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As You Enroll

This guide is designed to help you understand your Benefit Enrollment options. Included are summaries of your plan choices, including medical, dental, life insurance, AD&D and retirement options. You will also find comparison charts for convenient at-a-glance referencing and plan contact information. Please read your materials carefully, then choose the plans that best meet your needs.

As you prepare to enroll or make changes in your coverage, consider your benefit needs carefully. Think about the types and levels of coverage that you might need, both now and throughout the plan year. Do not forget to factor costs into your benefits picture.

Employees who do not complete the 2009-10 Open Enrollment process will maintain their current benefit elections with the exception of participation in the Medical Expense Reimbursement (FSA).

We encourage you to keep this guide as a reference throughout the year. If you have questions, contact EBSD or the plan directly. Plan phone numbers and web sites are listed in the Contact Information section of this booklet.

This guide only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between this Guide and the official documents, the official plan documents will prevail.

What's New & Different in 2009

Economic Stimulus - COBRA Subsidy for Assistance Eligible Individuals

COBRA Subsidy On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act (ARRA) of 2009. ARRA created a temporary federal subsidy of COBRA premiums for employees (and their dependents) who elect COBRA coverage in connection with an involuntary termination of employment occurring between September 1, 2008, and December 31, 2009. The premium subsidy is available immediately and will last for up to nine months, ending earlier if the individual becomes eligible for coverage under another group health plan or Medicare. "Assistance Eligible Individuals" need only pay 35% of the usual COBRA premium. The County will advance the other 65% of the premium, before obtaining reimbursement through a credit against its federal payroll tax liability.

Second Chance COBRA Election ARRA also provided that any individual who would have been an Assistance Eligible Individual had he or she elected COBRA coverage (or not let such coverage lapse before ARRA's enactment date of February 17, 2009) must be offered a second opportunity to elect COBRA coverage. By electing COBRA during this second election period, they may take advantage of the 65% premium subsidy.

An "Assistance Eligible Individual" will also have the opportunity to switch to coverage that costs less than the coverage held before the job loss.

Commuter Services

Effective March 2009, the Federal Commuter Benefits program has temporarily increased the pre-tax dollar allowance for transit and vanpool from \$120 to a maximum of \$230 per month. This increase should last through December 2010.



529 Education Savings Plan

ING is now offering a 529 Education Savings Plan with Fidelity Investments. This plan offers County employees a way to invest in their children's and grandchildren's education. The minimum bi-weekly deferral is \$50 and is deducted on an after-tax basis. For more information, contact the local ING office at (909) 748-6468.

Basic Life, Accidental Death and Dismemberment (AD&D) and Voluntary Term Life Insurance Plans

Minnesota Life Insurance Company is our new provider for Basic Life, AD&D, and Voluntary Term Life benefits for all eligible County employees and dependents.

While there are no major changes to the benefit plan coverage, premiums were reduced and some enhanced benefits are available at no additional cost.

My Health Matters!

If you want to improve your fitness and become more focused on healthy living, the County of San Bernardino Human Resources Department would

like to encourage you to enroll in the new online program - Steps to Success. The program launched on January 1, 2009, as part of My Health Matters! renewed focus on fitness and weight management.

With *Steps to Success* you will:

- ◆ Increase awareness of activity levels
- ◆ Improve your fitness
- ◆ Track your activities and BMI
- ◆ Earn incentives as you reach your step milestones
- ◆ Earn a monthly chance to win \$250*

**Must be enrolled in a County-sponsored health plan to be eligible for the reward.*

Recording your steps and activity is simple, quick and fun. You will be able to see your progress and earn incentive prizes as your steps add up.

Enroll now and receive your free pedometer! Just visit *Steps to Success* online at <http://www.healthycommunity.ca/sanbernardino/hr/Default.aspx>, click on "Not Registered?" and complete your quick Profile. (Registration Code: cosb)

More than 3000 employees have already joined us – don't wait any longer!

For more information

- ◆ Visit the Steps to Success website at <http://www.healthycommunity.ca/sanbernardino/hr/Default.aspx>
- ◆ Call your Wellness Advocate
- ◆ Contact EBSD

We encourage you to keep this guide as a reference throughout the year.

Dependent Election Proof

If your open enrollment election includes the addition of new dependents not currently or previously enrolled in a County plan, the deadline to submit proof of dependency is July 10, 2009. If this documentation is not received by the Employee Benefits and Services Division (EBS) by 5:00 p.m., July 10, 2009, your newly enrolled dependent(s) will not be added to your plan for the 2009/2010 plan year.

Additionally, if your newly enrolled dependent is aged 19 to 23 and a full-time student or is mentally or physically disabled and aged 19 or over, an "Over-Age Dependent Certification" must be completed online using eBenefits.

Health Net Elect Open Access

There are no significant benefit changes for the Health Net Open Access plan. Please refer to the Premium Rate Table and Medical Plans Comparison Chart for specific information.



Kaiser Permanente

There are no significant benefit changes for the Kaiser Permanente plan. Please refer to the Premium Rate Table and Medical Plans Comparison Chart for specific information.

Health Net PPO/Needles

There are no significant benefit changes for the Health Net PPO/Needles plan. Please refer to the Premium Rate Table and Medical Plans Comparison Chart for specific information.

DeltaCare USA

For members with cardiovascular disease, diabetes, or who are pregnant, the number of prophylaxis cleanings has increased from two (2) to four (4) per year. Please refer to the Summary Plan Description for more information.

Delta Dental PPO

For members with cardiovascular disease or diabetes, the number of prophylaxis cleanings has increased from two (2) to four (4) per year. Expectant mothers may receive the following benefits:

- ◆ One additional oral examination plus two additional routine prophylaxis cleanings, or
- ◆ One additional periodontal scaling/root planning per quadrant, or
- ◆ One additional periodontal maintenance

Additionally, implants will be covered at 75% in-network and 70% out-of-network, subject to the Annual Maximum Benefit.

Please refer to the Summary Plan Description for more information.

Vision Plan

For General and Safety employees, the frame and contact lens allowances increased from \$85 to \$120. Polycarbonate lens co-payments decreased from \$40 to \$20. For Exempt employees, the frame and contact lens allowance increased from \$125 to \$135. The polycarbonate lens co-payment decreased from \$40 to \$0.

Medical Expense Reimbursement (FSA) Plan

The HEART Act passed on May 22, 2008, enables Military Reservists called to at least one hundred eighty (180) days of active duty to withdraw any funds remaining in a Medical Expense Reimbursement (FSA) Account, less any pending reimbursements, at the time of call through a Qualified Reservist Distribution (QRD).

Short-Term Disability (STD) Plan

There are no significant benefit changes to the STD plan. For more information on this plan, please refer to the enclosed plan highlights, the STD Plan Documents, or go online at http://countyline/hr/benefits/short_term_disability.asp.

Tell Us What You Think!

Providing exceptional customer service is EBSD's top priority. Please tell us how we are doing by participating in a brief survey. The link to the survey site is www.surveymonkey.com/s.asp?u=486291762554.

For a paper survey, please contact EBSD.



2009/2010 PREMIUM RATE TABLE

For Active Employees

Rates Effective July 18, 2009*

Coverage Effective August 1, 2009



Plan	Coverage Type	2009-10 Published Bi-Weekly Rates	2008-09 Published Bi-Weekly Rates	Difference in Bi-Weekly Premium	Percentage (%) Change from 2008/09
Kaiser Permanente	Employee Only	\$194.43	\$178.06	\$16.37	9.20%
	Employee + 1	\$387.03	\$354.39	\$32.64	9.21%
	Employee + 2 or more	\$546.90	\$500.75	\$46.15	9.22%
Health Net HMO	Employee Only	\$170.40	\$154.43	\$15.97	10.34%
	Employee + 1	\$364.21	\$329.98	\$34.23	10.37%
	Employee + 2 or more	\$499.08	\$452.15	\$46.93	10.38%
Health Net PPO	Employee Only	\$344.34	\$333.63	\$10.71	3.21%
	Employee + 1	\$699.88	\$678.14	\$21.74	3.21%
	Employee + 2 or more	\$1,085.30	\$1,051.61	\$33.69	3.20%
Health Net (Needles) **	Employee Only	\$170.40	\$154.43	\$15.97	10.34%
	Employee + 1	\$364.21	\$329.98	\$34.23	10.37%
	Employee + 2 or more	\$499.08	\$452.15	\$46.93	10.38%
Delta Dental PPO	Employee Only	\$20.68	\$19.27	\$1.41	7.32%
	Employee + 1	\$38.10	\$35.47	\$2.63	7.41%
	Employee + 2 or more	\$64.85	\$60.36	\$4.49	7.44%
DeltaCare USA	Employee Only	\$9.09	\$8.78	\$0.31	3.53%
	Employee + 1	\$14.68	\$14.18	\$0.50	3.53%
	Employee + 2 or more	\$19.15	\$18.51	\$0.64	3.46%

Rates subject to change pending Board approval.

* Premiums do not include any medical/dental premium subsidies and/or benefit plan dollars you may be eligible for. Please refer to Benefit Plan Dollars and Premium Subsidies on page 14.

** For employees assigned to work in the Needles, Trona and Baker work locations, the County has established a "Needles Subsidy." The Needles Subsidy is paid by the employee's department and will be equal to the amount of the premium difference between the indemnity health plan offered in these specific work locations and the Health Net HMO option.

Contact Information

	Address	Phone	Web Site
BOARD OF RETIREMENT	348 W. Hospitality Lane, Third Floor . . . San Bernardino, CA 92415-0014	909-885-7980 1-877-722-3721	www.sbcera.org
EMPLOYEE BENEFITS AND SERVICES	157 West Fifth Street, First Floor San Bernardino, CA 92415 Interoffice Mail Code: 0440 AD&D / Life Insurance COBRA DeltaCare USA / Delta Dental PPO . . . Health Net Kaiser Permanente Retirement Medical Trust Salary Savings. Vision	909-387-5787 909-387-5559 909-387-5552 909-387-5831 909-387-5831 909-387-5559 909-387-5537 909-387-6098 909-387-5648	http://countyline/hr/benefits www.sbcounty.gov/hr/benefits_home.aspx
EMPLOYEE BENEFITS AND SERVICES (Leaves and Disabilities)	222 West Hospitality Lane, Third Floor. . . San Bernardino, CA 92415 Interoffice Mail Code: 0015 Long-Term Disability Medical Emergency Leave Short-Term Disability	909-386-8600 909-386-8600 909-386-8746 909-386-8600	
EMPLOYEE HEALTH AND WELLNESS CENTER	400 North Pepper Avenue. Colton, CA 92324	909-580-1701 1-877-722-3721	http://countyline/hr/center/ www.sbcounty.gov/hr/center_
PROVIDERS:			
DeltaCare USA	12898 Towne Center Drive Cerritos, CA 90703-8546	1-800-422-4234	www.deltadentalins.com
Delta Dental PPO	P.O. Box 7736. San Francisco, CA 94120	1-888-335-8227	www.deltadentalins.com
EyeMed Vision	. . . . .	1-866-939-3633	www.eyemedvisioncare.com
Health Net EOA	P.O. Box 9103. Van Nuys, CA 91409-9103	1-800-676-6976	www.healthnet.com
Health Net PPO	. . . . .	1-800-676-6976	
Health Net Needles	. . . . .	1-800-861-7214	
ING	1200 California Street, Suite 108 Redlands, CA 92374.	909-748-6468 1-800-584-6001	www.ingretirementplans.com
Kaiser Permanente	Kaiser Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109	1-800-464-4000	www.kp.org
Managed Health Network (MHN)	P.O. Box 10697. San Rafael, CA 94912	1-800-777-9276	www.members.mhn.com
Minnesota Life	. . . . .	1-888-237-1838	www.minnesotalife.com
SAN BERNARDINO COUNTY PUBLIC EMPLOYEES ASSOCIATION (SBPEA)	433 North Sierra Way. San Bernardino, CA 92410.	909-889-8377 1-877-312-3333	www.sbpea.com
SAN BERNARDINO COUNTY SAFETY EMPLOYEES' BENEFIT ASSOCIATION (SEBA)	735 East Carnegie Drive, Suite 125 . . . San Bernardino, CA 92408.	909-885-6074 1-800-655-7322	www.seba.biz

2009 Open Enrollment Master Schedule

JUNE 1 Mon **Open Enrollment begins!** Informational meetings are scheduled throughout the County. Check the meeting schedule included in this booklet for locations, dates and times.

During Open Enrollment, if you are eligible, you may:

- ◆ Enroll in a medical and/or dental plan
- ◆ Change medical and/or dental plans
- ◆ Add eligible dependents to your medical and/or dental plans
- ◆ Drop dependents from your medical and/or dental plans
- ◆ Opt-Out of a County-sponsored medical plan and/or dental plan (other comparable group coverage required)
- ◆ Change your refundable/nonrefundable retirement contribution election
- ◆ Enroll in Voluntary Term Life, Accidental Death and Dismemberment (AD&D) insurance, and/or Medical Expense Reimbursement Plan
- ◆ Change your Benefit Plan Premium Conversion Option elections
- ◆ Add/change your beneficiary information

eBenefits sessions available for computer access and one-on-one assistance 8:00 a.m. to 5:00 p.m. Monday through Friday at the EBSD, 157 West Fifth Street, First Floor, San Bernardino. No registration necessary — walk-ins are welcome. You can receive this service on County time with your supervisor's approval.

NOTE: EVERY EMPLOYEE MAKING CHANGES, OR ENROLLING IN THE MEDICAL EXPENSE REIMBURSEMENT (FSA) PLAN MUST COMPLETE eBENEFITS, ONLINE OPEN ENROLLMENT.

JUNE 19 Fri **Open Enrollment ends!** This is the deadline to submit your 2009 Benefit Elections using eBenefits.

JULY 10 Fri **Deadline to submit proof of dependency for newly added dependents, and Opt-Out verification for new Opt Outs.** Failure to provide documentation will result in denial of new elections.

JULY 18 Sat Premium rate change effective date.

AUG 1 Sat Effective date of coverage for changes made to medical, dental, voluntary term life and AD&D plans.

AUG 4 Tue Confirmation Statements mailed to all employees.

AUG 12 Wed Pay warrants reflect Open Enrollment rate changes.

2009 Open Enrollment Meeting Schedule

Benefits are an important part of your total compensation package. Take advantage of this opportunity to discover your options. **Please allow 1½ hours per session.**

CITY	DATE	DAY	TIME	LOCATION
SAN BERNARDINO	June 1	Mon	10:00 a.m. & 1:00 p.m.	County Government Center, Board Chambers 385 North Arrowhead Avenue
ONTARIO	June 2	Tue	9:30 a.m. & 11:00 a.m.	TAD – Dorothy Rowe Conference Room 1637 East Holt Boulevard
FONTANA	June 2	Tue	1:30 p.m. & 3:00 p.m.	TAD – Crosswell Commons Room 7977 Sierra Avenue
COLTON	June 3	Wed	9:30 a.m. & 11:00 a.m.	ARMC – Oak Room 400 North Pepper Avenue
HESPERIA	June 4	Thur	9:30 a.m. & 11:00 a.m.	TAD – Conference Room B, Second Floor 9655 9th Avenue
BARSTOW	June 4	Thur	2:00 p.m.	JESD – Job Club Room 1300 East Mt. View
SAN BERNARDINO	June 8	Mon	9:30 a.m. & 11:00 a.m.	Hall of Records – ACR Conference Room A & B, Fourth Floor 222 W. Hospitality Lane
NEEDLES	June 9	Tue	10:00 a.m. & 1:00 p.m.	Needles Park & Recreation Gymnasium Arts and Crafts Room 1705 "J" Street
REDLANDS	June 10	Wed	9:30 a.m. & 11:00 a.m.	TAD – Conference Room A, Second Floor 881 East Redlands Boulevard
LOMA LINDA	June 11	Thur	9:30 a.m. & 11:00 a.m.	Child Support – Sunrise Room 10417 Mt. View Avenue
RANCHO CUCAMONGA	June 12	Fri	10:00 a.m. & 1:00 p.m.	Rancho Cucamonga Superior Court Executive Conference Room, First Floor 8303 Haven Avenue
SAN BERNARDINO	June 15	Mon	1:30 p.m. & 3:00 p.m.	General Services – Large Conference Room 777 East Rialto Avenue
VICTORVILLE	June 16	Tue	10:00 a.m. & 1:00 p.m.	Ambassador Hotel – Lounge 15494 Palmdale Road
SAN BERNARDINO	June 17	Wed	1:30 p.m. & 3:00 p.m.	Public Services Group – Hearing Room 825 East Third Street
YUCCA VALLEY	June 18	Thur	10:00 a.m.	TAD – Large Conference Room 56357 Pima Trail
JOSHUA TREE	June 18	Thur	1:00 p.m.	Joshua Tree Court House – Hearing Room 6527 White Feather Road

2009 HEALTH FAIRS

CITY	DATE	DAY	TIME	LOCATION
SAN BERNARDINO	June 1	Mon	9:00 a.m. to 3:00 p.m.	County Government Center – Rotunda 385 N. Arrowhead Avenue
NEEDLES	June 9	Tue	10:00 a.m. to 2:00 p.m.	Needles Park & Recreation Gymnasium 1705 "J" Street
RANCHO CUCAMONGA	June 12	Fri	9:00 a.m. to 3:00 p.m.	Rancho Cucamonga Superior Court Jury Assembly Room 8303 Haven Avenue
VICTORVILLE	June 16	Tue	9:00 a.m. to 3:00 p.m.	Ambassador Hotel Convention Room B and C 15494 Palmdale Road

✦ *Attend one of the four Open Enrollment Health Fairs throughout San Bernardino County. Take this opportunity to meet your insurance carrier representatives and to receive health and dental information, education, and confidential screenings.*



Eligibility

You must be an employee in a regular position scheduled to work a minimum of 40 hours per pay period, have received pay for at least one half plus one hour of scheduled hours (or be on an approved leave pursuant to the Family Medical Leave Act) and the benefit must be offered to you through a Memorandum of Understanding (MOU), Exempt Compensation Plan, Contract or Salary Ordinance. Safety employees must be scheduled and paid for a minimum 41 hours a pay period.

Dependent Eligibility

If you are eligible to participate in County-sponsored medical and dental plans, your eligible dependents may also participate. Proof of dependent status for newly enrolled dependents is required. Your eligible dependents include:

- ◆ Your legal spouse
- ◆ State Registered Domestic Partner
- ◆ Your unmarried children* who are:
 - ▲ Less than 19 years old
 - ▲ 19 years, but less than 24 years old, enrolled in school as a full-time student (12 units or more) and supported primarily by you
 - ▲ 19 or more years old and supported primarily by you and incapable of self-sustaining employment by reason of mental or physical disability

* Your children include children born to you, legally adopted by you (including those children during any waiting period before the finalization of their adoption), your stepchildren, your registered Domestic Partner's children, children for whom you are the legal guardian, and children you support as a result of a valid court order. Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, children under age 24 who marry and subsequently divorce, and relatives other than those listed above are not eligible. (Kaiser Permanente allows coverage for grandchildren if the dependent child was enrolled with Kaiser Permanente prior to giving birth to the grandchild.)

Coverage for the grandchild may continue as long as the dependent child is covered.)

The following documents may be used as proof of relationship:

- ◆ Spouse:
 - ▲ Photocopy of marriage certificate (legal or church – not keepsake or handwritten)
- ◆ Domestic Partner:
 - ▲ Photocopy of the Certificate of State Registered Domestic Partnership or equivalent out-of-state certificate
- ◆ Children:
 - ▲ Photocopy of birth certificate (legal or church – not keepsake or handwritten)
 - ▲ Photocopy of a certificate of baptism (must include date of birth and show employee as parent)
 - ▲ Photocopy of court documents for:
 - Adoption
 - Placement
 - Custody
 - Legal Guardianship
 - Other court order stating dependent status
 - Other court order stating benefit coverage must be provided

Enrollment

As a condition of County employment, all employees must be covered by health and dental insurance. If you are an eligible employee, you must enroll in a County-sponsored medical and dental plan unless you have other employer-sponsored group medical and/or dental insurance. Premiums for County-sponsored medical and dental insurance will be deducted from your paycheck.

If you are an active employee, enrolled in a County-sponsored medical plan, and reach age 65, you will be given the option of remaining on the County-sponsored plan or electing coverage under Medicare Parts A and B. You will be notified of this option just prior to turning 65.

Benefits Calculator Available On-Line

The benefits calculator is available for use on the Human Resources web page. The calculator can help you determine how much out-of-pocket expense you will have. You can access this calculator through the Internet or through Countyline. For Inter/Intranet access, go to www.sbcounty.gov/hr/benefits_home.aspx or <http://countyline.co.san-bernardino.ca.us/hr>.

Opt-Out

If you have other employer-sponsored group medical and/or dental insurance that offers coverage comparable to a County-sponsored plan, you may elect to Opt-Out of the County-sponsored medical and/or dental insurance.

If you are currently opted-out of the medical and/or dental plans and have no changes to the coverage on file, no further action is needed.

If you are newly Opting-Out during this annual Open Enrollment, you must also provide proof of other insurance. If you fail to provide the required documentation by **5:00 p.m., July 10, 2009**, you will be reenrolled in your previous coverage.

New employees and mid-year changes must complete the Opt-Out Election Agreement form and submit it to EBSD.

What Happens If You Don't Enroll Timely?

New Employees — As a new employee, you have thirty-one (31) days from your date of employment to enroll in a medical and dental plan. EBSD must physically receive your enrollment forms and supporting documentation within that 31-day period. If you do not enroll when you are first eligible (or if you submit your enrollment forms late), you will be enrolled automatically in the Health Net HMO Medical Plan (except Needles)

and the DeltaCare USA Dental Plan with employee only coverage, and premiums will be deducted after-tax. Dependent coverage and before-tax deductions will not be available to you until the next Open Enrollment.

Medical and Dental Plans ID Cards

Within a month of the effective date of your coverage, you should receive identification (ID) cards from your medical and dental plans. You may, however, begin using your medical and dental benefits before receiving your ID cards. If you do not receive your ID cards, or if you need replacement cards, call your plan's member services department. If you have a problem accessing care, call EBSD.

Mid-Year Changes

The enrollment options you elect during the 2009/2010 Open Enrollment period will remain in effect for the entire plan year. You will have to wait until the next Open Enrollment period to make changes UNLESS you experience an IRS "Change in Status Event," such as:

- ◆ A legal marital status change including marriage, death of spouse, divorce, or annulment
- ◆ Commencement or termination of Domestic Partnership
- ◆ A change in the number of dependents including birth, death, adoption or placement for adoption
- ◆ A change in employment status for you, your spouse, your domestic partner or your dependent such as termination or commencement of employment, a strike or lockout and commencement or return from an unpaid leave of absence which results in a change of eligibility for medical and/or dental benefits
- ◆ Your dependent satisfies or ceases to satisfy eligibility requirements due to age, student status, marital status or any similar circumstance
- ◆ A residence change affecting eligibility for you, your spouse, your state registered domestic partner, or your dependent

- ◆ You or your dependent becomes entitled to Medicare or Medicaid (eligibility or loss of eligibility)
- ◆ Significant changes in Group Benefit Plan costs or coverage terms including the addition or elimination of a benefit plan
- ◆ Commencement of or return from a leave of absence
- ◆ Judgment, decree or order resulting from a divorce, annulment or change in legal custody (including a qualified medical child support order as defined in Section 609 of the Employee Retirement Income Security Act of 1974) that requires medical or dental coverage for an employee's child or for a foster child who is a dependent of the employee.

If you experience a Change in Status Event and you want to request a mid-year change in your Benefit Plan Premium Conversion Election, you must:

- 1** Complete the applicable medical, dental, vision, Voluntary Term Life, and/or AD&D enrollment forms (available from your Payroll Clerk)
- 2** Complete a Benefit Plan Premium Conversion Election/Change form (available from your Payroll Clerk)
- 3** If the Change in Status Event makes you eligible to Opt-Out of your County-sponsored medical and/or dental plan, complete the appropriate "Opt-Out Election Agreement" form; and
- 4** Attach documentation that verifies the reason for the mid-year change; examples of acceptable documentation are:
 - ▲ Copies of birth, death, marriage, or state-registered domestic partner certificates
 - ▲ Copies of court papers for divorce or adoption
 - ▲ Copy of letter from employer verifying loss or gain of spouse's employment which results in a change of eligibility for medical and/or dental benefits

- ▲ Verification of other health and/or dental coverage if Opting-Out. Verification must show the coverage effective date

Your request to make a mid-year change must:

- 1** Be consistent with the qualifying event
- 2** Meet the guidelines of County contracts/agreements, plan documents and Internal Revenue Code Section 125
- 3** Be received by EBSD within **31** days of the qualifying event

Effective Date of Mid-Year Changes

All elections made during the plan year shall become effective the first day of the pay period following the date that the properly completed Benefit Plan Premium Conversion Election/Change Form and documentation are received by the Plan Administrator.

Elections shall only apply to compensation that has not yet been earned at the time of the election unless otherwise allowed under IRC Section 125, federal regulations, the County's Section 125 Premium Conversion Plan and the terms of the Group Benefit Plans. Examples: upon receipt of a timely request, newborns are covered on the date of their birth and children placed for adoption are covered on the date they are placed in the home. You will be billed for any premiums owed as a result of the addition of eligible dependents. If the Change in Status Event results in a decrease in premiums, you will receive a refund on a subsequent pay warrant for the premium overpayment. To reduce the time for a refund or to reduce the amount of premiums owed, you are encouraged to submit your paperwork as soon as possible.

PLEASE NOTE: For Health Net Elect Open Access Members, your newborn child will be covered under the medical group the mother (parent) is assigned to, until Health Net processes the new enrollment.

Section 125 Premium Conversion Plan

Purpose This plan allows employees to pay for eligible benefits using either before-tax or after-tax dollars. If no changes are made during Open Enrollment, the previous plan elections will continue automatically. For new employees, if no election is made, the deductions will automatically be taken after taxes are calculated and the employee will be subject to all plan requirements and restrictions.

Pre-Tax Premiums Premiums for the following plans may be deducted from your paycheck before taxes are calculated:

- ◆ Medical
- ◆ Dental
- ◆ Accidental Death & Dismemberment (AD&D)
- ◆ Life insurance premiums

NOTE: Premiums for life insurance coverage in excess of \$50,000 (including employer-paid life insurance) are subject to imputed income per IRS regulations.

Section 125 Premium Conversion Plan Election You must notify the County of your choice to deduct eligible insurance premiums from your paycheck either before or after taxes are calculated. Plan elections are irrevocable for the plan year unless you have an IRS Change in Status Event.

Before-Tax Option This option is especially attractive as it results in greater take-home pay. It does, however, limit your mid-year changes (involving premium increases or decreases) to the Change in Status Events as specified in Internal Revenue Code Section 125 and the County's Section 125 Premium Conversion Plan.

After-Tax Option This option results in less take home pay. Changes during the Plan year are still limited to those allowed by the County's contracts, agreements or plan documents governing the benefits.

Dependent Eligibility In order to be eligible for the pre-tax option, a dependent must be claimed on your Federal Tax return and meet the eligibility requirements of a qualifying child or qualifying relative as described in IRC Section 152. Eligibility for the pre-tax option does not affect your dependent's eligibility for County-sponsored insurance.

Election of Pre-Tax Benefits

Open Enrollment: To have your medical and dental premiums deducted from your pay before federal and state taxes are withdrawn, you must use eBenefits to select the appropriate before-tax plan.

Mid-Year Change: To have your medical and dental premiums deducted from your pay before federal and state taxes are withdrawn, you must submit a completed Benefit Plan Premium Conversion Election form. If you do not submit the form on a timely basis, all eligible insurance premiums will be deducted on an after-tax basis.

Plan Termination The plan terminates on the date you cease to be an eligible participant (e.g., termination or reduction in hours).

Benefit Plan Dollars and Premium Subsidies

The County helps you pay your medical and dental insurance premiums by giving you Benefit Plan Dollars and/or subsidizing your premium payments to plan carriers by way of a Medical and/or Dental Premium Subsidy. The amounts vary and are based on your bargaining unit, family size, hire date, plan selection, and the number of hours you work. For specific amounts, refer to the appropriate Memorandum of Understanding, Compensation Plan, Salary Ordinance, or Contract.

Important Benefits information for employees assigned to work in Needles, Trona or Baker:

Medical The County has established a “Needles Subsidy” for employees assigned to work in these locations. This amount is paid by the employee’s department and will be equal to the premium difference between the indemnity health plan offered (currently Health Net PPO) and the lowest cost HMO plan (currently Health Net HMO).

If you are eligible for this benefit and are not currently receiving the subsidy, please contact EBSD at (909) 387-5787. If you are no longer assigned to work in one of these specified areas and are still receiving this subsidy, you must report this change to EBSD. Failure to do so will result in repayment of ineligible subsidy amounts.

Dental You may elect to participate in either Delta Dental PPO or DeltaCare USA. If you choose to enroll in DeltaCare USA, you will need to contact EBSD to arrange enrollment in the special Needles group. Enrolling in the special Needles group allows you to utilize the same DeltaCare benefits but expands your provider choices in these remote areas. For specific information about the Needles group and providers, contact EBSD.



Health and Welfare Plans Highlights

As you review the comparison charts and plan highlights on the following pages, keep these important questions in mind:

- ◆ What are my current benefits needs?
- ◆ Are these needs different than they were in the past?
- ◆ Do I anticipate new or different needs for the coming year?
- ◆ How do these needs affect my current benefits elections and the choices I need to make?



eBenefits Instructions

What is eBenefits?	An Internet and Intranet based system that allows you to: <ul style="list-style-type: none"> ☞ Make changes to your benefits ☞ View your choices immediately for accuracy ☞ Print a confirmation statement eBenefits is available during the entire Open Enrollment period (June 1 through June 19, 2009). You must submit your benefit elections by June 19, 2009.	
Complete Your Open Enrollment Online Using eBenefits	You must use eBenefits if <ul style="list-style-type: none"> ☞ You are making any changes during the 2009/2010 Open Enrollment ☞ You want to renew participation in a Flexible Spending Account (Medical Expense Reimbursement Plan) 	
If you have no changes	You do not need to use eBenefits. You will maintain your current elections, with the exception of FSA as described above.	
How to access eBenefits	You must first enable Internet access in order to use eBenefits from a non-County computer <ol style="list-style-type: none"> 1) From a work computer <ul style="list-style-type: none"> ☞ Sign-in to EMACS. ☞ Click on <i>Self-Service>Employee>Tasks>Internet Access Change</i>. ☞ Check the box labeled "Enable Internet Access Change" then click "Save" 2) From home or other Internet connection: 3) Access the EMACS Sign In page https://emacsweb.co.san-bernardino.ca.us/Signon.html <ul style="list-style-type: none"> ☞ Click on the link labeled "Internet Access" ☞ Enter your User ID, Password, and SR# (located in the upper right hand corner of your Leave and Earnings Statement) ☞ Click "Enable" If you need assistance enabling Internet Access, please contact the Help Desk at 909-884-4884.	Sign on from a County Computer (Intranet) or the Internet <ol style="list-style-type: none"> 1) Go to the EMACS Sign-In Page https://emacsweb.co.san-bernardino.ca.us/Signon.html 2) Enter your User ID and Password <ul style="list-style-type: none"> ☞ Enter your 5 or 6 digit Employee (EE) ID Number (e.g. B1234) ☞ If your EE ID number starts with a number, replace the first number with the letter "X" 3) Click the "Sign In" Button
Add Dependents and/or Beneficiaries	<p>This page allows you to add dependents and/or beneficiaries to a list you will have available to select from once you are ready to make your medical, dental and insurance elections.</p> <p>Click on <i>Self Service>eBenefits>Enrollment>Dependent/Beneficiary Summary</i></p> <ul style="list-style-type: none"> ☞ Review the listing of dependents and/or beneficiaries you have to choose from. <p>Edit information on an existing dependent and/or beneficiary</p> <ul style="list-style-type: none"> ☞ Click on the name and then "Edit" ☞ Edit information as necessary then click "Save" ☞ Click "OK" ☞ Click "Return" to go back to the <i>Dependent/Beneficiary Summary</i> page 	

eBenefits Instructions (continued)

	<p>To add a dependent who is not listed</p> <ul style="list-style-type: none"> ☞ Click on "Add a dependent or beneficiary" and enter the required information. ☞ Click "Save" and then click "OK". Click "Return" to go back to the summary page <p>For dependents who are disabled or a full-time student between the ages of 19 and 23</p> <ul style="list-style-type: none"> ☞ You must complete the Over Age Dependent Certification section. ☞ Include the school information if applicable
To finalize dependent/beneficiary additions	<ul style="list-style-type: none"> ☞ Click "Enrollment" at the very top of the screen. ☞ Click "Benefits Enrollment" to begin the enrollment process
Enrollment Process	<p>Starts the enrollment process and allows you to view your current plans and to make changes.</p> <p>Click on <i>Self-Service > eBenefits > Enrollment > Benefits Enrollment</i></p> <p>Benefits Enrollment page</p> <ul style="list-style-type: none"> ☞ Click "Info" for general information ☞ Click "Select" to begin the enrollment process ☞ Review the information provided on the Section 125 Premium Conversion Plan, which explains tax options. ☞ Click "OK" <p>Enrollment Summary Page</p> <ul style="list-style-type: none"> ☞ Review your current benefit elections (scroll down the page to view all benefits) ☞ Click "Edit" to view and make changes as necessary.
Finalize and SUBMIT Open Enrollment Elections	<ul style="list-style-type: none"> ☞ Review your benefit elections on the Enrollment Summary page. Estimates of the bi-weekly premiums for new elections are displayed at the bottom of this page. ☞ Click "Submit" after reviewing your benefit elections to access the <i>Submit Benefit Choices</i> page ☞ Read the terms and conditions. Click "Submit" to finalize your benefit elections, which constitutes your signature. ☞ Print the <i>Submit Confirmation</i> page and retain it for future reference. You will not receive a confirmation statement from EBSD until August 2009. ☞ Click "OK" on the <i>Submit Confirmation</i> page to return to the <i>Benefits Enrollment</i> page. ☞ Click "Sign Out" in the upper right hand corner of the page to exit eBenefits. <p>NOTE: You may review or change your benefit elections in eBenefits until the Open Enrollment deadline at midnight June 19, 2009</p>
Need Further Assistance?	<ul style="list-style-type: none"> ☞ Contact the Help Desk at 909-884-4884 for technical assistance. Your call will be logged and a representative will contact you. Calls received after 5:00pm or on weekends will be returned the next business day. ☞ Contact EBSD at 909-387-5787.

eBenefits Instructions (continued)

	MEDICAL	DENTAL	OPT-OUT / WAIVE
What you need to know/do	View plan choices, premiums, and make changes	View plan choices, premiums, and make changes	Decline participation in County medical and/or dental plans if you have coverage under another group plan
To enroll	Click the button next to the plan name. To enroll dependents, check the "Enroll" box next to each dependent's name	Click the button next to the plan name. To enroll dependents, check the "Enroll" box next to each dependent's name	Click the "Edit" button next to the plan name
Additional steps	<p><i>New enrollees with Health Net Elect Open Access only:</i></p> <ul style="list-style-type: none"> › Select a Primary Care Physician and Medical Group for yourself and your dependent(s) by either calling Health Net Member Services at 800-676-6976 or click "Select a Provider" to enter Health Net's website › After obtaining your provider's "Enrollment Code" (participating Physician group # followed by the Physician ID#), scroll down the page and enter the code in the "Provider ID" box 	<p><i>New enrollees with DeltaCare USA only:</i></p> <ul style="list-style-type: none"> › Select a network dentist for yourself and/or your dependent(s) by either calling Delta Member Services at 800-422-4234 or click "Select a Provider" to enter Delta's website › After obtaining your provider's "Office Number," scroll down the page and enter the code in the "Provider ID" box 	<p>From among the plan choices, click the "Waive/Opt-Out" button. Select the appropriate "Waive Reason" from the box.</p> <ul style="list-style-type: none"> › If your coverage is provided by a non-County group, select "Opt-Out" <ul style="list-style-type: none"> • Complete the <i>Opt-Out Election Agreement</i> section with your other insurance information › Select "Covered by other County Employee" if this is the source of your other coverage <ul style="list-style-type: none"> • Enter the Employee ID of your spouse/domestic partner
Store	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page
NOTE	Continuing Health Net enrollees who simply want to select a new Primary Care Physician and/or Medical Group must contact Health Net Member Services at 800-676-6976 to request the change	Continuing DeltaCare USA enrollees who simply want to select a new Network Dentist must contact DeltaCare Member Services at 800-422-4234 to request the change	For new Waive or Opt-Out elections, you MUST provide verification of the other group-sponsored health/dental coverage to EBSD by July 10, 2009

eBenefits Instructions (continued)

	VISION	FSA	RETIREMENT OPTIONS
What you need to know/do	Select dependent coverage for Exempt and Safety employees only	Enrollment is voluntary, but you must enroll every year to continue participating in this benefit	Decide between refundable and nonrefundable options
To enroll	Employee Only enrollment is automatic	Click the next button next to "Yes, I elect to enroll"	
Additional steps	To add dependents, check the "Enroll" box next to each dependent's name	<ul style="list-style-type: none"> ➤ Enter your election for 2009-2010 in the "Annual Pledge" box <ul style="list-style-type: none"> • Click "Worksheet" to calculate your per-pay-period contributions ➤ Click "Return" to go back to the <i>Flexible Spending Account</i> page 	To select a different option, click the button to the left of your "Plan Name"
Store	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page

	BASIC LIFE	SUPPLEMENTAL AD & D	SUPPLEMENTAL LIFE
What you need to know/do	County pays 100% of the cost of the plan	Review coverage levels, premiums and tax options	Review coverage levels and tax options
To enroll	Enrollment is automatic	Enrollment in this benefit is voluntary	Enrollment in this benefit is voluntary
Additional steps	Make desired beneficiary and allocation changes	<ul style="list-style-type: none"> ➤ Click the button next to the level of desired coverage or click "Waive" to terminate coverage ➤ Make the desired beneficiary and allocation changes 	<ul style="list-style-type: none"> ➤ Enter a coverage amount to indicate your desired level of coverage or click "Waive" to terminate coverage ➤ Make the desired beneficiary and allocation changes
Store	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page

Medical Plans Comparison Chart

HEALTH NET ELECT OPEN ACCESS		
	Tier One	Tier Two
Allergy testing	You pay a \$10 copay (serum covered)	You pay a \$30 copay (serum covered)
Ambulance	No charge when medically necessary	Not covered
Chiropractic care	Not covered	Not covered
Choice of physician and other providers	Health Net HMO provider network	Health Net California PPO physicians only
Deductibles Calendar year	None	None
Hospital or ambulatory surgical center deductible	None	None
Non-certification deductible	None	PPO services that require certification are not covered
Diagnostic X-rays and lab tests	No charge	Covered only when performed in physician's office
Durable medical equipment	No charge	Not covered
Emergency room	You pay a \$50 copay (waived if admitted)	Not covered
Family planning Infertility services	You pay 50%; excludes GIFT, ZIFT and IVF	Not covered
Tubal ligation	You pay a \$10 copay	Not covered
Vasectomy	You pay a \$10 copay	Not covered

COMPARISON CHART

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between the Comparison Chart and the official documents, the official plan document will prevail.

	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	\$10 copay (serum covered)	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge when medically necessary	You pay 20% after deductible when medically necessary	You pay 30% after deductible when medically necessary
	Not covered	You pay 20% after CY deductible up to 30 visits per CY (combined PPO/OON)	You pay 30% after CY deductible up to 30 visits per CY (combined PPO/OON). Through OON max payable \$25 per visit
	Kaiser Permanente physicians and facilities only	Any Health Net California PPO network physician and/or facility	You may self-refer to any CA licensed providers; but you pay 30% after deductible plus any costs over the UCR amount
	None	\$250 each covered member \$750 family maximum Combined PPO/OON	\$250 each covered member \$750 family maximum Combined PPO/OON
	None	None	\$250 per hospital admission \$250 per outpatient surgery
	None	Inpatient: \$250 per admission unless preauthorization is obtained Outpatient: \$250 per visit	Inpatient: \$250 per admission unless preauthorization is obtained Outpatient: \$250 per visit
	No charge	You pay 20% after deductible	You pay 30% after deductible
	No charge	You pay 20% after deductible; up to \$5,000 combined PPO/OON per calendar year	You pay 30% after deductible; up to \$5,000 per calendar year
	You pay a \$50 copay (waived if admitted)	You pay a \$50 deductible (waived if admitted) plus 20%	You pay a \$50 deductible (waived if admitted) plus 20%
	You pay 50%; excludes GIFT, ZIFT and IVF	Not covered	Not covered
	You pay a \$10 copay	You pay 30% after deductible (coinsurance does not apply to out-of-pocket maximum)	You pay 50% after deductible (coinsurance does not apply to out-of-pocket maximum)
	You pay a \$10 copay	You pay 30% after deductible (coinsurance does not apply to out-of-pocket maximum)	You pay 50% after deductible (coinsurance does not apply to out-of-pocket maximum)

CY = Calendar Year

C&R = Customary and Reasonable
County of San Bernardino

UCR = Usual and Customary Rates

Medical Plans Comparison Chart *(continued)*

	HEALTH NET ELECT OPEN ACCESS	
	Tier One	Tier Two
Home health services	No charge when medically necessary	Not covered
Hospice Inpatient & outpatient	No charge when medically necessary	Not covered
Hospital care	No charge	Not covered
Lifetime benefits maximum	No limit	No limit
Maternity care	No charge except \$10 for first prenatal and postnatal visit	Not covered
Mental health services Non-severe mental disorders	Inpatient: No charge; up to 30 visits per year Outpatient: You pay \$20; up to 20 visits per year	Inpatient: Not covered Outpatient: Not covered
Severe mental disorders	Inpatient: No charge; unlimited days Outpatient: You pay \$10; unlimited days	Inpatient: Not covered Outpatient: Not covered
Out-of-pocket annual maximum	\$1,500 each member \$3,000 family maximum	Not applicable
Outpatient hospital services	No charge	Not covered

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between the Comparison Chart and the official documents, the official plan document will prevail.

	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	No charge when medically necessary; up to 100 two-hour visits per calendar year	You pay 20% after deductible; 100 visits combined PPO/OON per calendar year maximum	You pay 30% after deductible; 100 visits per calendar year maximum
	No charge when selected as alternative to traditional services covered by Kaiser Permanente	You pay 20% after deductible is met; \$10,000 lifetime combined PPO/OON benefit	You pay 30% after deductible; \$10,000 lifetime combined PPO/OON benefit
	No charge for approved services obtained in a Kaiser Permanente facility/approved facility	You pay 20% after deductible	You pay 30% after deductibles (per calendar year plus \$250 admission)
	No limit	\$5,000,000 combined PPO/OON	\$5,000,000
	No charge	You pay 20% after deductible	You pay 30% for outpatient visits; you pay 30% after deductible for hospital care
	<p>Inpatient: No charge; up to 30 days per calendar year</p> <p>Outpatient: You pay a \$10 copay/ \$5 copay group; up to 20 visits per calendar year</p> <p>Inpatient: No charge; unlimited days (up to 30 days per calendar year)</p> <p>Outpatient: You pay a \$10 copay; 20 visits individual per calendar year</p>	<p>Inpatient: Covered in full — no limit [CY deductible waived]</p> <p>Outpatient: Covered in full — no limit</p> <p>Inpatient: You pay 20%</p> <p>Outpatient: You pay 20% [CY deductible waived]</p>	<p>Inpatient: \$250 plus 30% after deductible</p> <p>Outpatient: You pay 30% after deductible</p> <p>Inpatient: \$250 plus 30% after deductible</p> <p>Outpatient: You pay 30% after deductible</p>
	\$1,500 each member \$3,000 family maximum	\$1,500 each member \$3,000 family maximum (Some benefits are excluded from out-of-pocket maximum. See Certificate of Insurance for details)	\$2,000 each member \$3,000 family maximum (Some benefits are excluded from out-of-pocket maximum. See Certificate of Insurance for details)
	\$10 copay per procedure	You pay 20% after deductible at network facilities	You pay 30% after deductible

CY = Calendar Year

C&R = Customary and Reasonable
County of San Bernardino

UCR = Usual and Customary Rates

Medical Plans Comparison Chart *(continued)*

	HEALTH NET ELECT OPEN ACCESS	
	Tier One	Tier Two
Physician services		
Hearing screenings	You pay a \$10 copay	You pay a \$30 copay
Home visits	You pay a \$10 copay	Not covered
Hospital services	No charge	Not covered
Immunizations	You pay a \$10 copay	You pay a \$30 copay
Office visits	You pay a \$10 copay	You pay a \$30 copay
Periodic health exams	You pay a \$10 copay	You pay a \$30 copay
Routine physicals	You pay a \$10 copay when requested by a third party such as school, camp, etc.	Not covered
Specialists	You pay a \$10 copay	You pay a \$30 copay
Surgical services	No charge	Physician's office only
Well baby Well child care	You pay a \$10 copay	You pay a \$30 copay
Well woman exam	You pay a \$10 copay	You pay a \$30 copay
Physical and occupational therapy	You pay a \$10 copay	You pay a \$30 copay; up to 12 visits per calendar year
Preexisting condition	Fully covered	Fully covered
Prescription drugs (per fill)	<p>Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary</p> <p>Mail Order (90-day supply): \$10 generic, \$20 brand name, \$50 non-formulary</p>	<p>Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary</p> <p>Mail Order (90-day supply): \$10 generic, \$20 brand name, \$50 non-formulary</p>

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between the Comparison Chart and the official documents, the official plan document will prevail.

	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge; only when medically necessary	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge	You pay 20% after deductible	You pay 30% after deductible
	No charge	You pay 20% through age 16 [CY deductible waived]	You pay 30% after deductible through age 16
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	See routine physicals below	You pay 20% [CY ded. waived]	You pay 30% after deductible
	You pay a \$10 copay	Not covered	Not covered
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	No charge	You pay 20% after deductible	You pay 30% after deductible
	No charge	You pay 20% [CY ded. waived]	You pay 30% after deductible \$20 maximum payable
	You pay a \$10 visit copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	You pay a \$10 copay	You pay 20%; up to 30 combined PPO/OON visits per calendar year [CY ded. waived]	You pay 30% plus any costs over \$25 per visit; up to 30 combined PPO/OON visits
	Fully covered	Fully covered	Fully covered
	Pharmacy (up to 100-day supply): <ul style="list-style-type: none"> • Generic: \$10 copay • Brand: \$15 copay • Drugs prescribed for the treatment of sexual dysfunction disorders: 50% coinsurance • Drugs for the treatment of infertility: 50% coinsurance 	Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary. Mail Order: \$30 generic, 50% coinsurance for lifestyle drugs \$60 brand and non-formulary Pharmacy and mail order copays do not apply toward the out-of-pocket maximum.	Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary plus 50% of the Rx drug covered expense.

Medical Plans Comparison Chart *(continued)*

		HEALTH NET ELECT OPEN ACCESS	
		Tier One	Tier Two
Skilled nursing facilities		No charge	Not covered
Speech therapy		You pay a \$10 copay	You pay a \$30 copay; up to 12 visits
Substance abuse	Rehab:	Inpatient: No charge; up to 30 days per year Outpatient: You pay \$20; up to 20 visits per year	Inpatient: Not covered Outpatient: Not covered
	Detox:	Inpatient: No charge; up to 3 days Outpatient: Not covered	Inpatient: Not covered Outpatient: Not covered
Urgent care		You pay a \$25 copay	Not covered
Vision (exam only)			
	Adult	You pay a \$10 copay	You pay a \$30 copay
	Children through age 16	You pay a \$10 copay	You pay a \$30 copay

COMPARISON CHART

Notes

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between the Comparison Chart and the official documents, the official plan document will prevail.

	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	No charge for authorized stays; maximum 100 days per benefit period at a contracting skilled nursing facility	You pay 20% after calendar year deductible; 100 days combined PPO/OON per year at a contracting skilled nursing facility	You pay 30% after calendar year deductible; plus \$250/100 days combined PPO/OON per calendar year at a contracting skilled nursing facility
	You pay a \$10 copay per visit	You pay 20% [CY ded. waived]; up to 24 combined PPO/OON visits per calendar year, when due to surgery, injury or organic disease	You pay 30% after deductible; up to 24 combined PPO/OON visits per calendar year; when due to surgery, injury or organic disease. Maximum payable per visit \$30.
	<p>Inpatient: \$100 per admission; up to 60 days per calendar year, not to exceed 120 days in any five-year period</p> <p>Outpatient: \$10 copay individual, \$5 copay group</p> <p>Inpatient: No charge</p> <p>Outpatient: \$10 copay individual, \$5 copay group</p>	<p>Inpatient (Rehab & Detox): You pay 100% for charges in excess of \$175 (does not apply to out-of-pocket maximum) [CY ded. waived] up to 30 days per CY for Rehab only, see Certificate of Insurance for Detox</p> <p>Outpatient (Rehab & Detox): You pay 100% over \$25 per visit; up to 50 visits (does not apply to out-of-pocket maximum) for Rehab only, see Certificate of Insurance for Detox [CY ded. waived]</p>	<p>Inpatient (Rehab & Detox): You pay 30% after CY deductible plus \$250 per admission deductible</p> <p>Outpatient (Rehab & Detox): You pay 30% after deductible</p>
	You pay a \$10 copay	You pay 20% after \$25 ded.	You pay 20% after \$25 ded., plus anything over UCR
	You pay a \$10 copay	You pay 20%	Not covered
	You pay a \$10 copay	You pay 20% [CY ded. waived]	You pay 30% after ded. plus anything over UCR

Health Net Elect Open Access

This is a general summary of Health Net Elect Open Access benefits. A more complete description of benefits and the terms under which they are provided, including limitations and exclusions, are contained in the plan documents. If there are any discrepancies between the information contained in this summary and the provisions of the plan documents, the plan documents are the controlling documents.

Health Net Elect Open Access is a Health Maintenance Organization (HMO) plan with a Point-of-Service (POS) provision. The HMO provision requires that you select a Primary Care Physician (PCP) from one of the Health Net Participating Physician Groups. The POS component gives you the option of seeking consultations and evaluations from any specialist within the Health Net network without a referral from your PCP. The HMO provision is referred to as TIER 1 and the POS provision as TIER 2.

Under TIER 1 (the HMO), you receive all of your care from within your PCP's network of participating physicians, hospitals, and other health care providers. Under TIER 2 (the POS option), you are allowed consultations with a doctor outside of your Participating Physician Group, but within Health Net's Preferred Provider

Organization (PPO) network, without a referral from your PCP.

How the Plan Works

With Health Net, you must choose a PCP from a Health Net Participating Physician Group when you enroll. If you also enroll dependents, each dependent can choose their own Participating Physician Group and PCP. You may not choose a specialist as a PCP. If you are a new Health Net enrollee and you do not select a PCP, a PCP will be selected for you. Your PCP will treat you for many medical conditions, perform preventive care services and coordinate all of your health care, including making referrals to specialists and hospitals within your Participating Physician Group. Also, under the HMO (TIER 1) component, you are allowed to self-refer for one annual OB/GYN appointment. You must select an OB/GYN provider who is in the same Participating Physician Group as your PCP for the visit to be covered at the HMO benefit level. Using your PCP and using the HMO option is the most cost effective, lowest out-of-pocket cost way to use the plan.

However, with the TIER 2 component, you may see any doctor or specialist in the Health Net Preferred Provider Organization network without a referral from your PCP. When you use this option, your costs will be higher and you may have to file claim forms for certain services. This direct access feature only covers office visits, consultation, evaluation and treatment — procedures that can be performed in the doctor's office. Some services may require certification from Health Net. Services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your PCP under the TIER 1 option.

If you need a Health Net HMO or PPO Provider Directory, please call Health Net's Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish), or use Health Net's web site at www.



healthnet.com. The directory lists physicians and medical groups accepting new patients. If your current physician or medical group accepts Health Net but is not listed in the Directory, call Health Net's Member Services for assistance. Once enrolled in Health Net, you can also call Member Services to change your PCP.

Copayments For most routine HMO care, you pay a \$10 copayment. For other services, copayments range from \$10 to 50% of actual charges. For TIER 2, copayments for covered benefits are normally \$30.

Deductible Under Health Net HMO, you pay no deductibles.

Hospitalization You are covered for all medically necessary hospitalization when admitted by your PCP.

Emergency Care If you need emergency services, you should call 911 or go directly to the nearest medical facility for treatment. Emergency Care is any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- ◆ His or her health would be put in serious danger (and in the case of a pregnant woman, the health of her unborn child)
- ◆ His or her bodily functions, organs or parts would become seriously damaged
- ◆ His or her bodily organs or parts would seriously malfunction

Health Net will make any final decisions about Emergency Care. If you seek Emergency Care, please inform Health Net of the locations, duration and nature of the services provided.

Out-of-Area Care If you need urgent medical care and cannot get to your PCP, call your PCP for guidance. If you are unable to contact your

PCP, you should seek care for Urgently Needed Services from a licensed medical professional where you are located and notify your Participating Physician Group as soon as possible afterwards.

Claim Forms Under the Health Net HMO component you do not have to file claim forms. You may have to file claim forms when using your TIER 2 benefits or following Emergency Care or out-of-area Urgent Care services.

Medical Transition of Care Benefit

As a new member you are entitled to a medical review that may allow you to continue your current treatment plan due to a specific diagnosis for a specified time frame with your prior provider.

Some examples of circumstances for you or a member of your family:

- ◆ You are in the second or third trimester of pregnancy or a high-risk pregnancy and are currently established with an Obstetrician.
- ◆ You are scheduled for surgery within 3 weeks after your effective date of coverage.
- ◆ You have documented follow-up care for surgery that was completed within 6 weeks prior to your effective date of coverage.
- ◆ You have complications resulting from surgery performed within the month prior to your effective date of coverage.
- ◆ You are presently undergoing a course of chemotherapy or radiation therapy.



- ◆ You are approved for or on a waiting list for a transplant.
- ◆ You have an acute or serious chronic condition.
- ◆ You are currently receiving outpatient mental health treatment or you are currently in a chemical dependency treatment program.

If you have a transition of care issue, please complete a Health Net Transition of Care Assistance Request Form. You can get a copy of the form from your payroll clerk, EBSD or by calling Health Net Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish).

How to Enroll

New employees must enroll within 31 days of hire into an eligible position. Remember, proof of dependent status is required for each dependent you enroll on the plan. Please refer to the Eligibility, Enrollment and Mid-Year Changes sections of this guide for specific details.

What's Covered

While covered under Health Net, you can take advantage of comprehensive medical benefits. Please refer to the Medical Plans Comparison Chart of this Guide for a summary of covered expenses. Remember, this Guide only provides a summary of the benefits available through Health Net. The Health Net contract determines the exact terms and conditions of coverage.

What's Not Covered

Exclusions and Limitations are subject to change. Please refer to the current Health Net Evidence of Coverage (EOC) or contact Health Net's Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish) for additional information.

General Exclusions

It is extremely important to read your EOC before you obtain services in order to know what Health Net will and will not cover. Health Net does not cover certain services or supplies. Also, services or

supplies that are excluded from coverage, appear in the EOC as "Not Covered," exceed EOC limitations, are not Medically Necessary, or are follow-up care to EOC exclusions or limitations will not be covered.

How to Get in Touch with Health Net

Call Health Net's Member Services at 1-800-676-6976, 1-800-331-1777 (Spanish), or go to Health Net's web site at www.healthnet.com for more information.



Kaiser Permanente

The Kaiser Permanente Health Maintenance Organization (HMO) is available only to employees and their eligible dependents living within the Kaiser Permanente service areas of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern and Ventura Counties. Certain outlying zip codes within the County are not eligible for coverage through Kaiser Permanente. Please contact Kaiser Permanente's Member Services number to verify that you are in an eligible service area.

How the Plan Works

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente facilities around the country. You have access to virtually full-service, unlimited medical care at little or no additional cost. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers. Otherwise, you will not be eligible to receive benefits, except in a life-threatening situation, such as an out-of-area urgent or emergency situation. The County has also contracted for premiums to cover durable medical equipment. See the durable medical equipment insert located in your materials from Kaiser Permanente for specific benefit information.

Copayments For most routine care, you pay \$10. For other services, copayments may range from \$5 to \$100.

Deductible Under Kaiser Permanente, you pay no deductible and your out-of-pocket annual expenses are limited to \$1,500 per person or \$3,000 per family.

Hospitalization Kaiser Permanente will coordinate all non-emergency admissions.

Emergency Care If you think you have an emergency medical condition and cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. Please see your Evidence of Coverage for more details on your coverage and benefits.

Out-of-Area Care If you need medical care and cannot get to a Kaiser Permanente facility, call the 800 number on the back of your ID card for guidance.

Claim Forms Under Kaiser Permanente, you do not have to file claim forms except for out-of-area urgent or emergency care.

How to Enroll

New employees must enroll within 31 days of hire into an eligible position. Please refer to the

Eligibility, Enrollment, and Mid-Year Changes sections of this guide (pages 10-12) for specific details.

Call Kaiser Permanente's Member Services if you

- ◆ Have a benefits question
- ◆ Need a member identification (ID) card
- ◆ Have an eligibility question
- ◆ Have a claims question
- ◆ Want to file a grievance

What's Covered

While covered under Kaiser Permanente, you can take advantage of comprehensive medical benefits. Please refer to the Medical Plans Comparison Chart of this Guide for a summary of covered expenses. Remember, this Guide only provides a summary of the benefits available through Kaiser Permanente. The Kaiser Permanente contract determines the exact terms and conditions of coverage.

What's Not Covered

Exclusions and Limitations are subject to change. Please refer to the current Kaiser Permanente EOC or contact Kaiser Permanente's Member Services at (800) 464-4000 for additional information.



General Exclusions

It is extremely important to read your EOC before you obtain services in order to know what Kaiser Permanente will and will not cover. Kaiser Permanente requires that you receive services through a Kaiser Permanente facility unless otherwise approved. If you obtain services from a non-Kaiser Permanente facility and/or representative, your services may not be covered. You can find excluded services and supplies in your EOC listed as "Exclusions."

How to Get in Touch with Kaiser Permanente

Kaiser Permanente Member Services is available seven days a week from 7:00 a.m. to 7:00 p.m., at 1-800-464-4000. You can also access their website at www.kp.org for more information.



Health Net PPO

Health Net PPO is a preferred provider organization. A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. With this PPO, you may choose the level of benefits you receive based on the providers you use when you receive care.



How the Plan Works

With Health Net PPO, you may obtain care from an in-network or out-of-network provider. It's your choice. However, when you receive your medical care from in-network, or "PPO providers," the plan pays 80% of most covered expenses. Some covered expenses are paid only after you have paid the deductible. If you use out-of-network providers, benefits will be 70% of Usual, Customary, and Reasonable (UCR) services for the area. You will pay 30% of UCR and all charges above UCR. With out-of-network providers, the plan cannot guarantee that your chosen provider will charge fees common to the area, so your out-of-pocket costs could exceed 30%.

Deductibles You pay a calendar year deductible of \$250 per individual or \$750 per family before the plan pays for certain services obtained from an in-network ("participating") or out-of-network ("nonparticipating") provider.

Hospitalization To avoid a \$250 precertification deductible, your provider must contact Health Net in advance of hospitalization. While many physicians will arrange precertification on behalf of their patients, you are advised to call Health Net at 1-800-676-6976.

Emergency Care If you need emergency services, get help immediately. If you are admitted to a hospital, you or your physician must call Health Net at 1-800-676-6976 as soon as possible.

Out-of-State Providers Health Net PPO has created a program which allows Covered Persons access to participating providers outside their state of residence. This program is through the out-of-state provider network shown on your Health Net ID Card and is limited to Covered Persons traveling outside their state of residence for a period not exceeding six months. The program is not intended for Covered Persons traveling outside their state of residence solely to receive medical care.

If you are traveling outside your state of residence, require medical care or treatment, and use a provider from the out-of-state provider network, your out-of-pocket expenses may be lower than those incurred when you use an Out-of-Network Provider.

When you obtain services outside your state of residence through the out-of-state provider network, you will be subject to the same copayments, coinsurances, deductibles, maximums and limitations as you would be if you obtained services from a Preferred Provider in your state of residence. There is the following exception: covered expenses will be calculated based on the lower of (i) the actual billed charges or (ii) the charge that the out-of-state provider network is allowed to charge, based on the contract between Health Net and the network. In a small number of states, local statutes may dictate a different basis for calculating your covered expenses.

How to Enroll

New employees must complete a Medical Plan Enrollment/Change form within the first 31 days of hire into an eligible position, and return it to their payroll clerk. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

Call Health Net Member Services if you:

- ◆ Have a benefits question
- ◆ Need hospital precertification
- ◆ Need a provider directory
- ◆ Need a member identification (ID) card
- ◆ Have an eligibility question
- ◆ Have a claims question

What's Covered

While covered under the PPO, you can take advantage of comprehensive medical benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to the maximum benefit amounts. Please refer to the Medical Plans Comparison Chart in this guide for key covered expenses.

What's Not Covered

Exclusions and Limitations are subject to change. Please refer to the current Health Net PPO EOC or contact Health Net's Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish) for additional information.

General Exclusions

It is extremely important to read your EOC before you obtain services in order to know what Health Net will and will not cover. Health Net does not cover certain services or supplies. Also, services or supplies that are excluded from coverage, appear in the EOC as "Not Covered," exceed EOC limitations, are not Medically Necessary, or are follow-up care to EOC exclusions or limitations will not be covered.

How to Get in Touch with Health Net PPO

Call Health Net Member Services at 1-800-676-6976, or go to the Health Net web site at www.healthnet.com for more information.

Dental Plans Comparison Chart Summary

The chart below is a summary of frequently used services and procedures. Please refer to the limitations and exclusions for more information about frequency limitations and other provisions.

Category	ADA Dental Codes	Description	DELTACARE		DELTA DENTAL PPO PLAN	
			Network Only (You pay...)	In-Network (You pay...)	In-Network (You pay...)	Out-of-Network (You pay... plus any costs over maximum allowance)
Preventive Care	00120	Periodic oral examination (2 per year)*	No Charge	No Charge	No Charge	0%
	00210	Full mouth X-ray (see frequency limitations)	No Charge	No Charge	No Charge	0%
	09110	Emergency, palliative treatment of dental pain	\$5.00	No Charge	No Charge	0%
	01201	Topical Fluoride (child) – see limitations	No Charge	No Charge	No Charge	0%
	01110	Prophylaxis (cleanings) (1 per 6-month period)*	No Charge	No Charge	No Charge	0%
Adjunctive General Services	09972	External bleaching – self-treatment with bleaching tray & gel	\$125.00 each	Not Covered	Not Covered	Not Covered
	09940	Occlusal guard (night guard), by report – limited to 1 in 3 years	\$95.00	Not Covered	Not Covered	Not Covered
	09951	Occlusal adjustment, limited	\$20.00	No Charge	No Charge	10%
	09952	Occlusal adjustment, complete	\$40.00	Not Covered	Not Covered	Not Covered
	01351	Sealant (per tooth) limitations may apply	\$5.00	No Charge	No Charge	10%
	07270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50.00	Benefit covered through Medical Plan / Delta pays as secondary coverage under Basic Benefits	Benefit covered through Medical Plan / Delta pays as secondary coverage under Basic Benefits	Benefit covered through Medical Plan / Delta pays as secondary coverage under Basic Benefits
Restorative Dentistry	02140-50	Amalgam (“silver” fillings) on primary or permanent teeth:	No Charge	No Charge	No Charge	10%
	60-61	1, 2, 3 or 4 surfaces				
	02330-31	Composite resin (white fillings), anterior (front) teeth:	No Charge	No Charge	No Charge	10%
	-32-35	1, 2, 3 or 4 surfaces				
	02391-92-93	Composite resin (white fillings), posterior (molars):	\$45.00 to \$75.00	No Charge	No Charge	10%
	-94	1, 2, 3 or 4 surfaces				
02510	Gold inlay – one surface	No Charge	25% upon review, predetermination recommended	25% upon review, predetermination recommended	30% upon review, predetermination recommended	
02650	Composite resin inlay (white) – one surface	\$85.00	25% upon review, predetermination recommended	25% upon review, predetermination recommended	30% upon review, predetermination recommended	
02610	Porcelain/ceramic inlay – one surface	\$135.00	25% upon review, predetermination recommended	25% upon review, predetermination recommended	30% upon review, predetermination recommended	
Periodontics	04240	Gingival flap, per quadrant	\$75.00	10%	10%	10%
	04263	Bone replacement graft – first site in quadrant	\$195.00	10%	10%	10%
	04264	Bone replacement graft – each additional site in quadrant	\$60.00	10%	10%	10%
	04210	Gingivectomy/gingivoplasty (gum surgery), per quadrant	\$75.00	10%	10%	10%

Endodontics	03220 03310 03320 03330	Therapeutic pulpotomy Root canal – Anterior (front) teeth Root canal – Bicuspid Root canal – Molar	No Charge \$30.00 \$60.00 \$90.00	No Charge No Charge No Charge No Charge	10% 10% 10% 10%
Oral Surgery	07286 07111 07220 07230 07240 09215 09220 09221 7450-51	Biopsy of soft oral tissue Uncomplicated extraction, single tooth Extraction – impacted soft tissue, per tooth Extraction – impacted partially bony, per tooth Extraction – impacted completely bony, per tooth Local anesthesia General anesthesia – first 30 minutes (only with oral surgery) General anesthesia – each additional 15 minutes (only with oral surgery) Removal of benign odontogenic cyst or tumor	No Charge No Charge No Charge \$30.00 \$40.00 No Charge \$165.00 \$80.00 No Charge	No Charge No Charge No Charge No Charge No Charge No Charge No Charge No Charge No Charge	10% 10% 10% 10% 10% 10% 10% 10% Benefit covered through Medical Plan / Delta pays as secondary coverage under Basic Benefits
Crowns and Bridges	02740 06740 02752/06752 06930 02920 06241 06980	Crown – porcelain/ceramic substrate (front teeth or molars – chipped tooth) Crown – porcelain/ceramic substrate (front teeth or molars – missing tooth) Crown – porcelain fused to noble metal (front teeth or molars) Recement fixed partial denture Recement crown Pontic – porcelain fused to base metal (front teeth or molars) Fixed partial denture repair, by report	\$60.00 \$195.00 \$60.00 No Charge No Charge \$60.00 \$15.00	25%, add'l cost for porcelain on posterior teeth 25%, add'l cost for porcelain on posterior teeth 25% 25% 25%, add'l cost for porcelain on posterior teeth 25%	30%, add'l cost for porcelain on posterior teeth 30%, add'l cost for porcelain on posterior teeth 30% 30% 30%, add'l cost for porcelain on posterior teeth 30%
Prosthetics	05110-20 05211-12 05670-71 05510 05410 05520 02790/06790 Various	Complete upper or lower denture Upper or lower partial denture – resin base Replace all teeth (upper or lower) on cast metal framework Repair broken upper or lower denture, no tooth damage Complete denture adjustment Replace broken tooth on denture Crown – full cast high noble metal (gold) Implants – surgical placement, removal, repair and/or re cementation; Implant-supported prosthetics	\$75.00 \$85.00 \$75.00 \$15.00 No Charge \$5.00 \$160.00 Not Covered	25% 25% 25% 25% 25% 25% 25% predetermination recommended	30% 30% 30% 30% 30% 30% 30% predetermination recommended
Orthodontics	Various D8090-80-70 D8010-30 D8040 Various	Pre-treatment records & diagnostic services Comprehensive orthodontic treatment Limited ortho treatment of primary, transitional or adolescent teeth Limited orthodontic treatment of the adult teeth Post-treatment records	\$200.00 \$1,450.00 \$ 950.00 \$1,150.00 \$70.00	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)	50% of treatment cost + any cost over \$1,700 (max. lifetime benefit \$1,700)
Calendar Year Benefit Maximum		Not applicable		\$1,700 per person (excluding orthodontia)	\$1,700 per person (excluding orthodontia)

DeltaCare USA

This is a general summary of DeltaCare USA plan benefits. A more complete description of benefits and the terms under which they are provided, including limitations and exclusions, are contained in the plan document. If there are any discrepancies between the information contained in this summary and the provisions of the plan document, the plan document is the controlling document.

DeltaCare USA is a prepaid “HMO-style” dental plan covering more than 650,000 Californians through a network of private practice dental offices.

In an effort to reduce the incidence of periodontal disease, we are offering additional benefits. Effective August 1, 2009, members with cardiovascular disease, diabetes, or who are pregnant, may be eligible for two (2) additional cleanings per year.

How the Plan Works

When you enroll in DeltaCare USA, you must select a dentist for yourself and for your dependents. Call DeltaCare USA at 1-800-422-4234 or visit their website at www.deltadentalins.com for the most current provider directory.

Each family member can select their own dentist (up to three (3) per family). You must utilize the selected provider for all of your dental services. If services are not obtained through the primary care dental office, or if DeltaCare USA has not

authorized services elsewhere, those services will not be covered. Referral for specialist services must be issued by your primary dentist and must be authorized in writing by DeltaCare USA.

Copayments For most basic and preventative services, you pay no copayment. For other services, you pay a small fee.

Deductible Under the DeltaCare USA Plan, you pay no deductible. Claim Forms Under the DeltaCare USA Plan, you have no claim forms to file.

Orthodontia Coverage You and your covered dependents may obtain comprehensive and/or limited orthodontic care from any DeltaCare USA orthodontist of your choice. Pretreatment records and diagnostic services are covered at a \$200 copayment. For comprehensive orthodontic treatment, you pay a \$350 startup fee along with a \$1,450 copayment for 24 months of usual and customary treatment. For limited and/or interceptive orthodontic treatment, the copayment is \$950 for primary, transitional, and adolescent (to age 19) teeth, and \$1,450 for adult teeth which covers 24 months of usual and customary treatment. You can obtain a list of DeltaCare USA orthodontists by calling Member Services at 1-800-422-4234.

Out-of-State Dependent Coverage If you have covered dependents living outside of California, contact EBSD for a list of covered states.

Emergency Care If you need emergency services, call your primary care dental office. If your primary care dental office is unavailable, call DeltaCare USA at 1-800-422-4234 and you will be directed to an available DeltaCare dentist.

Out-of-Area Care If you need dental care away from home, call DeltaCare USA at 1-800-422-4234 and you will be directed to an available DeltaCare USA dentist. If a DeltaCare USA dentist



is not available within a 35-mile radius, obtain care from a nearby licensed dentist and then submit a claim to DeltaCare USA. You must submit your claim within 12 months (365 days) of the date you obtained out-of-area (out-of-network) care. You will be reimbursed the cost of treatment less any copays up to the maximum of \$100.

How to Enroll

New employees must complete a Dental Plan Enrollment/Change form within the first 31 days of hire into an eligible position and return it to their payroll clerk. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

DeltaCare USA Features

- ◆ No claim forms
- ◆ No deductibles
- ◆ No annual maximum benefit
- ◆ Preexisting conditions are not excluded, except for work in progress
- ◆ Out-of-pocket savings are substantial
- ◆ Specialty services available

Call DeltaCare USA if you:

- ◆ Need to select a new DeltaCare USA dentist
- ◆ Have a benefits question
- ◆ Need a provider directory
- ◆ Need a member ID card
- ◆ Have an eligibility question
- ◆ Have a claims question

What's Covered

While covered under the DeltaCare USA Plan, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to plan exclusions and limitations. Please refer to the Dental Plans Comparison Chart in this guide for a sample of covered expenses. Please refer to the plan's Evidence of Coverage Document for a comprehensive explanation of benefits.

What's Not Covered

It is extremely important to read your EOC before you obtain services in order to know what Delta Dental will and will not cover. Exclusions and Limitations are subject to change, please refer to the current DeltaCare USA EOC or contact Delta Dental Member Services at 1-800-422-4234 for additional information.

How to Get In Touch With DeltaCare USA

For information about DeltaCare USA, call 1-800-422-4234 or visit DeltaCare's website at www.deltadentalins.com.



Delta Dental PPO

This is a general summary of Delta Dental PPO benefits. A more complete description of benefits and the terms under which they are provided, including limitations and exclusions, are contained in the plan document. If there are any discrepancies between the information contained in this summary and the provisions of the plan document, the plan document is the controlling document.

Delta Dental PPO allows you to choose to receive care from a network provider or from an out-of-network provider. It is your choice. You may change between in and out-of-network dentists anytime without notifying Delta Dental in advance. Dual coverage is now allowed between two County employees enrolled in a County-sponsored dental plan.

In an effort to reduce the incidence of periodontal disease, we are offering additional benefits. Effective August 1, 2009, members with cardiovascular disease or diabetes may be eligible for additional screenings. Additional benefits may be available for pregnant members.

In addition, as an alternative to partial and full dentures and bridges, dental implants and related procedures offer enrollees an additional choice to replace lost teeth. Implants will be covered under the prosthodontic benefit level and will be subject to the plan's prosthodontic limitation (a benefit once every five years), as well as the plan's annual maximum and deductible. Implant procedures include:

- Surgical placement of the implant (and removal, if necessary)
- Implant-supported prosthetics (crowns)
- Any repair and/or recementation

How the Plan Works

In-Network When you receive your dental care from a Delta Dental PPO network dentist, you will pay a percent of the dentist's discounted Delta Dental PPO rates: 0% for preventive services, 0% for basic restorative services, and 25% for advanced restorative services. To know what your cost will be in advance, you may request a preauthorization. To obtain a Delta Dental PPO Preferred Provider Directory, please call Delta Dental at 1-888-335-8227.

Out-of-Network When you receive care from an Out-of-Network dentist, you will pay a

percentage (0% for preventive services, 10% for basic restorative services, and 30% for advanced restorative services) of Delta Dental PPO's maximum allowance as established by Delta Dental. Your share of the cost will be the applicable percentage of the service plus the difference between the Delta Dental maximum allowance for the service and the amount that your out-of-network dentist is charging you. This cost will vary by provider.

For example: Let's assume you had an out-of-network periodontic root planing and your out-of-network dentist charged \$125. If Delta's maximum allowance for that service was \$100, then you would pay 10% of \$100 (\$10) plus the additional \$25 difference between Delta's maximum allowance and the dentist's billed amount. This additional cost is referred to as "balance billing." Your total out-of-pocket expense for this procedure would be \$35. If you used a Delta Dental PPO provider, the average contracted charge for this procedure is \$85. You would pay 10% of the \$85 (\$8.50). There is no "balance billing" when you access a Preferred provider. (Note: the numbers cited are for example purposes only and they may not be the actual rates associated with this procedure.)

Copayments Copayments vary by procedure. However, most preventive services will be provided at no cost to you from in-network providers and out-of-network providers (within maximum allowance limitations).

The most important person who cares for your teeth is you! Only you can give your teeth the daily care they need. Brush and floss every day to remove plaque and help yourself to good dental health.

Deductible Under Delta Dental PPO, you pay no deductible.

Emergency Care In an emergency, get the care you need. The plan will pay benefits based on whether your emergency care was received from an in-network or Out-of-Network dentist.

Orthodontia Coverage You and your covered dependents may obtain orthodontic care from any licensed orthodontist of your choice. The plan pays 50% of your orthodontia expenses up to a lifetime maximum of \$1,700. For DeltaCare members who are currently under an orthodontist's care, your orthodontia treatment will be continued by Delta Dental PPO up to the maximum benefit limit allowed under your previous plan.

Out-of-Area Care If you need dental care away from home, call Delta Dental at 1-888-335-8227. If possible, you will be directed to an available in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit automatically.

Predetermination of Covered Benefits A predetermination is particularly useful for more costly procedures such as crowns, wisdom teeth extractions, bridges, dentures or periodontal surgery. When your dentist predetermines treatment with Delta, you'll receive an estimate of your share of the cost and how much Delta will pay – before treatment begins.

To predetermine treatment, your dentist sends Delta a proposed treatment plan, along with x-rays relevant to the case. Delta then checks to be sure the services are covered by your dental program. Delta also calculates how any copayments and dollar maximum limits might affect your share of the cost. Your dentist then receives an estimate of the amount Delta will pay for approved services.

Claim Forms Under Delta Dental PPO, your network dentist will submit a standard claim

form directly to Delta Dental. If your dentist needs a claim form, call the Delta Dental Claims Department at 1-800-765-6003.

If your dentist is not contracted with Delta Dental, the claim payments will be sent directly to you. It is your responsibility to pay your dentist for services rendered.

How to Enroll

New employees must complete a Dental Plan Enrollment/Change form within the first 31 days of hire into an eligible position and return it to their payroll clerk. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this guide for specific details.

Call Delta Dental PPO at (888) 335-8227 if you:

- ◆ Have a benefits question
- ◆ Need a provider directory
- ◆ Need a member ID card
- ◆ Have an eligibility question
- ◆ Have a claims question

What's Covered

While covered under Delta Dental PPO, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to the maximum benefit amounts. Please refer to the Dental Plans Comparison Chart in this booklet for examples of covered expenses. For a comprehensive explanation of benefits, please refer to the plan's Evidence of Coverage Document.

*Under Delta Dental PPO, you may obtain dental care in or out-of-network **and** you have a good selection of in-network providers from which to choose.*

What's Not Covered

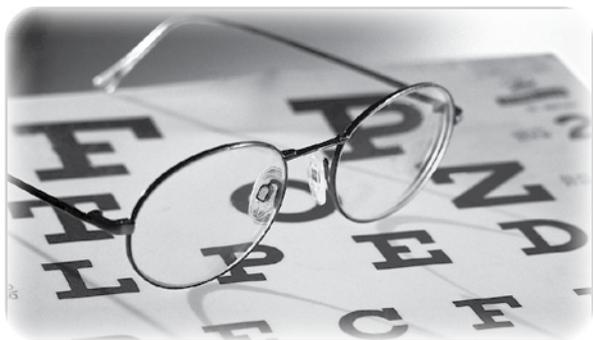
It is extremely important to read your EOC before you obtain services in order to know what Delta Dental will and will not cover. Exclusions and Limitations are subject to change, please refer to the current Delta Dental PPO EOC or contact Delta Dental Member Services at 1-888-335-8227 for additional information.

How To Get In Touch With Delta Dental PPO

For information about Delta Dental PPO, call Delta Dental at 1-888-335-8227 or visit Delta's website at www.deltadentalins.com.

EyeMed Vision

The County of San Bernardino has contracted with EyeMed Vision as the vision care provider. EyeMed Vision Care is one of the leading managed vision care organizations in the industry.



Its unique relationship with recognized vision care leaders and its corporate owned leading optical retailers offer a vision care program that combines ultimate choice, quality, value and service that over 120 million members count on for their vision care needs.

The County of San Bernardino participates in a comprehensive plan that offers you:

- ◆ No eye exam deductibles
- ◆ Large network of vision care providers
- ◆ Freedom to see any provider you choose, in- and out-of-network benefits

- ◆ Additional in-network discounts on frames (select frames only)
- ◆ Exams, frames, standard lenses and contact lenses every 12 months
- ◆ On-line service features
- ◆ Customer service representatives available 7 days a week and evenings

Effective August 1, 2009, for General and Safety employees, the frame and contact lens allowances increased from \$85 to \$120. Polycarbonate lens co-payments decreased from \$40 to \$20. For Exempt employees, the frame and contact lens allowance increased from \$125 to \$135. The polycarbonate lens co-payment decreased from \$40 to \$0.

In addition to all of this, EyeMed Vision Care features a full service website that will allow you to access and download valuable information about the company, maintain membership data in real time, view benefit levels, locate providers and order replacement ID cards. Visit them at their web address, <https://www.eyemedvisioncare.com>. To locate a provider near you, click the "provider locator" under "member access," then enter your zip code. It's that simple!

Limitations and Exclusions

1. Charges for procedures, services or material that are not include as Covered Charges.
2. Any portion of a charge in excess of the Maximum Benefit Allowance.
3. Orthoptic or vision training, subnormal vision aids, Aniseikonic lenses, and any associated supplemental training.
 4. Medical and/or surgical treatment of the eye, eyes, or supporting structures.
 5. Corrective eye wear required as a condition of employment.
 6. Safety eye wear unless specifically covered under the Policy.
 7. Services provided as a result of any Workers' Compensation law, or similar legislation, or

required by any governmental agency or program whether Federal, State, or subdivisions.

8. Plano (nonprescription) lenses.
9. Nonprescription sun glasses, except for 20% discount.
10. Two pair of glasses in lieu of bifocals.
11. Services or materials provided by group benefit providing vision care.
12. Certain frame brands in which the manufacturer imposes a no discount policy.
13. Services and materials for replacement or repair of lost or broken lenses, frames, glasses, or contact lenses.

If you are enrolled in more than one EyeMed Vision Care plan, you will receive the benefits of the plan that is presented at the time of service; the benefits do not coordinate.

How to Get in Touch with EyeMed Vision Care

For further information, please contact the EyeMed Service Department at 1-866-9-EYEMED (1-866-939-3633). Service Representatives are available daily from 5 a.m. to 8 p.m. (PST).

COBRA Continuation Coverage

General Information

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1986 to offer employees and their covered dependents the opportunity to elect a temporary extension of their plan coverage in certain instances where coverage would otherwise end.

The employee has the right to elect continuation coverage if plan coverage is lost due to any of the following "qualifying events":

- Termination of your employment (for reasons other than gross misconduct).
- Reduction in the hours of your employment.

The covered spouse or domestic partner of an employee has the right to elect continuation coverage if Plan coverage is lost due to any of the following Qualifying Events:

- The death of the employee.
- Voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in spouse's or domestic partner's hours of employment with the County of San Bernardino.
- Divorce, legal separation or dissolution of domestic partnership.

The covered dependent child of an employee has the right to elect continuation coverage if Plan coverage is lost due to any of the following Qualifying Events:

- Voluntary or involuntary termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the County of San Bernardino.
- The death of the employee parent.
- Parent's divorce, legal separation or dissolution of domestic partnership.
- The child ceases to be a "dependent child" under the terms of the Plan(s).

Employees and qualified beneficiaries are eligible to continue health and dental coverage for a maximum period of eighteen (18) months from the qualifying event date. The employee or qualified beneficiary is responsible for the full applicable premium plus a 2% administration fee. Under California law, an extension of coverage is available for up to 18 additional months for medical coverage only (the cost may be 110% of the premium).

New Temporary COBRA Subsidy

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act (ARRA) of 2009. ARRA created a temporary federal subsidy of COBRA premiums for employees (and their dependents) who

elect COBRA coverage in connection with an involuntary termination of employment occurring between September 1, 2008, and December 31, 2009. The premium subsidy is available on or after February 17, 2009, and will last for up to nine months, ending earlier if the individual becomes eligible for coverage under another group health plan or Medicare. "Assistance Eligible Individuals" need only pay 35% of the usual COBRA premium. The County will advance the other 65% of the premium, before obtaining reimbursement through a credit against its federal payroll tax liability.

An "Assistance Eligible Individual" is the employee or a member of his/her family who is eligible for COBRA as a result of the employee's involuntary termination between September 1, 2008 and December 31, 2009; elects COBRA coverage; and pays their 35% of the COBRA premium.



Second Chance COBRA Election

ARRA also provided that those terminated employees who did not elect COBRA when it was first offered OR who did elect COBRA, but are no longer enrolled (for example because they were unable to continue paying the premium) have a new election opportunity. This special election period does not extend the period of COBRA continuation coverage beyond the original maximum period (generally 18 months from the employee's involuntary termination). By electing

COBRA during this second election period, they may take advantage of the 65% premium subsidy.

Expedited Review of Denials of Premium

Reduction: Individuals who are denied the subsidy may request an expedited review of the denial by the Health and Human Services Department. The Department must make a determination within 15 business days of receipt of a completed request for review.

Switching Benefit Options: If an employer offers additional coverage options to active employees, the employer may (but is not required to) allow "Assistance Eligible Individuals" to switch the coverage options they had when they became eligible for COBRA. The different coverage must have the same or lower premiums as the individual's original coverage.

The information in this section is only a highlight of COBRA and does not include specific rights and responsibilities. At the time of a qualifying event, you will receive detailed information. For more information or questions regarding COBRA, contact EBSD at (909) 387-5552.

Important Notice from the County of San Bernardino About Your Prescription Drug Coverage and Medicare

Certificate of Creditable Medicare Prescription Drug Coverage

The County of San Bernardino hereby certifies that the prescription drug coverage it provides to Medicare-eligibles is expected to pay out, on average for all such participants, at least as much as the standard Part D coverage would pay. It is therefore designated as providing "creditable coverage," meaning that any participant who later enrolls in a Part D plan will not be charged a late enrollment penalty.

If you have any questions about this benefit, please call the County's Human Resources Department, EBSD (909) 387-5787, or request a copy in writing from the County of San Bernardino, Human Resources Department, EBSD, 157 West Fifth Street, First Floor, San Bernardino, CA 92415-0440. You will be informed if the County's plan ever loses its creditable coverage status.

Medical Expense Reimbursement (FSA) Plan

If you participate in the Medical Expense Reimbursement (FSA) Plan available to eligible employees, you can save money by paying for certain medical care expenses with pre-tax dollars.

How the Plan Works

When you participate in the FSA, you elect to set aside a portion of your biweekly salary before taxes are calculated and taken out. The money you set aside is placed into an account, which can be used to pay for qualifying medical care expenses that you, your spouse, and your eligible dependent(s) incur. There are some expenses that you know you will incur during the year that will not be reimbursed by your group health plan, other insurance, or other accident or health plan. These expenses include amounts paid for hospital bills, doctor and dental bills or co-pays,

chiropractic care, prescription drugs, and some nonprescription (over-the-counter) drugs. Normally you would pay for these expenses with after-tax dollars. However, with the FSA, you would be reimbursed from your Flexible Spending Account with your pre-tax dollars.

Minimum/Maximum Contribution Amounts

Contribution amounts are based on each bargaining unit. Please refer to the appropriate Memorandum of Understanding, Compensation Plan, Salary Ordinance, or Contract for specific minimum and maximum contribution limits.

Eligible Expenses

Expenses are generally considered eligible for reimbursement if the expenses are incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease. With the exception of over-the-counter medications, the expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Over-the-counter medications must be for the treatment of an existing injury or illness, not for preventive purposes. Expenses solely for cosmetic reasons generally are not considered expenses for medical care. Also, expenses that are only beneficial to one's general health (e.g. health spas, vitamins, etc.) are not considered expenses for medical care. A list of most common covered expenses is available on the County's intranet site at <http://countyline/hr/benefits/FSAexpenses.asp>.

Reimbursement

You may apply for reimbursement of qualifying medical care expenses by submitting a completed claim form to EBSD, 157 West Fifth Street, First Floor, San Bernardino, CA 92415-0015 no later than ninety (90) days after the end of the plan year. Each plan year ends on the last day of pay period 16. Invoices, receipts, bills, or other statements from an independent third party showing the amount and date of the qualifying



medical care expenses incurred must be attached to the claim form, together with proof that the expense was paid by you, and any other documentation that the Plan Administrator may request. If requesting reimbursement for over-the-counter medications, the name of the medication must appear on the receipt and the item should be circled on the receipt. Requests for reimbursement may be made as the expenses are incurred or at the end of the Plan Year. However, except for the final reimbursement claim for a Plan Year, no claim for reimbursement of less than \$25 will be processed for payment. Reimbursement requests for less than \$25 will be held until other reimbursement claims are made and claims received total \$25 or more.

Eligible expenses will be reimbursed by a check issued separate from payroll and made payable directly to the participant, as soon as possible after receipt of a properly completed claim form and required documentation. If reimbursement is not received within thirty (30) days from submission of a claim, you should contact EBSD at (909) 387-5648.

Important Rules on Medical Expense Reimbursement (FSA) Plans

Plan very carefully! The IRS governs the terms of these plans, which means that your election to put money into an FSA is irrevocable. Therefore, once you have made an election to participate in the Plan, you may not revoke or change your election for the remainder of the Plan Year unless you experience a qualified Change in Status Event during the Plan Year and the requested change in your FSA election is consistent with the event.

Be conservative in your estimates! Do not contribute more money into your account than you know you will use. Why? The IRS says you must use all of the funds in your account by the end of the Plan Year or you will lose them. So, if you choose to participate in the Plan, you should take the time to conservatively estimate the amount of

out-of-pocket expenses you expect to have during the Plan Year before you make your election.

At the end of the Plan Year, if any balance remains in your FSA that has not been reimbursed, you will forfeit your right to the balance. Balances cannot be carried forward to the next Plan Year.

NOTE: This is only a summary and partial listing of FSA Plan benefits, terms, conditions, exclusions and limitations. For a full and complete listing, please refer to the appropriate plan document. If



any differences appear between this summary and the plan document, the information in the plan document shall govern.

For more information on the Medical Expense Reimbursement (FSA) Plan, contact EBSD or go online to www.sbcounty.gov/hr/benefits or <http://countyline/hr/benefits>.

Dependent Care Assistance Program (DCAP)

The County of San Bernardino offers this plan to all eligible employees who are in a regular position scheduled for a minimum of forty-one (41) hours a pay period and are paid for a minimum of one half plus one of the scheduled hours. The purpose of the plan is to permit Participants to pay

for certain dependent care expenses on a pre-tax basis. The DCAP Open Enrollment period is in November of each year.

Eligibility

In order for dependent care expenses to be eligible, the expense must be for a qualified dependent and provided by an eligible care provider. A qualified dependent under the DCAP is a dependent whom you claim for federal tax purposes and is either a child living with you under age 13; your spouse, a relative, or a child age 13 or over who is physically or mentally incapable of self-care and is living with you at least eight hours a day; any individual who qualifies as a dependent under any employer sponsored health care plan or insurance contract, and for purposes of pre-tax contributions or reimbursement on a pre-tax basis qualifies as a dependent under Section 152 of the Internal Revenue Code.

Under the DCAP, eligible day care providers include a licensed day care center (if it cares for more than six children who don't live there), a private babysitter, a care center for the elderly or handicapped, or an attendant who comes to your home. Housekeeper expenses can be paid only if that person's services benefit the dependent. You must provide the name, address and social security number or the tax identification number of your dependent care provider on all claims and also on your tax return. Expenses that are not eligible for reimbursement under the DCAP include expenses paid for dependent care which do not enable you to work; expenses paid to a person who you or your spouse are entitled to claim as an exemption for federal income tax purposes; tuition or education expenses for a child in kindergarten or above; fees paid to your child who is age 18 or younger for babysitting; overnight care at a convalescent nursing home for a dependent relative; overnight camp; or expenses for lessons, tutoring or transportation.

How the Plan Works

Each year during the DCAP Open Enrollment in November, you may enroll and authorize a biweekly deduction amount from your pay to be placed into your Dependent Care Reimbursement Account. The deduction will be taken from your paycheck before federal, state, and Medicare taxes are deducted. When you incur an eligible expense, you file a Reimbursement Request form, along with the bill or receipt for the expense. Participants are charged a nominal fee of 70 cents per pay period to cover administrative costs. You are responsible for paying a bill by its due date, whether or not you have received a reimbursement. You may file claims any time before January 31st following the end of the plan year.

NOTE: Tax laws are complex and it is important that you seek professional tax advice before enrolling in the plan.



Maximum Contribution

The maximum annual contribution for the calendar year is the lowest of either the participant's earned income or \$5,000 for married couples filing jointly; \$5,000 for single persons; or \$2,500 for married couples filing tax returns separately. If your spouse also participates in the DCAP, the annual maximum includes any benefits he or she received under the DCAP. The deduction amount you choose should be conservative as Internal Revenue Service Regulations stipulate that your



elections are irrevocable and you may not change or cancel your deduction amount during the plan year unless you experience a change in status event as outlined in IRC Section 125. Changes in status include: marriage, divorce, birth or adoption of a child, death of spouse or child, spouse's termination or gain of employment, or a significant change in cost of child care. The requested change must be consistent with the qualifying event.

Important Rules on DCAP

According to federal tax law, any amounts in your DCAP account that are not used to reimburse you for eligible dependent care expenses do not "roll-over" from one plan year to the next. The funds will be forfeited and applied towards the cost of administering the plan. It is important that you carefully calculate your expected dependent care

expenses before making your DCAP contribution election.

NOTE: This is only a summary and partial listing of the DCAP. For a full description of the plan, refer to the plan document. If any differences appear between this summary and the plan document, the plan document shall govern.

For more information on the Dependent Care Assistance Program (DCAP), contact EBSD or go on line to www.sbcounty.gov/hr/benefits or <http://countyline/hr/benefits>.

Short-Term Disability (STD) Plan

The County provides STD benefits to employees in the event of a non-work related illness or injury that requires the employee to be off work more than seven (7) consecutive calendar days. STD benefits provide partial income replacement while the employee is off work. These benefits may be integrated with the employee's available leave accruals.

Eligibility

Your Memorandum of Understanding (MOU), Exempt Compensation Plan, Salary Ordinance, or Contract governs eligibility for STD. Employees in the occupational units listed below are eligible:

- ◆ Administrative Services
- ◆ Craft Labor and Trades
- ◆ Management
- ◆ Nurses (CNA)
- ◆ Professional
- ◆ Supervisory
- ◆ Clerical
- ◆ Technical and Inspection
- ◆ Attorney
- ◆ Specialized Peace Officer
- ◆ Specialized Peace Officer Supervisory
- ◆ Exempt

◆ Other Board Approved employees or employee groups

If you belong to one of the eligible groups described above, your coverage under the plan is automatic. Your labor association has negotiated this benefit on your behalf to replace State Disability Insurance (SDI).

However, employees who participated in SDI at any time within the eighteen (18) months immediately prior to enrollment in STD or employees who have a second job that participates in SDI may be eligible to receive SDI benefits. An employee covered under SDI must apply for SDI benefits and provide a copy of the SDI determination letter to the departmental payroll clerk. The STD benefit amount will be reduced by the amount of the SDI benefit the employee is eligible for or receiving. In the event that the SDI benefit amount is greater than the allowable STD benefit amount, no STD benefits will be paid.

With the exception of Exempt employees, in order to be eligible to receive Plan Benefits, all of the following conditions must be met: 1) Employee must be employed in a regular position budgeted for forty (40) hours or more per pay period; 2) Employee must have completed at least two (2) pay periods of continuous service, each with a



minimum of one-half (1/2) plus one (1) hour of scheduled hours of paid time; and 3) Employee must be designated as a member of one (1) of the groups covered by this Plan.

In order for Exempt employees to be eligible to receive Plan Benefits, all of the following conditions must be met: 1) Employee must be employed in a regular County position budgeted for forty (40) hours or more per pay period; 2) Employee must have completed at least one (1) pay period of continuous service; and 3) Employee must be designated as an Exempt employee or expressly approved for Plan coverage by the County Board of Supervisors.

Filing a Claim

On your fourth day of absence, contact your department payroll clerk to obtain paperwork and start the claim process. To file a claim for Plan benefits, you must complete and submit an STD Claim Packet, which includes:

- ◆ Short-Term Disability (STD) Application for Benefits (3 parts – Employer’s Statement, Claimant’s Statement, and Physician’s Statement)
- ◆ Release of Medical Information for STD and/or MEL
- ◆ Leave Integration Request

You can obtain an STD Claim Packet from your department payroll clerk or download the forms from the intranet at <http://countyline/emacs/forms.asp>. No Plan Benefits will be paid until all completed forms have been received by the claims administrator listed on the claim forms.

NOTE: Failure to furnish completed forms within the first fifteen (15) days of the disability period will result in the loss of benefits.

Benefit Payments

After you have satisfied a seven (7) consecutive calendar day waiting period, you are eligible to receive STD benefits. Generally, your Normal

Weekly Benefit will be fifty-five percent (55%) of your Normal Weekly Earnings, not to exceed \$959 per week for represented employees, or \$1261 per week for Exempt employees. These amounts are subject to change per Board of Supervisors approval. Benefits due for any partial weeks will be calculated at the daily amount of one-seventh (1/7) of the Normal Weekly Benefit. Your STD payments will be included in your biweekly pay warrant. Your normal weekly benefit will be reduced by the amount you receive or are entitled to receive from:

1. Social Security disability payments
2. Railroad Retirement Act disability payments
3. Other County-sponsored benefit plan or County recognized union plan payments
4. State Disability Insurance (SDI) payments

The maximum benefit amount an employee covered by the Represented STD Plan may receive for any one (1) disability claim is fifty-two (52) times the Normal Weekly Benefit. Exempt employees may receive a maximum benefit amount of eighty-three (83) times the daily benefit amount. An Extended Maximum Benefit Amount of up to twenty-six (26) times the Normal Weekly Benefit may be available to Exempt employees who are returned to Transitional Work due to the disability.

Transitional Work

Transitional Work means temporary changes to an employee's Regular and

Customary Work in an effort to accommodate temporary restrictions placed on the employee by the treating physician and approved by the Center for Employee Health and Wellness and Employee Health and Productivity (EHaP).

If an employee returns to work part-time through Transitional Work and suffers a partial wage loss, Plan Benefits may continue up to their Normal Weekly Earnings, limited to the Normal Weekly Benefit. Under no circumstances will an employee be entitled to receive more than 100% of their Normal Weekly Earnings when their part-time weekly salary and Plan Benefit payments are added together.

Integration of Benefits

Plan Benefit payments may be fully or partially integrated with other paid time including, but not limited to, sick leave, vacation leave, holiday leave, and regular work hours. Employees may not receive more than 100% of their Normal Weekly Earnings. Employees who elect to fully integrate Plan Benefit payments with other paid time will receive all benefits and accruals as if they were receiving full regular pay. If an employee elects not to fully integrate, or is not eligible to fully integrate, only paid time recorded will be attributable toward benefits and accruals. Employees may also elect not to integrate any other paid time with Plan Benefits. All benefits and accruals will be administered in accordance with the applicable MOU, Contract, or Salary Ordinance pertaining to the employee.

For any questions or additional information regarding Short-Term Disability, contact EBSD, Hospitality at (909) 386-8600, or go online to www.sbcounty.gov/hr/benefits or <http://countyline/hr/benefits>.

Long Term Disability

Long Term Disability is a County-paid benefit that provides partial income replacement for Exempt



employees that are unable to work due to a non-work related disability. The benefit pays 60% of Monthly Salary but cannot exceed:

- \$5,000 for Executive County Administrators
- \$3,000 for Associate County Administrators, Executive Assistants & Other Exempt employees

Payments begin after 90 days of disability. Benefits are paid up to 60 months or age 70. Plan Benefit payments may NOT be fully or partially integrated with other paid time. Benefits are subject to change pending Board of Supervisors approval.

For further information contact EBSD at (909) 386-8600. To file a claim, contact MetLife at (800) 858-6506.

Medical Emergency Leave

The purpose of the Medical Emergency Leave (MEL) plan is to allow the unused accrued leave of one County employee to be voluntarily donated for use by another County employee, who has exhausted all of his or her earned leave due to a long-term serious medical condition.

Eligibility Criteria

To be eligible to participate in the MEL plan, employees must have regular status with the County of San Bernardino or one (1) year of continuous service in a regular position with the County.

The employee must meet all of the following criteria before he or she becomes eligible to receive MEL donations under this plan.

1. Be on an approved medical leave of absence for at least thirty (30) consecutive calendar days (160 working hours) exclusive of an absence due to a work related injury/illness;
2. Have exhausted all usable leave balances prior to initial eligibility-subsequent accruals will not affect eligibility;
3. Have recorded at least forty (40) hours of sick

leave without pay during the current period of disability; and

4. Submit a doctor's off work order verifying the medical requirement to be off for a minimum of thirty (30) calendar days (160 working hours).

Medical Emergency Leave may not be used to care for a member of the employee's family. Job and/or personal stress (not the result of a diagnosed mental disorder) are specifically excluded for receipt by the employee of Medical Emergency Leave. A statement from the employee's treating physician, subject to review by the Center of Employee Health and Wellness or medical designee is required.

An employee is not eligible for Medical Emergency Leave if he or she is receiving Worker's Compensation benefits. An employee eligible for State Disability Insurance and/or Short Term Disability must agree to integrate these benefits with Medical Emergency Leave.

Filing a Claim

To file a claim for Medical Emergency Leave benefits, you must complete and submit:

- ◆ Medical Emergency Leave (MEL) Request
- ◆ Medical Emergency Leave Permission to Advertise
- ◆ Physician Statement
- ◆ Leave Integration Request

You can obtain MEL forms from your department payroll clerk or download the forms from the intranet at <http://countyline/emacs/forms.asp>. No MEL Benefits will be paid until all completed forms have been received by EBSD.

NOTE: Failure to furnish completed forms prior to returning to work will result in the loss of MEL benefits.

For further information contact EBSD at (909) 386-8746.

Life Insurance

Life insurance provides your beneficiaries with valuable financial protection in the event of your death.

Basic Life Insurance

The County pays the premium for a term life insurance policy for each employee according to their MOU, Compensation Plan, Salary Ordinance or Contract.

Your life insurance becomes effective on the same date as your medical and dental benefits. You must designate a beneficiary at the time of enrollment. Benefits will be paid according to your instructions. If your beneficiary dies before you, the benefits will be paid to your estate.

Term life benefits are specified by bargaining unit, and are stated within each MOU.

Voluntary Term Life

Eligible employees may purchase additional life insurance through the voluntary term life insurance plan.

Eligibility

Your MOU, Exempt Compensation Plan, Salary Ordinance, or Contract governs eligibility for Voluntary Term Life Insurance. All Units are eligible, except for the following:

- ◆ Fire Fighters
- ◆ Per Diem Nurses
- ◆ Certain Contract Positions (Please refer to your contract for eligibility)

Before you enroll in the plan or make changes to your elections during the annual Open Enrollment, you must:

- ◆ Work 41 hours or more per pay period (you are not eligible to enroll in or increase coverage if you are on a leave of absence)

Voluntary Term Life Biweekly Cost Schedule

Your Age	Biweekly Premium Cost Per \$1,000 Of Coverage
Under 30	\$0.02
30 but less than 35	\$0.03
35 but less than 40	\$0.03
40 but less than 45	\$0.04
45 but less than 50	\$0.05
50 but less than 55	\$0.08
55 but less than 60	\$0.15
60 but less than 65	\$0.23
65 but less than 70	\$0.44
70 and over*	\$0.72

* The Voluntary Term Life Insurance coverage amount will be reduced on the date an employee reaches 70, 75 and 80. For employees who enroll and who have already reached age 70, the reduction becomes effective on the Voluntary Term Life Insurance effective date. Reduction amounts are available in the Voluntary Term Life Insurance booklet that is available from your payroll clerk.

You may enroll within 31 days of becoming eligible, or during the annual Open Enrollment. After your initial enrollment, you may make changes in coverage only during the annual Open Enrollment.

Plan Options

If you are eligible to participate in the plan, you may choose coverage in \$10,000 increments (i.e., \$70,000, \$80,000, \$90,000, etc) up to a maximum of \$700,000. Coverage of up to \$250,000 is guaranteed without requiring evidence of good health. If you elect more than \$250,000 coverage, you will be required to provide evidence of good health to the insurance company. If you are denied coverage above \$250,000, your Voluntary Term Life will be limited to \$250,000.

Beneficiary for Voluntary Term Life Insurance

Benefits will be paid automatically to your beneficiary in the following order:

(1) surviving spouse, (2) surviving children, (3) your parents, (4) brothers and sisters, (5) estate. If more than one beneficiary becomes entitled to your benefits, they will share equally. To

change the automatic beneficiary order, you must complete the Voluntary Term Life Insurance Beneficiary Designation/Change section of eBenefits (during the Open Enrollment period only) or through your payroll clerk.

NOTE: Premiums for life insurance coverage in excess of \$50,000 (including employer-paid life insurance) are subject to imputed income per IRS regulations.

Payroll Deductions and Effective Date of Coverage

Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium. If you have requested coverage above \$250,000, your coverage date is subject to insurance company approval.

Waiver of Premium While Disabled

Waiver of premium is a provision which allows for continued participant life insurance, without payment of premium, while you are disabled.



If you return to work for the County and want to continue coverage, you must contact your payroll clerk or EBSD at (909) 387-5559 within 31 days of your return-to-work date. If your disability ends but you do not return to work for the County, you may convert the County's group plan under the same terms as a terminating County employee.

Accelerated Benefits Option

If you are diagnosed as being terminally ill, you may request that your benefits be paid to you prior to your death. The minimum face amount to be eligible for this benefit is \$10,000. Refer to the County's group policy for further details.

Termination of Coverage

Your Voluntary Term Life Insurance coverage will terminate if:

- ◆ You cancel your coverage
- ◆ You cease to be an eligible employee
- ◆ You fail to pay your required premiums when due
- ◆ The master contract is terminated
- ◆ You are on an approved leave of absence for more than 12 months

Conversion to an Individual Policy

You may convert your Voluntary Term Life coverage from the County's group policy to an individual policy if:

- ◆ You cease to be an employee of the County and the master contract is still in effect
- ◆ The master contract terminates and you have been insured for at least five years
- ◆ Loss of coverage due to age reductions
- ◆ You are on an approved leave of absence for more than 12 months

IMPORTANT: If your group life coverage ends, you have 31 days from the loss of coverage date or 15 days from the date the Conversion was signed by the employer, whichever is later, to convert to an individual policy with Minnesota Life, without having to complete a Personal Health Statement to show proof of good health. Please contact Minnesota Life at 1-888-237-1838.

How To Get In Touch With The Voluntary Term Life Insurance Plan

For questions about plan design, claim status/ payments, medical underwriting and eligibility, call Minnesota Life at 1-888-237-1838. For questions about enrollment, current coverage or to request claim paperwork, call EBSD at (909) 387-5559.

AD&D Plan Options Table

Plan	Employee	Spouse or Domestic Partner	Each Child
1	\$ 10,000	\$ 5,000	\$ 3,125
2	25,000	12,500	6,250
3	50,000	25,000	12,500
4	100,000	50,000	25,000
5	150,000	75,000	25,000
6	200,000	100,000	25,000
7	250,000	125,000	25,000

Accidental Death & Dismemberment (AD&D)

Employee Eligibility

Your MOU, Exempt Compensation Plan, Salary Ordinance, or Contract governs eligibility for AD&D. All Units are eligible, except for the following:

- ◆ Fire Fighters
- ◆ Per Diem Nurses
- ◆ Safety and Safety Management – Please refer to your MOU for alternate coverage information available for certain groups.
- ◆ Certain Contract Positions (Please refer to your contract for eligibility)

Eligible Dependents for AD&D Coverage

- ◆ Spouse
- ◆ Registered Domestic Partner
- ◆ Unmarried children (including legally adopted children) who are under age 19 and who are dependent upon you for support, or who are at least 19 but less than 24 who are students and dependent upon you for support.

If you choose dependent coverage, all of your eligible dependents will be enrolled. However, to enroll your dependent(s), you must enroll yourself.

Plan and Coverage Options

You have four coverage options and seven AD&D plans from which to choose. Employee plus dependent coverage is governed by the type of dependents you intend to enroll/cover.

Coverage Options

- 1 Employee-only coverage:** Coverage will be the amount listed in the Employee column on the following Plan Options Table corresponding to the plan level you select. Employee plus dependent coverage is governed by the type of dependents you intend to enroll/cover, such as:
- 2 Employee plus Spouse or Domestic Partner [no child(ren)]:** Coverage amounts will be the amount listed in the Employee column plus the amount in Spouse or Domestic Partner column.
- 3 Employee plus child(ren) (no spouse):** Coverage amounts will be the amounts listed in the Employee column plus the amount in Each Child column.
- 4 Employee plus family:** Coverage amounts will be the amounts listed in the Employee column, the Spouse or Domestic Partner column and Each Child column.

For benefit levels, please refer to the Group Benefit Plan.

If you marry after enrolling for AD&D coverage,

AD&D Premium Table

Plan	Employee Only Coverage	Family Coverage	Employee and Spouse or Domestic Partner Coverage	Employee and Child Coverage
1	\$ 0.09/pay period	\$ 0.14/pay period	\$ 0.14/pay period	\$ 0.14/pay period
2	\$ 0.23/pay period	\$ 0.35/pay period	\$ 0.35/pay period	\$ 0.35/pay period
3	\$ 0.46/pay period	\$ 0.69/pay period	\$ 0.69/pay period	\$ 0.69/pay period
4	\$ 0.92/pay period	\$ 1.38/pay period	\$ 1.38/pay period	\$ 1.38/pay period
5	\$ 1.38/pay period	\$ 2.07/pay period	\$ 2.07/pay period	\$ 2.07/pay period
6	\$ 1.84/pay period	\$ 2.76/pay period	\$ 2.76/pay period	\$ 2.76/pay period
7	\$ 2.30/pay period	\$ 3.45/pay period	\$ 3.45/pay period	\$ 3.45/pay period

you may add your new spouse by submitting new enrollment and payroll deduction authorization forms within 31 days of the date of marriage. Once family coverage is in force, all newly eligible dependents (such as a newborn) are enrolled automatically.

Beneficiary for AD&D

Insurance benefits will be automatically paid to your beneficiary in the following order: (1) surviving spouse, (2) surviving children, (3) your parents, (4) brothers and sisters, (5) estate. If more than one beneficiary becomes entitled to your benefits, they will share equally. To change the automatic beneficiary arrangement, you must complete the beneficiary designation form.

Payroll Deductions and Effective Date of Coverage Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium. Before-tax payroll deductions for AD&D premiums are available. If before-tax dollars are used to pay the premiums, you may cancel the plan only when you have a Benefit Plan qualified change in status/life event.

Termination of Coverage

Your AD&D coverage will terminate if:

- ◆ You cancel your coverage
- ◆ You cease to be an eligible employee
- ◆ You fail to pay your required premiums when due
- ◆ The master contract is terminated
- ◆ You are on an approved leave of absence for more than 12 months

Conversion to an Individual Policy

You may convert your AD&D coverage from the County's group policy to an individual policy if:

- ◆ You cease to be an eligible employee and the master contract is still in effect
- ◆ You have not failed to pay any premium
- ◆ Loss of coverage due to age reductions
- ◆ You are on an approved leave of absence for more than 12 months

IMPORTANT: If your group coverage ends, you have 31 days to convert to an individual policy with Minnesota Life without giving medical evidence of insurability for yourself and your eligible dependents who are covered under the policy on the date your coverage ceases.

How To Get In Touch With An AD&D Representative

For questions about plan design, claim status/ payments, medical underwriting and eligibility, call Minnesota Life Insurance Company at 1-888-237-1838. For questions about enrollment, current coverage or to request claim paperwork, call EBSD at (909) 387-5559.

Employee Assistance Program (EAP)

The County provides an EAP for all employees, their dependents and members of their households through Managed Health Network (MHN). The EAP offers services designed to help employees reduce stress, balance their work and family responsibilities and improve the quality of their lives.

The program offers counseling and support services, resources and referral services, and online information and interactive tools.

The EAP services can help with problems such as:

- ◆ Marriage, family and relationship issues
- ◆ Crisis situations
- ◆ Stress and anxiety
- ◆ Depression
- ◆ Grief and loss
- ◆ Anger management
- ◆ Alcohol and drug dependency
- ◆ Other emotional health issues
- ◆ And many more!

MHN also provides work/life EAP services that offer answers, information and support for many of the questions and issues people face in their day-to-day lives. Work/life issues include:

Child and Eldercare: Assistance with accessing community and financial resources, and referrals to prescreened childcare and eldercare providers. You may also be entitled to help with special needs, educational matters and other parenting issues.

Financial Issues: Budgeting, credit and financial guidance.

Federal Tax Assistance: Help with IRS audits and unfiled or past-due tax returns (not a tax representation or preparation service).

Identity Theft Recovery Services: A 60-minute consultation with a fraud resolution specialist who can advise you on how to place fraud alerts, freeze credit, file police reports and other related activities necessary to resolve fraud.

Preretirement Planning: Guidance for planning a quality retirement.

Organizing Life's Affairs: Help organizing records and vital documents and with arranging "final details" for a loved one.

Concierge Services: Referrals for everyday errands, travel, event planning and more.

How Much Does it Cost?

EAP services are County paid. Employees and household members are provided with up to three (3) face-to-face, telephone, individual or group family counseling sessions per problem area each year at no cost. If further services are required beyond the free sessions, every effort will be made to help the client access appropriate care through their health plan, or through community or private resources.

Who Will Know?

EAP services are confidential. Privacy is guaranteed under the law when an employee self-refers. No information will be released without the written consent of the employee.

How to Access the EAP

EAP services are accessible 24 hours a day, 7 days a week.

- ◆ Call toll free 1-800-777-9276 (TDD 1-800-327-0801)
- ◆ Log on to www.members.mhn.com
 1. Select Log In link
 2. Enter "COSB" in the "Company Code" field using either upper or lower case letters

For further information regarding the EAP, contact EBSD at (909) 387-5787.



Health Club Membership

County employees are eligible for a health club membership at a reduced rate at 24-Hour Fitness, The Club in Twin Peaks, American Sports University or Power Source Gym. This program is part of the County's commitment to help you stay well and maintain a healthier lifestyle.

County employees who already have a non-County membership at 24-Hour Fitness, The Club in Twin Peaks, American Sports University or Power Source Gym are eligible to have monthly dues reduced to the County's rate.

24-Hour Fitness

Employees may enroll at any 24-Hour Fitness club location for a One Club or All Sports Club membership valid at over 140 club locations. Super and Ultra-Sport club memberships are also available. The County has paid initiation fees, and has negotiated the following discounted monthly membership dues and no processing fees to the employees:

	Processing & Initiation Fee	One Club	All Sports Club	Super Sports Club
Employee only	\$0	\$23/mo	\$27/mo	\$44/mo
Each additional member	\$0	\$15/mo	\$15/mo	\$25/mo

Upon initial enrollment, employees will be responsible for immediate payment of first and last months' dues. Monthly dues are paid thereafter by electronic fund transfer (EFT) directly from the employee's checking or savings account. Payroll deduction is not available. Additional members must be the employee's spouse, State registered domestic partner, or child (12-18 years of age), and living at the same address to be eligible. Employees must provide proof of County employment. Please note that employees may cancel their 24-Hour Fitness membership at any time without penalty.

The Club in Twin Peaks

The Club in Twin Peaks serves the Lake Arrowhead, Crestline, and Running Springs areas in the San Bernardino Mountains. The following discounted rates are available for County employees:

	Set-up fees	Monthly dues (EFT only)	Additional monthly non-EFT charge
Employee only	\$49	\$25	\$5
Employee + 1	\$0 if added at time of enrollment	\$45	\$5
Employee + 2	\$0 if added at time of enrollment	\$60	\$5

Note: Annual memberships may also be purchased with no set up fee when paid in full in advance.

Monthly dues may be paid by electronic funds transfer (EFT) directly from the employee's checking or savings account. Payroll deduction is not available. There is an additional \$5 per month fee for non-electronic debit accounts. Additional members must be the employee's spouse, State registered domestic partner, or child (14 to 22 years old, unmarried) and living at the same address to be eligible. Employees must provide proof of County employment. Please note that employees may cancel their Club in Twin Peaks membership at any time without penalty.



American Sports University Fitness Center

Located in downtown San Bernardino, American Sports University (ASU) offers the following discounted rates:

	Enrollment fees	Monthly dues (EFT only)	Additional monthly non-EFT charge
Employee only	\$0	\$12	\$5
Each additional member	\$0 if added at time of enrollment	\$9	\$5

Monthly dues may be paid by electronic funds transfer (EFT) directly from the employee’s checking or savings account. Payroll deduction is not available. There is an additional \$5 per month fee for non-electronic debit accounts. Additional members must be the employee’s spouse, State registered domestic partner, or child (14 to 22 years old, unmarried) and living at the same address to be eligible. Employees must provide proof of County employment. Please note that employees may cancel their ASU membership at any time without penalty.



Power Source Gym – Running Springs

The Power Source Gym in Running Springs offers the following discounted rates for County employees:

	Set up fees	Monthly dues (EFT only)	Additional monthly non-EFT charge
Employee only	\$0	\$15	\$5
Each eligible household member	\$0 if added at time of enrollment	\$19	\$5

Note: Annual memberships may also be purchased with no set up fee when paid in full in advance.

Monthly dues may be paid by electronic funds transfer (EFT) directly from the employee’s checking or savings account. Payroll deduction is not available. There is an additional \$5 per month fee for non-electronic debit accounts. Additional members must be the employee’s spouse, State registered domestic partner, or child (14 to 22 years old, unmarried) and living at the same address to be eligible. Employees must provide proof of County employment. Please note that employees may cancel their Power Source membership at any time without penalty.

Contact Information

- 24-Hour Fitness (800) 204-2400
or email tbohannon@24hourfit.com
- The Club in Twin Peaks (909) 337-7071
- American Sports University (909) 881-8202
- Power Source Gym (909) 867-2998
- EHaP (909) 387-1000

Retirement Plan Highlights

Eligibility

All employees working at least 40 hours per pay period in a retirement-eligible position are automatically members of the San Bernardino County Employees' Retirement Association (SBCERA). As a member of SBCERA, you make contributions each pay period for your retirement and survivor benefits by payroll deduction. There will be a change to your required retirement contribution and the premiums for survivor benefits effective June 20, 2009. The survivor benefit premiums will decrease from \$2.45 to \$1.57 per pay period. The Contribution Rate Table below details the new refundable and nonrefundable rates for both General and Safety employees.

Employee Retirement Contribution Rate Table

General Employees Contribution Rate (%)		Safety Employees Contribution Rate (%)	
Refundable Entry Age 2009	Nonrefundable Entry Age 2009	Refundable Entry Age 2009	Nonrefundable Entry Age 2009
16..... 7.42	16..... 6.68	16..... 9.52	16..... 9.15
17..... 7.54	17..... 6.79	17..... 9.69	17..... 9.32
18..... 7.68	18..... 6.92	18..... 9.85	18..... 9.47
19..... 7.81	19..... 7.04	19..... 10.02	19..... 9.63
20..... 7.93	20..... 7.14	20..... 10.18	20..... 9.79
21..... 8.08	21..... 7.28	21..... 10.35	21..... 9.95
22..... 8.21	22..... 7.40	22..... 10.53	22..... 10.13
23..... 8.35	23..... 7.52	23..... 10.71	23..... 10.30
24..... 8.49	24..... 7.65	24..... 10.89	24..... 10.47
25..... 8.64	25..... 7.78	25..... 11.07	25..... 10.64
26..... 8.78	26..... 7.91	26..... 11.25	26..... 10.82
27..... 8.93	27..... 8.05	27..... 11.44	27..... 11.00
28..... 9.07	28..... 8.17	28..... 11.64	28..... 11.19
29..... 9.23	29..... 8.32	29..... 11.84	29..... 11.38
30..... 9.39	30..... 8.46	30..... 12.04	30..... 11.58
31..... 9.55	31..... 8.60	31..... 12.24	31..... 11.77
32..... 9.71	32..... 8.75	32..... 12.47	32..... 11.99
33..... 9.86	33..... 8.88	33..... 12.67	33..... 12.18
34..... 10.03	34..... 9.04	34..... 12.91	34..... 12.41
35..... 10.20	35..... 9.19	35..... 13.13	35..... 12.63
36..... 10.39	36..... 9.36	36..... 13.38	36..... 12.87
37..... 10.57	37..... 9.52	37..... 13.63	37..... 13.11
38..... 10.75	38..... 9.68	38..... 13.89	38..... 13.36
39..... 10.95	39..... 9.86	39..... 14.17	39..... 13.63
40..... 11.14	40..... 10.04	40..... 14.47	40..... 13.91
41..... 11.35	41..... 10.23	41..... 14.76	41..... 14.19
42..... 11.55	42..... 10.41	42..... 15.01	42..... 14.43
43..... 11.78	43..... 10.61	43..... 15.22	43..... 14.63
44..... 12.01	44..... 10.82	44..... 15.39	44..... 14.80
45..... 12.27	45..... 11.05	45..... 15.51	45..... 14.91
46..... 12.51	46..... 11.27	46..... 15.61	46..... 15.01
47..... 12.73	47..... 11.47	47..... 15.65	47..... 15.05
48..... 12.90	48..... 11.62	48..... 15.65	48..... 15.05
49..... 13.05	49..... 11.76	49 & over ... 15.29	49 & over ... 14.70
50..... 13.16	50..... 11.86		
51..... 13.23	51..... 11.92		
52..... 13.27	52..... 11.95		
53..... 13.27	53..... 11.95		
54 & over ... 12.96	54 & over ... 11.68		

The refundability factors are 1.11 for General and 1.04 for Safety.

The easiest way to determine your pre-tax retirement obligation is to look at your Leave and Earnings Statement for your earnable compensation. Determine your contribution rate from the Employee Retirement Contribution Rate Table on the preceding page. Subtract the County "pick-up" you may be eligible for. For eligibility criteria, refer to the appropriate MOU, Compensation Plan, Salary Ordinance, or Contract. Your earnable compensation, multiplied by this resulting percentage, is your retirement obligation.

Note: Cash benefits* might change from pay period to pay period, so your retirement obligation could fluctuate.

$$\left[\left(\frac{\text{Wage Rate}}{\text{Scheduled Hours}} \times \text{Scheduled Hours} \right) + \frac{\text{Cash Benefits*}}{\text{Scheduled Hours}} \right] \times \left[\frac{\text{Contribution Rate}}{\text{Scheduled Hours}} - \text{County Pick-Up \%} \right] = \frac{\text{Retirement Obligation}}{\text{Scheduled Hours}}$$

For example: The biweekly refundable retirement contribution for a full-time General member eligible for a 7% County pick-up with an entry age of 43, earning \$10.05 per hour, receiving biweekly benefit plan dollars of \$190.00 is calculated as:

$$[(\$10.05 \times 80 \text{ hours}) + \$190.00] \times [11.78\% - 7.0\%] = \$49.23 \text{ obligation per pay period}$$

* A 1997 California Supreme Court decision, *Ventura County Deputy Sheriff's Association vs. Board of Retirement of Ventura County Employees' Retirement Association*, requires many benefits received in cash to be added to your compensation for determining your retirement contributions. Cash benefits include, but are not limited to, your biweekly benefit plan, uniform and tool allowances, bilingual pay and many types of pay differentials. Note: Overtime is never a cash benefit as defined by the Ventura Ruling.

Refundable and Nonrefundable Retirement Options

You may change your retirement contribution option each year during Open Enrollment. If you wish to change your retirement option, you must complete the *Retirement System Contribution Election* section of eBenefits. Elections will be effective pay period 14 and you will see the election change on the pay warrant you will receive on or about July 15, 2009.

Refundable Retirement Contributions If you designate your retirement contributions as refundable, then you must pay one dollar for each dollar required to meet your retirement contribution. If you leave employment without retiring, you may withdraw this contribution plus earned interest in one lump sum from the SBCERA.

Nonrefundable Retirement Contributions

If you designate your retirement contributions as nonrefundable, your retirement obligation will be reduced for each dollar required to meet your retirement contribution. This reduction is determined by the Board of Retirement annually and is subject to change. Currently, General employees pay \$1.00 for every \$1.11 required to satisfy their retirement obligation; Safety employees pay \$1.00 for every \$1.04 required. If you leave the County without retiring, you may not withdraw this contribution from the SBCERA. When, and if, you are eligible you may receive a retirement benefit.

Refundable vs. Nonrefundable Table

The following table outlines some of the advantages and disadvantages of choosing between the refundable and nonrefundable retirement options. Generally, if you have less than five (5) years of full-time service, it may be beneficial to choose the refundable option.

EVENT	REFUNDABLE OPTION	NONREFUNDABLE OPTION
Employee's biweekly cost	Safety and General employees contribute \$1.00 for every \$1.00 required.	General employees contribute \$1.00 for every \$1.11 required; Safety employees contribute \$1.00 for every \$1.04 required.
Termination before five (5) years of County employment completed	All employee and employer pick-up contributions made on your behalf that were paid under the refundable option will either, if elected, be refunded to you in a lump sum with interest; or, you may choose to leave said funds "on-deposit" with the retirement system to earn the applicable member deposit interest rate as determined by the Board of Retirement.	None of the employee and employer pick-up contributions made on your behalf that were paid under the nonrefundable option will be paid in a lump sum. Note: Employees with contributions under both the refundable and nonrefundable options will be refunded only those contributions that were designated as refundable.
Termination after five (5) years of County employment	The employee has the option of deferred retirement or receiving a lump-sum refund of employee and completed employer contributions made on your behalf with interest.	Deferred retirement OR refund of refundable contributions, if any exist.
Non service-related death before five (5) years of County employment	Spouse, dependent children or other named beneficiary receive return of employee refundable contributions, interest and one month's salary for each completed year of service, up to a maximum of six months' salary; survivor benefits are available if general member worked at least 18 months.	Spouse, dependent children or other named beneficiary receive one month's salary for each completed year of service, up to a maximum of six months' salary; survivor benefits are available if general member worked at least 18 months.
Non service-related death after five (5) years of County employment	<p>Survivorship: Eligible spouse, registered domestic partner or dependent children receive 60% of the amount awarded in a nonservice-connected disability retirement.</p> <p>Death Benefit, Plus Modified Survivorship: Lump-sum payment of one month's salary for each completed year of service for a maximum of six months; plus a monthly amount actuarially reduced according to the age of the beneficiary.</p>	<p>Survivorship: Eligible spouse, registered domestic partner or dependent children receive 60% of the amount awarded in a nonservice-connected disability retirement.</p> <p>Death Benefit, Plus Modified Survivorship: Lump-sum payment of one month's salary for each completed year of service for a maximum of six months; plus a monthly amount actuarially reduced according to the age of the beneficiary.</p>

Refundable vs. Nonrefundable Table *(continued)*

EVENT	REFUNDABLE OPTION	NONREFUNDABLE OPTION
<p>Nonservice-related death after five (5) years of County employment <i>(continued)</i></p>	<p>Death Benefit, Plus Death Refund: The employee’s named beneficiary will be entitled to one month’s salary for each completed year of service, up to a maximum of six months, plus the return of the employee’s refundable contributions plus interest.</p>	<p>Death Benefit, Plus Death Refund: The employee’s named beneficiary will be entitled to one month’s salary for each completed year of service, up to a maximum of six months, plus the return of the employee’s refundable contributions plus interest, should any exist.</p>
<p>Service-related death before retirement</p>	<p>Survivorship: Eligible spouse or registered domestic partner receives 100% of the amount awarded in a service-connected disability retirement; Safety employee’s spouse, registered domestic partner or dependents may receive an additional payment.</p> <p>Death Benefit, Plus Modified Survivorship: Same as previous page.</p> <p>Death Benefit, Plus Death Refund: Same as above.</p>	<p>Survivorship: Eligible spouse or registered domestic partner receives 100% of the amount awarded in a service-connected disability retirement; Safety employee’s spouse, registered domestic partner or dependents may receive an additional payment.</p> <p>Death Benefit, Plus Modified Survivorship: Same as previous page.</p> <p>Death Benefit, Plus Death Refund: Same as above.</p>

The information contained in the Refundable vs. Nonrefundable Table is a summary of information provided by SBCERA.

How to Get in Touch with a Representative of SBCERA

For more information about the retirement plan, please refer to your retirement plan notebook, “The Compass: Navigating Your Retirement Benefit Plan”; or call SBCERA at (909) 885-7980, or toll free at (877) 722-3721.

Also, members can visit the SBCERA website at www.sbcera.org for information or access to retirement planning tools such as a Benefit Estimate Calculator.



457(b) Deferred Compensation Plan

The 457(b) is a supplemental retirement Plan that allows employees to contribute a portion of their pre-tax salary, within certain Internal Revenue Service (IRS) limits, to a personal account currently maintained by ING Life Insurance and Annuity (ING). Employees may select from multiple mutual funds and a stable value account when investing their funds. The County, as Plan Administrator, regularly monitors the investment options and deletes or replaces funds that fail to perform according to the guidelines set forth in the *County of San Bernardino Investment Policy and Procedures Statement*.

Eligibility

All general employees in regular positions, and other employees that are granted this benefit through an employment contract or exempt compensation plan, are eligible to participate in the County's 457(b) Deferred Compensation Plan and can enroll at any time.

Contributions

Contributions to this account and any earnings that accumulate are not taxed until the funds are received. The IRS does impose restrictions on when these funds can be accessed. Upon complete separation from County service, participants may choose to withdraw a portion or all of their 457(b) account balance and will only pay the Federal and State taxes on the amount withdrawn. Unlike most 401(k) plans, there is no penalty for withdrawals made from a 457(b) Plan prior to the participant's attainment of age 59½.

In-Service Distributions

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship

provisions in the 457(b) Plan document before participating in the plan.

Any employee who has questions, or who is interested in participating in the 457(b) Plan, should contact the local ING office at (909) 748-6468 to schedule an appointment. This benefit does not have an Open Enrollment period so employees can enroll at any time.

For more extensive information on the County's 457(b) Plan and ING, please visit the County's custom ING website at www.ingretirementplans.com/custom/sanbernardino.



401(k) Salary Savings Plan

Traditional 401(k) Allows participating employees to reduce their taxable income by contributing a portion of their gross income to the 401(k) on a pre-tax basis. Contributions and earnings are not taxed until they are received, generally at retirement when participants are usually in a lower tax bracket.

Roth 401(k) Allows participating employees the opportunity to take tax-free distributions upon retirement, as long as the participant meets certain qualifications, by paying taxes on their contributions up front. Unlike the Traditional

401(k), the Roth 401(k) offers the participant the potential for tax-free retirement income later by investing on an after-tax basis now.

Eligibility

Exempt employees, Elected Officials and other employees that are granted this benefit through an employment contract are eligible to participate in this supplemental retirement plan that allows employees to defer a portion of their salary on a pre-tax (Traditional) or after-tax (Roth) basis, within certain IRS limits, to an account maintained by an investment service provider. The current investment provider is ING Life Insurance and Annuity (ING).

Employees may enroll at any time and may select from multiple investment options including a stable value account when investing their funds.

In addition to the employee's contribution, the County will match up to 4% of the participant's salary at a ratio of 2 to 1 for employees in Exempt Group A, B and C. The County will match up to 3% of the participant's salary at a ratio of 2 to 1 for employees in Exempt Group D. For example, if a participant elects to defer 4% or more of their biweekly base salary to the Plan, the County will contribute a maximum of 4% times two (8%) of the biweekly base salary. However, if the participant elects to defer less than 4% of their biweekly base salary then the County will only match the elected percentage times two.

Withdrawal Period

The IRS does impose restrictions on when these funds can be accessed. There is a substantial early withdrawal penalty that will be assessed against any distributions made prior to age 59½ (or age 55 if eligible to retire under SBCERA at that age).

In-Service Distributions

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship

provisions in the 401(k) Plan document before participating in the plan.

Any employee who has questions, or who is interested in participating in the 401(k) Plan, should contact the local ING office at (909) 748-6468 to schedule an appointment. This benefit does not have an Open Enrollment period so employees can enroll at any time.

For more extensive information on the County's 401(k) Plan and ING, please visit the County's custom ING website at www.ingretirementplans.com/custom/sanbernardino.



Retirement Medical Trust Fund

The Retirement Medical Trust Fund Plan was implemented by the County of San Bernardino to assist eligible retirees and their dependents with the high cost of health related expenses. It provides a method for eligible participants to pay, on a nontaxable basis, for qualified expenses including medical, dental and long term care premiums, (as defined in Internal Revenue Code section 213), that are not otherwise reimbursed by insurance.

The Trust is funded by County contributions and the eligible cash value of the participant's sick leave upon separation from service. All funds contributed to the Trust are maintained

in individual accounts administered by ING exclusively for the benefit of the participant or the participant's eligible dependent(s). Upon reaching the Normal Retirement Age under the Plan, the account balance is available for the reimbursement. Please refer to your Memorandum of Understanding, Employment Contract, or Salary Ordinance for specific information on participation eligibility, cash conversion formulas of unused sick leave accruals and County contributions.

For any questions or additional information regarding Retirement Medical Trust Fund, contact EBSD at (909) 387-5537, or go online to www.sbcounty.gov/hr/benefits or <http://countyline/hr/benefits>.

529 Education Savings Plan

A new 529 Education Savings Plan is offered by Fidelity Investments. This plan offers all County employees a way to invest in their children's and grandchildren's education. The minimum bi-weekly deferral is \$50 and is deducted on an after-tax basis. You must contact ING to participate in the plan.

Potential tax advantages:

This plan offers tax-deferred growth of any earnings and tax-free withdrawals for qualified higher education expenses such as room, board, and tuition.

Control and Flexibility:

The owner of a 529 plan controls the assets in the account, even after the beneficiary turns 18. There are no income restrictions and account assets can be used at most accredited colleges and universities.

Additional Advantages:

The advantages to the Fidelity 529 Education Savings Plan are:

- ◆ Ability to accept bi-weekly payroll deductions
- ◆ Low investment management fees
- ◆ Low annual account fees

- ◆ Quality and quantity of investment options

For more information or to schedule an appointment with an ING representative, contact the local ING office at (909) 748-6468. This benefit does not have an Open Enrollment period so employees can enroll at any time.

Commuter Services

Commuter Services' Rideshare Program assists County employees with alternative solutions to driving alone. Ridesharing includes walking, bicycling, public transportation, carpooling and vanpooling. Services provided include:

- ◆ Vanpool and Transit Pass purchases through payroll deduction with up to \$230 per month in pre-tax dollars;
- ◆ assistance in finding a carpool partner or a space on an existing vanpool;
- ◆ vanpool formation and information on public transportation.

Employees participating in the Rideshare Program for the first time are eligible to earn \$2 per day for the first 90 days and a Rideshare Plus discount card good at over 500 merchants in the Inland Empire. Commuter Services honors long-time participants with awards, an annual luncheon and prize drawings. Additionally, all vanpool drivers receive 50% off the standard vanpool rate.

Effective March 2009, the Federal Commuter Benefits program has temporarily increased the pre-tax dollar allowance for transit and vanpool from \$120 to a maximum of \$230 per month. This increase should last through December 2010.

For more information on Commuter Services programs, events and rewards, please contact Commuter Services at (909) 387-9639, or email at commuterservices@sbcounty.gov. You can also visit their website at <http://countyline/commuterservices> or <http://www.sbcounty.gov/commuterservices>.

Sick Leave Conversion

Employees who have used less than forty (40) hours of sick leave in a fiscal year may, at the employee's option, convert sick leave to vacation by the following formula: Hours of sick leave used are subtracted from forty (40). Sixty percent (60%) of the remainder, or a portion thereof, may be added to vacation leave to be utilized in the same manner as other accrued vacation leave. See MOU for details.

NOTE: This benefit only applies to certain bargaining units. Check your MOU to determine if you are eligible for this benefit.

Vacation/Holiday Cash-Out

An employee may sell back vacation or holiday time at the base hourly rate of the employee as hereinafter provided, upon approval of the appointing authority. Eligible employees may exercise this option under procedures established by the Director of Human Resources or designee. In lieu of cash, the employee may designate that part or all of the value of vacation time to be sold back is allocated to a deferred income plan if the County approves such a plan and credit for vacation time is allowed under the plan. See MOU for details.

NOTE: This benefit only applies to certain bargaining units. Check your MOU to determine if you are eligible for this benefit.

Unemployment Insurance

The Unemployment Insurance Program, commonly referred to as UI, provides weekly unemployment insurance payments for workers who lose their jobs through no fault of their own. Eligibility for benefits requires that the claimant be able to work, be seeking work, and be willing to accept a suitable job. Employees do not pay for this benefit, it is financed by employers.

There are several ways to file a claim:

1. File using the on-line application at www.edd.ca.gov
2. File by telephone using the toll-free number to contact the call center at 1-800-300-5616 between 8:00 a.m. – 5:00 a.m., Monday through Friday
3. Download the paper application from www.edd.ca.gov You print the document, hand write your answers and either fax or mail it to EDD, P.O. Box 5007, Buena Park, CA 90622-5007, or fax to 1-866-215-9159.

Your Medical and Dental Benefits Upon Retirement

When you retire from the County of San Bernardino, you are eligible to participate in the County-sponsored medical and dental plans. However as a retiree, you are responsible for paying 100% of the cost of premiums. Subsequent changes to enrollment can only be made during Retiree Open Enrollment, which is held annually during the month of November. Exceptions to this would be if you experience a mid-year qualifying event. At the time you meet with a Retirement Specialist at the SBCERA, you will be instructed to contact Human Resources, EBSD for an appointment to discuss your medical and dental enrollment options.

Employee Benefits and Services Division Appeals Procedure

General Information

The County of San Bernardino EBSD maintains and provides documents that explain the policies, requirements, and limits of coverage for all employee benefit programs. In the event that an employee or beneficiary believes that a request

or claim for a benefit under a health and welfare, flexible spending account, or salary savings plan has been improperly denied, he or she may appeal the decision within the parameters set forth in the following procedure.

Appeals for claims that are denied solely by one of the County's benefit carriers must be submitted within the guidelines established by that carrier. The EBSD, if requested to do so, will act as an advocate and will assist to ensure that the appeal receives due consideration.

Timeframes

Any employee or beneficiary whose request or claim for benefits is denied has the right to request a review by filing an appeal in writing directly with the EBSD Appeals Unit within 30 calendar days of the notice of denial or adverse decision. The appeal should include the basis for the appeal, as well as any supporting documentation. Within 15 calendar days of the date the appeal is received, the EBSD Appeals Unit will review the facts and respond in writing of its findings. Should special circumstances require an extension of time

for a decision on review, the review period may be extended by an additional 15 days. The EBSD Appeals Unit will provide written notification if an extension is needed.

If the appeal does not contain the information necessary to make a decision, an extension may be granted to obtain such information. The appellant will be notified in writing of the extension which will specifically describe the required information and will be afforded 15 calendar days from the date of the notice to provide the specified information.

Upon timely delivery of the requested information, and within 15 calendar days, the EBSD Appeals Unit must report its findings. Should the requested information not be received by the EBSD within the time specified, the EBSD Appeals Unit will make a decision without it, in which case, the decision is final and is not eligible for re-appeal.

Notification

Notice of the appeal decision will include the following:

1. The EBSD Appeal Unit's decision;
2. The specific reason(s) for the appeal determination;
3. A reference to the specific Plan provision(s) on which the determination is based;
4. A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on in making the adverse determination;
5. For the exception of appeals processed without the necessary information as described above, a statement advising the appellant that if he or she disagrees with EBSD Appeal Unit's decision, a second appeal can be made to the attention of the EBSD Benefits Chief whose decision will be final. Such appeals must be received within 15 calendar days of the notice of the appeals decision.



EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV





YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at **<http://www.dol.gov/elaws/userra.htm>**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

Publication Date—July 2008



Department of Fair Employment and Housing



Discrimination and Harassment in Employment are Prohibited by Law

Laws enforced by the Department of Fair Employment and Housing (DFEH) protect you from illegal discrimination and harassment in employment based on

- **Race**
- **Color**
- **Religion**
- **Sex** (pregnancy or gender)
- **Sexual orientation**
- **Marital status**
- **National origin** (including language use restrictions)
- **Ancestry**
- **Disability** (mental and physical, including HIV and AIDS)
- **Medical condition** (cancer/genetic characteristics)
- **Age** (40 and above)
- **Denial of family and medical care leave**
- **Denial of pregnancy disability leave or reasonable accommodation**

The California Fair Employment and Housing Act (Part 2.8 commencing with Section 12900 of Division 3 of Title 2 of the Government Code) and the Regulations of the Fair Employment and Housing Commission (California Code of Regulations, Title 2, Division 4, Sections 7285.0 through 8504):

- **Prohibit harassment** of employees, applicants, and independent contractors by any persons and require employers to take all reasonable steps to prevent harassment. This includes a prohibition against sexual harassment, gender harassment, and harassment based on pregnancy, childbirth, or related medical conditions.
- **Prohibit employers from limiting or prohibiting the use of any language** in any workplace unless justified by business necessity. The employer must notify employees of the language restriction and consequences for violation.
- **Require that all employers provide information** to each of their employees on the nature, illegality, and legal remedies that apply to sexual harassment. Employers may either develop their own publications, which must meet standards as set forth in California Government Code Section 12950, or use a brochure from the DFEH.
- **Require employers with 50 or more employees and all public entities to provide sexual harassment prevention training** for all supervisors.
- **Require employers to reasonably accommodate** an em-

ployee or job applicant's religious beliefs and practices.

- **Require employers to reasonably accommodate employees or job applicants with a disability** in order to enable them to perform the essential functions of a job.
- **Permit job applicants and employees to file complaints** with the DFEH against an employer, employment agency, or labor union that fails to grant equal employment as required by law.
- **Prohibit discrimination** against any job applicant or employee in hiring, promotions, assignments, termination, or any term, condition, or privilege of employment.
- **Require employers, employment agencies, and unions** to preserve applications, personnel records, and employment referral records for a minimum of **two years**.
- **Require employers to provide leaves** of up to four months to employees disabled because of pregnancy, childbirth, or a related medical condition.
- **Require an employer to provide reasonable accommodations** requested by an employee, on the advice of her health care provider, related to her pregnancy, childbirth, or related medical conditions.
- **Require employers of 50 or more persons to allow eligible employees to take up to 12 weeks leave** in a 12-month period for the birth of a child; the placement of a child for adoption or foster care; for an employee's own serious health condition; or to care for a parent, spouse, or child with a serious health condition. (Employers are required to post a notice informing employees of their family and medical leave rights.)
- **Require employment agencies to serve all applicants equally**, refuse discriminatory job orders, and prohibit employers and employment agencies from making discriminatory pre-hiring inquiries or publishing help-wanted advertising that expresses a discriminatory hiring preference.
- **Require unions not to discriminate** in member admissions or dispatching to jobs.
- **Prohibit retaliation** against a person who opposes, reports, or assists another person in opposing unlawful discrimination.

The law provides for administrative fines and remedies for individuals, including the following: hiring, front pay, back pay, promotion, reinstatement, cease-and-desist order, expert witness fees, reasonable attorney's fees and costs, punitive damages, and damages for emotional distress.

Job applicants and employees: If you believe you have experienced discrimination, you may file a complaint with DFEH.

Independent contractors: If you believe you have been harassed, you may file a complaint with DFEH.

Complaints must be filed within **one year** of the last act of discrimination/harassment, or, for victims who are under the age of 18, not later than one year of that person's eighteenth birthday.

For more information, contact DFEH toll free at (800) 884-1684, Sacramento area & out-of-state at (916) 478-7251, TTY number at (800) 700-2320, or visit our web site at www.dfeh.ca.gov

Government Code Section 12940 and Title 2 California Code of Regulations Section 7287 require all employers to post this document. It must be conspicuously posted in hiring offices, on employee bulletin boards, in employment agency waiting rooms, union halls, and other places employees gather.

In accordance with the California Government Code and ADA requirements, this publication can be made available in Braille, large print, computer disk, or tape cassette as a disability-related reasonable accommodation for an individual with a disability. To discuss how to receive a copy of this publication in an alternative format, please contact the DFEH at the numbers above.

State of California
Department of Fair Employment & Housing

Equal Employment Opportunity is

THE LAW

Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under the following Federal authorities:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Executive Order 11246, as amended, prohibits job discrimination on the basis of race, color, religion, sex or national origin, and requires affirmative action to ensure equality of opportunity in all aspects of employment.

INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, prohibits job discrimination because of disability and requires affirmative action to employ and advance in employment qualified individuals with disabilities who, with reasonable accommodation, can perform the essential functions of a job.

VIETNAM ERA, SPECIAL DISABLED, RECENTLY SEPARATED, AND OTHER PROTECTED VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C., 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment qualified Vietnam era veterans, qualified special disabled veterans, recently separated veterans, and other protected veterans. A recently separated veteran is any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

RETALIATION

Retaliation is prohibited against a person who files a charge of discrimination, participates in an OFCCP proceeding, or otherwise opposes discrimination under these Federal laws.

Any person who believes a contractor has violated its nondiscrimination or affirmative action obligations under the authorities above should contact immediately:

The Office of Federal Contract Compliance Programs (OFCCP), Employment Standards Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210, (202) 693-0101 or call an OFCCP regional or district office listed in most telephone directories under U.S. Government, Department of Labor. For individuals with hearing impairment, OFCCP's TTY number is (202) 693-1337.

Private Employment, State and Local Governments, Educational Institutions, Employment Agencies and Labor Organizations

Applicants to and employees of most private employers, state and local governments, educational institutions, employment agencies and labor organizations are protected under the following Federal laws:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

Title VII of the Civil Rights Act of 1964, as amended, prohibits discrimination in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment, on the basis of race, color, religion, sex (including pregnancy and sexual harassment) or national origin. Religious discrimination includes failing to reasonably accommodate an employee's religious practices where the accommodation does not impose undue hardship.

DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990 (ADA), as amended, protect qualified applicants and employees with disabilities from discrimination in hiring, promotion, discharge, pay, job training, fringe benefits, classification, referral, and other aspects of employment on the basis of disability.

The law also requires that covered entities provide qualified applicants and employees with disabilities with reasonable accommodations, unless such accommodations would impose an undue hardship on the employer.

AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination on the basis of age in hiring, promotion, discharge, compensation, terms, conditions or privileges of employment.

SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act of 1964, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in payment of wages to women and men

performing substantially equal work, in jobs that require equal skill, effort and responsibility under similar working conditions, in the same establishment.

RETALIATION

Retaliation is prohibited against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes discrimination under these Federal laws.

If you believe that you have been discriminated against under any of the above laws, and to ensure that you meet strict procedural timelines to preserve the ability of EEOC to investigate your complaint and to protect your right to file a private lawsuit, you should immediately contact:

The U.S. Equal Employment Opportunity Commission (EEOC), Washington, DC 20507 or an EEOC field office by calling toll free (1-800) 669-4000. For individuals with hearing impairments, EEOC's toll free TTY number is 1-800 669-6820.

Programs or Activities Receiving Federal Financial Assistance

RACE, COLOR, SEX, NATIONAL ORIGIN

In addition to the protection of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs.

Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal assistance.

INDIVIDUALS WITH DISABILITIES

Section, 504 of the Rehabilitation Act of 1973, as amended, prohibits employment discrimination on the basis of disability in any program or activity which receives Federal financial assistance in the federal government, public or private agency. Discrimination is prohibited in all aspects of employment against persons with disabilities who, with or without reasonable accommodation, can perform the essential functions of a job.

If you believe you have been discriminated against in a program of any institution which receives Federal assistance, you should contact immediately the Federal agency providing such assistance.

Publication OFCCP 1420
Revised August 2008

DEPARTMENT OF FAIR EMPLOYMENT & HOUSING

2218 Kausen Drive, Suite 100
Elk Grove, CA 95758

**"NOTICE A"****PREGNANCY DISABILITY LEAVE**

Under the California Fair Employment and Housing Act (FEHA), if you are disabled by pregnancy, childbirth or related medical conditions, you are eligible to take a pregnancy disability leave (PDL). If you are affected by pregnancy or a related medical condition, you are also eligible to transfer to a less strenuous or hazardous position or to less strenuous or hazardous duties, if this transfer is medically advisable. You are also eligible to receive reasonable accommodation for conditions related to pregnancy, childbirth, or related medical conditions if you request it with the advice of your health care provider.

- The PDL is for any period(s) of actual disability caused by your pregnancy, childbirth or related medical conditions up to four months (or 88 work days for a full-time employee) per pregnancy.
- The PDL does not need to be taken in one continuous period of time but can be taken on an as-needed basis.
- Time off needed for prenatal care, severe morning sickness, doctor-ordered bed rest, childbirth, and recovery from childbirth would all be covered by your PDL.
- Generally, we are required to treat your pregnancy disability the same as we treat other disabilities of similarly situated employees. This affects whether your leave will be paid or unpaid.
- You may be required to obtain a certification from your health care provider of your pregnancy disability or the medical advisability for a transfer or reasonable accommodation. The certification should include:
 - 1) the date on which you become disabled due to pregnancy or the date of the medical advisability for the transfer or reasonable accommodation;
 - 2) the probable duration of the period(s) of disability or the period(s) for the advisability of the transfer or reasonable accommodation; and,
 - 3) a statement that, due to the disability, you are unable to work at all or to perform any one or more of the essential functions of your position without undue risk to yourself, the successful completion of your pregnancy or to other persons or a statement that, due to your pregnancy, the transfer or reasonable accommodation is medically advisable.
- At your option, you can use any accrued vacation or other accrued time off as part of your pregnancy disability leave before taking the remainder of your leave as an unpaid leave. We may require that you use up any available sick leave during your leave. You may also be eligible for state disability insurance for the unpaid portion of your leave.
- Taking a pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave, the impact of the leave on your seniority and benefits, and our policy for other disabilities, please contact

Employer's Contact Person at Employer's Telephone Number

DEPARTMENT OF FAIR EMPLOYMENT & HOUSING

2014 T Street, Suite 210
Sacramento, CA 95814-5212

**"NOTICE B"****FAMILY CARE AND MEDICAL LEAVE (CFRA LEAVE)
AND PREGNANCY DISABILITY LEAVE**

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with us and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.
- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take a pregnancy disability leave of up to four months, depending on your period(s) of actual disability. If you are CFRA-eligible, you have certain rights to take BOTH a pregnancy disability leave and a CFRA leave for reason of the birth of your child. Both leaves contain a guarantee of reinstatement to the same or to a comparable position at the end of the leave, subject to any defense allowed under the law.
- If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or of a family member). For events which are unforeseeable, we need you to notify us, at least verbally, as soon as you learn of the need for the leave.
- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.
- We may require certification from your health care provider before allowing you a leave for pregnancy or your own serious health condition or certification from the health care provider of your child, parent, or spouse who has a serious health condition before allowing you a leave to take care of that family member. When medically necessary, leave may be taken on an intermittent or a reduced work schedule.
- If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.
- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. If you want more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits, please contact

[_____] .
Employer's Telephone Number

Notice to Employees:

THIS EMPLOYER IS REGISTERED UNDER THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE AND IS REPORTING WAGE CREDITS THAT ARE BEING ACCUMULATED FOR YOU TO BE USED AS A BASIS FOR:

UI

Unemployment Insurance

(funded entirely by employers' taxes)

When you are unemployed or working less than full-time and are ready, willing, and able to work, you may be eligible to receive Unemployment Insurance benefits. There are three ways to file a claim:

Internet

File on-line with eApply4UI—the fast, easy way to file a UI claim! Access eApply4UI at <https://eapply4ui.edd.ca.gov/>.

Telephone

File by contacting a customer service representative at one of the toll-free numbers listed below:

English 1-800-300-5616	Spanish 1-800-326-8937
Cantonese 1-800-547-3506	Vietnamese 1-800-547-2058
Mandarin 1-866-303-0706	TTY (non voice) 1-800-815-9387

Mail or Fax

File by mailing or faxing a UI Application (DE 1101I), by accessing the paper application on-line at www.edd.ca.gov. Print out the application, hand write your answers, and mail or fax it to EDD for processing.

Note: File promptly. If you delay in filing, you may lose benefits to which you would otherwise be entitled.

DI

Disability Insurance

(funded entirely by employees' contributions)

When you are unable to work or reduce your work hours because of sickness, injury, or pregnancy, you may be eligible to receive Disability Insurance (DI) benefits.

Your employer must provide a copy of "Disability Insurance Provisions," DE 2515, to each newly hired employee and to each employee leaving work due to pregnancy or due to sickness or injury that is not related to his/her job.

Claim Forms

- If your employer operates an approved voluntary plan in place of disability insurance and you have chosen to be covered by it, obtain DI claim forms from your employer.
- If you are **not** covered by a voluntary plan, obtain claim forms from your doctor, hospital, or directly from any California Disability Insurance (DI) Claim Management offices.
- File your "Claim for DI Benefits," DE 2501, within 49 days of the first day of your disability to avoid losing benefits.

FOR MORE INFORMATION ABOUT DI, VISIT THE EDD WEB SITE AT www.edd.ca.gov OR CONTACT THE DISABILITY INSURANCE CUSTOMER SERVICE CENTER AT 1-800-480-3287.
STATE GOVERNMENT EMPLOYEES SHOULD CALL 1-866-352-7675.
TTY (FOR DEAF OR HEARING-IMPAIRED INDIVIDUALS ONLY) IS AVAILABLE AT 1-800-563-2441.

PFL

Paid Family Leave

(funded entirely by employees' contributions)

When you stop working or reduce your work hours to care for a family member who is seriously ill or to bond with a new child, you may be eligible to receive Paid Family Leave (PFL) benefits.

Your employer must provide a copy of "Paid Family Leave Program Brochure," DE 2511, to each newly hired employee and to each employee leaving work to care for a seriously ill family member or to bond with a new child.

Claim Forms

- If your employer operates an approved voluntary plan in place of disability insurance and you have chosen to be covered by it, obtain PFL claim forms from your employer.
- If you are **not** covered by a voluntary plan, obtain claim forms from doctors, hospitals, or directly from any California Disability Insurance (DI) Claim Management offices or the PFL office.
- File your "Claim for PFL Benefits," DE 2501F, within 49 days of the first day of your family leave to avoid losing benefits.

FOR MORE INFORMATION ABOUT PFL, VISIT THE EDD WEB SITE AT www.edd.ca.gov OR CONTACT THE PAID FAMILY LEAVE CUSTOMER SERVICE CENTER AT:

English 1-877-238-4373	Spanish 1-877-379-3819
Armenian 1-866-627-1567	Tagalog 1-866-627-1569
Cantonese 1-866-692-5595	Vietnamese 1-866-692-5596
Punjabi 1-866-627-1568	TTY (non voice) 1-800-445-1312
STATE GOVERNMENT EMPLOYEES SHOULD CALL 1-877-945-4747	

NOTE: SOME EMPLOYEES MAY BE EXEMPT FROM COVERAGE BY THE ABOVE INSURANCE PROGRAMS. IT IS ILLEGAL TO MAKE A FALSE STATEMENT OR TO WITHHOLD FACTS TO CLAIM BENEFITS. FOR ADDITIONAL GENERAL INFORMATION, VISIT THE EDD WEB SITE AT www.edd.ca.gov.

NOTICE TO EMPLOYEES **UNEMPLOYMENT INSURANCE BENEFITS**

This employer is registered under the California Unemployment Insurance Code and is reporting wage credits that are being accumulated for you to be used as a basis for unemployment insurance benefits.

If you are:

- Unemployed, or
- Working less than full-time, **AND**
- You are ready, willing, and able to work full-time, or as instructed by the Employment Development Department,

You may be eligible to receive unemployment insurance benefits.

Employees of Educational Institutions:

Unemployment Insurance benefits based on wages earned while employed by a public educational institution may not be paid during a school recess period if the employee has reasonable assurance of returning to work at the end of the recess period (California Unemployment Insurance Code Section 1253.3). Benefits based on other covered employment may be payable during recess periods if the unemployed individual is in all other respects eligible, and the wages earned in other covered employment are sufficient to establish an unemployment insurance claim after excluding wages earned from an educational institution(s).

NOTE: Some employees may be exempt from unemployment and disability insurance coverage.

File your claim by telephone or Internet:

Toll-Free Telephone Numbers

English 1-800-300-5616

Mandarin 1-866-303-0706

Spanish 1-800-326-8937

Vietnamese 1-800-547-2058

Cantonese 1-800-547-3506

TTY (Non Voice) 1-800-815-9387

EDD's Internet Address to Complete and Submit Your On-Line Application:

<https://eapply4ui.edd.ca.gov>

Note: If contacting us to file a claim, you must contact us by Friday to receive credit for the week. If calling, Mondays are our busiest days. For faster service, call Tuesday through Thursday.

