

Annual Enrollment For Extra Help Employees Only

Tuesday, December 6, 2011 through Wednesday, December 21, 2011

Effective date of coverage is February 1, 2012

Annual Enrollment for extra help employees will be held Tuesday, December 6, 2011 through Wednesday, December 21, 2011. 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, 2012 – Jan. 31, 2013 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 4, 2012. Please note there is a premium increase for the plan year February 1, 2012 through January 31, 2013. 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. Wednesday, December 21, 2011.**

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.

**2012 Extra Help Kaiser Permanente Health Plan Rate Chart
Premium Deductions for Rates Beginning in January for Coverage Effective February 1, 2012**

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	110.99	200.00	310.99
Self + Spouse/DP	479.10	200.00	679.10
Self + Children	417.70	200.00	617.70
Family	724.57	200.00	924.57

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.

Benefit Summary

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

Principal Benefits for Kaiser Permanente Traditional Plan (2/1/12—1/31/13)

The Services described below are covered only if all of 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 Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

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

Most primary and specialty care consultations, exams, and treatment	\$15 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	\$15 per visit
Physical, occupational, and speech therapy	\$15 per visit

Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injections (including allergy serum)	\$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health educational programs	No charge

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs No charge

Emergency Department visits \$50 per visit

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing)

Ambulance Services \$50 per trip

Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service \$10 for up to a 100-day supply

Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines 20% Coinsurance

Inpatient psychiatric hospitalization No charge
Individual outpatient mental health evaluation and treatment \$15 per individual visit

continued

Mental Health Services	
Group outpatient mental health treatment	\$7 per group visit
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	\$15 per visit
Group outpatient chemical dependency treatment	\$5 per visit
Home health care (up to 100 visits per calendar year)	No charge
Eyewear purchased at Plan Medical Offices or 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
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	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).