

MetLife Absence Management Frequently Asked Questions

County of San Bernardino

MetLife makes it easy to report your disability claim as well as other types of absence, such as those that qualify under the Family and Medical Leave Act (FMLA), other applicable state leave laws, and Short Term Disability. The following information explains how to report your Short Term Disability claim or FMLA absence request and what to expect.

When should I report an absence?

Contact MetLife if you are absent from work, or know you will be absent from work for more than 3 calendar days due to the following:

- Your own serious health condition, including pregnancy
- To care for your newborn child or the placement of your adopted or foster child
- To provide care for a qualifying family member with a serious health condition
- To care for a covered servicemember injured in the line of duty

How do I notify MetLife about an absence?

- Follow your department's call in procedures and notify your supervisor
- Call the MetLife Claim Center at 877.638.8269 or
- Report your absence online through MetLife's MyBenefits website at <https://mybenefits.metlife.com>
 - Choose **County of San Bernardino** as provider to your group benefits
 - Create a new account by entering your personal information including social security number
 - Enter the one-time verification code that will be sent to your phone

The MetLife Disability Leave Coordinator will assist you in determining the type of leave which you are entitled to and qualify for, based on the County's absence policy and consistent with applicable law.

When can I call in my absence?

The MetLife Claims Center is available Monday through Friday between 5:00 am and 8:00 pm Pacific Time and MyBenefits portal is available 24/7 - 365 days a year.

When I call to request Leave or to report my absence, what questions will I be asked?

You will be asked to provide the following information, in addition to other questions about your absence:

- The last day you were at work or are expected to be at work
- Reason leave is requested
- Your authorization to release your medical information if applicable. Let your Physician(s) know that you authorize the release of your medical information to MetLife and complete the "Authorization To Disclose Information About Me" form.

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County of San Bernardino

When should I report an intermittent absence?

Your absence should be reported as soon as you are aware that you will miss scheduled time off from work. You must report your intermittent absence within 48 hours of the start of the first shift you miss. Failure to do so may jeopardize your job protection for those absences.

Please note that the County has a late reporting provision which requires you to report your request for intermittent absences within 2 calendar days of the incident.

What should I expect after I initiate a claim or leave?

- After you submit your disability claim or request a leave of absence, MetLife will send you a written acknowledgment of your claim or request
- You may be contacted by a case manager or leave coordinator within a few business days to clarify any of your information or if any information is missing. The case manager or leave coordinator will provide their direct contact information at that time.
- MetLife may also contact your Physician(s) and/or the County

How can I get information on my claim or absence?

- You are encouraged to call your case manager at any time should you have questions or concerns about the program or your case.
- The customer service center is also available from 5:00 am – 8:00 pm, Monday through Friday at 877.638.8269
- You can check the status of your claim any time by visiting <https://mybenefits.metlife.com>
- You can also check the status of your claim or absence on the MetLife App (search “MetLife” on iTunes App Store or Google Play to download the app)

How long does it normally take for an STD Claim Decision?

It will take approximately one week to make a claim decision. We will communicate claims decisions via both a call from your case manager as well as written correspondence.

If my claim for Short Term Disability is approved, how long will it take to receive my first check?

After the Benefit Waiting Period of 7 days has been completed, and your Short Term Disability claim has been approved, benefits are paid in arrears on a weekly basis. Checks are mailed Tuesday of each week and will be mailed directly to your mailing address.

Will FICA taxes be deducted from my benefit payment?

FICA tax is composed of two parts, Social Security and Medicare. As a County employee, you will not contribute to Social Security tax, however, Medicare will be withheld based on applicable law. Your case manager will be able to discuss this with you in greater detail.

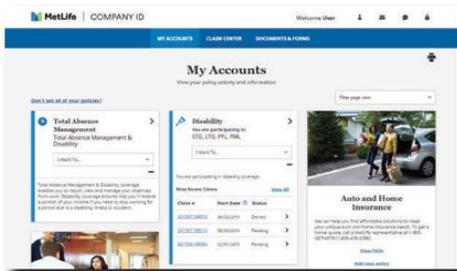
MetLife Absence Management Frequently Asked Questions County of San Bernardino

Can I receive my benefit payment via Direct Deposit?

Electronic Funds Transfer (EFT) is an available option for receiving benefit payments. Information about initiating the EFT/direct deposit will be included in your approval letter.

How do I get information on my claim or absence online?

You can look up information on your claim through MetLife's online portal at <https://mybenefits.metlife.com>. After establishing your login information, you will be able to view claim information, next payment, and more.



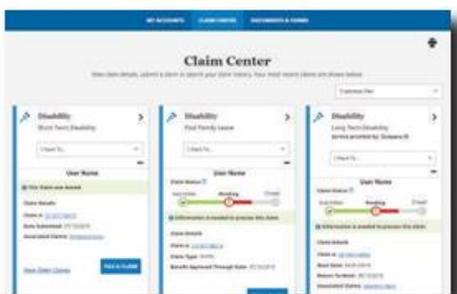
My Accounts Page

- Product Summary Cards with policy and claim detail
- Ability to see absence number, start date, and status
- 'I want to' menu for quick access to what you need
- Easy access to the claim center and Documents and Forms



Absence Detail

- Absence number and status bar at the top of the page
- Absence Detail Card – includes absence type and programs
- Activity for This Absence Card – includes date, activity and brief description of your leave claim



Claim Center

- A centralized claims experience where you can manage your claims
- Submit claims online and check status
- View past/current claims
- Print/download/email claim history

More Questions?

Call MetLife's Claim Center at **877.638.8269**





Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

LEAVE REQUEST FOR EXTENDED SICK AND SPECIAL LEAVE

Employees must contact MetLife no later than the 4th day of leave to initiate the leave process.¹

Must print in Black or Blue ink ONLY

Check box if applying for STD

Employee ID	Rcd No.	Last Name, First Name		
Job Title		Department		Department ID

To Be Completed By Employee (Supervisor may complete in employee's absence)

Home Address		City	State	Zip Code
Mailing Address (if different than Home)		City	State	Zip Code
Telephone Numbers:	Home	Work	Alternate	
Type of Request <input type="checkbox"/> New <input type="checkbox"/> Continuation <input type="checkbox"/> Revision	Reasons for Leave			
	<input type="checkbox"/> Own serious health condition (non-work related)			
	<input type="checkbox"/> Occupational injury/illness			
	<input type="checkbox"/> Indicate due date if pregnant :			
	<input type="checkbox"/> Care for child/spouse/domestic partner/parent for a serious health condition ²			
	<input type="checkbox"/> Birth, placement or adoption of a child's other parent is a county employee, indicate name and employee ID:			
	<input type="checkbox"/> Care for other family member, including legal guardianship, for serious health condition			
<input type="checkbox"/> Military leave, educational leave, or other leave not specified above				

¹Please refer to the MetLife's Frequently Asked Question about Reporting Absences and Filing for Short Term Disability Benefits

Leave Type ²	Leave Begin Date	Leave End Date	Check If Applicable
<input type="checkbox"/> Sick Leave With Pay or <input type="checkbox"/> Sick Leave Without Pay			<input type="checkbox"/> Reduced Schedule <input type="checkbox"/> Intermittent Leave
<input type="checkbox"/> Leave With Pay or <input type="checkbox"/> Leave Without Pay			<input type="checkbox"/> Reduced Schedule <input type="checkbox"/> Intermittent Leave
<input type="checkbox"/> Leave With Right To Return To Position or <input type="checkbox"/> Leave Without Right To Return To Position			
Military Leave (attach active duty orders)			
Occupational Injury/ Illness <small>(Pending Risk Management's approval and requires an Employer's Report of Occupationally Injury or Illness)</small>			<input type="checkbox"/> Reduced Schedule <input type="checkbox"/> Intermittent Leave
Other - Explain:			<input type="checkbox"/> Reduced Schedule <input type="checkbox"/> Intermittent Leave

	Print & Sign	Date
Employee ³		
Supervisor/Title		
Appointing Authority or Designee		
Human Resources Officer ⁴		

² At no time will the Employee receive more than 100% of pay from County paid leave, Short Term Disability or any other state leave program.

³ If employees is unable to sign , write SNA and indicate date copy sent to employee's mailing address

⁴ Required for Leave With/Without Right to Return, Medical Leave of Absence, educational leave

DISTRIBUTION:

- Original-EBSD-Leaves Team (0440)
- Leave With Right-EBSD-Leaves Team (0440)
- Leave Without Right-EBSD-Leaves Team (0440)
- Medical Leave of Absence-EBSD-Leaves Team (0440)
- 1st Copy - Department
- 2nd Copy - Supervisor
- 3rd Copy - Employee

Office Use Only				
Payroll Specialist Name		Approved	Approved Pending Cert.	
Mail Code	Reviewed By	Date	Keyed By	Date



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

LEAVE INTEGRATION REQUEST (STD, SDI and WORKERS' COMPENSATION)

*Notice: This form must immediately be submitted for processing based on the distribution choice below.
Integration choice will begin based on the date this form is received.*

NO FUTURE OR RETRO PROCESSING WILL BE MADE

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name	Department ID
Type of Request <input type="checkbox"/> New Request <input type="checkbox"/> Revised	Type of Integration <input type="checkbox"/> Full <input type="checkbox"/> No Integration <input type="checkbox"/> Partial Integration - List number of hours per pay period: _____		Department Name
Date of Injury/ Start of Leave	Type of Benefit Payments <input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> State Disability Insurance (SDI)		Union Code

Requested Order of Use

Default Order of Use - Check box if requesting to use leave in the order listed.

Requested Order of Use - Check box if requesting an order other than default, enter the requested order of leave to be used.

Sick Only - Check box if requesting to use sick leave only.

Note: Leaves will be used until exhausted, then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

If a box is not checked, the default order will be used

Type of Leave	<input type="checkbox"/>	Default Order of Use	<input type="checkbox"/>	Requested Order of Use	<input type="checkbox"/>	Sick Only	
Sick		1		1		1	
MOU Mandated Leave		2		2			
Vacation		3					
Holiday		4					
Compensatory Time		5					
Annual		6					
Administrative		7					
Attorney		8					
Other		9					
Medical Emergency Leave (MEL) <i>Must be integrated with STD</i>		Medical Emergency Leave (MEL) donations will be integrated with STD when leave accruals have been exhausted.					

I understand that all leave benefits will be administered in accordance with the MOU and County/Special Districts Policy. I have received a copy of the Leave Integration Guidelines (page 3). I authorize my supervisor, department payroll specialist and/or Central Payroll to code or modify my paid time to be consistent with this Leave Integration Request. I understand that the maximum amount of pay that I am allowed to receive while out on leave and integrating with another benefit (disability or Workers' Compensation payments) shall not exceed 100% of my base salary.

Employee Signature *	Telephone	Date
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** I have been given authorization and direction on completing this form on behalf of the above employee - **REQUIRED** if form is completed by someone other than the employee*

* Appointee (Print & Sign)	Telephone	Date
Appointing Authority or Designee (Print & Sign)		Date
Payroll Specialist (Print & Sign)	Telephone	Date

DISTRIBUTION: Original - STD - EBSD - Leaves Team (0440)
- SDI / Workers' Compensation - Central Payroll (0032)
Copy - Department, Supervisor and Employee

Leave Integration Guidelines

Integration of available leave balances with any Short-Term Disability (STD) Benefit Payments, State Disability Insurance (SDI) Benefit Payments, Workers' Compensation Benefit Payments, and/or regular/transitional work hours shall not exceed 100% of your normal base salary. In the event that any combination of these payments exceeds 100% of your normal base salary, the County will recover the overpayment from future pay warrants per MOU guidelines.

Medical Emergency Leave (MEL) will not be considered "eligible leave" for certain purposes such as the accumulation of leave accruals, eligibility for step advancement or retirement credit per the MOU. However, the use of MEL will count towards the minimum requirement for the receipt of Benefit Plan Dollars and/or premium subsidies. If you are using MEL, you must contact your payroll specialist to determine exactly how your benefits and accruals will be affected.

It is your responsibility to provide your supervisor and department payroll specialist any and all information regarding changes in your leave status, copies of all off-work orders and your anticipated return to work date. You should check with your Appointing Authority for specific department policies and procedures.

Each pay period your paid time will be coded with the anticipated number of leave hours required to integrate with your additional benefit payment and any time worked so that you may receive 100% of your normal biweekly base salary or the amount specified according to your election.

Receipt of Benefit Plan Dollars and/or premium subsidies, leave accruals, retirement credit and eligibility for step advancements will be administered in accordance with the appropriate MOU, contract or salary ordinance provisions governing your terms of employment.

The Leave Integration Request will be honored for the current pay period as long as it is submitted in time to meet payroll deadlines.

In addition to this form, it is your responsibility to complete any additional paperwork required for your STD, SDI, MEL and/or Workers' Compensation Benefits. Delay in submitting the required forms may also result in the loss or delay of benefits.

Short-Term Disability payments are taxable income; however, taxes are not automatically withheld. If you wish to have taxes withheld from your disability payments, submit a DE-4S to request state income taxes and a W-4S to request federal income taxes. Mail or fax these forms directly to the County Short-Term Disability provider as listed in the Employee Benefits Guide or per the "STD and FMLA Filing a Request Instructions and Form". You will receive a W-2 at the end of the year from this provider.

PRELIMINARY FMLA DESIGNATION NOTIFICATION

This is to inform you that your extended and/or intermittent leave will be preliminarily designated as FMLA (Family Medical Leave Act) and/or CFRA (California Family Rights Act) Leave in accordance with federal and state laws. These laws are there to protect your job and employer paid benefits while you are out on a qualified leave of absence.

As indicated on this *Leave Request for Extended Sick and Special Leave* form, you are requesting an extended leave for your own serious health condition, the serious health condition of your child, spouse, domestic partner, or parent, for the birth or adoption of a child or to care for a family member with a serious injury or illness who is a member of the Regular Armed Forces, the National Guard or Reserves, and the illness or injury incurred in the line of duty. Leave for any of these reasons qualifies as FMLA and/or CFRA Leave.

A "serious health condition" for a family member requires either:

- ◆ Hospitalization; or
- ◆ Any period of incapacity of more than three calendar days that involves continuing treatment by a health care provider; or
- ◆ Any health condition that if left untreated would result in a period of incapacity of at least three days (including chronic conditions); or
- ◆ For prenatal care
- ◆ Written documentation confirming the covering service member's injury/illness was incurred in the line of duty on active duty and the covered service member is undergoing treatment for such injury or illness by a health care provider.

The definition of a "serious health condition" is the same for an employee with the addition that it must prevent the employee from performing the functions of his/her position.

If the reason for your leave meets the above criteria **and** you meet the eligibility requirements, your leave will be counted as FMLA and/or CFRA. ***This does not impact how or if you are paid during your leave. You are still required to complete the necessary paperwork to receive sick pay and/or disability, if eligible.*** A formal notification will be sent to you indicating the dates covered, what entitlement your leave counts against, your eligibility, and if there is any additional information required.

For more information, please refer to the *FMLA and Pregnancy Supplemental Brochures*. If you have any further questions, call your departmental payroll specialist.

**Request for Federal Income Tax
 Withholding From Sick Pay**

2020

▶ Give this form to the third-party payer of your sick pay.
 ▶ Go to www.irs.gov/FormW4S for the latest information.

Your first name and middle initial	Last name	Your social security number
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Home address (number and street or rural route)

City or town, state, and ZIP code

Claim or identification number (if any)	
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See Worksheet below.)	\$

Employee's signature ▶	Date ▶
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----- **Separate here and give the top part of this form to the payer. Keep the lower part for your records.** -----

Worksheet (Keep for your records. Do not send to the Internal Revenue Service.)

1 Enter amount of adjusted gross income that you expect in 2020	1	
2 If you plan to itemize deductions on Schedule A (Form 1040 or Form 1040-SR), enter the estimated total of your deductions. See Pub. 505 for details. If you don't plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional standard deductions for age and blindness.) Note: There is no deduction for personal exemptions for 2020	2	
3 Subtract line 2 from line 1	3	
4 Tax. Figure your tax on line 3 by using the 2020 Tax Rate Schedule X, Y-1, Y-2, or Z on page 2. Do not use any tax tables, worksheets, or schedules in the 2019 Instructions for Forms 1040 and 1040-SR	4	
5 Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.)	5	
6 Subtract line 5 from line 4	6	
7 Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2020 or paid or to be paid with 2020 estimated tax payments	7	
8 Subtract line 7 from line 6	8	
9 Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	9	
10 Divide line 8 by line 9. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under <i>Amount to be withheld</i> below. If it does, enter this amount on Form W-4S above	10	

General Instructions

Purpose of form. Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You aren't required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Don't use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

Note: If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

Definition. Sick pay is a payment that you receive:

- Under a plan to which your employer is a party, and
- In place of wages for any period when you're temporarily absent from work because of your sickness or injury.

Amount to be withheld. Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, \$35, not \$34.50).
- Must be at least \$4 per day, \$20 per week, or \$88 per month based on your payroll period.

- Must not reduce the net amount of each sick pay payment that you receive to less than \$10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of \$100 a week normally has \$25 (25%) withheld, then \$20 (25%) will be withheld from a partial payment of \$80.

Caution: You may be subject to a penalty if your tax payments during the year aren't at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, Tax Withholding and Estimated Tax. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. You may estimate your federal income tax liability by using the worksheet above.

Sign this form. Form W-4S is not valid unless you sign it.

Statement of income tax withheld. After the end of the year, you'll receive a Form W-2, Wage and Tax Statement, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the Internal Revenue Service.

(continued on back)

Changing your withholding. Form W-4S remains in effect until you change or revoke it. You may do this by giving a new Form W-4S or a written notice to the payer of your sick pay. To revoke your previous Form W-4S, complete a new Form W-4S and write “Revoked” in the money amount box, sign it, and give it to the payer.

Specific Instructions for Worksheet

You may use the worksheet on page 1 to estimate the amount of federal income tax that you want withheld from each sick pay payment. Use your tax return for last year and the worksheet as a basis for estimating your tax, tax credits, and withholding for this year.

You may not want to use Form W-4S if you already have your total tax covered by estimated tax payments or other withholding.

If you expect to file a joint return, be sure to include the income, deductions, credits, and payments of both yourself and your spouse in figuring the amount you want withheld.

Caution: If any of the amounts on the worksheet change after you give Form W-4S to the payer, you should use a new Form W-4S to request a change in the amount withheld.

Line 2—Deductions

Itemized deductions. Itemized deductions include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your adjusted gross income. See Pub. 505 for details.

Standard deduction. For 2020, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying widow(er)	\$24,800*
Head of household	\$18,650*
Single or Married filing separately	\$12,400*

* If you're age 65 or older or blind, add to the standard deduction amount the additional amount that applies to you as shown in the next paragraph. If you can be claimed as a dependent on another person's return, see *Limited standard deduction for dependents*, later.

Additional standard deduction for the elderly or blind. An additional standard deduction of \$1,300 is allowed for a married individual (filing jointly or separately) or a qualifying widow(er) who is 65 or older or blind, \$2,600 if 65 or older **and** blind. If both spouses are 65 or older or blind, an additional \$2,600 is allowed on a joint return. If both spouses are 65 or older **and** blind, an additional \$5,200 is allowed on a joint return. Additional standard deductions are also allowed on your separate return for your spouse who is 65 or older and/or blind if your spouse has no gross income and can't be claimed as a dependent by another taxpayer. An additional \$1,650 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, \$3,300 if 65 or older **and** blind. See the 2020 Estimated Tax Worksheet—Line 2 Standard Deduction Worksheet in Pub. 505.

Limited standard deduction for dependents. If you are a dependent of another person, your standard deduction is the greater of (a) \$1,100 or (b) your earned income plus \$350 (up to the regular standard deduction for your filing status). If you're 65 or older or blind, see Pub. 505 for additional amounts that you may claim.

Certain individuals not eligible for standard deduction. For the following individuals, the standard deduction is zero.

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual. For exceptions, see Pub. 519, U.S. Tax Guide for Aliens.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

Line 5—Credits

Include on this line any tax credits that you're entitled to claim, such as the child tax credit and credit for other dependents, higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled. See the Tax Credits table in Pub. 505 for more information.

Line 7—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2020 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

2020 Tax Rate Schedules

Schedule X—Single				Schedule Z—Head of household			
If line 3 is:	But not over—	The tax is:	of the amount over—	If line 3 is:	But not over—	The tax is:	of the amount over—
Over—				Over—			
\$0	\$9,875	\$0 + 10%	\$0	\$0	\$14,100	\$0 + 10%	\$0
9,875	40,125	987.50 + 12%	9,875	14,100	53,700	1,410 + 12%	14,100
40,125	85,525	4,617.50 + 22%	40,125	53,700	85,500	6,162 + 22%	53,700
85,525	163,300	14,605.50 + 24%	85,525	85,500	163,300	13,158 + 24%	85,500
163,300	207,350	33,271.50 + 32%	163,300	163,300	207,350	31,830 + 32%	163,300
207,350	518,400	47,367.50 + 35%	207,350	207,350	518,400	45,926 + 35%	207,350
518,400	and greater	156,235 + 37%	518,400	518,400	and greater	154,793.50 + 37%	518,400
Schedule Y-1—Married filing jointly or Qualifying widow(er)				Schedule Y-2—Married filing separately			
If line 3 is:	But not over—	The tax is:	of the amount over—	If line 3 is:	But not over—	The tax is:	of the amount over—
Over—				Over—			
\$0	\$19,750	\$0 + 10%	\$0	\$0	\$9,875	\$0 + 10%	\$0
19,750	80,250	1,975 + 12%	19,750	9,875	40,125	987.50 + 12%	9,875
80,250	171,050	9,235 + 22%	80,250	40,125	85,525	4,617.50 + 22%	40,125
171,050	326,600	29,211 + 24%	171,050	85,525	163,300	14,605.50 + 24%	85,525
326,600	414,700	66,543 + 32%	326,600	163,300	207,350	33,271.50 + 32%	163,300
414,700	622,050	94,735 + 35%	414,700	207,350	311,025	47,367.50 + 35%	207,350
622,050	and greater	167,307.50 + 37%	622,050	311,025	and greater	83,653.75 + 37%	311,025

Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue

law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.



Human Resources Department

Diane Rundles
Director

Mark DeBoer
Assistant Director

Dear County Employee:

SUBJECT: Your Benefits While on Medical Leave of Absence

The purpose of this letter is to explain your benefit eligibility and to obtain instruction from you regarding continued enrollment in benefit plans through the County of San Bernardino during your approved medical leave of absence.

You may choose to discontinue or modify benefit coverage during your medical leave of absence. Please complete and return the Continuation of Benefits Designation form to indicate which plans, if any, you wish to remain enrolled in during your medical leave of absence. Refer to the benefits matrix on the reverse of this letter for the impact of a medical leave of absence to your benefits.

Per section § 825.209(e) of the Family Medical Leave Act, California Code of Regulations, Title 2, Div.4, and/or applicable Memorandum of Understanding, Exempt Compensation Plan, Salary Ordinance, or Contract, you can receive benefits through any one of the following four ways:

1) Certain benefits specify that you must be paid for one-half plus one of your scheduled hours (e.g. if you are scheduled to work 80 hours per pay period, you must be paid at least 41 hours in REG, SCK, VAC, etc.) to receive benefits, including Premium Subsidies. If there is no minimum hour requirement specified, then you must at least be receiving pay for '0.25' coded hours on payroll to maintain eligibility and enrollment.

Or

2) As long as you fully integrate accrued leave time with Short-Term Disability (maximum of 52 weeks) you are eligible to receive Premium Subsidies. Your coverage will be terminated if you are not fully integrating paid leave time as long as you have received benefits while on leave in accordance with applicable law. If you are not able to fully integrate, medical and dental coverage may continue if you are receiving paid hours as described in option one.

Or

3) You must be on an approved FMLA/CFRA leave of absence (generally 12 weeks, but could be longer in the case of pregnancy or military leave) to receive benefits, including Premium Subsidies. If you are not eligible for FMLA/CFRA then your benefits may be terminated immediately.

Or

4) You must be on an approved Workers' Compensation Claim (maximum of 20 pay periods)

a) If you are on an approved FMLA/CFRA absence, after the 6th pay period off work, you are no longer eligible for active employee medical and dental plan coverage. Your benefits will be terminated and you will have the option of enrolling in COBRA continuation coverage (see below). If you elect COBRA coverage, you will receive Premium Subsidies for 14 additional pay periods (maximum of 20 pay periods). Please note if you do not enroll in COBRA continuation coverage you will not receive Premium Subsidies.

b) Fully accrued leave integration with Worker's Compensation does not impact benefit eligibility.

COBRA Continuation Coverage - When you are no longer eligible for active employee coverage due to certain qualifying events, the County of San Bernardino, as required under provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, will offer you and your covered family members the

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Gary McBride
Chief Executive Officer

Your Benefits While on Medical Leave

12/16/2019

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opportunity to elect a temporary extension of coverage (called "continuation coverage" or "COBRA coverage"). Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since the County usually pays a part of the premium for active employees while COBRA participants pay the entire premium.

Contact the Employee Benefits and Services Division (EBS) at (909) 387-5787 to elect to continue benefits or to make arrangements to continue to pay your share of premium payments on your health insurance to maintain your benefits while you are on leave. If payment is not made timely, your County coverage may be cancelled provided you receive notification in writing at least 15 days before the date that your health coverage will lapse.

If you have questions, contact EBS at the phone number above or email at ebs@hr.sbcounty.gov.

Benefits subject to FMLA Protection

Benefit/Deduction	While on medical leave of absence	You will need to...
Medical/Dental/Vision Insurance	<p>For FMLA, County Contributions will continue for 6 pay periods (other leaves may extend this – check with EBSD)</p> <p>You are responsible for your portion of applicable premiums.</p>	<p>Let the County know if you wish to continue your medical insurance while you are on a leave.</p> <p>Complete the Continuation of Benefits Designation Form. You will be billed for the balance of any premiums or monies due not collected through your pay warrant. All bills provide thirty (30) days to pay, with no grace period. If payment is not received by the due date, your enrollment will be cancelled back to the date premiums were paid in full.</p>

Benefits not subject to FMLA Protection

Benefit/Deduction	While on medical leave of absence	You will need to...
Opt Out/Waive	Opt Out/Waive contributions do not continue.	No action is required; this is an automatic change to payroll.
County Paid Life Insurance	<p>This is not an FMLA covered benefit.</p> <p>To maintain your coverage, you must pay the premium (employer's share) while you are on a leave directly to EBSD.</p> <p>If you are on leave more than four months, you may apply for a waiver of premium through Minnesota Life. If a "waiver of premium" is approved, then no premium payments are required.</p>	<p>Let the County know if you wish to continue your basic life insurance while you are on a leave.</p> <p>Complete the Continuation of Benefits Designation Form. You will be billed for the balance of any premiums or monies due not collected through your pay warrant. All bills provide thirty (30) days to pay, with no grace period. If payment is not received by the due date, your enrollment will be cancelled back to the date premiums were paid in full.</p> <p>It is important to note, that those who wish to apply for a waiver of premium should indicate that they wish to keep their basic life insurance and pay the premiums until the "Waiver of Premium" is approved by Minnesota Life.</p>
Supplemental Life Insurance/AD&D	<p>You have the option to continue or terminate your coverage.</p> <p>If you do not have enough money in your paycheck for the premium(s) to be deducted, you will receive a bill from EBSD.</p> <p>If you are on leave more than four months, you may apply for a waiver of premium through Minnesota Life.</p>	<p>Let the County know if you wish to continue your supplemental life insurance and or AD&D insurance while you are on a leave.</p> <p>Complete the Continuation of Benefits Designation Form. You will be billed for the balance of any premiums or monies due not collected through your pay warrant. All bills provide thirty (30) days to pay, with no grace period. If payment is not received by the due date, your enrollment will be cancelled back to the date premiums were paid in full.</p>
FSA/DCAP	You have the option to revoke or reduce your election.	Let the County know if you wish to reduce or revoke your elections while you are on leave by completing the Continuation of Benefits Designation Form.
Commuter Services/Ride Share	You have the option to stop Vanpool participation. If you choose to not to continue the deduction, your seat will no longer be reserved and your participation will cease. If you are no longer receiving pay from the County this will happen automatically.	Let the County know if you wish to stop your election while you are on leave by completing the Continuation of Benefits Designation Form and notify your Vanpool driver.
Combined Giving	As long as there is money available in your pay check, your deductions will continue to be taken.	<p>Let the County know if you wish to stop your Combined Giving deductions while out on leave by completing the Continuation of Benefits Designation Form.</p> <p>You will need to re-start your deduction by filling out a new election form upon your return.</p>
401(k)/457(b) Loans	<p>You have the option to continue making loan payments while you are on a leave.</p> <p>Interest will continue to accrue and all loan payments remain due during any period of leave that is not due to Military Service.</p> <p>If you are receiving pay from the County, loan payments will continue to be collected. If you are not receiving pay, you can remit loan payments to the County.</p> <p>If you do not make payments during your leave, interest will continue to accrue on the unpaid balance and the remaining loan balance will still be due by the original repayment date (loan will be re-amortized).</p>	Let the County know if you wish to continue making loan payments while on leave by completing the Continuation of Benefits Designation for Medical Leave of Absence Form.



CONTINUATION OF BENEFITS DESIGNATION

Employee ID	Rcd No.	Last Name, First Name		
Department		Contact Email	Department ID	Telephone

Please check the applicable box(es) below to indicate which plan(s) you wish to remain enrolled in.

If you elect to continue benefits, you will be billed for the balance due not collected through your pay warrant. With few exceptions, bills provide thirty (30) days to pay, with no grace period. If payment is not received by the due date, your enrollment may be cancelled back to the date premiums were paid in full.

Upon return to work, you must complete the forms necessary to re-enroll in medical/dental/vision coverage, as applicable, within 60 days of your return to work date.

Benefit Elections (Protected Leaves/Unpaid Status/Under Minimum Hours Requirement)

Benefit	Option		
	I DO want to continue this benefit and will pay for the applicable portion of the premium to continue the benefit	I do NOT want to continue this benefit, terminate my coverage immediately	FMLA Only. I want to CHANGE my benefit coverage level (drop dependent(s))
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Benefit Elections (Unpaid Status/Under Minimum Hours Requirement)

Benefit	Option		
	I DO want to continue this benefit and will pay for the applicable portion of the premium to continue the benefit	I do NOT want to continue this benefit, terminate my coverage immediately	I want to CHANGE my election
County Paid Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Voluntary/Supplemental Life	<input type="checkbox"/>	<input type="checkbox"/>	N/A
AD&D	<input type="checkbox"/>	<input type="checkbox"/>	N/A
457(b)/401(k) Loan Suspension	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Salary Savings Deductions (as applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical Expense Reimbursement Plan (FSA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Care Assistance Plan (DCAP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Commuter Services Rideshare Deduction	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Combined Giving Deductions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Employee Signature	Date
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Please return this form to:
 County of San Bernardino, HR-EBSD 157 W 5th Street, First Floor San Bernardino, CA 92415-0440
 Fax (909) 387-5566