SACRAMENTO COUNTY

Special District Benefits Summary

An overview of health benefits available to employees of Special Districts

2016

INTRODUCTION

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

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

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

DISCLAIMER

This information is only a summary of the benefit options, responsibilities, and/or the opportunities to change the benefits that are available to you as a participant in the benefit programs offered by the County of Sacramento. It is not intended to be exhaustive in detail or address all of the possible regulations that govern the administration of our benefit programs. The County of Sacramento reserves the right to revise, supplement, or rescind any segment or portion of the information provided as it deems appropriate.

The benefits and the policies governing those benefits may change as legislation is revised or contract provisions are modified, and reasonable attempts will be made to inform you of those changes; however, it is your responsibility to read, understand, and comply with the County's policies, and stay informed of changes; changes will have effect regardless of whether any particular notice is received.

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

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

OVERVIEW

As an employee of a Special District participating in the County of Sacramento benefit plans, you have a wide variety of benefits available. This Summary provides an overview of:

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

COVERAGE OPTIONS

The options available to you through the County's benefit program vary from District to District. You will have different benefits available to you based upon your District's participation. Below is a list of each District and benefits that are being participated in through the County. For information on benefits that are not listed, contact your District office directly, as there may be a contract with other entities for those benefits.

	MEDICAL	DENTAL	VISION	LIFE INSURANCE
CARMICHAEL PARK	X	X	X	X
ELK GROVE CEMETARY	X	X	X	X
MISSION OAKS	X	X	X	X
ORANGEVALE PARK	X	X	X	X
SETA	X	X	X	X
SUNRISE PARK	X	X	X	X

COST OF COVERAGE

Each Special District has a unique benefit and contribution package. For some benefits your District pays the entire cost of your coverage. For others, you may contribute all or just a portion of the cost of coverage. Your premiums will vary according to the plan and number of dependents you enroll, and/or the level of coverage you select. See the last pages of this handbook for more information on the cost of these benefits.

USING THIS SUMMARY

We encourage you to thoroughly review this summary; however it may not address all of your specific questions. Contact your District Human Resources Office or the County of Sacramento Employee Benefits Office with any questions you might have.

ELIGIBILITY FOR BENEFITS

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

EMPLOYEE

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

A regular employee includes an employee who is not working full-time, but who is still considered to be in active pay status. (This includes the use of any combination of sick leave, vacation, overtime, workers' compensation, or §4850 pay.)

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 in accordance with the annual salary ordinance.

DEPENDENTS

Eligible dependents include:

- **Your spouse**-lawfully married;
- **Your domestic partner**-registered with the Secretary of State;
- **Children**-natural, step, adopted, a child that you have legal guardianship of (up to age 26), and/or foster minor children of the employee or spouse/domestic partner.
  - Your grandchildren are not eligible for coverage unless you or your spouse/domestic partner has legal guardianship or a foster placement agreement for that child.

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

INELIGIBLE DEPENDENTS

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

CHANGING COVERAGE

NEW HIRES

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

MID-YEAR LIFE EVENTS

During the year, you may experience a "qualifying event" such as marriage, divorce, domestic partnership, birth, loss or gain of group coverage, etc. For mid-year events such as a birth or adoption, the coverage becomes effective on the date of birth or adoption in accordance with HIPAA regulations, as long as you enroll and provide any required documentation timely. For all other midyear qualifying events, the coverage is effective the first day of the month following eligibility, enrollment **and** timely submission of required documentation.

After your initial enrollment you can generally only make changes to coverage during qualified "life events" and/or Open Enrollment. The change must be on account of and consistent with the event, and must be made within 30 days of the event. Documentation to verify the event is also required within 7 days of submitting your enrollment. A Social Security number is required for dependents.

Failure to complete your enrollment within 30 days or provide supporting documentation will result in your inability to make changes until the next qualified status change event or Open Enrollment. **If you do not have the supporting documentation or social security number, you still need to complete the enrollment within 30 days and request additional time for documents.**

OPEN ENROLLMENT

All employees are allowed a one-time opportunity each year during "Open Enrollment" to change health insurance plans. Employees may also add or delete dependents at this time.

If you add dependents or waive medical coverage supporting documentation is required and must be submitted to the Employee Benefits Office for final approval or your changes may not go into effect. Changes made during Open Enrollment are generally done in October and coverage is effective on January 1st of the following year.

WAIVER OF COVERAGE

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

MEDICARE WHILE WORKING

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

Medicare coverage consists of the following options:

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

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

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

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

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

MEDICAL PLANS

For employees of Districts participating in the medical program, you may choose from three (3) traditional Health Maintenance Organization (HMO) plans or three (3) High Deductible Health Plans (HDHP). Employees and dependents must be enrolled in the same plan. For 2016, your medical plan enrollment options are below:

HMO PLAN OPTIONS	HDHP PLAN OPTIONS
Kaiser Permanente HMO	Kaiser Permanente HDHP
Sutter Health Plus HMO	Sutter Health Plus HDHP
Western Health Advantage HMO	Western Health Advantage HDHP

DIFFERENCE BETWEEN HMO VS HDHP

Although there can be substantial annual savings when selecting an HDHP over a traditional HMO, there may be some important factors to consider. For family coverage, the entire deductible must be met before services are covered at 100%, even if one person has met the individual threshold. Additionally, prescriptions are charged at the full network price, and generally must be paid in full at the time of pick-up, so you could face early out of pocket expenses at the beginning of the calendar year when deductibles are reset. You can find out the cost of any ongoing prescriptions by contacting your medical carrier ahead of time.

	HMO	HDHP
Choice of Dr	Network PCP selection required	Network PCP selection required
Specialist	Requires PCP referral	Requires PCP referral
Paycheck cost	Higher cost	Lower cost
Cost for visits	Set co-pay, $15 for most services	You pay annual deductible, then plan pays 100%
Vision	Included	Option to purchase

MEDICAL PLANS

HEALTH MAINTENANCE ORGANIZATION (HMO)

One medical plan option is a Health Maintenance Organization or HMO. Under an HMO plan, a primary care physician (PCP) directs all of your medical care and specialty referrals. You and each of your enrolled family members select a PCP. Each enrolled member of the plan may choose a different PCP. If you do not choose a PCP, one will be assigned to you and each family member. You may change your PCP at any time by calling the carrier's customer service number. You will generally pay a fixed copayment at the time of care.

Some points to consider in making this choice:

• The doctor you choose becomes your primary care physician and coordinates all medical care-including hospitalization and referral to other health professionals.
• Preventive and well-care services are provided at no additional cost.
• Copayments apply to doctor's office visits and prescriptions.
• Coverage for treatment of occupational, physical, and speech therapy for rehabilitation purposes may be limited.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP)

High Deductible plans are still HMO plans requiring in-network services and a PCP. However, in a HDHP both medical (except for certain types of preventive care) and prescription expenses must apply to the deductible. High Deductible Health Plans are not available once you or an enrolled dependent become entitled to Medicare. These plans are lower in monthly premium than traditional HMO plans but have a larger initial out of pocket expense. You pay for services at the time of care. Once you reach the deductible, most services are covered at 100%. If you choose to enroll in one of the HDHP medical plans, you may also be eligible to establish a Health Savings Account (HSA).

Some points to consider in making this choice:

- With the HDHP the doctor you choose becomes your PCP and all medical care, including routine care, hospitalization, and referral to other health professionals must be coordinated under the direction of your PCP.
- Preventive care and routine physicals are provided at no additional cost.
- Coinsurance for doctor's office visits and prescriptions apply to the deductible.
- Most services are covered at 100% after you reach your deductible.

HMO PLAN COMPARISONS

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

Refer to the plans EOC for specific details on coverage and exclusions

HIGH DEDUCTIBLE HMO COMPARISONS

	Kaiser Permanente	Sutter Health Plus	Western Health Advantage
General Plan Information			
Lifetime Plan Maximum	None		
Annual Deductibles	$1,500 Individual / $3,000 Family		
Annual Out-of-Pocket Limit	$1,500 Individual / $3,000 Family		
Deductible Inc in out-of-pocket limits?	Yes		
Office Visit / Specialist Visit	100% covered after deductible		
Outpatient Services (Preventive)			
Adult Periodic Exams w Prevent Tests	100% covered Deductible Waived		
Well-Child Care			
Immunizations			
Well Woman Exams			
Diagnostic X-Ray and Lab Tests-- Deductible waived for prevent screens	100% covered after deductible		
Maternity Care			
Pregnancy/Maternity Care (Pre-Natal) Deductible Waived	100% covered		
Inpatient Hospital/Surgical Services			
Inpatient Hospitalization/ Outpatient	100% covered after deductible		
Emergency Services			
Emergency Room	100% covered after deductible		
Air or Ground Ambulance			
Mental Health Benefits			
Inpatient Care /Outpatient Care	100% covered after deductible		
Substance Abuse			
Inpatient Hospitalization	100% covered after deductible		
Outpatient Services			
Prescription Drugs			
Retail	100 Day Supply	30 Day Supply	
Generic	100% covered after deductible	100% covered after deductible	
Brand (Formulary/Preferred)			
Brand (Non-Formulary/Non-pref)	N/A		
Other Services and Supplies			
Durable Medical Equipment & Prosthetics Annual limits	100% covered after deductible; $2,500		100% covered after deductible
Home Health Care (limited to 100 visits/yr)	100% covered after ded. (3 visits per day)	100% covered after deductible	
Skilled Nursing/Extended Care Facility	100% covered after deductible/100 days per cal year		
Outpatient Rehabilitative Therapy (Physical, Occupational, Speech)	100% covered after deductible		

Refer to the plans EOC for specific details on coverage and exclusions

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a voluntary savings account used for payment of qualified medical expenses. You must be enrolled in an HDHP to be eligible to contribute to an HSA. You may enroll in an HSA at any time, and you may change or stop your contributions at any time. An HSA is not a medical plan. It is an individual account at a financial institution that you contribute to and use for payment of medical expenses.

Among the benefits of an HSA are:

- Contributions, earnings and interest are exempt from Federal (not State) taxes;
- Distributions are tax free when used for qualified medical expenses;
- Assets roll over from year to year—no "use it or lose it";
- You can change the contribution at any time;

In order to contribute to an HSA, you must:

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

OPENING AN ACCOUNT

You are not required to have an HSA if you enroll in HDHP coverage. You may select the financial institution of your choice to open an account. You make contributions to the bank on a post-tax basis, then take a deduction when filing your itemized Federal income tax return. Contribution maximums are set by the IRS. For 2016, the maximums are:

Coverage	Under Age 55	Age 55+
Individual	$3,350.00	$4,350.00
Family	$6,750.00	$7,750.00

LOSS OF ELIGIBILITY

Even if you are no longer eligible to contribute to an HSA, whether you switch from a HDHP or are no longer enrolled in a medical plan, your HSA account remains active for the payment of qualified medical expenses until it is depleted. Non-medical withdrawals are considered taxable income, and a 20% penalty will apply if you are under 65.

DENTAL BENEFITS

The County provides a comprehensive dental plan through Delta Dental of California for benefit eligible employees and their enrolled dependents.

BENEFIT LEVELS

This plan provides three levels of benefit:

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

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

DEDUCTIBLE

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

COVERAGE AMOUNT

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

ACCESSING COVERAGE

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

VISION BENEFITS

Vision coverage is available to benefit eligible employees and enrolled dependents; it is either bundled with your HMO medical plan or have the option to purchase it if you have waived medical coverage or are enrolled in one of the high deductible plans.

ENROLLMENT

You can enroll in the vision plan within 30 days of becoming a new hire, during any Open Enrollment period, or within 30 days of a qualified life event. Once coverage takes effect, you can only make changes during a life event or Open Enrollment.

BUNDLED PLANS

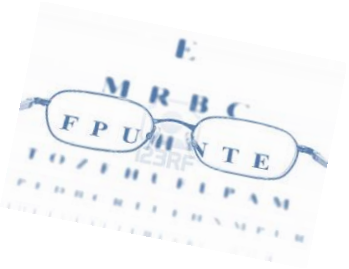
If you are enrolled in an HMO medical plan the cost and coverage for vision benefits is included with your HMO; no separate enrollment for vision is required. Any dependent also enrolled in your HMO medical plan has vision coverage.

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

OPTION TO PURCHASE

Vision benefits are not included if you enroll in a high deductible plan or you waive medical coverage; you may elect to purchase vision coverage separately. Benefits are provided by VSP.

COVERAGE	
Schedule of benefits	**VSP**
Eye exam	$15 copay
Frame allowance	$130 frames
Exam frequency	12 months
Lenses frequency	12 months
Frames frequency	24 months
Contacts frequency	12 months



LIFE INSURANCE

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

BASIC LIFE INSURANCE

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

OPTIONAL LIFE INSURANCE

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

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

INCREASING COVERAGE

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

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

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

COST OF COVERAGE

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

Age	< 30	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70+
Cost Per thousand	$.034	$.045	$.069	$.080	$.133	$.203	$.345	$.541	$1.046	$1.690

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

LIFE INSURANCE (cont'd)

Example

Employee with, annualized salary of $43,257. Employee requests Option 2; two times salary is $86,514, rounded up is $87,000. Employee is age 43; cost per thousand is $.080. ($0.080 times 87 equals $6.96 with rounding). Monthly premium is $6.96/month; premium is $3.48 per payday and will be taken the first two paydays in each month post-tax.

DECREASING COVERAGE

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

DEPENDENT COVERAGE

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

- If your District paid basic coverage is $18,000 or $50,000

  Dependents automatically have $2,000 of coverage, no enrollment is required, and there is no cost

- If your District paid basic coverage is $15,000

  You must enroll dependents for coverage, and the coverage amount is $5,000. You will be charged imputed income for this benefit. Dependents must be enrolled within 30 days of initial employment and/or a "change in status" event, or during Open Enrollment. Dependents may be deleted from life insurance coverage at any time.

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

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

Cost example:

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

The value 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).

LIFE INSURANCE (cont'd)

PREMIUM CHANGES

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

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

Changes in the premium will take effect the first day of the next month (following ageing into a new bracket or a salary increase), and you will see the change on the first paycheck of that month.

BENEFICIARY INFORMATION

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

ACCELERATED DEATH BENEFIT

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

LEAVE OF ABSENCE

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

WAIVER OF PREMIUM

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

CONVERSION / PORTABILITY

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

LEAVE OF ABSENCE

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

COMMENCEMENT OF LEAVE

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

LIFE EVENTS WHILE ON LEAVE

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

RETURNING TO WORK

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

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

CONTINUATION COVERAGE (COBRA)

What is Continuation Coverage?

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

Who is eligible for COBRA?

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

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

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

What benefits can be continued?

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

What should I do when there is a qualifying event?

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

How long can benefits continue under Continuation Coverage?

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

What if I have questions about Continuation Coverage?

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

SACRAMENTO EMPLOYMENT & TRAINING AGENCY (SETA)

WWW.HEADSTART.SETA.NET

925 Del Paso Blvd #100, Sacramento, CA 95815

Employees in benefit eligible positions have the following coverage options:

Medical coverage	Basic Life insurance*
Dental coverage*	Optional Life insurance
Optional Vision coverage	Dependent Life insurance

This chart reflects your cost for each carrier; amounts, if any, are pre-tax.

SETA	Pay Period Cost	
Carrier	Employee Only	Family
Kaiser HMO	$82.17	$453.06
Kaiser HDHP	$12.40	$274.66
Sutter HMO	$79.80	$447.13
Sutter HDHP	$7.54	$262.21
WHA HMO	$92.72	$481.01
WHA HDHP	$12.50	$275.60
Dental	$0	$0
Optional Vision	$2.52	$6.46

All benefit eligible employees have life insurance paid for by the District. Coverage amount is based upon classification.

$15,000	Regular Represented employees
$50,000	Management/Conf Non-Rep employees

***The District pays the full cost of your basic life insurance and dental coverage.**

CARMICHAEL RECREATION & PARK DISTRICT

www.Carmichaelpark.com
5750 Grant Avenue, Carmichael, CA 95608
(916) 485-5322

Employees in benefit eligible positions have the following coverage options:

Medical coverage	Basic Life insurance
Dental coverage	Optional Life insurance
Optional Vision coverage	Dependent Life insurance

This chart reflects your cost for each carrier; amounts, if any, are pre-tax.

CARMICHAEL	Pay Period Cost (Reg F/T only)	
Carrier	EMPLOYEE	WITH FAMILY
Kaiser HMO	$0	$0
Kaiser HDHP	$0	$0
Sutter HMO	$0	$0
Sutter HDHP	$0	$0
WHA HMO	$0	$0
WHA HDHP	$0	$0
Dental	$0	$0
Vision	$0	$0

Part-time employees should contact the Administrative Services Office for cost of coverage.

All benefit eligible employees have life insurance paid for by the District. Coverage amount is based upon classification.

$18,000	Non-Management employees
$50,000	Management employees

ORANGEVALE RECREATION & PARK DISTRICT

WWW.OVPARKS.COM
6826 Hazel Avenue, Orangevale, CA 95662
(916) 988-4373

Employees in benefit eligible positions have the following coverage options:

Medical coverage	Basic Life insurance*****
Dental coverage*****	Optional Life insurance
Optional Vision coverage	Dependent Life insurance

This chart reflects your cost for each carrier; amounts, if any, are pre-tax.

Orangevale	Pay Period Cost	
Carrier	Employee Only	Family
Kaiser HMO	$0	$231.03
Kaiser HDHP	$0	$182.14
Sutter HMO	$0	$229.43
Sutter HDHP	$0	$178.73
WHA HMO	$0	$238.86
WHA HDHP	$0	$182.52
Dental	$0	$0
Vision	$0	$1.77

All employees eligible for benefits have $18,000 of life insurance.

***The District pays the full cost of your basic life insurance and dental coverage.**

ELK GROVE-COSUMNES CEMETERY DISTRICT

WWW.EGCCD.COM
8540 Elk Grove Boulevard, Elk Grove, CA 95624
(916) 686-6030

Employees in benefit eligible positions have the following coverage options:

Medical coverage	Basic Life insurance*
Dental coverage*	Optional Life insurance
Optional Vision coverage	Dependent Life insurance

This chart reflects the cost for non-management employees; amounts are pre-tax.

Elk Grove Cemetery	Monthly Cost	
Carrier	EMPLOYEE	WITH FAMILY
Kaiser HMO	$0	$1,026.78
Kaiser HDHP	$0	$669.32
Sutter HMO	$0	$1,014.92
Sutter HDHP	$0	$645.08
WHA HMO	$21.10	$1,082.68
WHA HDHP	$0	$671.86
Dental	$0	$0
Vision	$5.04	$12.92

All non-management employees eligible for benefits have $15,000 of life insurance.

***The District pays the full cost of your basic life insurance and dental coverage.**

SUNRISE RECREATION & PARK DISTRICT

www.SunriseParks.com
7801 Auburn Blvd, Citrus Heights, CA 95610
(916) 725-1585

Employees in benefit eligible positions have the following coverage options:

Medical coverage Dental coverage	Optional Life insurance
Basic Life insurance*	Dependent Life insurance

This chart reflects your pay period cost for each carrier; amounts are pre-tax.

SUNRISE	Pay Period Cost	
Carrier	EMPLOYEE	WITH FAMILY
Kaiser HMO	$2.37	$5.93
Kaiser HDHP	$4.86	$12.45
Sutter HMO	$0	$0
Sutter HDHP	$0	$0
WHA HMO	$12.92	$33.88
WHA HDHP	$4.96	$13.39
Dental	$0	$0

All employees eligible for benefits have $18,000 of life insurance.

***The District pays the full cost of your basic life insurance and dental coverage.**

MISSION OAKS RECREATION PARK

WWW.MORPD.COM
3344 Mission Avenue, Carmichael, CA 95608
(916) 488-2810

Employees in benefit eligible positions have the following coverage options:

Medical coverage	Basic Life insurance*
Dental coverage*	Optional Life insurance
Optional Vision coverage	Dependent Life insurance

This chart reflects your cost for each carrier; amounts, if any, are pre-tax.

MISSION OAKS	Pay Period Cost	
Carrier	EMPLOYEE	WITH FAMILY
Kaiser HMO	$32.97	$84.31
Kaiser HDHP	$25.60	$66.47
Sutter HMO	$32.73	$83.72
Sutter HDHP	$25.51	$65.22
WHA HMO	$34.02	$87.10
WHA HDHP	$26.00	$66.56
Dental	$0	$0
Vision	$.26	$.64

All employees eligible for benefits have $18,000 of life insurance.

***The District pays the full cost of your basic life insurance and dental coverage.**

BENEFITS CONTACTS

COUNTY OFFICE	PHONE	WEBSITE
Employee Benefits Office	916-874-2020	http://www.personnel.saccounty.net/Benefits
MEDICAL CARRIERS		
Kaiser Permanente	800-464-4000	www.kp.org
Sutter Health Plus	855-315-5800	www.sutterhealthplus.com
Western Health Advantage	888-563-2250	www.mywha.org/personalaccess
OTHER VENDORS		
Delta Dental	800-765-6003	www.deltadentalins.com/cos
Prudential (Life Insurance)	800-524-0542	www.prudential.com
Prudential (Critical Illness)	877-920-4778	www.myprubenefits.com
VSP	800-877-7195	www.vsp.com

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