; limited to 100 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. year 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. Where abbreviated, "cal yr" = calendar year

**NOTES:**

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

<sup>2</sup> 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.

# MEDICARE ADVANTAGE PLANS

	Health Net HMO Seniority Plus Plan (#5738-SP)	Kaiser HMO Senior Advantage Plan (#600644-0001)
<b>General Plan Information</b>		
Lifetime Plan Maximum	Unlimited	Unlimited
Annual Deductibles	None	None
Annual Out-of-Pocket Limit	N/A	\$1,500 Indiv / \$3,000 Family
Office Visit/Exam	\$15 copay	\$15 copay
Outpatient Specialist Visit	\$15 copay	\$15 copay
<b>Outpatient Services (Preventive)</b>		
Adult Periodic Exams with Preventive Tests	\$15 copay	\$15 copay
Diagnostic X-Ray and Lab Tests	100% covered	100% covered
<b>Inpatient Hospital/Surgical Services</b>		
Inpatient Hospitalization	100% covered (Semi-Private Room & Board, including services & supplies)	100% covered (Semi-Private Room & Board, including services & supplies)
Outpatient Surgery	100% covered	\$15 copay
<b>Emergency Services</b>		
Emergency Room	\$20 copay (waived if admitted)	\$35 copay,(waived if admitted)
<b>Mental Health Benefits</b>		
Inpatient Care	100% covered; 190 days lifetime maximum	100% covered; first 190 days per lifetime as covered by Medicare. Thereafter, limited to 45 days/cal year
Outpatient Care	\$20 copay/visit for individual/group therapy	\$15 copay indiv / \$7 group
<b>Substance Abuse</b>		
Inpatient Hospitalization	100% covered	100% covered (detox only) after cal yr deductible
Inpatient Detoxification Services	100% covered	100% covered (detox only)
Outpatient Services	\$20 copay/visit for individual/group therapy	\$15 copay indiv / \$5 group
<b>Prescription Drugs</b>		
<b>Retail</b>		
	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)	N/A	N/A
<b>Mail Order</b>		
	90-Day Supply Limit	100-Day Supply Limit
Generic	\$20 copay	\$10 copay
Brand (Formulary/Preferred)	\$40 copay	\$20 copay
Brand (Non-Formulary/Non-preferred)	N/A	N/A
<b>Other Services and Supplies</b>		
Durable Medical Equipment & Prosthetics	100% covered	100% covered; formulary guidelines apply
Home Health Care	100 % covered	100% covered; part time intermittent
Skilled Nursing or Extended Care Facility	100% covered; limited to 100 days/benefit period	100% covered; limited to 100 days/benefit period
Chiropractic Services	\$15 copay; limited to 20 visits/calendar year; \$50 annual allowance for chiropractic appliances	\$15 copay; limited to 30 visits/calendar year
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	100% covered if significant improvement is expected	\$15 copay

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

# MEDICARE COORDINATED HMO PLANS

	Blue Shield HMO Coordinated Plan (H30839-0002)	Health Net HMO Coordinated Plan (66047-C)	Kaiser Permanente Cost Plan** (600644-0001)
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
Annual Deductibles	None	None	None
Annual Out-of-Pocket Limit	\$1,000 Individual / \$2,000 Family	\$1,500 Individual / \$4,500 Family	\$1,500 Individual / \$3,000 Family
Office Visit/Exam	\$15 copay	\$15 copay	\$15 copay
Outpatient Specialist Visit	\$15 copay, \$30 for self referred Access+ specialist	\$15 copay	\$15 copay
<b>Outpatient Services (Preventive)</b>			
Adult Periodic Exams w/ Preventive Tests	100% covered	\$15 copay	\$15 copay
Diagnostic X-Ray and Lab Tests	100% covered	100% covered	100% covered
<b>Inpatient Hospital/Surgical Services</b>			
Inpatient Hospitalization	100% covered (Semi-Private Room & Board, including services & supplies)	100% covered (Semi-Private Room & Board, including services & supplies)	100% covered (Semi-Private Room & Board, including services & supplies)
Outpatient Surgery	\$50 copay	100% covered	\$15 copay
<b>Emergency Services</b>			
Emergency Room	\$50 copay (waived if admitted)	\$35 copay (waived if admitted)	\$35 copay (waived if admitted)
<b>Mental Health Benefits</b>			
Inpatient Care	100% covered	100% covered; limited to 30 days/ calendar year (non-severe) combined with Inpatient Substance Abuse	100% covered; limited to 45 days/ calendar year
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 for severe mental health, no visit limit	\$15 copay individual / \$7 group; limited to 20 individual & group visits/calendar year. Up to 20 extra group visits that meet the Med Group criteria in the same calendar year
<b>Substance Abuse</b>			
Inpatient Hospitalization	100% covered after \$50 copay/day; limited to 30 days/calendar year combined with Inpatient & day treatment	100% covered; limited to 30 days/ calendar year combined with Inpatient Mental Health	Not covered
Inpatient Acute Detoxification Services	100% covered	100% covered	100% covered (detox only)
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	\$15 copay individual / \$5 group
<b>Prescription Drugs</b>			
<b>Retail</b>			
	30-Day Supply Limit	30-Day Supply Limit	100-Day Supply Limit
Generic	\$10 copay	\$10 copay	\$10 copay
Brand (Formulary/Preferred)	\$20 copay	\$20 copay	\$20 copay
Brand (Non-Formulary/Non-preferred)	\$35 copay	\$35 copay	N/A
<b>Mail Order</b>			
	90-Day Supply Limit	90-Day Supply Limit	100-Day Supply Limit
Generic	\$15 copay	\$15 copay	\$10 copay
Brand (Formulary/Preferred)	\$30 copay	\$30 copay	\$20 copay
Brand (Non-Formulary/Non-preferred)	\$50 copay	\$50 copay	N/A
<b>Other Services and Supplies</b>			
Durable Medical Equipment & Prosthetics	80% covered of allowable charges (Prosthetic Devices are 100% covered)	100% covered	100% covered; formulary applies
Home Health Care	\$15 copay; limited to 100 visits/calendar year	\$15 copay; copay starts 31st calendar day after 1st visit	100% covered; part time intermittent
Skilled Nursing Facility	100% covered; 100 days/calendar year	100% covered; 100 days/calendar year	100% covered; 100 days/calendar year
Chiropractic Services	\$10 copay; limited to 30 visits/calendar year	\$5 copay; limited to 40 visits/calendar year; \$50 annual allowance for chiropractic appliances	\$10 copay; limited to 30 visits/calendar year
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	\$15 copay	100% covered if significant improvement is expected	\$15 copay

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

\*\*The Kaiser Permanente Cost Plan is for current enrollees only. No new enrollments are permitted due to Medicare regulations.

# MEDICARE COORDINATED PPO PLAN

## Blue Shield PPO - Medicare Coordinated Plan (#975510)

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	\$250 Individual/\$500 Family (combined in/out of network)	\$250 Individual / \$500 Family (combined in/out of network)
Annual Out-of-Pocket Limit	\$2,000 Individual / \$4,000 Family	\$5,000 Individual / \$10,000 Family
Coinsurance	80% covered after calendar year deductible	50% covered after calendar year deductible
Office Visit/Exam	\$15 copay; calendar year deductible does not apply	50% covered after calendar year deductible
Outpatient Specialist Visit	\$15 copay; calendar year deductible does not apply	50% covered after calendar year deductible
Diagnostic X-Ray and Lab Tests	\$15 copay (other diagnostic testing – 80% covered after calendar year deductible)	50% covered (other diagnostic testing – 50% covered after calendar year deductible)
<b>Inpatient Hospital/Surgical Services</b>		
Inpatient Hospitalization	80% covered after calendar year deductible	50% covered after calendar year deductible; \$600/day maximum allowed
Semi-private room & board including services & supplies	80% covered after calendar year deductible	50% covered after calendar year deductible; \$600/day maximum allowed
Outpatient Surgery	80% covered	50% covered; \$350/day maximum allowed
<b>Emergency Services</b>		
Emergency Room	\$75 copay (waived if admitted) + 20% of covered charges for professional services	\$75 copay (waived if admitted) + 20% of covered charges for professional services
<b>Mental Health Benefits</b>		
Inpatient Care	80% covered after calendar year deductible	50% covered after calendar year deductible; \$600/day maximum allowed
Outpatient Care	\$15 copay severe mental health; \$25 copay non-severe mental health; limited to 20 visits/calendar year (in/out of network) combined with outpatient Substance Abuse	50% covered for severe mental health; limited to 20 visits/cal. year (in/out of network) combined with outpatient Substance Abuse; not covered for non-severe mental health;
<b>Substance Abuse</b>		
Inpatient Hospitalization	80% covered; 30 days/calendar year in/out of network combined	50% covered; 30 days/calendar year in/out of network combined; \$175/day maximum allowed
Inpatient Acute Detoxification Services	80% covered after calendar year deductible	50% covered after calendar year deductible; \$600/day maximum allowed
Outpatient Services	\$25 copay; limited to 20 visits/calendar year combined with outpatient non-severe Mental Health	Not covered
<b>Prescription Drugs</b>		
<b>Retail</b>		
	30-Day Supply Limit	30-Day Supply Limit
Generic	\$5 copay	25% plus \$5 copay
Brand (Formulary/Preferred)	\$10 copay	25% plus \$10 copay
Brand (Non-Formulary/Non-preferred)	\$25 copay <sup>1</sup>	25% plus \$25 copay
<b>Mail Order</b>		
	90-Day Supply Limit	
Generic	\$10 copay	Not covered
Brand (Formulary/Preferred)	\$20 copay	Not covered
Brand (Non-Formulary/Non-preferred)	\$45 copay <sup>1</sup>	Not covered
<b>Other Services and Supplies</b>		
Durable Medical Equipment & Prosthetics	80% covered after deductible; limited to \$2000 calendar year in/out of network combined	50% covered after deductible; limited to \$2000 calendar year in/out of network combined
Home Health Care	80% covered after deductible; limited to 100 authorized days/calendar year in/out of network combined	80% covered (only if authorized) after deductible; limited to 100 days/calendar year in/out of network combined
Skilled Nursing Facility	80% covered after deductible; limited to 100 days/calendar year in/out of network combined	50% covered after deductible if in hospital; \$600/day maximum allowed; 100 days/calendar year in/out of network combined
Chiropractic Services	\$25 copay; limited to 12 visits/calendar year in/out of network combined	50% covered; limited to 12 visits/calendar year in/out of network combined
Outpatient Rehabilitative Therapy Services (Physical, Occupational, Speech)	\$15 copay after calendar year deductible	50% 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.

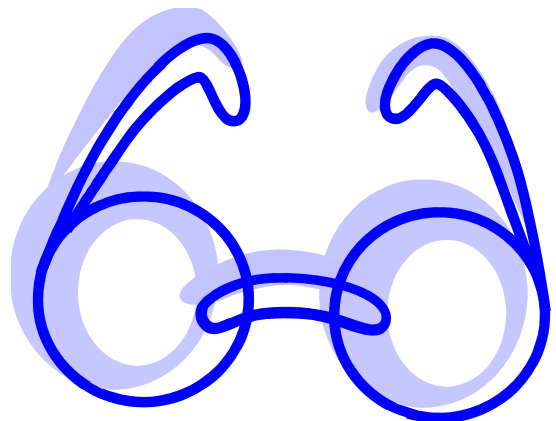
<sup>1</sup> Brand Copay for Non-Formulary/Non-preferred drugs does not accrue to annual out-of-pocket maximum. If a generic drug is available and a brand drug is requested, member is responsible for the generic copay plus the difference between cost of generic and brand drug.

# VISION COVERAGE

All of the County sponsored medical plans include a vision benefit. If you enroll in Kaiser, your vision benefits are provided through Kaiser. If you enroll in a Health Net or Blue Shield medical plan, your vision benefits are managed through Vision Service Plan (VSP). You will not have vision coverage if you waive County medical coverage.

	Vision Service Plan (VSP)	Kaiser HMO Traditional Plan	Kaiser HMO High Deductible Health Plan (HDHP)
<b>Vision Benefits</b>			
Allowance Amount	\$100 every 24 months for frames	\$175 every 24 months for frames & lenses combined	Not covered
Examination	\$15 copay (exam and materials)	\$15 copay	100% covered after calendar year deductible
<b>Benefit Frequency</b>			
Examination	12 months	24 months	24 months
Lenses	24 months	24 months	Not covered
Frames	24 months	24 months	Not covered
Contacts	24 months	24 months	Not covered

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



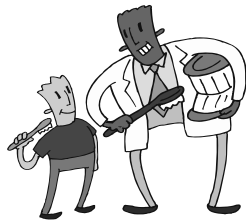
# DENTAL PLAN

## VOLUNTARY DENTAL PLAN

Retirees pay 100% of the cost for themselves, their spouse/domestic partner and/or their dependent children coverage.

## DENTAL COVERAGE

All eligible retirees, survivors, or beneficiaries receiving a monthly retirement allowance as defined by the Sacramento County Employee Retirement System (SCERS) may participate in the retiree dental insurance program. You may not be enrolled in a dental plan as a retiree and as a beneficiary or as a spouse of another retiree. Retirees may elect to enroll their spouse, registered domestic partner, and/or dependent children at the time of retirement or during Open Enrollment. Spouses, domestic partners, and/or dependent children may also be added within 30\* days of a "Qualified Status Change Event" provided the 12/24 month lock has been satisfied. Children may only be enrolled as dependents of one retiree. Once you have enrolled in a



dental plan, that coverage will continue year to year until you make a change.

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

## 12/24 MONTH LOCK

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

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

Evidence of Coverage booklets, that contains details about the dental plan is available from the Employee Benefits Office.

# PLAN COSTS

## DENTAL PREMIUMS

Coverage	Retiree only	Retiree with 1 Dependent	Retiree with two or more dependents
<b>Monthly Premium</b>	\$34.90	\$64.08	\$95.50

## NON-MEDICARE PLAN PREMIUMS

### Monthly Plan Premiums

	Blue Shield HMO	Health Net HMO	Kaiser Permanente HMO	Kaiser Permanente HDHP HMO	Blue Shield HDHP PPO
Retiree Only	\$744.12	\$560.05	\$498.90	\$393.08	\$610.62
Retiree With 1 Dependent	\$1,488.22	\$1,120.09	\$997.78	\$786.20	\$1,305.06
Retiree With 2+ Dependents	\$2,105.88	\$1,584.92	\$1,411.84	\$1,112.46	\$1,867.20

## MEDICARE ADVANTAGE PLAN PREMIUMS

### Medicare Advantage HMO Plan

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

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

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

	Health Net Seniority Plus	Kaiser Permanente Senior Advantage
Retiree Only	\$288.25	\$287.14
Retiree With 1 Dependent	\$848.30	\$786.04
Retiree With 2+ Dependents	\$1,396.72	\$1,200.08

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

(Both enrolled in Advantage Plan)

	Health Net Seniority Plus	Kaiser Permanente Senior Advantage
Retiree With 1 Dependent	\$576.50	\$574.28
Retiree With 2+ Dependents	\$1,135.71	\$988.34

### Retiree AND Spouse/Domestic Partner Both Have Medicare A, B, & D

(One Enrolled In Advantage Plan And One Enrolled In HMO Coordinated Plan)

	Health Net Seniority Plus	Kaiser Permanente Senior Advantage
Retiree With 1 Dependent	\$733.54	\$972.14
Retiree With 2+ Dependents	\$1,292.75	\$1,386.20

## MEDICARE COORDINATED PLAN PREMIUMS

### Medicare Coordinated HMO Plans

The member chooses an HMO plan, and claims are billed directly by the HMO to Medicare. Any covered balances are the responsibility of the HMO. The member must follow the HMO and Medicare guidelines and is only responsible for applicable co-payments. Contact the Employee Benefits Office regarding the Medicare Part D enrollment requirements.

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

	Blue Shield HMO Coordinated	Health Net HMO Coordinated	Kaiser Permanente Cost Plan *
Retiree Only	\$468.30	\$445.29	\$685.00
Retiree With 1 Dependent	\$1212.40	\$1,005.34	\$1,183.90
Retiree With 2+ Dependents	\$1,830.06	\$1,553.76	\$1,682.80

### Both Retiree AND Spouse/Domestic Partner With Medicare A & B

	Blue Shield HMO Coordinated	Health Net HMO Coordinated	Kaiser Permanente Cost Plan *
Retiree With 1 Dependent	\$936.62	\$890.58	\$1,370.00
Retiree With 2+ Dependents	\$1,554.28	\$1,449.79	\$1,784.06

\* The Kaiser Permanente Cost Plan is for current enrollees only. No new enrollments are permitted by Kaiser Permanente due to Medicare regulations.

**OUT OF AREA  
PLAN PREMIUMS**

**No Member Enrolled In Medicare**

	<b>Blue Shield HDHP PPO</b>	<b>Kaiser Permanente KPMP*</b>
Retiree Only	\$610.62	\$639.65
Retiree With 1 Dependent	\$1,305.06	\$1,279.30
Retiree With 2+ Dependents	\$1,867.20	\$1,918.75

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

	<b>Blue Shield Coordinated PPO</b>	<b>Kaiser Permanente KPMP*</b>
Retiree Only	\$565.78	\$235.61
Retiree With 1 Dependent	\$1,799.20	\$875.26
Retiree With 2+ Dependents	\$2,545.92	\$1,514.91

**Both Retiree AND Spouse/Domestic Partner With Medicare A & B**

	<b>Blue Shield Coordinated PPO</b>	<b>Kaiser Permanente KPMP*</b>
Retiree With 1 Dependent	\$1,131.56	\$471.22
Retiree With 2+ Dependents	\$1,878.28	\$1,110.87

\* Kaiser Permanente rates for retirees living outside of California and within another Kaiser Permanente service area. Co-payments for these plans may vary.

Contact the Employee Benefits Office regarding the Medicare Part D enrollment requirements.

# CONTINUATION COVERAGE LONG TERM CARE INSURANCE

## What is Continuation of Coverage?

Federal legislation requires most employer sponsored group health plans to offer an extension of health coverage at group rates. This applies to situations in which the coverage would otherwise end due to certain Qualifying Events. This program is often referred to as "COBRA."\*

## Who is eligible for Continuation Coverage?

Any family member who loses County-sponsored group coverage due to a Qualifying Event is eligible to elect continuation coverage. Generally, each person losing coverage has an independent right to this coverage.

Domestic partners of retirees, same sex spouses and the children of domestic partners or same sex spouses are not eligible to elect to continue coverage after a loss of eligibility.

## What should I do when there is a qualifying event?

You must notify our office within 60 days of the date of the qualifying event for your dependent to be eligible to continue coverage. It is the responsibility of each retiree or covered family member to inform the Employee Benefits Office within 60 days of a qualifying event (a dependent's loss of dependent status, divorce, death) to be eligible to continue coverage.

## LONG TERM CARE INSURANCE

All retirees are eligible to apply for long-term care coverage from the State of California's CalPERS\* Long-Term Care program. A retiree's spouse, parents, parents-in-law, and siblings are also eligible to apply for this program.

This plan will help pay for care at home, in an assisted living facility, or in a nursing home. Premiums are determined by age and by plan type at the time of application. This is not a payroll deduction plan.

## What County benefit plans can be continued?

Medical and Dental coverage may be continued. If your dependent is eligible for this coverage, you will receive a notice that explains the benefits that may be continued, the election time frames, cost, and the length of time that coverage may be continued.

## How long can benefits continue under Continuation Coverage?

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

## What if I have questions about Continuation of Coverage?

Direct your questions about your Continuation of Coverage rights to:

Employee Benefits Office  
Continuation of Coverage  
700 H Street, 6<sup>th</sup> Floor, Room 6750  
Sacramento, CA 95814  
Phone: (916) 874-5480

\*Consolidated Omnibus Budget Reconciliation Act of 1985

An enrollment period is normally held in the spring and summer months of each year. For more information, you may call 1-800-758-7070 or visit the CalPERS website at:

[www.calpers.ca.gov](http://www.calpers.ca.gov)

\* CalPERS is the California Public Employees' Retirement System

# DEFERRED COMPENSATION / RETIREMENT HEALTH SAVINGS PLAN

## DEFERRED COMPENSATION

Once you have separated employment from the County of Sacramento, you are eligible to receive distributions from your deferred compensation account(s). Your options include;

- Keep your account balance in the County of Sacramento 457(b) and /or 401(a) Plan(s);
- Request a distribution of a lump sum, partial lump sum, monthly/quarterly/annual distribution or stop a distribution arrangement at any time;
- Rollover to another retirement plan such as an IRA, 401(k), etc.

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

Distributions can be made as soon as Fidelity is notified of your separation. Taxes are paid as ordinary income. The default tax amount for any distribution from your 457(b) Plan is 20% Federal and 2% State;

If you were in Recognized Employee Organization (REO) 020, 021, or Unrepresented Management (050) after 7/1/2007, you may have been eligible for the 401(a) Plan and at distribution your default tax amount is 20% Federal, 2% State and if you are under age 59 ½ you may be assessed an extra 10%.

More information about the impact of taxes on your distributions is available in IRS form 402(f) which is available at [www.irs.gov](http://www.irs.gov).

You may also contact Fidelity at 800-343-0860 or [www.fidelity.com/atwork](http://www.fidelity.com/atwork) for more information, or the Deferred Compensation Office at 916-874-2020, [www.PSDbenefits@saccounty.net](mailto:www.PSDbenefits@saccounty.net) .

**Important: Always keep your Beneficiary Form updated with any new life event (marriage, divorce, death, etc) and your address current !**

## RETIREMENT HEALTH SAVINGS PLAN

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

Benefits eligible for reimbursement consist of all Medical Expenses eligible under the Internal Revenue Code Section 213 (IRS Publication 502). Expenses include most medical insurance premiums, medical out-of-pocket expenses, Medicare Part B and D insurance premiums, dental insurance premiums, dental out-of-pocket expenses, vision insurance premiums, vision out-of-pocket expenses, qualified Long-Term Care insurance premiums, non-prescription medications allowed under IRS guidance, and other qualifying medical expenses.

There is a \$7.50 claims administration charge to your account each quarter after you leave County service. Claims for medical expenses that qualify under RHSP are submitted for reimbursement on *VantageCare Retirement Health Savings Plan Benefits Reimbursement Request Form*. This form is available from the Department of Personnel Services Employee Benefits Office, or directly from the Meritain Health, (1-888-587-9441).

Upon your death, remaining assets will be transferred to an account for continuing tax-free use by your surviving IRS eligible surviving spouse and/or dependents for their own qualifying health expenses. Please contact ICMA-RC at (800) 669-7400 or Meritain Health, Inc. at (888) 587-9441 if you have any questions.

# CONTACTS

<u>Contact</u>	<u>Phone</u>	<u>Email or Web Site</u>
<b>County Employee Benefits Office</b>	(916) 874-2020	<a href="mailto:PSDbenefits@saccounty.net">PSDbenefits@saccounty.net</a>
COBRA (County COBRA Coordinator) .....	(916) 874-5480	<a href="mailto:PSDbenefits@saccounty.net">PSDbenefits@saccounty.net</a>
<b>Deferred Compensation</b>		
County of Sacramento .....	(916) 874-2020	
Fidelity Investments.....	(800) 343-0860	<a href="http://www.fidelity.com/atwork">www.fidelity.com/atwork</a>
<b>Dental Plan</b>		
Delta Dental.....	(800) 765-6003	<a href="http://www.deltadentalca.org">www.deltadentalca.org</a>
<b>Health Plans</b>		
Blue Shield HMO.....	(800) 642-6155	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>
Blue Shield PPO.....	(800) 642-6155	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>
Blue Shield Out-Of-Area .....	(800) 642-6155	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>
Blue Shield PPO Pre-Certification (Radiology) .....	(888) 642-2583	
Blue Shield Mental Health and Substance Abuse Pre-Certification .....	(877) 263-7178	
Health Net HMO .....	(800) 522-0088	<a href="http://www.healthnet.com">www.healthnet.com</a>
Health Net's Mental Health and Substance Abuse .....	(888) 426-0030	
Kaiser Permanente HMO .....	(800) 464-4000	<a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>
<b>Retiree Health Savings Plan</b>		
ICMA-RC.....	(800) 669-7400	<a href="http://www.icmarc.org/xp/plans/sacramentorhs/">http://www.icmarc.org/xp/plans/sacramentorhs/</a>
<b>Sacramento County Employees Retirement System</b>		
SCERS Office.....	(916) 874-9119	<a href="http://www.retirement.saccounty.net">www.retirement.saccounty.net</a>
Toll Free .....	(800) 336-1711	
<b>Vision</b>		
Vision Service Plan (VSP).....	(800) 877-7195	<a href="http://www.vsp.com">www.vsp.com</a>



**DEPARTMENT OF PERSONNEL SERVICES  
EMPLOYEE BENEFITS OFFICE  
700 H Street, Room 6750  
Sacramento, CA 95814  
Phone (916) 874-2020  
Fax (916) 874-4621**

**<http://hra.co.sacramento.ca.us/employ/ben/content.htm>**