



2008–2009

EMPLOYEE BENEFITS GUIDE

County of San Bernardino • Active Employees



EMPLOYEE
BENEFITS AND SERVICES
HUMAN RESOURCES

- ◆ Medical Plans
- ◆ Dental Plans
- ◆ Life Insurance
- ◆ Retirement Options
- ◆ Section 125 Premium Conversion Plan
- ◆ Medical Expense Reimbursement (FSA) Plan
- ◆ Additional Benefits Information

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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. And don't forget to factor costs into your benefits picture.

We encourage you to keep this guide as a reference throughout the year. If you have questions, contact Employee Benefits and Services or the plan directly. Plan phone numbers and web sites are listed in the Contact Information section of this booklet on page 6.

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 2008

Reminder:

◆ *You must reenroll through eBenefits to continue your Medical Expense Reimbursement Account.*

Center for Employee Health and Wellness (CEHW) Opens in Victorville

◆ On January 7th, 2008, the Center for Employee Health and Wellness (CEHW) opened a satellite clinic in Victorville in order to meet the needs of those departments whose employees either work or live in the High Desert areas. This satellite clinic is located at 17330 Bear Valley Road, Suite A-106, Victorville, 92395. The hours of operation are from 7:30 am to 4:00 pm, Monday through Friday, excluding County holidays. You can contact the clinic at (760) 962-1450.

This clinic is now treating all work-related injuries as well as blood borne pathogen exposures and providing preemployment exams for most County positions. Return to work exams for both occupational injury or nonwork-related illnesses and DMV exams are also conducted.

Family and Medical Leave Act (FMLA) Revision

On January 28, 2008, the President signed the National Defense Authorization Act, which amends FMLA to provide up to 26 weeks of job-protected leave to eligible employees to care for injured or ill service members and to allow leave because of a qualifying exigency arising out of the fact that a covered family member is on active duty or has been notified of an impending call to active duty status. The provisions of allowing leave to care for a covered service member became effective immediately on January 28, 2008. The provisions regarding a qualifying exigency are not effective until the Secretary of Labor issues regulations defining "qualifying exigencies." Please refer to page 71 for the "Required Notice" for additional information.

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 or <http://countyline.co.san-bernardino.ca.us/hr>

Wellness 360 Program

To enhance the “My Health Matters!” program and give all County employees a chance to learn more about health and wellness, we are providing you with a FREE tool that will reward you — in CASH — for all that you do to embrace a healthy lifestyle.

On **Wellness360** you can learn information about eating right and exercising. The site offers you an easy way to meet your fitness and nutrition goals with interactive exercise tracking, menu planning, progress monitoring, and suggestions from experts. On **Wellness 360** you can create and safeguard your FREE online medical record, available to you 24/7 for personal use and in case of a medical emergency.

Creating your personal account on **Wellness 360** is easy! It takes just three simple steps:

1. Go online to www.wellness360.com
2. Click on “New Members with an Enrollment Code Enroll Here”
3. Enter your *Enrollment Code* and get ready to take a journey into wellness.

You can easily obtain your **Enrollment Code** via the Internet at <http://countyline/hr/ehap/Wellness360/default.asp> or by contacting your Wellness Advocate, which you can find listed at the same site.

*Open Enrollment is
June 1 through June 20, 2008*

New Opt-Outs

If you are electing to Opt-Out for the first time, you must certify online using eBenefits and send verification of other employer-sponsored coverage to the Employee Benefits and Services Division by **July 11, 2008**. If this documentation is not received by the Employee Benefits and Services Division by **5:00 p.m. on July 11, 2008**, your Opt-Out request will not be approved for the 2008/2009 plan year and your health and/or dental elections will revert to your previous 2007/2008 plan year's election.

New 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 11, 2008*. If this documentation is not received by the Employee Benefits and Services Division by **5:00 p.m., on July 11, 2008**, your newly enrolled dependent(s) will not be added to your plan for the 2008/2009 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 for 2008/2009. 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 for 2008/2009. 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 for 2008/2009. Please refer to the Premium Rate Table and Medical Plans Comparison Chart for specific information.

DeltaCare USA

There are no significant benefit changes for the DeltaCare USA plan for 2008/2009. Please refer to the Premium Rate Table and Dental Plans Comparison Chart for specific information.

Delta Dental PPO

There are no significant benefit changes for the Delta Dental PPO plan for 2008/2009. Please refer to the Premium Rate Table and Dental Plans Comparison Chart for specific information.

Vision Plan

There are no significant benefit changes for the EyeMed Vision Plan for 2008/2009. Please refer to the Vision Plan section of this booklet for specific information.



Medical Expense Reimbursement (FSA) Plan

There are no significant benefit changes for the FSA plan. Please refer to the appropriate Memorandum of Understanding, Compensation Plan, Salary Ordinance, or Contract for specific details.

Short-Term Disability (STD) Plan

For more information on this plan, please refer to the enclosed plan highlights, the Short-Term Disability Plan Documents, or go online at http://countyline/hr/benefits/short_term_disability.asp.

Voluntary Term Life Insurance Plan and AD&D

There are no significant benefit changes to the County's AD&D Plan for 2008/2009. Voluntary Supplemental Life premiums were reduced.

Tell Us What You Think!

Providing exceptional customer service is the Employee Benefits and Services Division'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 or if you prefer to complete a paper survey, please contact the Employee Benefits and Services Division at 157 West Fifth Street, First Floor, San Bernardino, CA 92415; (909) 387-5787; fax (909) 387-5566; or e-mail at ebsd@hr.sbcounty.gov



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

2008/2009 PREMIUM RATE TABLE

For Active Employees

Rates Effective July 5, 2008

Coverage Effective July 19, 2008



PLAN AND ENROLLMENT STATUS	2007 BIWEEKLY PREMIUM	2008 BIWEEKLY PREMIUM*	DIFFERENCE IN BIWEEKLY PREMIUM	PERCENTAGE CHANGE
Health Net HMO				
Employee only	\$148.68	\$154.43	\$5.75	3.87%
Employee with one dependent	\$317.98	\$329.98	\$12.00	3.77%
Employee with two or more dependents	\$435.82	\$452.15	\$16.33	3.75%
Kaiser Permanente HMO				
Employee only	\$171.79	\$178.06	\$6.27	3.65%
Employee with one dependent	\$342.16	\$354.39	\$12.23	3.57%
Employee with two or more dependents	\$483.58	\$500.75	\$17.17	3.55%
Health Net (PPO)				
Employee only	\$302.02	\$333.63	\$31.60	10.46%
Employee with one dependent	\$614.07	\$678.14	\$64.07	10.43%
Employee with two or more dependents	\$952.34	\$1,051.61	\$99.27	10.42%
Health Net (Needles)**				
Employee only	\$148.68	\$154.43	\$5.75	3.87%
Employee with one dependent	\$317.98	\$329.98	\$12.00	3.77%
Employee with two or more dependents	\$435.82	\$452.15	\$16.33	3.75%
DeltaCare USA				
Employee only	\$8.66	\$8.78	\$0.12	1.39%
Employee with one dependent	\$14.06	\$14.18	\$0.12	0.85%
Employee with two or more dependents	\$18.39	\$18.51	\$0.12	0.65%
Delta Dental Plan				
Employee only	\$18.29	\$19.27	\$0.98	5.36%
Employee with one dependent	\$33.72	\$35.47	\$1.75	5.19%
Employee with two or more dependents	\$57.42	\$60.36	\$2.94	5.12%

* Rates subject to change pending Board approval.

** For employees assigned to work in the Needles, Trona, Baker, and Ridgecrest 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
Employee Benefits and Services	222 West Hospitality Lane, Third Floor San Bernardino, CA 92415 Interoffice Mail Code: 0015 Long-Term Disability Medical Emergency Leave Nurse Care Advisory Short-Term Disability	909-386-8600 909-386-8600 909-386-8746 909-387-1091 909-386-8600	http://countyline/hr/benefits www.sbcounty.gov/hr/benefits
Employee Health and Wellness Centers	400 North Pepper Avenue Colton, CA 92324 17330 Bear Valley Road, Suite A-106 Victorville, CA 92395	909-580-1701 1-877-722-3721 760-962-1450	http://countyline/hr/center/ www.sbcounty.gov/hr/center
Providers:			
AD&D (The Hartford)	(Contact your Payroll Clerk or Employee Benefits and Services)	1-877-ONE-HART 909-387-5559	
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	
Kaiser Permanente	Kaiser Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109	1-800-464-4000	www.kp.org
Managed Health Network (MHN)		1-800-777-9276	www.members.mhn.com
Variable Universal Life	10681 Foothill Boulevard, Suite 301 Rancho Cucamonga, CA 91730	1-877-833-1776 x28	
Voluntary Term Life (The Hartford)	(Contact your payroll clerk or Employee Benefits and Services)	1-877-ONE-HART 909-387-5559	
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

2008 Open Enrollment Master Schedule

JUNE 1 Sun 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

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

JUNE 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 Employee Benefits & Services Division, 157 West Fifth Street, First Floor, San Bernardino and Tuesdays and Thursdays, June 2 through June 19 at PERC Victorville Center, 17270 Bear Valley Road, Suite 107, Victorville. No registration necessary — walk-ins are welcome. You can receive this service on County time with your supervisor's approval.

JUNE 2 Mon *San Bernardino Open Enrollment Health Fair* 9:00 a.m. to 3:00 p.m., County Government Center, 385 North Arrowhead Avenue, Rotunda, San Bernardino

JUNE 13 Fri *Rancho Cucamonga Open Enrollment Health Fair* 9:00 a.m. to 3:00 p.m., Superior Court of California, Jury Assembly Room, 8303 Haven Avenue, Rancho Cucamonga

JUNE 17 Tue *Victorville Open Enrollment Health Fair* 9:00 a.m. to 3:00 p.m., Ambassador Hotel and Conference Center, 15494 Palmdale Road, Victorville

JUNE 20 Fri *Needles Open Enrollment Health Fair* 10:00 a.m. to 2:00 p.m., Needles Park & Recreation, 1705 "J" Street, Gymnasium, Needles

JUNE 20 Fri *Open Enrollment ends!* This is the deadline to submit your 2008 Benefits Elections using eBenefits.

JULY 11 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 19 Sat Effective date of coverage for changes made to medical, dental, voluntary term life, and AD&D plans.

JULY 30 Wed Pay warrants reflect Open Enrollment rate changes.

AUG 4 Mon Confirmation Statements mailed to all employees.

2008 Open Enrollment Meeting Schedule

Benefits are an important part of your total compensation package. Take advantage of this opportunity to discover your options. The County has arranged to have insurance plans and ING representatives on-site to answer your questions.

Please allow 1½ hours per session.

CITY	DATE	DAY	TIME	LOCATION
COLTON	May 30	Fri	9:00 a.m. & 10:30 a.m.	Arrowhead Regional Medical Center, 400 North Pepper Avenue, Oak Room
SAN BERNARDINO	June 2	Mon	9:00 a.m. , 10:30 a.m. & 1:30 p.m.	HEALTH FAIR at County Government Center, 385 North Arrowhead Avenue, Board Chambers
ONTARIO	June 3	Tue	9:00 a.m. & 10:30 a.m.	TAD, 1637 East Holt Boulevard, Dorothy Rowe Conference Room
FONTANA	June 3	Tue	1:30 p.m. & 3:00 p.m.	TAD, 7977 Sierra Avenue, Crosswell Commons Room
REDLANDS	June 4	Wed	9:00 a.m. & 10:30 a.m.	TAD, 881 East Redlands Boulevard, Conference Room A, Second Floor
LOMA LINDA	June 5	Thur	9:00 a.m. & 10:30 a.m.	Child Support, 10417 Mt. View Avenue, Sunrise Room
SAN BERNARDINO	June 5	Thur	1:30 p.m. & 3:00 p.m.	General Services, 777 East Rialto Avenue, Large Conference Room
SAN BERNARDINO	June 10	Tue	9:00 a.m., 10:30 a.m. & 1:30 p.m.	Hall of Records, 222 W. Hospitality Lane, Solid Waste Department, Second Floor, Conference Room A
TRONA	June 11	Wed	1:30 p.m.	Library, 82805 Mt. View
YUCCA VALLEY	June 12	Thur	9:00 a.m. & 10:30 a.m.	TAD, 56357 Pima Trail, Large Conference Room
JOSHUA TREE	June 12	Thur	1:00 p.m.	Joshua Tree Court House, 6527 White Feather Road, Jury Assembly Room
TWENTYNINE PALMS	June 12	Thur	3:00 p.m.	TAD, 73629 Sun Valley Drive, Conference Room
RANCHO CUCAMONGA	June 13	Fri	9:00 a.m. , 10:30 a.m. & 1:30 p.m.	HEALTH FAIR at Superior Court, 8303 Haven Avenue, Jury Assembly Room
SAN BERNARDINO	June 16	Mon	9:00 a.m. & 10:30 a.m.	Public Services Group, 825 East Third Street, Hearing Room
VICTORVILLE	June 17	Tue	9:00 a.m. , 10:30 a.m. & 1:30 p.m.	HEALTH FAIR at Ambassador Hotel & Conference Center, 15494 Palmdale Road
TWIN PEAKS	June 18	Wed	10:00 a.m.	County Complex, 26010 State Highway 189, Conference Room
HESPERIA	June 19	Thur	9:00 a.m. & 10:30 a.m.	TAD, 9655 9th Avenue, Conference Room B, Second Floor
BARSTOW	June 19	Thur	2:00 p.m.	JESD, 1300 East Mt. View, Job Club Room
NEEDLES	June 20	Fri	10:00 a.m. & 1:00 p.m.	HEALTH FAIR at Needles Park & Recreation, 1705 "J" Street

2008 HEALTH FAIRS

~ There will be four health fairs this year ~
 ~ There's sure to be one near you . . . don't miss out ~

CITY	DATE	DAY	TIME	LOCATION
SAN BERNARDINO	June 2	Mon	9:00 a.m. to 3:00 p.m.	County Government Center, 385 N. Arrowhead Ave., Rotunda
RANCHO CUCAMONGA	June 13	Fri	9:00 a.m. to 3:00 p.m.	Superior Court of California, Jury Assembly Room, 8303 Haven Avenue
VICTORVILLE	June 17	Tue	9:00 a.m. to 3:00 p.m.	Ambassador Hotel & Conference Center, 15494 Palmdale Road
NEEDLES	June 20	Fri	10:00 a.m. to 2:00 p.m.	Needles Park & Recreation, 1705 "J" St., Gymnasium

- ✦ *Attend one of the four Open Enrollment Health Fairs throughout San Bernardino County. There will be prize giveaways, health and dental information, education and screenings.*
- ✦ *Come and speak to a representative from Health Net, Kaiser, Delta Dental, EyeMed, ING, 24-Hour Fitness, EAP, Employee Benefits and many, many more.*
- ✦ *Some screenings include: Blood pressure and blood sugar, body composition analysis and many others.*



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. If you are a Safety employee or firefighter, you are not eligible for VUL and AD&D coverage.

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 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)
- ◆ Domestic Partner:
 - ▲ Photocopy of the Certificate of State Registered Domestic Partnership or equivalent out-of-state certificate
- ◆ Children:
 - ▲ Photocopy of birth certificate (legal or hospital)
 - ▲ 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.

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. on July 11, 2008**, 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 Employee Benefits and Services.

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. The Employee Benefits and Services Division 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.

Open Enrollment — Kaiser Permanente, Health Net, Delta Dental PPO and DeltaCare USA members who do not complete the 2008/2009 Open Enrollment process will maintain their current elections.

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 the Employee Benefits and Services Division of Human Resources.

Mid-Year Changes

The enrollment options you elect during the 2008/2009 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, legal separation 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
- ◆ 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 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, legal separation, 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 domestic partner certificates
 - ▲ Copies of court papers for divorces, separations or adoptions
 - ▲ Copy of letter from employer verifying loss or gain of spouse's employment
 - ▲ 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 Employee Benefits and Services within **31** days of the qualifying event

Effective Date of Mid-Year Changes

All elections made during the plan year shall become effective beginning with the pay period that immediately follows the date that the properly completed Benefit Plan Premium Conversion Election/Change Form and documentation is received by the Plan Administrator during the applicable Election Period. 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. If you have questions about mid-year changes, please call the Employee Benefits and Services Division.

The Contact Information on page 6 of this guide lists the Employee Benefits and Services phone numbers, as well as plan phone numbers and websites.

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.

Eligible Before-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) is subject to imputed income per IRS regulations. Variable Universal Life is not eligible for before-tax deductions.

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 pretax 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 pretax option does not affect your dependent's eligibility for County-sponsored insurance.

Election of Before-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/Medical 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, Ridgecrest 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 the Employee Benefits and Services Division 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 the Employee Benefits and Services Division. 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 Employee Benefits 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 the Employee Benefits and Services Division.



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?	<p>An Internet and Intranet based system that allows you to:</p> <ul style="list-style-type: none"> ☞ Make changes to your benefits ☞ View your choices immediately for accuracy ☞ Print a confirmation statement <p>eBenefits is available during the entire Open Enrollment period (June 1 through June 20, 2008). You must submit your benefit elections by June 20, 2008.</p>	
Complete Your Open Enrollment Online Using eBenefits	<p>You must use eBenefits if</p> <ul style="list-style-type: none"> ☞ You are making any changes during the 2008/2009 Open Enrollment ☞ You want to renew participation in a Flexible Spending Account (Medical Expense Reimbursement Plan) 	
If you have <i>no</i> changes	<p>You do not need to use eBenefits. You will maintain your current elections, with the exception of FSA as described above.</p>	
How to access eBenefits	<p>You must first enable Internet access in order to use eBenefits from a non-County computer</p> <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” <p>If you need assistance enabling Internet Access, please contact the Help Desk at 909-884-4884.</p>	<p>Sign on from a County Computer (Intranet) or the Internet</p> <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 “<i>Add a dependent or beneficiary</i>” 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 2008. ☞ 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 20, 2008</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 Employee Benefits and Services at 909-387-5787.

eBenefits Instructions (continued)

	MEDICAL	DENTAL	OPT-OUT / WAIVE
What you need to know/do	View plan choices, premiums, and make choices	View plan choices, premiums, and make choices	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 11, 2008

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 2008-2009 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



eBenefits Instructions (continued)

	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 › 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 combined PPO/OON	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

	KAISER PERMANENTE	HEALTH NET PPO	
		In-Network (PPO)	Out-of-Network (OON)
	\$10 copay	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)
	Kaiser 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 Usual, Customary and Reasonable amount
	None	\$250 each covered member \$750 family maximum	\$250 each covered member \$750 family maximum
	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)

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

	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>(Combined with substance abuse)</p> <p>Inpatient: Plan pays \$175 per day (does not apply to Out-of-Pocket maximum)</p> <p>Outpatient: You pay \$25 per visit; up to 50 visits per calendar year (does not apply to out-of-pocket maximum)</p> <p>Inpatient: You pay 20%</p> <p>Outpatient: You pay 20% [CY deductible waived]</p>	<p>(Combined with substance abuse)</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

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	See routine physicals below	See routine physicals below
Routine physicals	You pay a \$10 copay; maximum 1 per calendar year	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 (annual)	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)	Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary Mail Order (90-day supply): \$10 generic, \$20 brand name, \$50 non-formulary	Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary Mail Order (90-day supply): \$10 generic, \$20 brand name, \$50 non-formulary

	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 copay	You pay 20% [CY ded. waived]	You pay 30% after deductible
	You pay a \$10 copay; up to 60 visits per calendar year	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: generic \$10 copay, brand name \$15 copay, sexual dysfunction and 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. Mail Order: \$30 generic, 50% coinsurance for lifestyle drugs. \$60 brand/non-formulary + 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:	<p>Inpatient: No charge; up to 30 days per year</p> <p>Outpatient: You pay \$20; up to 20 visits per year</p>	<p>Inpatient: Not covered</p> <p>Outpatient: Not covered</p>
Detox:	<p>Inpatient: No charge; up to 3 days</p> <p>Outpatient: Not covered</p>	<p>Inpatient: Not covered</p> <p>Outpatient: Not covered</p>
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 _____

	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>(Combined with mental health services)</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</p>	<p>(Combined with mental health services)</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% [CY ded. waived]	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, you will be defaulted to a PCP. 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, the Employee Benefits and Services Division 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 zip code 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 at (800) 464-4000 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

Kaiser Permanente benefits include routine checkups, physicals, vision exams, hearing exams, pediatric checkups and health education to help keep you and your family healthy. Please refer to the Medical Plans Comparison Chart in this booklet for key covered expenses. The Mental Health Parity Law (AB88) requires coverage for the diagnosis and medically necessary treatment services for severe mental illness of a person of any age. Coverage must be provided for these mental health services in the same way

that other medical conditions are covered (e.g., same copayments and limits). The nine specific diagnoses identified as severe mental illnesses are: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder (Manic-Depressive Disorder), Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Development Disorder or Autism, Anorexia Nervosa and Bulimia Nervosa.

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 facility unless otherwise approved. If you obtain services from other than a Kaiser 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

Please call Member Services, available seven days a week from 7:00 a.m. to 7:00 p.m., at 1-800-464-4000, or go to Kaiser Permanente's web site 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 thorough 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

No payment will be made under this EOC for expenses incurred for or in connection with any of the items below, regardless as to whether you utilized the services of a Preferred Provider or an Out-of-Network Provider. Also, services or supplies that are excluded from coverage in the EOC exceed EOC limitations, or are follow-up care (or related to follow-up care) to EOC exclusions or limitations will not be covered.

The listing below is not all inclusive, you must refer to your EOC or contact Health Net PPO for a complete listing of all limitations and exclusions.

Excess Charges Amounts charged by Out-of-Network Providers for covered medical services and treatment which Health Net determines to be in excess of Covered Expense, as defined in the "Definitions" section of the EOC.

Clinical Trials Although clinical trials are covered, as described in the "Medical Benefits" portion of the "Plan Benefits" section of this EOC, coverage for clinical trials does not include the following items:

- ◆ Drugs or devices that are not approved by the FDA;
- ◆ Services other than health care services, including but not limited to cost of travel, or costs of other nonclinical expenses;
- ◆ Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- ◆ Health care services that are specifically excluded from coverage under this EOC; and
- ◆ Items and services provided free of charge by the research sponsors to Covered Persons in the trial.

Cosmetic Services and Supplies Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Covered Person are not covered. However, the EOC does cover Medically Necessary services and supplies for complications which exceed routine follow-up care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair transplantation, hair analysis, hairpieces and wigs, chemical frace peels, abrasive procedures of the skin, liposuction or epilation are not covered.

However, reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or diseases is covered.

Breast reconstruction surgery is subject to the Certification requirements described in the "Certification Requirement" portion of the "Plan Benefits" section of the EOC. However, hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and Certification for determining the length of stay will not be required.

The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the Women's Health and Cancer Rights Act of 1998.

Contraceptives Vaginal, oral and emergency contraceptives are covered as described in the "Outpatient Prescription Drug Benefits" portion of the "Plan Benefits" section of the EOC. Vaginal



contraceptives include diaphragms and cervical caps, and are only covered when a Physician performs a fitting examination and prescribes the device. Such devices are only available through a prescription from a pharmacy and limited to one fitting and prescription per Calendar Year unless additional fittings or devices are Medically Necessary. Injectable contraceptives (when administered by a Physician) and intrauterine devices (IUDs) are covered as a medical benefit. If Your Physician determines that none of the methods specified as covered by the Plan are medically appropriate, then the Plan will provide coverage for another FDA-approved prescription or contraceptive method as prescribed by Your Physician.

Dental Services Dental services are limited to the services stated in “Dental Injury” under the “Plan Benefits” section of the EOC and in the following situation:

◆ General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Covered Person requires that an ordinarily noncovered dental service which would normally be treated in a dentist’s office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary, subject to the other limitations and exclusions of the EOC and will only be covered under the following circumstances (a) Covered Persons who are under seven years of age or (b) Covered Persons who are developmentally disabled or (c) Covered Persons whose health is compromised and general anesthesia is Medically Necessary.

Care or treatment of teeth and supporting structures; extraction of teeth; treatment of dental abscess or granuloma; dental examinations and treatment of gingival tissues other than tumors are not covered, except as stated above. Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, active splints or orthotics (whether custom fit or not), dental implants (materials implanted into or on bone or soft tissue), or other dental appliances, and related surgeries to treat dental conditions are not covered regardless of reason for such services.

Temporomandibular (Jaw) Joint Disorders

Temporomandibular Joint Disorder (also known as TMD or TMJ disorder) is a condition of the jaw joint which commonly causes headaches, tenderness of the jaw muscles, tinnitus or dull aching facial pain. These symptoms often result when chewing muscles and jaw joints do not work together correctly. Custom-made oral appliances (intraoral splint or occlusal splint) and surgical procedures to correct a TMD/TMJ disorder are covered when determined to be Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints, dental implants and other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered.

Surgery and Related Services for Disorders of the Jaw (often referred to as “Orthognathic Surgery” or “Maxillary and Mandibular Osteotomy”) Used for the purpose of correcting the malposition or improper development of the bones of the upper or lower jaw, except when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants and other dental appliances are not covered under any circumstances.

Dietary or Nutritional Supplements Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the Phenylketonuria (PKU) provision in the “Plan Benefits” section).

Refractive Eye Surgery Any eye surgery for the purpose of correcting refractive defects of the eye, such as a near-sightedness (myopia), far-sightedness (hyperopia) and astigmatism, unless Medically Necessary, recommended by the Covered Person’s treating Physician and authorized by Us.

Sex Change Any procedure or treatment designed to alter physical characteristics of the Covered Person to those of the opposite sex, and any other treatment or studies related to sex transformations.

Reconstruction of Prior Surgical Sterilization Procedures Services to reverse voluntarily surgically induced infertility.

Conception by Medical Procedures Services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include but are not limited to:

- ◆ In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), artificial insemination, zygote intrafallopian transfer (ZIFT) or any other process that involves the harvesting, transplanting or manipulating of a human ovum. Also not covered are services or supplies, (including injections and injectable medications) which prepare the Covered person to receive these services.

Experimental or Investigational Procedures

Experimental or Investigational drugs, devices, procedures or other therapies are only when:

- ◆ Independent review deems them appropriate as described in the “Independent Medical Review of Investigational or Experimental Therapies” portion of the “General Provisions” section of the EOC, or
- ◆ Clinical trials for cancer patients are deemed appropriate according to the “Medical Benefits” portion of the “Plan Benefits” section.

Inpatient Diagnostic Tests Inpatient room and board charges incurred in connection with an admission to a Hospital for diagnostic tests which could have been performed safely on an outpatient basis.

Chemical Dependency Treatment of chronic alcoholism, drug addiction and other Chemical Dependency problems, including detoxification services are not covered, except as specifically stated in the “Plan Benefits” section of the EOC.

Mental Disorders Care as a condition of parole or probation and court ordered testing is not covered under this EOC.

Noncovered items Any expenses related to the following items, whether authorized by a physician or not.

- ◆ Air purifiers, air conditioners and humidifiers
- ◆ Hearing Aids
- ◆ Food Supplements
- ◆ Support appliances and supplies such as stockings, arch supports
- ◆ Disposable supplies for home use

- ◆ Hygienic equipment , Jacuzzis and spas
- ◆ Personal or comfort items

Worker Compensation If you require services for which benefits are in whole or in part either payable or required to be provided under any Worker Compensation or Occupational Disease Law, HNL will not provide covered benefits. You are entitled and will pursue recovery from the Worker Compensation carrier liable for the cost of medical treatment related to your illness or injury.

Expenses before Coverage Begins Services received before the covered Person’s effective date.

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	Therapeutic pulpotomy	No Charge	No Charge	10%
	03310	Root canal – Anterior (front) teeth	\$30.00	No Charge	10%
	03320	Root canal – Bicuspid	\$60.00	No Charge	10%
	03330	Root canal – Molar	\$90.00	No Charge	10%
Oral Surgery	07286	Biopsy of soft oral tissue	No Charge	No Charge	10%
	07111	Uncomplicated extraction, single tooth	No Charge	No Charge	10%
	07220	Extraction – impacted soft tissue, per tooth	No Charge	No Charge	10%
	07230	Extraction – impacted partially bony, per tooth	\$30.00	No Charge	10%
	07240	Extraction – impacted completely bony, per tooth	\$40.00	No Charge	10%
	09215	Local anesthesia	No Charge	No Charge	10%
	09220	General anesthesia – first 30 minutes (only with oral surgery)	\$165.00	No Charge	10%
	09221	General anesthesia – each additional 15 minutes (only with oral surgery)	\$80.00	No Charge	10%
	7450-51	Removal of benign odontogenic cyst or tumor	No Charge	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
	Crowns and Bridges	02740/06740	Crown – porcelain/ceramic substrate (front teeth or molars)	\$60.00	25%, add'l cost for porcelain on posterior teeth
02752/06752		Crown – porcelain fused to noble metal (front teeth or molars)	\$60.00	25%, add'l cost for porcelain on posterior teeth	30%, add'l cost for porcelain on posterior teeth
06930		Recement fixed partial denture	No Charge	25%	30%
02920		Recement crown	No Charge	25%	30%
06241		Pontic – porcelain fused to base metal (front teeth or molars)	\$60.00	25%, add'l cost for porcelain on posterior teeth	30%, add'l cost for porcelain on posterior teeth
06980		Fixed partial denture repair, by report	\$15.00	25%	30%
Prosthetics	05110-20	Complete upper or lower denture	\$75.00	25%	30%
	05211-12	Upper or lower partial denture – resin base	\$85.00	25%	30%
	05670-71	Replace all teeth (upper or lower) on cast metal framework	\$75.00	25%	30%
	05510	Repair broken upper or lower denture, no tooth damage	\$15.00	25%	30%
	05410	Complete denture adjustment	No Charge	25%	30%
	05520	Replace broken tooth on denture	\$5.00	25%	30%
02790/06790	Crown – full cast high noble metal (gold)	\$160.00	25%	30%	
Orthodontics	various	Pre-treatment records & diagnostic services	\$200.00	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)
	D8090-80-70	Comprehensive orthodontic treatment	\$1,450.00	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)
	D8010-30	Limited ortho treatment of primary, transitional or adolescent teeth	\$950.00	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)
	D8040	Limited orthodontic treatment of the adult teeth	\$1,150.00	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	various	Post-treatment records	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.

How the Plan Works

When you enroll in DeltaCare USA, you must select a dental office from the Participating DeltaCare Dental Offices directory. If you need a directory, call DeltaCare USA at 1-800-422-4234. After you select your dental office, that office becomes the “primary care dental office” for you and all covered dependents. You must go to this office for all of your dental services. If you do not obtain dental services through your primary care dental office, or if DeltaCare USA has not authorized services elsewhere, you will not be covered. Referral of specialist services must be by a contract dentist and must be authorized by DeltaCare USA in writing.

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 Employee Benefits and Services 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

- ◆ Cosmetic dental care, except external bleaching which is limited to one bleaching tray and gel for 2 weeks of self-treatment for a copayment of \$125.
- ◆ Dental conditions arising out of and due to Enrollee's employment or for which Worker's Compensation is payable; services which are provided to the Enrollee by state government or agency thereof or are provided without cost to the Enrollee by any municipality, county or other subdivision.
- ◆ Treatment required by reason of war.

- ◆ Dental services performed in a hospital and related hospital fees.
- ◆ Treatment of fractures and dislocations.
- ◆ Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures, retainers).
- ◆ Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
- ◆ Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility with the DeltaCare program (e.g., teeth prepared for crowns, root canals in progress).
- ◆ Any service that is not specifically listed as a covered expense.
- ◆ Congenital malformations (e.g. congenitally missing teeth, supernumerary).
- ◆ Removal of malignancies.
- ◆ Dispensing of drugs not normally supplied in a dental office.
- ◆ Cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
- ◆ Dental services received from any dental office other than the assigned DeltaCare office or a participating network specialist.
- ◆ Prophylactic removal of impactions (asymptomatic/nonpathological).
- ◆ "Specialist consultations" for noncovered benefits.
- ◆ Implant placement or removal, appliances placed on or services associated with implants including, but not limited to, prophylaxis and periodontal treatment.
- ◆ Crown lengthening procedures.

Limitations

- ◆ Accidental injury, except as noted in Accident Injury Rider; that is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth; damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits.
- ◆ Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy).
- ◆ General anesthesia and/or intravenous sedation/

analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions.

- ◆ Full upper and/or lower dentures are not to exceed one each in any five year period from initial placement
- ◆ Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- ◆ Denture relines are limited to one per denture during any 12 consecutive months.
- ◆ Crowns and bridges are not to be replaced within any five-year period from initial placement.
- ◆ Periodontal treatments (root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months.
- ◆ Full mouth debridement (gross scale) is limited to one treatment during any 12 consecutive month period.
- ◆ Bitewing X-rays are limited to not more than one series of four films in any 12 consecutive month period.
- ◆ Full mouth X-rays are limited to one set every 24 consecutive months.
- ◆ Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

Limitations To Orthodontic Benefits

- ◆ Orthodontic treatment must be provided by a DeltaCare orthodontist.
- ◆ Plan benefits cover 24 months of usual and customary orthodontic treatment
- ◆ Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not DeltaCare will be responsible for payment of balance due of \$2,800 for dependent children to age 19 and

\$3,000 for covered full-time students and adults; the amount will be pro-rated over the number of months to completion of the treatment and will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the orthodontist

- ◆ Orthodontic treatment in progress is limited to new DeltaCare Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. DeltaCare is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions To Orthodontic Benefits

- ◆ Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances.
- ◆ Retreatment of orthodontic cases.
- ◆ Copayments for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$75, may apply.
- ◆ Treatment in progress at inception of eligibility.
- ◆ Transfer after banding has been initiated.

How to Get In Touch With DeltaCare USA

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

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.

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.

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 percentage of the service plus the difference between what the plan covers out-of-network and what 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).

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- 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 current 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.

What's Not Covered

- ◆ Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability Laws.
- ◆ Services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in California Health and Safety Code Section 1373(a).
- ◆ Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to: cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- ◆ Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
- ◆ Prosthodontic services or any Single Procedure stated prior to the date the person became eligible for such services under this plan.
- ◆ Prescribed or applied therapeutic drugs, premedication or analgesia.
- ◆ Experimental procedures.
- ◆ All hospital costs and any additional fees charged by the Dentist for hospital treatment.
- ◆ Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered Oral Surgery services.
- ◆ Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- ◆ Implants (materials implanted into or on bone

or soft tissue) or the repair or removal of implants or any treatment in conjunction with implants, except as provided under Limitations.

- ◆ Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- ◆ Replacement of existing restorations for any purpose other than active tooth decay.
- ◆ Intravenous sedation, occlusal guards and complete occlusal adjustment.

Limitations

- ◆ Only the first two general dentist oral examinations and specialist consultations provided in a calendar year are Benefits while the patient is an Enrollee under any Delta program.
- ◆ Delta pays for full-mouth x-rays only after five years have elapsed since any prior set of full-mouth x-rays was provided under any Delta program.
- ◆ Bitewing x-rays are provided on request by the dentist, but not more than twice in any calendar year while patient is an Enrollee under any Delta program.
- ◆ Diagnostic casts are a Benefit only when made in connection with subsequent orthodontic treatment covered under this program.
- ◆ Only the first two cleanings, fluoride treatments, or Single Procedures which include cleaning, or combination thereof, provided to a patient in a calendar year while he or she is an Enrollee under any Delta program are Benefits under this program.
- ◆ Periodontal maintenance is limited to four (4) treatments provided in a calendar year while he or she is an Enrollee under any Delta program.
- ◆ Sealant Benefits include the application of sealants only to permanent first molars up to age nine and second molars up to age 14 if they are without caries (decay), or restoration on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
- ◆ Direct composite (resin) restorations are Benefits on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optimal services and Delta's payment

is limited to the cost of the equivalent amalgam restorations.

- ◆ Crowns, Jackets, Inlays, Onlays or Cast Restoration are Benefits on the same tooth only once every five years while the patient is an Enrollee under any Delta program, unless Delta determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.
- ◆ Prosthodontic appliances that were provided under any Delta program including, but not limited to fixed bridges and partial or complete dentures, will be replaced only after five years have passed, unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory.
- ◆ Delta will pay the applicable percentage of the dentist's fee for a standard cast chrome or acrylic partial denture of a standard complete denture, up to a maximum fee allowance which is at least the Prevailing Fee for a standard denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth which is constructed using accepted and conventional procedures and materials.)



The maximum allowance is revised periodically as dental fees change. Any denture and/or related service for which a charge is made which exceeds this allowance is an optional service, and the patient is responsible for the portion of the dentist's fee which exceeds the maximum allowance.

◆ Implants (materials implanted into or on bone or soft tissue) or their removal are not Benefits under this plan. However, if implants are provided in association with a covered prosthodontic appliance, Delta will allow the cost of a standard complete or partial denture toward the cost of the implant procedures and prosthodontic appliances. If Delta makes an allowance toward the cost of such procedures, Delta will not pay for any replacement placed within five years thereafter.

◆ If an Enrollee selects a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta will pay the applicable percentage of the lesser fee and the patient is responsible for the remainder of the Dentist's fee. For example: a crown, where a silver filling would restore the tooth, or a precision denture, where a standard denture would suffice.

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.deltadentalca.org.

*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.*

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

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

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).

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. You may also request a Summary Plan Description (SPD) at any time. For more information or questions regarding COBRA, contact Employee Benefits and Services at (909) 387-5552.



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

2007 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, Employee Benefits and Services Division (909) 387-5787, or request a copy in writing from the County of San Bernardino, Human Resources Department, Employee Benefits and Services Division, 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

You can save money by paying for certain medical care expenses with pretax dollars. How? By participating in a Medical Expense Reimbursement (FSA) Plan available to eligible employees. This is a type of Flexible Spending Account or FSA.

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 a separate account, which can be used to pay for qualifying medical care expenses that you, your spouse, and 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 reimburse yourself from your account with your pretax 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 the Employee Benefits and Services Division, 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 Employee Benefits and Services 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 an irrevocable election. 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 Employee Benefits and Services Division or go on-line 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 pretax 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 pretax contributions or reimbursement on a pretax 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 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 in 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 information the plan document shall govern.

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



Short-Term Disability (STD) Plan

The County provides Short-Term Disability (STD) benefits to employees in the event of a **nonwork-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 hours.

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 \$917 per week for represented employees, or \$1311 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) Program.

Employees are required, as a condition of participation in this Plan, to actively cooperate with the efforts of the EHaP Nurse Care Coordinators in recovering from their disability. 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 Employee Benefits and Services, Hospitality at (909) 386-8600, or go online to www.sbcounty.gov/hr/benefits or <http://countyline/hr/benefits>

~ PLEASE NOTE ~

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

For further information contact Employee Benefits and Services Division 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 Employee Benefits and Services Division.

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

For further information contact Employee Benefits and Services Division at (909) 386-8746.

Life Insurance

Life insurance provides your beneficiaries with valuable financial protection in the event of your death. Eligible employees may purchase additional life insurance in two ways: 1) through the Voluntary Term Life Insurance Plan, and 2) through the Variable Universal Life (VUL) Insurance Plan. Participation in either plan is voluntary.

Voluntary Term Life

Eligibility

Your Memorandum of Understanding (MOU), Exempt Compensation Plan, salary ordinance, or your contract governs eligibility for Voluntary Term Life Insurance. Employees in the occupational units listed below are eligible (dependent coverage is not available under the Voluntary Term Life Insurance Plan):

- ◆ Administrative Services
- ◆ Attorneys
- ◆ Clerical
- ◆ Contract (depending on contract)
- ◆ Craft, Labor & Trades
- ◆ Elected Officials
- ◆ Exempt Employees
- ◆ Management
- ◆ Nurses
- ◆ Professional
- ◆ Safety

- ◆ Safety Management & Supervisory
- ◆ Specialized Peace Officers
- ◆ Specialized Peace Officers-Supervisory
- ◆ Supervisory
- ◆ Supervisory Nurses
- ◆ Technical & Inspection

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

- ◆ Be in an eligible position (see list above)
- ◆ Work 41 hours or more per pay period (**You are NOT eligible to enroll or increase coverage if you are on a leave of absence**)
- ◆ Complete 1040 hours of service (160 hours for Attorneys and 13 pay periods for Safety, Safety Management & Supervisory).

Once you have met the eligibility requirements, you may enroll initially within 31 days of becoming eligible, or you may wait and enroll 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 and the insurance company will not require evidence of good health or a physical exam to participate in this plan. If you elect more than \$250,000 coverage, you will be required to provide evidence of good health to the insurance company. Evidence of good health may include questionnaires, physical exams or written documentation required by 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 arrangement, 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) is subject to imputed income per IRS regulations. Variable Universal Life is not eligible for before-tax deductions.

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. After the County receives the insurance company's approval of your application, coverage will begin the first day of the pay period following the date the County receives your premium.

Waiver of Premium While Disabled The Waiver of Premium benefit is a safeguard against losing your life insurance in the event of financial hardship caused by a disability. If you are unable to engage in any occupation for profit or gain, as determined by the insurance company, you will continue to have coverage without further premium payments provided the disability occurred while covered by the plan and before age 65. The insurance company requires proof of disability within 12 months of the date total disability begins and once each year so long as the disability continues. The benefit coverage amount is subject to reduction at age 70.

If you return to work for the County and want to continue coverage, you must contact your payroll clerk or Employee Benefits and Services 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.

Living Benefits Option When an employee is coping with a terminal illness, the Living Benefits Option pays a portion of the benefit now, with unrestricted use, and pays the remainder as a death benefit later.

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	\$0.04
40 but less than 45	\$0.06
45 but less than 50	\$0.09
50 but less than 55	\$0.14
55 but less than 60	\$0.23
60 but less than 65	\$0.34
65 but less than 70	\$0.56
70 and over**	\$0.75

*Effective pay period 16 (warrant received July 30, 2008.)

**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.

The request cannot exceed 80% of the value of your life insurance policy, and is subject to a minimum of \$3,000 and a maximum of \$500,000.

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 to convert to an individual policy with Hartford Life, without having to complete a Personal Health Statement to show proof of good health. Please contact Hartford at 1-877-ONE-HART (1-877-663-4278).

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 The Hartford at 1-877-ONE-HART. For questions about enrollment, current coverage or to request claim paperwork, call Employee Benefits and Services at (909) 387-5559.

*Life insurance helps provide
your beneficiaries with
financial protection*

Variable Universal Life

This benefit does not have an Open Enrollment period, so employees can enroll at any time.

Pacific Life and Annuity underwrites the Variable Universal Life (VUL) Insurance Plan. Strategic Financial is the consulting firm who will provide investment counseling for participants in the VUL Plan. Variable Universal Life differs from Voluntary Term Life Insurance coverage in that a portion of the premiums is placed into an investment account. Money in the investment account is used to offset insurance cost increases due to aging.

Some of the benefits include:

- ◆ Cash-value growth
- ◆ Tax-free death benefits and tax-deferred growth
- ◆ Withdrawal and loan privileges
- ◆ Portability (you may take your policy with you if leave County employment)

Eligibility

Eligibility for VUL is governed by your Memorandum of Understanding (MOU), Exempt Compensation Plan, salary ordinance, or contract. Employees in the occupational units listed below are eligible (dependent coverage is not available under the Variable Universal Life Insurance Plan) to enroll:

- ◆ Administrative Services
- ◆ Attorneys
- ◆ Clerical
- ◆ Contract (depending on contract)
- ◆ Craft, Labor & Trades
- ◆ Elected Officials
- ◆ Exempt Employees
- ◆ Management
- ◆ Nurses
- ◆ Professional
- ◆ Supervisory
- ◆ Supervisory Nurses
- ◆ Technical & Inspection
- ◆ Units represented by SBPEA

Note: Safety employees and Firefighters are not eligible for this benefit.

Before you may enroll in the plan or make changes to your elections, you must:

- ◆ Be in an eligible position (see the list above)
- ◆ Work 41 hours or more per pay period

Payroll Deductions and Effective Date of Coverage

The premiums for this policy are based upon individual factors, such as base rate of pay, age, and smoking status. To obtain a personal illustration of premium cost, you must call or meet with an Strategic Financial registered representative, Please call Strategic Financial at 1-877-833-1776 ext. 28.

Once you have met with an Strategic Financial representative and your premiums are established Strategic Financial will notify the County of your premium deduction. Deductions are taken from the first and second pay warrant of the month, 24 times a year. Premiums are collected a month in advance of the coverage month.

County Contribution The employee pays the cost of this benefit. However, if you are an elected official or an Exempt employee and you elect to purchase VUL insurance, the County will contribute toward your biweekly premium based upon your Benefit Group:

- ◆ Elected Officials and Benefit Group A: 100% of the one-time base annual salary earnings option.
- ◆ Benefit Group B: 50% of the one-time base annual salary earnings option.

- ◆ Benefit Group C and D: 25% of the one-time base annual salary earnings option.

Beneficiary for Variable Universal Life Insurance 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.

How To Enroll

To enroll in the VUL Plan, you must speak or meet with a registered Strategic Financial representative. The Strategic Financial registered representative will explain the plan, its benefits and features, and answer your questions. Also, the Strategic Financial representative will explain your investment choices and give you the information and paperwork you need to enroll. To arrange for your personal and confidential consultation, call 1-877-833-1776 ext. 28.

Accidental Death & Dismemberment (AD&D)

Employee Eligibility

Employees in the occupational units listed below may enroll within 31 days of completing 1040 hours (160 hours for Attorneys) of satisfactory employment. If you do not enroll at that time, your next opportunity to enroll is during the annual Open Enrollment period. You may make changes in your AD&D coverage during Open Enrollment.

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

- ◆ Administrative Services
- ◆ Attorneys
- ◆ Clerical
- ◆ Contract (depending on contract)
- ◆ Craft, Labor & Trades
- ◆ Elected Officials
- ◆ Exempt Employees
- ◆ Management
- ◆ Nurses
- ◆ Professional
- ◆ Specialized Peace Officers
- ◆ Specialized Peace Officers - Supervisory
- ◆ Supervisory
- ◆ Technical & Inspection

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.

Note: Safety employees and firefighters are not eligible for this benefit.

Plan and Coverage Options

You have four coverage options and seven AD&D plans from which to choose:

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.

Benefits The plan will pay the following benefit for the loss of:

- Life The Principal Sum
- Both Hands or Both Feet
or Sight of Both Eyes The Principal Sum
- One Hand and One Foot The Principal Sum
- Speech and Hearing The Principal Sum
- Either Hand or Foot
and Sight in One Eye The Principal Sum

Premium Table

Plan	Employee Only Coverage	Family Coverage	Employee and Spouse or Domestic Partner Coverage	Employee and Child Coverage
1	\$.14/pay period	\$.17/pay period	\$.15/pay period	\$.15/pay period
2	\$.35/pay period	\$.43/pay period	\$.38/pay period	\$.38/pay period
3	\$.70/pay period	\$.85/pay period	\$.75/pay period	\$.75/pay period
4	\$ 1.40/pay period	\$ 1.70/pay period	\$ 1.50/pay period	\$ 1.50/pay period
5	\$ 2.10/pay period	\$ 2.55/pay period	\$ 2.25/pay period	\$ 2.25/pay period
6	\$ 2.80/pay period	\$ 3.40/pay period	\$ 3.00/pay period	\$ 3.00/pay period
7	\$ 3.50/pay period	\$ 4.25/pay period	\$ 3.75/pay period	\$ 3.75/pay period

Movement of Both Upper and Lower Limbs (Quadriplegia)	The Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters The Principal Sum
Movement of Both Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half The Principal Sum
Either Hand or Foot	One-Half The Principal Sum
Sight of One Eye	One-Half The Principal Sum
Speech or Hearing	One-Half The Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum

Benefits are limited to the full benefit for losses from one accident.

If you marry after enrolling for AD&D coverage, 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.

Initial Enrollment

New employees may enroll within 31 days of the date they complete 1040 hours of satisfactory performance (160 hours for attorneys). If you are a new employee and you do not enroll within the specified 31-day

enrollment period, you will be eligible to enroll during the next annual Open Enrollment period.

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 to employees through their Benefit Plan Premium Conversion Option. 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 Hartford 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 The Hartford at 1-877-ONE-HART. For questions about enrollment, current coverage or to request claim paperwork, call Employee Benefits and Services at (909) 387-5559.

LifeAssist Employee Assistance Program (EAP) MHN (Managed Health Network)

The County provides an Employee Assistance Program (EAP) for **all employees**, their dependents and members of their households through Managed Health Network (MHN). The *LifeAssist* 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. Therefore, no information will be released without the written consent of the employee.

How to Access the EAP

LifeAssist 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. For Company Code type “COSB” using either upper or lower case letters

For further information regarding the *LifeAssist* EAP, contact the Employee Health and Productivity (EHaP) Program at (909) 387-1005.

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, or Hazlewood Fitness in Needles. 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, or Hazlewood Fitness in Needles 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 an Active club membership valid at over 140 Active club locations during all club hours, excluding Sport clubs. Sport and Super-Sport memberships are also available, and are valid at all Sport and Active 24-Hour Fitness clubs. The County has paid initiation fees, and has negotiated the following discounted monthly membership dues:

Sport	Initiation Fee	Active Club	Sport Club	Super-Club
Employee only	\$0	\$18/mo	\$27/mo	\$49/mo
Each additional member	\$0	\$10/mo	\$10/mo	\$24/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 related as spouse, State certified domestic partner, or child (12-18 years of age, unmarried), and living at the same address. Employees must provide proof of County employment. Please note that employees may cancel their 24-Hour Fitness memberships 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	\$49	\$45	\$5
Employee + 2	\$49	\$60	\$5
Each additional member	\$49	\$10	\$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 nonelectronic debit accounts. Additional members must be related as spouse, State certified domestic partner, or child (12 to 22 years old, unmarried) and living at the same address. Employees must provide proof of County employment. Please note that employees may cancel their Club in Twin Peaks memberships at any time without penalty.

Hazlewood Rates and Information

Hazlewood Fitness in Needles offers single monthly memberships for no set up fee and monthly dues of \$30, or single monthly memberships paid by EFT are \$25. Single annual memberships may be purchased for \$240 with no set up fee when paid in full in advance. Add ons can be spouse, child (12 to 22 years old, unmarried), or certified domestic partner.

Contact Information

24-Hour Fitness Corporate Representative (909) 806-0875
 The Club in Twin Peaks Manager . . (909) 337-7071
 Hazlewood Fitness in Needles (760) 326-9663
 Employee Health and Productivity (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 21, 2008. The survivor benefit premiums will decrease from \$2.74 to \$2.45 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	2008	Nonrefundable Entry Age	2008	Refundable Entry Age	2008	Nonrefundable Entry Age	2008
16	8.97	16	8.15	21	11.07	21	10.54
17	8.96	17	8.15	22	11.10	22	10.57
18	8.95	18	8.14	23	11.13	23	10.60
19	8.95	19	8.14	24	11.17	24	10.64
20	8.95	20	8.14	25	11.24	25	10.70
21	8.96	21	8.15	26	11.31	26	10.77
22	9.00	22	8.18	27	11.39	27	10.85
23	9.02	23	8.20	28	11.48	28	10.93
24	9.07	24	8.25	29	11.59	29	11.04
25	9.12	25	8.29	30	11.70	30	11.14
26	9.18	26	8.35	31	11.81	31	11.25
27	9.24	27	8.40	32	11.95	32	11.38
28	9.32	28	8.47	33	12.09	33	11.51
29	9.40	29	8.55	34	12.24	34	11.66
30	9.49	30	8.63	35	12.39	35	11.80
31	9.58	31	8.71	36	12.57	36	11.97
32	9.68	32	8.80	37	12.74	37	12.13
33	9.79	33	8.90	38	12.92	38	12.30
34	9.90	34	9.00	39	13.11	39	12.49
35	10.01	35	9.10	40	13.30	40	12.67
36	10.13	36	9.21	41	13.49	41	12.85
37	10.26	37	9.33	42	13.68	42	13.03
38	10.39	38	9.45	43	13.89	43	13.23
39	10.52	39	9.56	44	14.09	44	13.42
40	10.65	40	9.68	45	14.28	45	13.60
41	10.79	41	9.81	46	14.49	46	13.80
42	10.93	42	9.94	47	14.70	47	14.00
43	11.07	43	10.06	48	14.90	48	14.19
44	11.21	44	10.19	49 & over	15.11	49 & over	14.39
45	11.37	45	10.34				
46	11.52	46	10.47				
47	11.67	47	10.61				
48	11.83	48	10.75				
49	11.99	49	10.90				
50	12.16	50	11.05				
51	12.32	51	11.20				
52	12.49	52	11.35				
53	12.66	53	11.51				
54 & over	12.84	54 & over	11.67				

The refundability factors are 1.10 for General and 1.05 for Safety.

The easiest way to determine your pretax 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 7% to account for the County “pick-up.” 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.

$$\left[\left(\frac{\text{Wage Rate}}{\text{Scheduled Hours}} \times \text{Scheduled Hours} \right) + \frac{\text{Cash Benefits}^*}{\text{Cash Benefits}^*} \right] \times \left[\frac{\text{Contribution Rate}}{\text{Contribution Rate}} - 7.0\% \right] = \frac{\text{Retirement Obligation}}{\text{Retirement Obligation}}$$

*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.

For example: The biweekly refundable retirement contribution for a general member with an entry age of 43, earning \$10.05 per hour, receiving a biweekly benefit plan of \$190.00 and \$40.00 per pay period in bilingual pay is calculated as:

$$[(\$10.05 \times 80 \text{ hours}) + \$230.00] \times [11.07\% - 7.0\%] = \$42.08 \text{ obligation per pay period}$$

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 15 and you will see the election change on the pay warrant you will receive on or about July 16, 2008.

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 \$1.10 required to satisfy their retirement obligation; Safety employees pay \$1.00 for every \$1.05 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 \$1.10 required; Safety employees contribute \$1.00 for every \$1.05 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

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. This is a supplemental retirement Plan that allows employees to contribute a portion of their pretax 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 fixed interest 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*.

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 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

All employees in the Exempt Unit, Elected Officials and other employees that are granted this benefit through an employment contract are eligible to participate in the County's 401(k) Plan. This is a supplemental retirement Plan that allows employees to contribute a portion of their pretax 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 fixed interest 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*.

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.

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. 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 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 Employee Benefits and Services at (909) 387-5537, or go online to www.sbcounty.gov/hr/benefits or <http://countyline/hr/benefits>



Commuter Services

Commuter Services' Rideshare Program assists County employees with alternative solutions to driving alone. Ridesharing includes walking, bicycling, public transportation, carpooling and vanpooling. Among the services it provides are: Vanpool and Transit Pass purchases through payroll deduction with up to \$115 per month in pretax 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 they start ridesharing 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. Those individuals using public transportation or on a vanpool may purchase their seats using Commuter Benefits, a Federal program that allows up to \$115 per month in tax deferred dollars. This translates in up to \$1,380 of an individual's annual income not being taxed.

For more information on Commuter Services programs, events and rewards, please contact Commuter Services at (909) 387-9639, e-mail Commuter_Services (global address list), or go online <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, Employee Benefits and Services 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 Employee Benefits and Services Division (EBSA) 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 Employee Benefits and Services Division, 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 EBSA 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 EBSA 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 EBSA 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 EBSA Appeals Unit must report its findings. Should the requested information not be received by the Employee Benefits and Services Division within the time specified, the EBSA 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 EBSA 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 the EBSA Appeal Unit's decision, a second appeal can be made to the attention of the EBSA Division Chief whose decision will be final. Such appeals must be received within 15 calendar days of the notice of the appeals decision.



Your Rights under the Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over

the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for *any* of the following reasons:

- 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.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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:

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

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.

For Additional Information:

If you have access to the Internet visit our FMLA website: <http://www.dol.gov/esa/whd/fmla>. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243): a customer service representative is available to assist you with referral information from 8am to 5pm **in your time zone**; or log onto our Home Page at <http://www.wagehour.dol.gov>.



U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
Revised August 2001

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 Employee Benefits and Services Division at (909) 386-8600.

NOTICE

Military Family Leave

On January 28, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

- (1) New Qualifying Reason for Leave.** Eligible employees are entitled to up to 12 weeks of leave because of “any qualifying exigency” arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. By the terms of the statute, this provision requires the Secretary of Labor to issue regulations defining “any qualifying exigency.” In the interim, employers are encouraged to provide this type of leave to qualifying employees.

- (2) New Leave Entitlement.** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the servicemember. This provision became effective immediately upon enactment. This military caregiver leave is available during “a single 12-month period” during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA leave.

Additional information on the amendments and a version of Title I of the FMLA with the new statutory language incorporated is available on the FMLA amendments Web site at http://www.dol.gov/esa/whd/fmla/NDAA_fmla.htm.



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.



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 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. 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 this notice where they customarily place notices for employees.



U.S. Department of Justice



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



1-800-336-4590

Publication Date—January 2006

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 Employee Benefits and Services Division at (909) 386-8600.

