

Annual Enrollment For Extra Help Employees Only

Monday, November 15, 2010 through Friday, December 17, 2010

Effective date of coverage is February 1, 2011

Annual Enrollment for extra help employees will be held Monday, November 15, 2010 through Friday, December 17, 2010. Kaiser Permanente medical coverage is available for extra help employees who meet the eligibility requirements outlined below. A brief summary description of the plan benefits is contained in this brochure.

What are the eligibility criteria to enroll in the Extra Help Kaiser medical plan?

Extra-help employees who meet all of the following criteria before coverage starts may enroll during this annual enrollment period:

- 1) Employed with the County for at least 11 consecutive pay periods, and
- 2) Worked at least 440 hours, and
- 3) Worked at least 160 hours in the previous 4 pay periods, and
- 4) Must generally work at least 40 hours per pay period, and
- 5) Live or work within 30 miles of a Kaiser facility. Please verify by visiting the Kaiser website at www.kp.org or calling (800)464-4000.

How much does it cost?

The County contribution is up to \$400 per month if you work 40 hours or more biweekly. Premiums for the medical plan must be paid in advance on the first two pay dates of each month through payroll deduction. Coverage is on a monthly basis for as long as benefit eligibility and premium payments are maintained. **Please note the four-tier rate structure in the enclosed chart.**

EMPLOYEE COST VARIES BASED ON THE NUMBER OF HOURS WORKED.

The **enclosed chart** provides an example of benefit costs for Feb. 1, 2011 – Jan. 31, 2012 coverage dates for an extra help employee who works 40+ hours per pay period.

How much will I pay if I work less than 40 hours per pay period?

When an employee's hours fall below 40 hours bi-weekly, the employee's premium costs will increase proportionate to the number of hours worked. Please see your payroll clerk if you have any questions.

What happens if I work less than 20 hours per pay period?

There will be no county contribution towards coverage for pay periods when hours worked are below 20 hours. If you work less than 20 hours and you have extra-help coverage, Auditor-Controller-Treasurer-Tax Collector's (ACTTC) Central Payroll office will send you a letter explaining your payment options.

What if I am a County retiree and have retiree medical?

You can be enrolled as either a retiree or an extra help employee. Generally coverage as a retiree is better. If you decide to maintain your retiree coverage, you can discard this notice. Federal regulations require that all eligible employees be notified of annual enrollment rights.

What if I'm currently enrolled?

If you are currently enrolled, the new premium deductions will start on January 5, 2011. Please note there is a premium increase for the plan year February 1, 2011 through January 31, 2012. If you would like additional information about the plan coverage, you may call Kaiser Permanente Member Services at (800) 464-4000. Your group # is 38655-0004.

What if I am already enrolled and I want to add dependents?

You may enroll additional dependents at this time. Please contact the Human Resources Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org to obtain the forms necessary to enroll your dependent(s) in the medical plan.

How do I enroll?

If you meet the eligibility criteria and are not currently enrolled, please contact the Human Resources Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org to obtain the forms necessary to enroll in the plan:

1. County of Sonoma Extra Help Employees Medical Benefits Enrollment Form
2. Kaiser Permanente California Region Group Enrollment/Change Form

***ALL FORMS MUST BE RECEIVED BY THE HUMAN RESOURCES BENEFITS UNIT
BY 5:00 p.m. Friday, December 17, 2010.***

What if I miss this deadline?

- As a new enrollee . . .
You must wait until the next annual enrollment period.
- If you want to add newly eligible dependents . . .
Submit forms within 31 days of the qualifying life status change. The change in premiums will be effective on the 1st pay date administratively feasible. Please see the following page for more details. If you have further questions, please contact the Human Resources Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.
- If you want to delete dependents or cancel coverage . . .
Submit forms no later than 31 days after the dependent ceases to be eligible. The change in premiums will be effective on the 1st pay date administratively feasible. Please see the following page for more details. If you have further questions, please contact the Human Resources Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org.

**2011 Extra Help Kaiser Permanente Health Plan Rate Chart
Premium Deductions for Rates Beginning in January for Coverage Effective February 1, 2011**

For employees working 40 hours or more biweekly, the County contributes up to \$400 per month towards the premium cost for coverage.

	Employee Semi-monthly Cost	Employer Semi-monthly Cost	Total Semi-monthly Cost
Self	86.79	200.00	286.79
Self + Spouse/DP	425.89	200.00	625.89
Self + Children	369.33	200.00	569.33
Family	652.01	200.00	852.01

IMPORTANT ELIGIBILITY REQUIREMENTS

Changes Outside of Annual Enrollment 31 Day Deadline

IRS regulations and plan rules greatly limit changes that can be made outside of Annual Enrollment, must be made within 31 days of the event and are generally limited to:

- Gaining or losing eligibility for other group coverage
- A qualifying life status change, such as birth, marriage or divorce
- Circumstances allowed under the Children's Health Insurance Program Reauthorization Act of 2009

IMPORTANT

The circumstances under which you may change benefits elections outside of an Annual Enrollment period are described in the plans' evidence of coverage booklet. The list shown above provides examples of common reasons; it is not an exhaustive list. Contact the Human Resources Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org with specific questions regarding qualifying life status changes.

Notice on Grandfathered Status as Required by the Affordable Care Act

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Human Resources Benefits Unit at (707) 565-2900 or benefits@sonoma-county.org or Health Care Employees/Employer Medical Trust (925) 803-1880. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Are you struggling with problems at home or work?

The County's Employee Assistance Program (EAP), offered through Managed Health Network (MHN), can help County employees with referrals to a range of professional counselors, including psychologists, social workers, marriage and family counselors, financial advisors, child and elder care providers, retirement counselors and lawyers.

MHN can be reached at 800-227-1060
24 hours a day, seven days a week.

Benefits Summary

38655-0004 Health Care Employees/Employer Dental & Medical Trust

Principal Benefits for Kaiser Permanente Traditional Plan (2/1/2011—1/31/2012)

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible or Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Routine preventive care:

Physical exams	\$15 per visit
Well-child visits (through age 23 months)	\$5 per visit
Family planning visits	\$15 per visit
Scheduled prenatal care visits and first postpartum visit	\$5 per visit
Eye exams for refraction	\$15 per visit
Hearing tests	\$15 per visit
Flexible sigmoidoscopies	\$15 per visit
Primary and specialty care visits	\$15 per visit
Urgent care visits	\$15 per visit
Physical, occupational, and speech therapy	\$15 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injection visits	\$3 per visit
Allergy testing visits	\$15 per visit
Most vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education:	
Individual visits	\$15 per visit
Group educational programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
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Emergency Health Coverage

You Pay

Emergency Department visits	\$50 per visit
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Emergency Health Coverage	You Pay
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing)	
Ambulance Services	You Pay
Ambulance Services	\$50 per trip
Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order service .	\$10 for up to a 100-day supply
Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20% Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	No charge
Outpatient individual and group visits.....	\$15 per individual visit \$7 per group visit
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual visits.....	\$15 per visit
Outpatient group visits	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year).....	No charge
Other	You Pay
Eyewear purchased from plan optical sales offices every 24 months	Amount in excess of \$175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).