COUNTY OF SAN JOAQUIN

HEALTH BENEFITS SUMMARY FOR NEW EMPLOYEES

2014-15

Human Resources Division
44 N. San Joaquin St, Ste 330
Stockton, CA 95202
Telephone (209) 468-9987
Fax (209) 468-9734
employeebenefits@sjgov.org
www.sjgov.org/hr

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Summary of Medical Plans

	Select Plan	Premier Plan	Kaiser Permanente
Covered Expenses	**Plan Provisions and Participant Share of Cost Under Each Plan**		
Plan Providers	Providers in the following medical groups only: SJC Health Care Services, Sutter Gould, SJHA Focus, MedCore	All providers in the Interplan Network including SJC Health Care Services	Kaiser facilities and doctors only
Deductible (applies to all services except doctor's office visits and prescription drugs) per Plan Year	$250 per person $500 per family	$125 per person $250 per family	None
Reduced Deductible for EXCLUSIVE use of San Joaquin General Hospital providers and facilities for all services (*signed form required*)	$125 per person $250 per family (Must sign Form for Exclusive Use of SJGH)	Does not apply	Does not apply
Out-of-Pocket Maximum • Once annual maximum is reached, Plan pays 100% of eligible expenses for balance of Plan Year.	$1,000 per person $2,500 per family Certain expenses do not count toward out-of-pocket maximum.	$1,000 per person $2,500 per family Certain expenses do not count toward out-of-pocket maximum.	$1,500 per person $3,000 per family Certain expenses do not count toward out-of-pocket maximum.
Acupuncture/Chiropractor • Up to 20 visits combined per Plan year	Deductible applies Plan pays up to $25 per visit	Deductible applies Plan pays up to $25 per visit	Not covered Discounts available, contact Kaiser for details

	Select Plan	Premier Plan	Kaiser Permanente
Covered Expenses	**Plan Provisions and Participant Share of Cost Under Each Plan**		
Ambulance	Deductible applies	Deductible applies	$0
Doctor Office Visit • Physical/Preventive Exam • In-office consultation by specialist • Allergy Testing or treatment	$10 co-payment per visit $5 co-payment at Health Care Services	$5 co-payment per visit	$10 co-payment per visit
Durable Medical Equipment, Orthotics, Prosthetics	Deductible applies 50% of charges	Deductible applies 50% of charges	20% of charges
Emergency Room • Hospital facility charge – waived if admitted • Emergency Room Physician	Deductible applies $100 co-payment per visit $40 co-payment at San Joaquin General Hospital	Deductible applies $100 co-payment per visit	$100 co-payment per visit
Home Health Care	Deductible applies	Deductible applies	$0
Hospice	Deductible applies	Deductible applies	$0
Hospital Inpatient or ICU • Hospital inpatient services and supplies	Deductible applies $100 co-payment per admission, waived at San Joaquin General Hospital	Deductible applies $100 co-payment per admission, waived at San Joaquin General Hospital	$0
• Surgeon, assistant surgeon, anesthesiologist	Deductible applies	Deductible applies	$10 co-payment
• Hospital or Skilled Nursing Facility doctor visit	Deductible applies	Deductible applies	$10 co-payment
Laboratory Services	Deductible applies	Deductible applies	$0

	Select Plan	Premier Plan	Kaiser Permanente
Covered Expenses	**Plan Provisions and Participant Share of Cost Under Each Plan**		
Mental Health • Outpatient Therapy	$10 co-payment per visit	$5 co-payment per visit	$5 co-payment for group therapy visit $10 co-payment for individual therapy visit
• Inpatient/Day Care	Deductible applies $100 co-payment per admission	Deductible applies $100 co-payment per admission	$0
Outpatient Surgery Facility	Deductible applies	Deductible applies	$10 per procedure
Prescription Drugs • 30 day supply	$5 generic $15 brand on formulary Non-formulary not covered*****	$5 generic $10 brand on formulary $30 Non-formulary	$10 generic $20 brand on formulary Non-formulary not covered
• 90 day supply at pharmacy or mail order	$10 generic $30 brand on formulary Non-formulary not covered*****	$10 generic $20 brand on formulary $60 Non-formulary	$10 generic $20 brand on formulary Non-formulary not covered
Preventive Care Services Recommended under the Affordable Care Act	No charge	No charge	No charge
Rehabilitation Therapy (physical, speech, occupational therapy)	Deductible applies $10 co-payment per visit	Deductible applies $5 co-payment per visit	$10 co-payment per visit
Urgent Care Center	Deductible applies $40 co-payment per visit	Deductible applies $40 co-payment per visit	$10 co-payment per visit
X-rays	Deductible applies	Deductible applies	$0

***See information for approval of non-formulary drugs on the next page under Select Plan.**

Select Plan

The Select Plan requires that you and each of your enrolled family members choose a primary care physician from one of four medical groups: San Joaquin County Health Care Services, Sutter Gould, SJHA Focus, Physicians or MedCore. You must coordinate all of your care through your primary care physician and use specialists who are in the same medical group as your primary care physician. Certain services require prior authorization from the Claims Administrator in order to be paid. A directory of network providers is available on the County's website or at Human Resources.

Lower Your Deductible: Under the Select Plan, you and your enrolled family members can reduce your deductible by 50% by using San Joaquin General Hospital (HCS) providers and facilities **exclusively** for **all** of your medical care. If you select this option, you and all of your enrolled family members will be required to maintain this selection for the entire Plan year. **To participate in this exclusive option, you must sign a form for Reduced Deductible for exclusive use of HCS Providers.** The form is available on the County's website or at Human Resources. If you are currently enrolled in this option and wish to use providers outside of HCS, you must complete a form to revoke that option. The form is available on the County's website or at Human Resources.

Process for Approval of Non-formulary Drug: Your physician can submit a Prior Authorization Form to the Claims Administrator and request to have a non-formulary drug covered. The co-payment for approved non-formulary drugs is the same as the brand name drug co-payment.

Premier Plan

The Premier Plan requires that you and each of your enrolled family members choose a primary care physician from the Interplan Provider Directory located on the County's website. You must coordinate all of your care through your primary care physician. Certain services require prior authorization from the Claims Administrator in order to be paid.

New Requirement for Select and Premier Plans

Covered persons with End-Stage Renal Disease (permanent kidney failure) must enroll in Medicare Part B, when eligible.

Kaiser Permanente HMO Plan

Under the Kaiser Permanente HMO, you and your family may choose a primary care physician from the staff of general or family practitioners, internists, pediatricians or OB/GYN physicians. All services are provided at Kaiser Permanente medical offices and hospitals or other contracted facilities. Care received from non-Kaiser Permanente providers is limited to emergency services or urgently needed services as defined by Kaiser.

Disclaimer

This chart provides highlights of the benefits available under the plans. Certain conditions, requirements, and limitations not described in this chart apply to some of the benefits listed. Refer to the appropriate benefit booklet for more details. If there is any conflict between this chart and the official plan documents and contracts, the official plan documents and contracts will always govern.

Your Bi-Weekly Benefit Plan Premiums
Effective June 30, 2014

Plan Options	County's Share 2014-15	Employee's Share 2014-15
Medical Plans		
Select Plan		
Employee only	$325.51	81.38
Employee + 1 dependent	$651.02	$162.76
Employee + Family	$911.40	$227.89
Premier Plan		
Employee only	$325.51	$115.54
Employee + 1 dependent	$651.02	$231.08
Employee + Family	$911.40	$323.54
Kaiser Permanente		
Employee only	$236.74	$59.19
Employee + 1 dependent	$473.50	$118.37
Employee + Family	$669.99	$167.50
Dental Plans		
Delta Dental with Orthodontia		
Employee only	$23.39	$0
Employee + 1 dependent	$23.39	$22.21
Employee + Family	$23.39	$53.14
Pacific Union Dental		
Employee only	$10.79	$0
Employee + 1 dependent	$10.79	$9.72
Employee + Family	$10.79	$18.30
Vision Plan		
Vision Service Plan		
Employee only	$2.72	$0
Employee + 1 dependent	$2.72	$2.72
Employee + Family	$2.72	$7.04

Summary of Dental and Vision Plans

Dental Benefits	Delta Dental - Premier Plan	Pacific Union Dental – Sonoma Plan
Dental Providers	Any licensed dentist of your choice: 92% of dentists in California belong to Delta Dental's network	Must select a dentist from a ***limited*** network of dental offices; employee and dependents may select different dental offices.
Deductible	No Deductible	No Deductible
Benefit Maximum	$3,000 per person per calendar year	No maximum
Diagnostic and Preventive Benefits (exams, cleanings, x-rays, etc.)	Plan pays 80% of Delta dentist's fee	No charge for exams, cleanings and x-rays
Basic Benefits (extractions, fillings, root canals, periodontal treatment)	Plan pays 80% of Delta dentist's fee	Your co-payments based on specific service: Extractions: $5 - $52 Fillings: $5 - $9 Root canal: $27 - $101 Periodontal: $7 - $23
Crowns, and other Cast Restorations	Plan pays 80% of Delta dentist's fee	Your co-payments based on specific service: Crown: $70 – $122
Prosthodontic Benefits (bridges, partial dentures, full dentures)	Plan pays 50% of Delta dentist's fee	Your co-payments based on specific service: Bridges: $70 - $116 Partial Dentures: $108-$133 Full Dentures: $155
Orthodontic Benefits	For dependent children only up to age 18 – Plan pays: 50% of Delta dentist's fee Up to $1,200 lifetime maximum per person	Discounted orthodontic provision for employees and covered dependents Your co-payments: Start-up: $250 Phase I: $1350 Phase II: $2300 Retention: $250

Vision Plan Benefits through Vision Service Plan	Frequency of Service	Your Co-Pays at Network Providers
Exams	Every 12 months	$10
Prescription Glasses – Lenses and Frames $130 allowance on frames	Every 24 months	$25
Contacts	Every 24 months	No co-pay
Scratch resistant and anti-reflective coatings & progressives		Up to 20% savings

Key Eligibility Rules and Your Responsibilities

Who is an Eligible Dependent under the County's Health Plans?

- Your spouse, under a legally valid marriage (**a marriage certificate must be provided at the time of enrollment)**
- Your same-sex domestic partner or partners of the opposite sex over age 62, under a Registered Domestic Partnership (**certificate of domestic partnership must be provided at the time of enrollment)**
- Your natural or legally adopted children, step children, and domestic partner's children (**birth certificate must be provided at the time of enrollment)**
- Any other child for whom a Court has issued a Qualified Domestic Relations Order **(legal documentation must be provided at the time of enrollment)**

What are the Age Limits for Dependent Children?

- Children may be covered until their 26th birthday.
- Children who are incapable of self-support because of mental retardation or physical incapacity that commenced prior to age 26 (documentation of disability required).

When Can I Enroll Dependents?

- When you enroll yourself as a new employee
- During the annual open enrollment period
- Within 60 days of a change in status, such as birth, adoption, marriage, registered domestic partnership, even if you are on a leave of absence (late enrollment is not allowed)
- Within 60 days of dependents' loss of another employer's group coverage (late enrollment is not allowed)
- To comply with a Qualified Domestic Relations Order issued by a Court

How Do I Delete Dependents Who Are No Longer Eligible?

- Dependents may be deleted within 60 days of the effective date of coverage under another health plan.
- You must delete dependents who are no longer eligible within 60 days of a change in status—divorce.
- You must complete an enrollment form for all applicable plans to delete dependents that become ineligible.
- You could be held responsible for claims paid for ineligible dependents.

Note: Your requested election change must be consistent with and on account of your qualifying status change. You must make the enrollment change within 60 days of the qualifying event.

Group Term Life Insurance Benefit

The County provides eligible employees with life insurance according to the following schedule:

At least one but less than three continuous years of service	$1,000
Three but less than five continuous years of service	$3,000
Five but less than ten continuous years of service	$5,000
Ten or more years of continuous service	$10,000

Employees in the Exempt, Senior Management, Middle Management, Sheriff's Management, Sergeants, and Confidential representation units also receive additional life insurance in accordance with their respective MOU or Resolution.

Employees may purchase additional term life insurance and accidental death and dismemberment in increments of $25,000, to a maximum of $200,000 based on MOU provisions. Life insurance up to $100,000 is guarantee issuance if enrolled within 30 days of date of hire. A separate application form must be completed. Evidence of good health may also be required.

Beneficiary: If you are in the retirement system, your beneficiary is the person you listed as your beneficiary for retirement, unless you file a Change Form with Human Resources designating a separate life insurance beneficiary.

Employee Assistance Program – Options

The County provides an Employee Assistance Program--Options to all County employees free of charge. This program entitles you to receive up to 5 visits with a counselor for confidential assessment, counseling and/or referral to assist you with the following types of issues:

- Marriage and family relationships
- Parent-child communication
- Alcohol or chemical dependency
- Emotional and stress-related problems
- Emotional strain caused by financial or legal concerns

Options can be reached at 953-8900.

Voluntary Insurance Products

You may purchase the following types of voluntary insurance products through payroll deduction:

- Short-Term & Long Term Disability Insurance and Accident Insurance
- Voluntary Group Term Life & Universal Life Insurance
- Cancer and Critical Illness Plans

For more information, contact Chimienti and Associates toll-free at (877) 733-1670.

Section 125 – Health Spending Account

What is a Section 125 Flex Plan?

A Section 125 Plan is an IRS regulated, employer-sponsored benefit plan that allows employees to voluntarily convert part of their compensation into tax-free benefits. Contributions made through Section 125 are entirely free of federal, state and FICA taxes.

How Do Employees Benefit from a Health Spending Account?

The health spending account allows for certain out-of-pocket health expenses to be paid for on a pre-tax basis. Employee elections are payroll deducted and placed in an account for reimbursement of eligible expenses.

How Does the Plan Work?

When you elect to participate in a medical spending account, a specified amount of pretax dollars are deducted from your paycheck each pay period for the Plan Year (which runs from July 1 through June 30). These funds are deducted from your gross earnings before taxes and placed in a reimbursement account.

Funds may be used for out-of-pocket healthcare expenses for the employee, their spouse, and any dependents you claim as dependents on your federal income tax. Funds may only be used for expenses incurred during the Plan year (July 1 – June 30) and during the time you are participating in the Plan. Funds may not be used for expenses that are paid under any insurance plan or program or to reimburse you for insurance premiums.

When you submit a claim for an eligible expense, you will be reimbursed from this account. Claims for reimbursement must be submitted to American Fidelity Assurance Company.

What Expenses Are Eligible for Reimbursement?

A medical reimbursement plan may be used to pay many types of healthcare expenses not covered under any other plan. These eligible expenses are often the same expenses allowed for income tax return deductions. Please note that expenses reimbursed through the Section 125 plan cannot be itemized by the employee on their income tax return. Qualified expenses include:

- Deductibles, co-payments and other payments you and your dependents make under medical, dental and vision plans.
- Charges not covered under your medical, dental and vision plans other than cosmetic procedures.

Employees may file claims online or print the paper claim form on American Fidelity's website at www.americanfidelity.com .Employees may file a claim via the internet, mobile app or paper claim. Reimbursement requests must be submitted to **American Fidelity Assurance Company,** AWD/Flex Account Administration**,** PO Box 268887, Oklahoma City, OK 73126-8887. Tel# (800) 438-1011, fax# (888) 243-2638.

When Must Charges Be Incurred?

Eligible expenses must be incurred during the Plan year, which runs from July 1st through June 30th, and during the participant's coverage under the Plan. Expenses are incurred when the participant is provided with the healthcare, not when the participant is billed or charged for or pays for the service or treatment.

How Do Employees Receive Reimbursements?

Employees may file claims online or print the paper claim form on American Fidelity's website at www.americanfidelity.com .Employees may file a claim via the internet, mobile app or paper claim. Reimbursement requests must be submitted to **American Fidelity Assurance Company,** AWD/Flex Account Administration**,** PO Box 268887, Oklahoma City, OK 73126-8887. Tel# (800) 437-1011, fax# (888) 243-2638. Supporting documentation can be a receipt, a bill, an explanation of benefits and /or any documentation that provides the date of service, the type of service and the amount. After the claim has been reviewed and the expense approved, payment is then issued to the employee via reimbursement check. Claims are processed bi-weekly with checks issued each payday.

How Much Can You Contribute?

You may set aside a minimum of $260 ($10 per pay period) and a maximum of $2,500 ($96.15 per pay period) per plan year (July through June). Your annual election is divided into equal installments and is payroll deducted pre-tax each pay period. Employees cannot change their individual elections during a Plan year unless they experience a qualifying event.

How Do You Enroll in the Plan?

You must complete an enrollment form each year in order to participate in the plan. You may only enroll when you are initially hired or become eligible for benefits and during Open Enrollment each year.

What Is the "Use It Or Lose It" Rule?

The IRS has modified the "Use It or Lose It" rule to allow participants to carry over up to $500 of unspent funds into the following plan year. The new rules also provide that a carryover does not reduce the following year's deferral limit, which allows you to plan ahead for larger, discretionary medical expenditures (such as a child's orthodontia) to have additional funds available.

Because of the tax advantages of a medical spending account, the IRS has established strict guidelines – the "Use It Or Lose It Rule" – for funds in excess of the $500 carryover amount that are not used by the end of the year. If you contribute funds to a Medical Spending Account and leave a balance over $500 in your account, you will lose any remaining balance in the account at the end of the Plan year. For this reason, you should plan carefully when you determine how much to place in the account..

May I Change My Election During The Year?

You may not change your election during the plan year unless you experience a qualifying status change, such as:

- The birth, death or adoption of a family member, marriage or divorce
- Covered child reaching age 26
- Employee or spouse becoming employed, losing a job or retiring
- Family member losing group health or dental coverage

Where Can I Get More Information?

You may contact the Employee Benefits Office (Human Resources) at 468-9987. You may also contact American Fidelity at (800) 437-1011 or visit their website at www.americanfidelity.com.

Section 125 – Dependent Care Account

What is a Section 125 Flex Plan?

A Section 125 Plan is an IRS regulated, employer-sponsored benefit plan that allows employees to voluntarily convert part of their compensation into tax-free benefits. Contributions made through Section 125 are entirely free of federal, state and FICA taxes.

How Do Employees Benefit From a Dependent Care Account?

The Section 125 Plan benefits employees by allowing them to pay for certain dependent daycare expenses with pre-tax dollars. Employee elections are payroll deducted and placed in an account for reimbursement of eligible expenses.

How Does the Plan Work?

When you elect to participate in the dependent care plan, a specified amount of pretax dollars are deducted from your paycheck each pay period for the Plan Year (which runs from July 1 through June 30). These funds are deducted from your gross earnings before taxes and placed in a reimbursement account.

Funds may be used to reimburse you for care of a dependent child under age 13 or a dependent relative or household member who is physically or mentally incapable of self-care. Funds may only be used for expenses incurred during the time when you are participating in the plan (which runs from July 1 through June 30). Private school tuition is not an eligible expense but before and after-school care may be claimed. Funds may not be used to pay for your dependent insurance premiums.

When you submit a claim for a qualified dependent care expense, you will be reimbursed from this account. Claims for reimbursement must be submitted to San Joaquin Health Administrators within 90 days of the end of the plan year.

What Expenses Are Eligible for Reimbursement?

You may use this plan for expenses that meet the following qualifications:

- The dependent care must enable you and your spouse to be employed or attend school full-time.

- The amount eligible for reimbursement must not be greater than your spouse's income or one-half of your income, whichever is less.

- A child must be under 13 years old and must be your dependent under federal tax rules. Note: If your child turns 13 during the plan year, reimbursements must stop. Your contributions, however, must continue throughout the plan year, so plan carefully.

- The services may be provided in your home or another location but not by someone who is your minor child or dependent for income tax purposes (for example, an older child). Expenses of an overnight camp do not qualify for reimbursement.

- If the services are provided by a day care facility that cares for six or more children at the same time, the facility must comply with state and local day care regulations.

- Services must be for the physical care of the child, not for education, meals, etc.

- Costs for the care of a spouse or dependent who is incapable of self-care and regularly spends at least eight hours per day in your home (i.e., an invalid parent).

When Must Charges Be Incurred?

Eligible expenses must be incurred during the plan year (July 1 – June 30) and during the participant's coverage under the Plan. **Expenses are incurred when the care is provided to the dependent**, not when the participant is billed or charged for or pays for the service. Services must be incurred while both the employee and spouse are working (unless a spouse is disabled).

How Do Employees Receive Reimbursements?

Employees may file claims online or print the paper claim form on American Fidelity's website at www.americanfidelity.com .Employees may file a claim via the internet, mobile app or paper claim. Reimbursement requests must be submitted to **American Fidelity Assurance Company,** AWD/Flex Account Administration**,** PO Box 268887, Oklahoma City, OK 73126-8887. Tel# (800) 437-1011, fax# (888) 243-2638. Supporting documentation can be a receipt, a bill, an explanation of benefits and /or any documentation that provides the date of service, the type of service and the amount. After the claim has been reviewed and the expense approved, payment is then issued to the employee via reimbursement check. Claims are processed bi-weekly with checks issued each payday.

How Much Can You Contribute?

You may set aside a maximum of $5,000 during each plan year (July through June). Your annual election is divided into equal installments and is payroll deducted pre-tax each pay period. Employees cannot change their individual elections during a Plan year unless they experience a qualifying event.

How Do You Enroll in the Plan?

You must complete an enrollment form each year in order to participate in the plan. You may only enroll when you are initially hired or become eligible for benefits and during Open Enrollment each year.

What Is the "Use It Or Lose It" Rule?

Because of the tax advantages of a dependent care reimbursement plan, the IRS has established strict guidelines for funds not used by the end of the year. If you contribute funds to a reimbursement account and do not use all of the monies in your account, you will lose any remaining balance at the end of the plan year. For this reason, plan carefully when you determine how much to place in the account.

May I Change My Election During The Year?

You may not change your election during the plan year unless you experience a qualifying status change, such as:

- The birth, death or adoption of a family member, marriage or divorce
- Employee or spouse changing work hours, shift or days
- Employee or spouse becoming employed, losing a job or retiring

Changing school or day care arrangements are NOT qualifying events

Where Can I Get More Information?

You may contact the Employee Benefits Office (Human Resources) at 468-9987. You may also contact American Fidelity at (800) 437-1011 or visit their website at www.americanfidelity.com.

San Joaquin County Deferred Compensation Plan

What is a Deferred Compensation Plan?

The Deferred Compensation Plan is an easy and convenient way to prepare for your retirement. It allows you to defer a portion of your salary through payroll deductions into the Plan and invest it, on a tax-deferred basis. The Plan is administered by Mass Mutual Insurance and is authorized under Section 457 of the Internal Revenue Code. It is similar to 401(k) plans that private companies offer to their employees.

How Much Can I Contribute?

The minimum deferral is $10 per pay period. The maximum amount you can contribute per calendar year is 100% of your includible income from the County or the following amounts for 2015:

Under age 50	$18,000
Age 50 and over	$24,000

If you have not contributed the maximum amount allowed during your employment with the County, there is a “catch-up” provision that may allow you to make additional contributions prior to retirement. Contact Mass Mutual for more information.

When Can I Enroll and How Do I Contribute?

You can enroll in the Plan at any time. You must complete a Mass Mutual Deferred Compensation Enrollment Form and contribute to the Plan through the convenience of payroll deductions. Your pre-tax contributions and any earnings will accumulate tax deferred until withdrawn (generally at retirement), at which time withdrawals will be taxed as ordinary income.

Can I Roll Other Retirement Accounts into the Deferred Compensation Plan?

If you have an existing 457 deferred compensation or retirement plan account with a prior employer or a traditional IRA, you may transfer (rollover) that account into the Plan at any time.

Can I Stop My Contributions and Restart Later?

You may start, stop, increase or decrease your contribution. You may stop contributing at any time and start again at a later date.

What’s the Impact to My Taxes?

Your current taxable income is reduced by the amount you contribute. For example: If your annual salary is $24,000 and you contribute $2,000 to the Plan, your taxable income is shown as $22,000 on your W-2 form.

What Are My Investment Choices?

The Plan offers a wide variety of investment choices to meet your needs, including a General (Declared Rate) Account which provides a credited rate of interest. You may direct your contributions into one or more of the available investment choices.

Will I Receive Regular Statements?

You will receive a comprehensive Statement of Account from Mass Mutual each quarter. The statement will show your account balance at the beginning of the period, any activity in your account during the period, the amount of any earnings, contributions, and your account balance at the end of the period. Also included with your statement is historical investment option performance and an informative newsletter written for retirement investors.

When Can I Access My Assets?

Your account assets may be withdrawn from your Deferred Compensation Plan under the following circumstances:

- Retirement
- Separation from County Service
- Unforeseeable emergency ("hardship")
- Death of participant

Do I Have Toll Free Account Access?

In addition to your local representative, you can call Mass Mutual's Account Access Line at 1-800-678-8645 for prompt, professional service. You can speak with a Customer Service Associate or utilize the automated voice or touch-tone system for a variety of account inquiries and financial transactions, including:

- Transferring assets between investment choices
- Changing the allocation of investment elections
- Obtaining information on investment choices

Can I Reach Mass Mutual on the Web?

Mass Mutual's secure website allows you to view your personal account, make a variety of inquiries and financial transactions, and obtain educational information. You can reach Mass Mutual interactive website at **www.massmutual.com/serve**

Who Can I Talk To About My Account or Enrolling in Deferred Compensation?

Your local Mass Mutual Representative is Andee Nusaath. She can provide you with information to help you make informed decisions about your retirement planning strategy. You can contact the local Mass Mutual office at (888) 811-4839 to arrange for a one-on-one personal consultation.

Benefits Enrollment Information

What is Needed to Complete Your Enrollment in County Benefits?

- Signed, dated and completed forms for your plan selections
- Required documentation for eligible dependents
  - Marriage certificate for spouse
  - Domestic Partner certificate
  - Birth Certificates for children

When Is Your Enrollment Information Needed?

Please provide your Enrollment Forms and documentation to Human Resources by next Monday.