SAN JOAQUIN COUNTY

HEALTH BENEFITS SUMMARY FOR NEW EMPLOYEES

2018-2019

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Summary of Medical Plans

	Select Exclusive Plan	Select Plan	Premier Plan	Kaiser Permanente Plan
Plan Providers	Health Care Services at San Joaquin General Hospital	Providers in the Anthem Prudent Buyer Network of CA in 3 Counties Only: San Joaquin, Sacramento & Stanislaus	All providers in the Anthem Prudent Buyer Network of CA	Kaiser facilities and providers only
Deductible (applies to all services except doctor's office visits and prescription drugs) per Plan Year	$125 per person $250 per family	$250 per person $500 per family	$125 per person $250 per family	None
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.	$1,000 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	Deductible applies Plan pays up to $25 per visit	Not covered Discounts available, contact Kaiser for details
Ambulance	Deductible applies	Deductible applies	Deductible applies	$0
Doctor Office Visit • **Specialist Office Visit** • **Allergy testing or treatment**	$5 co-pay per visit	$10 co-pay per visit	$5 co-pay per visit	$10 co-pay per visit
Durable Medical Equipment, Orthotics, Prosthetics	Deductible applies 50% of charges	Deductible applies 50% of charges	Deductible applies 50% of charges	20% of charges
Emergency Room • **Hospital facility charge – waived if admitted**	Deductible applies plus $40 co-pay per admission	Deductible applies plus $100 co-pay per admission	Deductible applies plus $100 co-pay per admission	$100 co-payment per visit per admission
Home Health Care	Deductible applies	Deductible applies	Deductible applies	$0
Hospice	Deductible applies	Deductible applies	Deductible applies	$0
Hospital Inpatient or Intensive Care Unit (ICU) services and supplies	Deductible applies	Deductible applies plus $100 co-pay per admission	Deductible applies plus $100 co-pay per admission	$0
• **Surgeon, assistant surgeon, anesthesiologist**	Deductible applies	Deductible applies	Deductible applies	$10 co-pay
• **Hospital or Skilled Nursing Facility Doctor Visit**	Deductible applies	Deductible applies	Deductible applies	Deductible applies

	Select Exclusive Plan	Select Plan	Premier Plan	Kaiser Permanente Plan
Laboratory Services	Deductible applies	Deductible applies	Deductible applies	$0
Mental Health				
• **Outpatient Therapy**	$5 co-pay per visit	$10 co-pay per visit	$5 co-pay per visit	$5 co-pay for group therapy visit ($10 individual visit)
• **Inpatient Therapy**	Deductible applies	Deductible applies plus $100 co-pay per admission	Deductible applies plus $100 co-pay per admission	$0
Outpatient Surgery Facility	Deductible applies	Deductible applies	Deductible applies	$10 per procedure
Prescription Drugs 30 Day Supply	$5 generic $15 preferred Non-preferred not covered	$5 generic $15 preferred Non-preferred not covered	$5 generic $10 preferred $30 non-preferred	$10 generic $20 preferred Non-preferred not covered
Prescription Drugs 90 Day Supply	$10 generic $30 preferred Non-preferred not covered	$10 generic $30 preferred Non-preferred not covered	$10 generic $20 preferred $60 non-preferred	$10 generic $20 preferred Non-preferred not covered
Preventive Care Services (Recommended Under the Affordable Care Act)	$0	$0	$0	$0
Rehabilitation Therapy (Physical, Speech, Occupational)	Deductible applies plus $10 co-pay per visit	Deductible applies plus $10 co-pay per visit	Deductible applies plus $5 co-pay per visit	$10 co-pay per visit
Urgent Care	Deductible applies plus $40 co-pay per visit	Deductible applies plus $40 co-pay per visit	Deductible applies plus $40 co-pay per visit	$10 co-pay per visit
X-Rays	Deductible applies	Deductible applies	Deductible applies	$0

Select Exclusive Plan

The Select Plan requires that you and your enrolled family members use San Joaquin General Hospital (HCS) providers and facilities exclusively for all of your medical care.

Select Plan

The Select Plan requires that you and each of your enrolled family members choose a primary care physician in the Anthem Prudent Buyer Network of CA within these three counties: San Joaquin County, Stanislaus County, and Sacramento County. You must coordinate all of your care through your primary care physician and use specialists who are in the same three counties. Certain services require prior authorization from the Third Party Administrator in order to be paid.

Premier Plan

The Premier Plan requires that you and each of your enrolled family members choose a primary care physician from the Anthem Prudent Buyer Network of CA. You must coordinate all of your care through your primary care physician. Certain services require prior authorization from the Third Party Administrator in order to be paid.

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.

Bi-Weekly Benefit Plan Premiums
Effective July 9, 2018

Plan Options	County Share 2018-19	Employee's Share 2018-19
Medical Plans		
Select Plan & Select Exclusive		
Employee only	$377.59	$94.40
Employee + 1 dependent	$755.18	$188.80
Employee + Family	$1057.26	$264.32
Premier Plan		
Employee only	$377.59	$134.03
Employee + 1 dependent	$755.18	$268.06
Employee + Family	$1057.26	$375.27
Kaiser Permanente		
Employee only	$256.76	$64.19
Employee + 1 dependent	$513.52	$128.38
Employee + Family	$726.63	$181.66
Dental Plans		
Delta Dental with Orthodontia		
Employee only	$20.42	$0
Employee + 1 dependent	$20.42	$19.39
Employee + Family	$20.42	$46.39
United Health Care		
Employee only	$10.70	$0
Employee + 1 dependent	$10.70	$9.64
Employee + Family	$10.70	$18.15
Vision Plan		
Vision Service Plan		
Employee only	$2.63	$0
Employee + 1 dependent	$2.63	$2.63
Employee + Family	$2.63	$6.79

Summary of Dental and Vision Plans

Dental Benefits	Delta Dental - Premier Plan	United Healthcare Direct Compensation
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 $150 allowance on frames or contacts	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 (**marriage certificate required)**
- Your same-sex domestic partner or partners of the opposite sex if one is over age 62 (**certificate of domestic partnership required)**
- Your natural or legally adopted children, step children, and domestic partner's children (**birth certificate required; marriage certificate also required if spouse of step children will not be enrolled)**
- Any other child for whom a Court has issued a Qualified Domestic Relations Order **(legal documentation from the Court)**

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).
- Foster and legal guardianship children may be covered until their 18th birthday.

When Can I Enroll Dependents?

- When you enroll yourself as a new employee
- During the annual open enrollment period
- Within 60 days of a qualifying life event, such as birth, adoption, marriage, registered domestic partnership, even if you are on a leave of absence. (Late enrollment is not allowed per IRS requirements.)
- Within 60 days of dependents' loss of another employer's group coverage. (Late enrollment is not allowed per IRS requirements.)
- To comply with a Qualified Domestic Relations Order issued by a Court, but only if the dependent is a qualified dependent.

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.
- You must complete an enrollment form for all applicable plans to delete dependents that become ineligible.
- You may be held financially 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 (EAP) – MHN

The County provides an EAP through MHN to all County employees and their dependents free of charge. This program entitles you and your family up to five 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

MHN can be reached at 1-800-242-6220, 24/7. County Code: sanjoaquin

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.

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,** Flex Account Administration P.O. Box 161968, Altamonte Springs, FL, 32716. Phone# (800) 662-1113, fax# (888) 319-3668. 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 issued to the employee via reimbursement check or direct deposit. Claims are processed within 3-4 business days.

How Much Can You Contribute?

For 2018, you may set aside a maximum of $2,650 per plan year (July 1 through June 30). Your annual election is divided into 24 equal installments and is payroll deducted pre-tax each pay period. A deduction is not made in the months that there are three paychecks. 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 <u>not</u> 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, dental, or vision coverage

Where Can I Get More Information?

You may contact the Employee Benefits Office at (209) 468-9987. You may also contact American Fidelity at (800) 662-1113 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 American Fidelity 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,** Flex Account Administration P.O. Box 161968, Altamonte Springs, FL, 32716. Phone# (800) 662-1113, fax# (888) 319-3668. 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 24 equal installments and is payroll deducted pre-tax each pay period. A deduction is not made in the months that there are three paychecks. 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
- Change in daycare facility and/or cost

Where Can I Get More Information?

You may contact the Employee Benefits Office at (209) 468-9987. You may also contact American Fidelity at (800) 662-1113 or visit their website at www.americanfidelity.com.

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
  - Social security card

When Is Your Enrollment Information Needed?

Please provide your Enrollment Forms and documentation to the Employee Benefits Office - Human Resources by next Monday.

State Disability Insurance (SDI)

The California SDI program provides short-term Disability Insurance (DI) and Paid Family Leave PFL) wage replacement benefits to eligible workers who need time off work due to non-work related illness, injury, pregnancy, or childbirth. You may be eligible for PFL to care for a seriously ill family member or to bond with a new child.

Not all bargaining units participate in the program. Check with your union to see if your group contributes into SDI.