

Picture...



My Benefits



My Health



My Choice



ANDREW LAMBERTO
Director of Human Resources

COUNTY OF SAN BERNARDINO

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Dear County Employee:

In anticipation of the 2012-13 Open Enrollment period that runs from June 1 through June 22, 2012, you will see many changes to your County benefit offerings. The Employee Benefits Advisory Committee (EBAC) vigorously negotiated the most cost effective benefits at the lowest possible premiums. As a result, the County opted for change!

The following are some of the most important and cost effective changes you will see:

- ✓ Medical Carrier – Blue Shield of California
- ✓ Dental Carrier – Cigna Dental Health of California, Inc.
- ✓ Disabilities/Leaves Administrator – Cigna
- ✓ Kaiser Permanente will continue to be offered

Health Net, Delta Dental and The Hartford will no longer be offered as options.

Based upon the changes made and to ensure you are making the appropriate choices for you and your family, I encourage you to take the time to carefully review the content of your 2012-13 Employee Benefits Guide.

To assist you with any health care transition questions, Blue Shield and Cigna have made available specific toll-free numbers. Also, additional information is now available on our website at: <http://mybenefitsatwork>, to assist you with your selections, such as current provider network directories, frequently asked questions, important contact information, just to name a few.

As you browse <http://mybenefitsatwork>, you will find detailed information about the many other benefit offerings available to you and your family. Specifically, the My Health Matters! Wellness and the Commuter Services program incentives are being planned with you in mind!

Should you have any questions or need assistance with your benefit offerings, please call Employee Benefits and Services at (909) 387-5787. We are available to assist you over the phone or in person, Monday through Friday, 7:30 a.m. to 5:00 p.m.

Wishing you continued health, wellness and prosperity,

Margaret D. Smith
Benefits Chief

Open Enrollment

Tips

- ✓ Visit <http://mybenefitsatwork> to learn more about your benefit options or to view a recorded Open Enrollment meeting
- ✓ Review What's New & Different In 2012 for important changes that may be of interest to you (page 2)
- ✓ Check important dates and Open Enrollment meeting locations (pages 10 & 11)
- ✓ Enroll or make changes using the eBenefits online Open Enrollment system at <https://emacapp.sbcounty.gov/psp/h90prd/?cmd=login>. Step-by-step instructions available on page 20
- ✓ Select the right coverage level. Review the medical and dental comparison charts and plan highlights (pages 24-51) and life insurance information (page 66)
- ✓ Enroll or re-enroll in the Medical Expense Reimbursement Plan (FSA)
- ✓ Review additional benefits that may be available to you (pages 61-71)
- ✓ Avoid the rush—enroll or make your changes early
- ✓ Submit any additional required documentation to EBSD by Monday, July 9, 2012

Detailed information about all this and more can be found in this Guide.

<http://mybenefitsatwork> | (909) 387-5787

Open Enrollment is June 1 through June 22, 2012

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AS YOU ENROLL

This Guide is designed to help you understand your Benefit Enrollment options for plan year 2012-13, which will become effective July 28, 2012. Included are summaries of your plan choices, such as medical, dental, vision, life insurance, accidental death & dismemberment and retirement options. Benefits vary depending on the bargaining unit that you belong to, so please check your applicable benefit summary for details at <http://countyline/hr/benefits/mybenefitsbyunit/home.asp>. You will also find in this benefits guide comparison charts for convenient at-a-glance referencing and plan contact information. Please read your materials carefully, and choose the plans that best meet your needs.

This year the County is utilizing a **“Positive Enrollment”** approach for Open Enrollment, which means that all Employees enrolled in medical and/or dental plans must logon to eBenefits and validate and/or update benefit selections. For more details on Positive Enrollment, please see Positive Enrollment in the “What’s New and Different for Plan Year 2012-13” section of this Guide.

We encourage you to use this Guide as a reference throughout the year. If you have questions, contact the Employee Benefits and Services Division (EBSB) or the plan provider directly. Plan phone numbers and web sites are listed in the Contact Information section on page 9 of this Guide.



Open Enrollment is June 1 through 22, 2012

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 Monday, July 9, 2012. If EBSB does not receive this documentation by 5:00 p.m., July 9, 2012, your dependent(s) will not be added to your plan for the 2012-13 plan year.

Additionally, if you are adding a dependent who is mentally or physically disabled and aged 26 or over, a “Disabled Dependent Certification” must be completed online using eBenefits.

WHAT'S NEW & DIFFERENT FOR PLAN YEAR 2012-13

There are some significant carrier changes that are taking place this plan year. Our carriers include:

Medical	Kaiser Permanente (HMO) Blue Shield of California Shield Signature HMO with level 2 benefits Blue Shield of California Shield (PPO) Blue Shield of California Shield Needles (PPO)
Dental	Cigna Dental Health of California, Inc. (DHMO) Cigna Dental Health of California, Inc. (DPPO)
Vision	EyeMed Vision Care
Short Term Disability/ Long Term Disability	Life Insurance Company of North America, a Cigna Company
Life Insurance	Minnesota Life

The following is a quick summary of significant changes:

Medical

Effective July 28, 2012, Blue Shield of California will become the new medical plan carrier, replacing Health Net. Blue Shield will provide comparable medical coverage for the HMO and PPO plans. Please check your applicable Evidence of Coverage (EOC) for full details and definitions.

- ✓ Copayments remain at \$10 for most services
- ✓ Mandatory mail order is no longer required for maintenance prescriptions under the Blue Shield plan
- ✓ No copayment for Preventative Care Services
- ✓ No Charge for Women's Preventive Health Services

More details are contained in the comparison charts within this guide, and the applicable EOC. EOCs can be obtained by visiting <http://countyline/hr/benefits/myhealth/home.asp>.



Your benefits are an important part of your compensation package

Dental

Effective July 28, 2012, Cigna will become the new dental plan carrier, replacing Delta Dental. Cigna will provide comparable dental coverage for both the DHMO and DPPO plans. Please refer to the applicable Evidence of Coverage (EOC) for full details, including plan limitations and exclusions. EOCs can be obtained online at <http://countyline/hr/benefits/myhealth/home.asp>.

An overview of the most highly utilized plan benefits and their applicable copayments can be found in the dental comparison chart within this guide.

If you or your dependent are receiving services for Orthodontia or started, but did not complete treatment on a tooth when the Cigna dental coverage becomes effective, your treatment should be covered under Transition of Care. To obtain detailed information on your Transition of Care benefits, contact Cigna's Customer Service Team at (800) 238-5834.

Disability and Protected Leave Administration

Effective July 28, 2012, Cigna will become the administrator for short-term disability (STD), long-term disability (LTD) and protected leaves, replacing The Hartford Disability. While this change will impact how employees report a leave request to the County, the STD, LTD and protected leave provisions remain the same.

- ✓ If you have a date of disability that begins before July 28, 2012, The Hartford will manage your STD claim until your disability ends. If you are also on a protected leave, Cigna will begin administering the leave effective July 28, 2012. All of the information pertaining to your leave will be transferred to Cigna.
- ✓ If your date of disability begins on or after July 28, 2012, Cigna will manage your disability claim.
- ✓ For protected leaves (FMLA, CFRA, Military Leave, etc), Cigna will receive all information pertaining to your leave, including continuous and intermittent absences from work, even if your leave began prior to July 28, 2012. Beginning July 28, 2012, report any leave time to Cigna.

Visit the EBSD website at http://countyline/hr/benefits/benefit_plans.asp where you will find the following:

- ✓ A brochure that explains how to report a protected leave and how to initiate a disability claim
- ✓ Frequently asked questions and answers
- ✓ Information on value added benefits such as will preparation assistance and identity theft protection

Cigna gives you the flexibility of managing your claim by phone or online. Contact Cigna by phone at (800) 238-5834 or visit their webpage at www.mycigna.com.

You are encouraged to use this Guide as a reference throughout the year

Due to the number of benefit changes during this Open Enrollment, June 1 through June 22, 2012, all employees enrolled in medical and/or dental plans will be required to logon to eBenefits to select and confirm your benefit choices.

Positive Enrollment

Due to the number of benefit changes for plan year 2012-13, the County is requiring all employees enrolled in a medical and/or dental plan(s) to make and/or confirm Open Enrollment elections using eBenefits.

Additionally, employees will need to certify that enrolled dependents meet the County and carriers' eligibility requirements by completing the Dependent Verification Affidavit.

What does this mean for me?

This means that during Open Enrollment, June 1 through June 22, 2012, all employees enrolled in medical and/or dental plans will be required to logon to eBenefits to select and confirm your benefit choices.

What if I don't have any changes?

You must still logon and validate your existing benefit selections and certify your eligible dependents.

What happens if I don't logon to eBenefits to select and confirm my benefit choices?

If you are currently enrolled in a medical and/or dental plan, you will be automatically enrolled in a plan that is comparable to your current coverage. For example, if you are currently enrolled in the Health Net HMO and Delta Dental DPPO plans, you would be enrolled in Blue Shield Signature HMO and Cigna Dental DHMO effective July 28, 2012.

For HMO or DHMO plans, a provider will be automatically selected for you and your eligible dependents if you do not make an election using eBenefits.

Do I have to provide documentation for my dependents?

You will be required to provide dependency documentation if you are adding a **new** dependent on to the plan. You will not need to submit any documentation to remove dependents from the plan during Open Enrollment.

All documentation for newly added dependents **must** be received in the Employee Benefits and Services Division of Human Resources by 5:00 p.m. on Monday, July 9, 2012.

Dependent Verification Affidavit

In addition to the Positive Enrollment, all employees are required to submit a Dependent Verification Affidavit during this year's Open Enrollment in order to certify that the dependents listed for coverage meet the County and carrier eligibility requirements. The Dependent Verification Affidavit can be completed online through eBenefits during the Open Enrollment period of June 1 through June 22, 2012.

If the list of dependents on eBenefits is inaccurate (for whatever reason), changes can be made during the Open Enrollment period by selecting the appropriate coverage level and listing the dependents that should be covered. The Dependent Verification Affidavit should be submitted only after corrections have been made.

*Reminder:
You must
enroll every
year to
participate
in the FSA
plan*

Medical Expense Reimbursement Plan (FSA)

Effective July 28, 2012, IRS legislation limits the amount that employees can contribute to the plan at \$2,500 per plan year. This may affect you, depending on your bargaining unit maximum allowable contribution.

Salary Savings Plans

457(b) Deferred Compensation Plan: *Attention SBPEA represented employees!*

Effective July 14, 2012, SBPEA represented employees who have completed one year of continuous service in a regular position and who contribute to the 457(b) plan, will be eligible for a biweekly match from the County. The match will be ½ times the employee's contribution up to ½% of the employee's biweekly base salary. For example if you contribute 1% of your biweekly base salary to the 457(b), you will receive a match from the County equal to ½% of your biweekly base salary.

Any matching funds from the County will be deposited into a 401(a) Defined Contribution account on your behalf. If you currently contribute to the 457(b) plan, there is no action needed. If you would like to open a 457(b) account with ING, you can do this in one of the following ways:

- ✓ Contact our local ING representatives at (909) 748-6468 to schedule an appointment, or
- ✓ Open a 457(b) account on-line at www.ingretirementplans.com/custom/sanbern and click the "Enroll Now" button shown on the top of the page.

Retirement Medical Trust (RMT): *Attention SBPEA represented employees!*

Effective July 14, 2012, SBPEA represented employees who have a certain number of years of continuous County service in a regular position, will receive the following:

- ✓ 10 years through 14 years 1.00% of biweekly base salary
- ✓ 15 years through 19 years 1.25% of biweekly base salary
- ✓ 20 years or more 1.50% of biweekly base salary

No action is needed by the employee; ING will set up the employees RMT account, called HRA001, where the funds will automatically default to a fixed account. Employees will have similar investment options available to them as in the 457(b) plan. After the initial deposit is made, employees can go onto www.ingretirementplans.com/custom.sanbern to view their account and make investment changes.

New Features offered by ING: *ING has gone mobile!*

ING introduces mobile account applications for owners of iPhone®, iPod Touch®, and Android™ devices. The mobile application will allow you to quickly check your ING account balance and more. To download this application, go directly to: iTunes App Store or the Android Market and use Keywords: ING Retire.

ING has also created a mobile game called STRUCT to boost your financial brain power! STRUCT is a game of fast-paced action for iPhone®, iPod Touch®, or iPad®. The skills you develop to succeed at the game translate to similar ones that are necessary to become a successful long-term saver. Go directly to: iTunes App Store and use keyword: STRUCT.

There are now even more benefits from contributing to a 457(b) Plan

Commuter Services

This year, Human Resources – Commuter Services (HR-CS) implemented the following program enhancements:

Subsidy Increase for Hybrid Vehicle Carpool Program (HVCP)

The monthly subsidy paid by Commuter Services increased from \$80 to \$165. This additional subsidy will help to further offset the employee cost of participating in the Hybrid Vehicle Carpool Program.

Modeled after the County's employee-funded vanpool program, this option allows three or four employees to use a hybrid vehicle from the Commuter Services fleet for carpooling. Commuter Services is currently accepting applications for this program. Interested employees may submit a Hybrid Vehicle Carpool Application to Commuter Services at Interoffice Mail Code (IOM) 0178, or fax the completed application to (909) 387-9641. A limited number of HVCP vehicles are available with the subsidy, so apply as soon as possible.

Subsidy Increase for Transit Pass Program

The monthly subsidy paid by Commuter Services has been increased from \$4 to \$8. This additional subsidy will help to further offset the employee cost of purchasing transit bus passes by matching the student bus pass rate.

The County's Transit Pass Program allows employees to pay for an Omnitrans monthly transit bus pass on a pre-tax basis through payroll deduction. Regular and Senior/Disability bus passes are available and the cost is distributed over 26 pay periods.

Interested employees may submit a Transit Pass Application to Commuter Services at Interoffice Mail Code (IOM) 0178, or fax the completed application to (909) 387-9641.

Change to Pre-Tax Benefit Amount!

Effective pay period 01/2012, the IRS reduced the pre-tax benefit amount for transit passes and vanpooling to \$125 per month.

Monthly Gift Card Drawings

Effective April 1, 2012, employees who track their participation each month will be entered into a monthly drawing for a chance to win a \$25 gift card. Separate drawings will be held for each mode of ridesharing.

The monthly drawings are an enhancement to the existing HR-CS incentive program. On a semi-annual basis, gift cards of varying denominations are issued to employees who participate in rideshare programs as follows:

\$25 Big 5 Gift Card – Bicycle/Walk/Take Public Transit to work at least 10 days per month

\$25 Gas Card – Carpool/Vanpool/Telecommute at least 15 days per month

\$10 Gas Card – Carpool/Vanpool/Telecommute at least 12 days per month

Rideshare Road Show

HR-CS will sponsor Brown Bag Luncheon events at locations across the County as part of the "Rideshare Road Show." Attendees will learn about various rideshare programs, incentives for participating, environmentally friendly tips for work and home, and much more.

There are more reasons than ever to check out Commuter Services!

For Road Show event information, or if you are interested in sponsoring a Road Show event at your location, call HR-CS at (909) 387-9640 or (909) 387-9639.

Visit the HR-CS Intranet site at <http://countyline.sbcounty.gov/commuterservices/> or call HR-CS at (909) 387-9640 to learn more about this year's enhancements, join or start a new carpool or vanpool, and for information on how participation in the County's rideshare program will benefit you.



Legislative Changes

Official Department of Labor and other required notices are included in this Employee Benefits Guide starting on page 82.

This Guide only highlights your benefits. It is not a summary plan description (SPD) or Evidence of Coverage (EOC). 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.

Tell Us What You Think!

Providing exceptional customer service is EBSD's top priority. Please tell us how we are doing by participating in a brief survey. The link to the survey site is www.surveymonkey.com/s.asp?u=486291762554. For a paper survey, please contact EBSD at (909) 387-5787.

2012-13 PREMIUM RATE TABLE

Rates Effective July 14, 2012*

Coverage Effective July 28, 2012

Plan	Coverage Type	2012-13 Bi-Weekly Rates	2011-12 Bi-Weekly Rates**	Difference in Bi-Weekly Premium	Percentage Change from 2011-12
Blue Shield Signature HMO	Employee Only	\$202.87	\$203.70	(\$0.83)	-0.41%
	Employee + 1	\$403.73	\$435.57	(\$31.84)	-7.31%
	Employee + 2	\$570.45	\$596.93	(\$26.48)	-4.44%
Blue Shield PPO	Employee Only	\$448.72	\$411.84	\$36.88	8.96%
	Employee + 1	\$912.42	\$837.25	\$75.17	8.98%
	Employee + 2	\$1,415.09	\$1,298.41	\$116.68	8.99%
Blue Shield Needles PPO	Employee Only	\$506.39	\$464.74	\$41.65	8.96%
	Employee + 1	\$1,029.40	\$944.57	\$84.83	8.98%
	Employee + 2	\$1,593.97	\$1,462.52	\$131.45	8.99%
Kaiser	Employee Only	\$253.93	\$240.09	\$13.84	5.76%
	Employee + 1	\$505.85	\$478.18	\$27.67	5.79%
	Employee + 2	\$714.96	\$675.79	\$39.17	5.80%
Cigna Dental HMO	Employee Only	\$8.68	\$9.91	(\$1.23)	-12.41%
	Employee + 1	\$13.88	\$16.00	(\$2.12)	-13.25%
	Employee + 2	\$18.03	\$20.85	(\$2.82)	-13.53%
Cigna Dental PPO	Employee Only	\$22.97	\$22.84	\$0.13	0.58%
	Employee + 1	\$42.66	\$42.14	\$0.52	1.23%
	Employee + 2	\$72.88	\$71.77	\$1.11	1.54%

*Premiums do not include any medical/dental premium subsidies and/or benefit plan dollars you may be eligible for. Please refer to the Benefit Plan Dollars and Premium Subsidies on page 19.

**2012-13 Blue Shield rates are compared to Health Net; 2012-13 Cigna Dental rates are compared to Delta Dental.

For employees assigned to work in the Needles, Trona and Baker work locations, the County has established a "Needles Subsidy." The Needles Subsidy is paid by the employee's Department and is equal to the amount of the premium difference between the indemnity health plan offered in these specific work locations and the lowest cost health plan provided by the County. Specifically, \$303.52 for Employee Only coverage, \$625.67 for Employee + 1 coverage, and \$1,023.52 for Employee + 2 coverage. Please refer to the Needles Subsidy Disclosure on page 19 of this guide.

CONTACT INFORMATION

	Address	Phone	Web Site
Board of Retirement	348 W. Hospitality Lane, Third Floor San Bernardino, CA 92415-0014	(909) 885-7980 (877) 722-3721	www.sbcera.org
Employee Benefits and Services	157 West Fifth Street, First Floor San Bernardino, CA 92415 Interoffice Mail Code: 0440	(909) 387-5787	http://mybenefitsatwork
	AD&D / Life Insurance	(909) 387-5537	http://countyline.sbcounty.gov/commuterservices/
	COBRA	(909) 387-5552	
	Combined Giving Campaign	(909) 387-5831	
	Commuter Services	(909) 387-9640	
	Dependent Care Assistance Program (DCAP)	(909) 387-5648	
	Medical Expense Reimbursement (FSA)	(909) 387-5648	
	Kaiser Permanente	(909) 387-5537	
	Long-Term Disability	(909) 387-5787	
	Medical Emergency Leave	(909) 387-5787	
Retirement Medical Trust	(909) 387-5537		
Salary Savings	(909) 387-6098		
Short-Term Disability	(909) 387-5787		
Vision	(909) 387-5831		
My Health Matters! Program		(909) 387-5787	http://mybenefitsatwork
Steps to Success	http://www.healthycommunity.ca/sanbernardino/hr/default.aspx		
Providers:			
Blue Shield of California (HMO, PPO and Needles PPO)	P.O. Box 272540 Chico, CA 95927-2540	(800) 642-6155	www.blueshieldca.com
Blue Shield Mental Health Service Administration (MHSA) (HMO, PPO and Needles PPO)	Blue Shield of California MHSA P.O. Box 719002 San Diego, CA 92171-9002	(877) 263-9952	www.blueshieldca.com
Cigna Dental Care (DHMO)	P.O. Box 188046 Chattanooga, TN 37422-8046	(800) 238-5834	www.cigna.com
Cigna Dental PPO	P.O. Box 188037 Chattanooga, TN 37422-8037	(800) 238-5834	www.cigna.com
EyeMed Vision	P.O. Box 8504 Mason, OH 45040-7111	(877) 406-4146	www.eyemedvisioncare.com
ING	1200 California Street, Suite 108 Redlands, CA 92374	(909) 748-6468 (800) 584-6001	www.ingretirementplans.com
Kaiser Permanente	Kaiser Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109	(800) 464-4000	www.kp.org
Kaiser Permanente Mental Health Offices and Services	(866) 205-3595 Appointments (800) 900-3277 Member help line, after hours, weekends and holidays		www.kp.org
Cigna (STD/LTD)	400 N. Brand Blvd., Suite 500 Glendale, CA 91203	(800) 238-5834 (800) 642-8533 Fax	www.mycigna.com
Cigna (FMLA/CFRA/PDL)	1640 Dallas Parkway Plano, TX 75093	(800) 238-5834 (866) 931-5095 Fax	www.mycigna.com
Minnesota Life	400 Robert Street St. Paul, MN 55101	(866) 293-6047	www.minnesotalife.com
San Bernardino County Public Employees Association (SBPEA)	433 North Sierra Way San Bernardino, CA 92410	(909) 889-8377 (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 (800) 655-7322	www.seba.biz

2012 OPEN ENROLLMENT MASTER SCHEDULE

JUNE 1	Fri	<p>Open Enrollment begins! Informational meetings are scheduled throughout the County. Check the meeting schedule included in this Guide for locations, dates and times.</p> <p>During Open Enrollment, if you are eligible, you may:</p> <ul style="list-style-type: none"> • Enroll in a medical and/or dental plan • Change medical and/or dental plans • Add dependents to or remove them 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 the Medical Expense Reimbursement Plan (FSA). If you choose to participate in the FSA Plan, you must enroll every year, even if you are currently participating. • Enroll in Supplemental Life and/or Accidental Death and Dismemberment (AD&D) insurance • Change your Benefit Plan Premium Conversion Option elections • Add/change your beneficiary information <p>Should you need help with completing your online Open Enrollment, computer access and one-on-one assistance is available 7:30 a.m. to 5:00 p.m. Monday through Friday at EBSD, 157 West Fifth Street, First Floor, San Bernardino. No registration necessary — walk-ins are welcome. You can receive this service on County time with your supervisor's approval.</p>
JUNE 22	Fri	Open Enrollment ends! This is the deadline to submit your 2012 Benefit Elections using eBenefits.
JULY 9	Mon	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 14	Sat	Premium rate change effective date.
JULY 28	Sat	Effective date of coverage for changes made to medical, dental, Supplemental Life and AD&D plans.
AUG 6	Mon	Confirmation Statements mailed to all employees.
AUG 8	Wed	Pay warrants reflect open enrollment rate changes.

Important:

All benefits-eligible employees must initiate an eBenefits session during Open Enrollment.

2012 OPEN ENROLLMENT MEETING SCHEDULE

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

City	Date	Day	Time	Location
San Bernardino	5/24/12	Thurs	9:00 a.m. & 2:00 p.m.	County Government Center - Board Chambers 385 North Arrowhead Avenue
Colton	5/31/12	Thurs	8:30 a.m. & 10:00 a.m.	ARMC – Oak Room 400 North Pepper Avenue
Ontario	6/4/12	Mon	9:30 a.m. & 11:00 a.m.	TAD - Dorothy Rowe Conference Room 1627 East Holt Boulevard
Fontana	6/4/12	Mon	1:30 p.m. & 3:00 p.m.	TAD - Crosswell Commons Conference Room 7977 Sierra Avenue
Needles	6/5/12	Tues	9:30 a.m. & 11:00 a.m.	City of Needles, Council Chambers 1111 Bailey Avenue
San Bernardino	6/5/12	Tues	9:30 a.m. & 2:00 p.m.	SBPEA, 433 North Sierra Way
Hesperia	6/6/12	Wed	10:00 a.m.	Jerry Lewis High Desert Government Center Conference Room 220, 15900 Smoke Tree Street
Hesperia	6/6/12	Wed	1:00 p.m. & 2:30 p.m.	TAD - Conference Room B 9655 9th Avenue
San Bernardino	6/11/12	Mon	9:30 a.m. & 11:00 a.m.	Hall of Records - ATC Conference Room A & B, Fourth Floor, 222 West Hospitality Lane
San Bernardino	6/12/12	Tues	10:30 a.m. & 1:00 p.m.	General Services - Large Conference Room 777 East Rialto Avenue
Barstow	6/13/12	Wed	10:30 a.m.	TAD/CFS – Calico Room 1900 East Main Street
Victorville	6/13/12	Wed	1:00 p.m. & 2:30 p.m.	Victorville CFS, Conference Room 1 15480 Ramona Avenue
Redlands	6/14/12	Thurs	9:30 a.m. & 11:00 a.m.	TAD - Conference Room A, Second Floor 881 West Redlands Boulevard
Rancho Cucamonga	6/18/12	Mon	9:30 a.m. & 11:00 a.m.	Department of Aging and Adult Services, Haven Room, 9445 Fairway View Place, Ste 110
San Bernardino	6/18/12	Mon	1:30 p.m. & 3:00 p.m.	County Government Center - Board Chambers 385 North Arrowhead Avenue
Joshua Tree	6/20/12	Wed	10:30 a.m.	Bob Burke County Government Center, Lower Floor Probation Conference Room 63665 Twentynine Palms Hwy
Yucca Valley	6/20/12	Wed	1:00 p.m.	TAD – Large Conference Room, 56357 Pima Trail
San Bernardino	6/21/12	Thurs	1:30 p.m. & 3:00 p.m.	Public Services Group – Hearing Room 825 East Third Street

Open Enrollment meeting broadcast on CountyDirect

The May 24 meeting will be broadcast on CountyDirect and archived for viewing throughout Open Enrollment. The meeting will be available year round at <http://countyline/Countydirect.asp> for your reference.

ELIGIBILITY

To be eligible for the benefits listed in this Guide, you must be an employee in a regular position scheduled to work a minimum of 40 hours per pay period and have received pay for at least one half plus one hour of your scheduled hours (or be on an approved leave pursuant to applicable law). 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 of 41 hours a pay period.

Dependent Eligibility

If you are eligible to participate in County-sponsored medical and dental plans, your eligible dependents may also participate. Your eligible dependents include:

- ✓ Your legal spouse
- ✓ State Registered Domestic Partner
- ✓ Your children up to age 26 OR 26 or more years old, 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, 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.)*



Proof of dependent status for newly enrolled dependents is required

The following documents may be used as proof of relationship:

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

Proof of dependent status for newly enrolled dependents is required. You or your dependent may also be responsible for any cost of services received while your dependent was listed as eligible. Mail or fax required documentation to:

Employee Benefits and Services Division
 157 West Fifth Street, First Floor
 San Bernardino, CA 92415
 Interoffice Mail Code: 0440
 Fax (909) 387-5566

Be sure to write your employee ID number on the top right corner of each page of your fax.

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.

*Detailed
eBenefits
instructions
are on pages
20-23 of
this Guide*

Benefits Calculator Available Online

The benefits calculator is available for use on the EBSD web page. The calculator can help you determine how much biweekly out-of-pocket expense you will have. You can access this calculator through the Internet at <http://www.sbcounty.gov/hr/benefitcalculator/BenefitCalculatorSearch.aspx> or through Countyline at <http://mybenefitsatwork>.

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 provide proof of other insurance. **If you fail to provide the required documentation by 5:00 p.m., July 9, 2012, you will be reenrolled in the plan(s) that are comparable to your previous coverage.**

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

What Happens If You Do Not Enroll on Time?

New Employees — As a new employee, you have sixty (60) days from your date of employment to enroll in a medical and/or dental plan. EBSD must receive your enrollment forms and supporting documentation within that 60-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 lowest cost medical HMO plan (Blue Shield Signature HMO) plan (except Needles) and the lowest cost dental HMO plan (Cigna Dental Care) with employee only coverage. Premiums will be deducted after-tax. Dependent coverage and before-tax deductions will not be available to you until the next Open Enrollment, unless you experience an IRC Section 125 Change in Status Event.

Medical and Dental Plan ID Cards

Within a month of the effective date of your coverage, July 28, 2012, 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, please refer to plan contact information on page 9 of this Guide. You can also request or print out your ID cards online at the plan website(s). If you have a problem accessing care, call EBSD at (909) 387-5787.

Medical
and
Dental ID
cards are
available
online at
the plan
websites

Mid-Year Changes

The enrollment options you elect during the 2012-13 Open Enrollment period will remain in effect for the entire plan year. You must wait until the next Open Enrollment period to make changes UNLESS you experience an IRC Section 125 Change in Status Event as noted in the Section 125 Change-in-Status Event Matrix contained within this Guide.

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 IRC Section 125
3. Be received by EBSD within 60 days of the qualifying event

Effective Date of Mid-Year Changes

All elections made during the plan year shall become effective the first day of the pay period following the date that the properly completed Premium Deduction Election form and documentation are received by EBSD.

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. 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.

NEWBORN CHILDREN, PLEASE NOTE: For Blue Shield, newborn children will be covered under the medical group the mother (parent) is assigned to, for the first 30 days. For Kaiser members, newborns are covered for the first 31 days including the date of birth. **Employee subscribers must still enroll the newborn under their respective plan through the County.** Contact EBSD or your Payroll Specialist to complete the newborn enrollment.



SECTION 125 CHANGE-IN-STATUS EVENT MATRIX			
QUALIFYING CHANGE-IN-STATUS EVENT	MID-YEAR CHANGE		DOCUMENTATION REQUIRED
	MEDICAL/DENTAL	FSA	
Gain Dependent <ul style="list-style-type: none"> • Marriage • Domestic Partnership • Birth/Adoption/ Placement for Adoption 	Employee may enroll newly eligible dependent(s)	Employee may enroll or increase annual election amount	To enroll dependent in health benefits or enroll/increase annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> • Premium Deduction Election Form • Medical Expense Reimbursement Plan Form or Medical/Dental Enrollment Form • Marriage Certificate, State Registered Domestic Partner Certificate and/or Birth Certificate(s) or hospital printout of birth
Lose Dependent <ul style="list-style-type: none"> • Divorce or annulment • Domestic Partnership Termination • Death 	Employee must remove spouse; may enroll self and eligible dependent(s)	Employee may enroll, increase or decrease annual election	To remove spouse or enroll self/dependent(s) in health benefits or increase/decrease annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> • Premium Deduction Election Form • Medical Expense Reimbursement Plan Form or Medical/Dental Enrollment Form • Divorce, legal separation, annulment, or Termination of Domestic Partnership decree • Death Certificate • Marriage/Birth Certificate(s)
Judgment, decree, or order resulting from divorce, annulment or change in legal custody that requires medical/dental coverage for your dependent child(ren)	Employee may enroll dependent	Employee may increase annual election	To enroll dependent(s) in health benefits, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> • Premium Deduction Election Form • Medical Expense Reimbursement Plan Form or Medical/Dental Enrollment Form • Judgment, decree or order • Birth Certificate(s)
Gain of Spouse's Employment or Other change in status that results in eligibility under spouse's plan	Employee may opt out (self) and/or remove spouse and dependent(s)	Employee may cease or decrease annual election	To remove self/dependent(s) from health benefits and cease/decrease annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> • Premium Deduction Election Form • Medical Expense Reimbursement Plan Form or Medical/Dental Enrollment Form • Proof of spouse's employment and plan benefit
Loss of Spouse's Employment	Employee must enroll self if coverage is lost and may enroll dependent(s)	Employee may enroll or increase annual election amount	To enroll self/dependent(s) in health coverage and enroll/decrease annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> • Premium Deduction Election Form • Medical Expense Reimbursement Plan Form or Medical/Dental Enrollment Form • Proof of spouse's employment and benefit plan loss • Marriage/Birth Certificate(s)

SECTION 125 CHANGE-IN-STATUS EVENT MATRIX <i>(continued)</i>			
QUALIFYING CHANGE-IN-STATUS EVENT	MID-YEAR CHANGE		DOCUMENTATION REQUIRED
	MEDICAL/DENTAL	FSA	
Change in Employment Status (i.e. part time to full time status)	Employee may elect to enroll if change caused employee to gain eligibility	Employee may elect to enroll and increase or decrease annual election amount	To enroll self/dependents in health benefits or to enroll/increase FSA annual election amount you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> Premium Deduction Election Form Medical Expense Reimbursement Plan Form or Medical/Dental Form Proof of Employment Status change Marriage/Birth Certificate(s)
Dependent Ceases to Satisfy Plan Eligibility Requirements (i.e. Over age dependent)	Employee must remove dependent	Employee may decrease election	To remove dependent from health benefits or to decrease annual election amount you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> Premium Deduction Election Form Medical Expense Reimbursement Plan Form or Medical/Dental Form Proof of loss of eligibility (FSA only)
Commencement unpaid leave of absence	County contributions for health benefits will automatically cease and employee will be responsible for premium payments; failure to pay premiums will result in termination of coverage	Employee may cease or suspend annual election.	Health Benefits cessation: No paperwork required. To cease/suspend annual FSA election amount, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> Premium Deduction Election Form Medical Expense Reimbursement Plan Form
Return from unpaid leave of absence	If coverage terminated, employee must elect to enroll or opt out and may enroll dependent(s)	Employee may elect to enroll or reinstate annual election	To enroll submit the following EMACS forms (within 60 days of event) <ul style="list-style-type: none"> Premium Deduction Election Form Medical Expense Reimbursement Plan Form or Medical/Dental Form Opt out Form (self) Proof of spouse's employment and plan benefit Marriage/Birth Certificate(s)
Residence change results in gain or loss of eligibility	Employee may enroll dependent or remove dependent	No change is permissible	To remove dependent(s) from health benefits, you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> Premium Deduction Election Form Medical/Dental Enrollment Form Proof of residence change Marriage/Birth Certificate(s)
Self or dependent becomes entitled or loses eligibility for Medicare or Medicaid	Employee may opt out (self), enroll or remove (dependent)	No change is permissible	To opt out (self) or enroll/remove dependents from health benefits you must submit the following EMACS forms (within 60 days of event): <ul style="list-style-type: none"> Premium Deduction Election Form Medical/Dental Enrollment Form Opt out Form(self) Proof of gain/loss of Medicare or Medicaid Marriage/Birth Certificate(s)

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 to the eligible benefits listed below during Open Enrollment, the previous Plan Year's elections will continue automatically. For new employees, if no election is made, the deductions will automatically be taken after tax and the employee will be subject to all plan requirements and restrictions.

Pre-Tax Premiums

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

- ✓ Medical
- ✓ Dental
- ✓ Accidental death & dismemberment (AD&D)
- ✓ Life insurance premiums

NOTE: Premiums for life insurance coverage in excess of \$50,000 (including employer-paid life insurance) are ineligible for pre-tax deduction per IRS regulations.

Section 125 Premium Conversion Plan Election

You must notify the County of your choice to deduct eligible insurance premiums from your paycheck either before or after taxes. Plan elections are irrevocable for the plan year unless you have an IRC 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 IRC Section 125 and the County's Section 125 Premium Conversion Plan.

Election of Pre-Tax Benefits

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

Mid-Year Change: To have your medical and dental premiums deducted from your pay before federal and state taxes are withdrawn, you must submit a completed Premium Deduction Election form.

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

Eligibility for the pre-tax option does not affect your dependent's eligibility for County-sponsored insurance.

Before-tax or after-tax dollars, the choice is yours

Benefit Plan Dollars and Premium Subsidies

The County helps you pay your medical and dental insurance premiums by giving you Benefit Plan Dollars and/or subsidizing your premium payments to plan carriers by way of a Medical and/or Dental Premium Subsidy. The amounts vary and are based on your bargaining unit, family size, hire date, plan selection, and the number of hours you work. For specific amounts, refer to the appropriate Memorandum of Understanding, Exempt Compensation Plan, Salary Ordinance, or Contract. Additional information regarding benefits by unit can also be found on Countyline at <http://countyline/hr/benefits/mybenefitsbyunit/home.asp>

Needles Subsidy Disclosure

Only employees who are assigned to work locations in Needles, Trona, and Baker are eligible for the Needles Subsidy.

It is the responsibility of the Employee to notify the Employee Benefits and Services division (EBSD) upon assignment to a Needles Subsidy-eligible work location. Conversely, if an Employee is receiving the Needles Subsidy, he or she must notify EBSD within 60 calendar days of a change to a non-eligible work location.

To designate or change an election for the Needles Subsidy, an Employee must submit to EBSD a completed Premium Deduction Election Form. The Premium Deduction Election Form may be obtained from EMACS Forms at <http://countyline/emacs/forms.asp>, the department Payroll Specialist, or by contacting EBSD at (909) 387-5787.

If it is discovered that an employee received the Needles Subsidy in error, the County will collect, through payroll deduction, any amount of subsidy the Employee received, but was not eligible.

For more information please refer to your applicable Memorandum of Understanding (MOU), Exempt Compensation Plan, Salary Ordinance or Contract.

eBENEFITS INSTRUCTIONS

ELIGIBILITY & ENROLLMENT

<p>What is eBenefits?</p>	<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 22, 2012). You must submit your benefit elections by June 22, 2012.</p>	
<p>Positive Enrollment Requirement</p>	<p>All Employees enrolled in a medical and/or dental plan must logon to eBenefits and validate and/or update their benefit selections. Additionally, you must use eBenefits if:</p> <ul style="list-style-type: none"> ✓ You are making any changes during the 2012-13 Open Enrollment ✓ You want to renew participation in a Flexible Spending Account (Medical Expense Reimbursement Plan). You must re-enroll every year to participate in this benefit. 	
<p>How to access eBenefits</p>	<p>If you need assistance, please contact the Help Desk at (909) 884-4884.</p>	<p>Sign on from a County Computer (Intranet) or from home (Internet)</p> <ol style="list-style-type: none"> 1) Go to the EMACS Sign-In Page, https://emacsapp.sbcounty.gov 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
<p>Add Dependents and/or Beneficiaries</p>	<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>Benefits>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 to go back to the <i>Dependent/Beneficiary Summary</i> page <p>To add a dependent who is not listed</p> <ul style="list-style-type: none"> ✓ Click on "Add a dependent or beneficiary" and enter the required information. ✓ Click "Save" and then click "OK". ✓ Click "Return to Dependent/Beneficiary Summary" to go back to the summary page <p>For dependents who are disabled</p> <ul style="list-style-type: none"> ✓ You must complete the Disabled Dependent Certification. 	

eBENEFITS INSTRUCTIONS *(continued)*

Enrollment Process	<p>Starts the enrollment process and allows you to view and make changes to your current plans.</p> <ul style="list-style-type: none"> ✓ Click on <i>Self-Service>Benefits>Benefits Enrollment</i> <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 biweekly 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 receive a confirmation statement from EBSD in August 2012. ✓ 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 22, 2012</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 5:00 p.m. or on weekends will be returned the next business day. ✓ Contact EBSD at (909) 387-5787

eBENEFITS INSTRUCTIONS *(continued)*

	Medical	Dental	Opt-Out / Waive
What you need to know/do	View plan choices, premiums, and make changes	View plan choices, premiums, and make changes	Decline participation in County medical and/or dental plans if you have coverage under another group plan
To enroll	Click the button next to the plan name. To enroll dependents, check the "Enroll" box next to each dependent's name	Click the button next to the plan name. To enroll dependents, check the "Enroll" box next to each dependent's name	Click the "Edit" button next to the plan name
Additional steps	<p>Blue Shield HMO enrollees only:</p> <ul style="list-style-type: none"> ✓ Select a Primary Care Physician and Medical Group for yourself and your dependent(s) in eBenefits by using the drop down list of providers to find your physician's provider number and medical group IPA number, by clicking the "Select a Provider" link to enter Blue Shield's website, or by calling Blue Shield Member Services at (800) 642-6155. ✓ Use the "Find a Provider" tool on Blue Shield's website to find your physician in the network. Click on the physician's name to locate the provider number and the medical group/IPA number. <p>In eBenefits, enter the 9-digit provider number and the 9-digit medical group/IPA number.</p> <p>If your physician is different for any listed dependents, you will need to provide the physician number and medical group/IPA number for each dependent enrolled in coverage.</p> <p>If you are an existing patient for the Physician number provided, be sure to check the box indicating that you have previously seen this provider.</p>	<p>Cigna Dental Care DHMO enrollees only:</p> <ul style="list-style-type: none"> ✓ Select a network dentist for yourself and/or your dependent(s) by either calling Cigna's Customer Service line at (800) 238-5834 or click "Select a Provider" to enter Cigna's website ✓ To locate a provider on Cigna's website, click on "Find a Doctor" at the top of the page. Choose the "Dentist" radio button and enter your search criteria (provider name, location, etc.). Select the "Cigna Dental Care (HMO)" radio button and then select "Dental Care Network" and a "Dentist Type" (optional) in the drop down boxes. <p>In eBenefits, enter the 6-digit dentist provider number. Omit any dashes or spaces when entering the number.</p> <p>If your Dentist is different than any of your listed dependents, you will need to provide a Dentist number for each dependent enrolled in coverage.</p> <p>If you are an existing patient of the Dentist number provided, be sure to check the box indicating that you have previously seen this provider.</p>	<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 Opt-Out Election Agreement 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	<p>If you do not select a provider or medical group, Blue Shield will assign one to you.</p> <p>You will be able to change your provider by calling Blue Shield Member Services at (800) 642-6155.</p>	<p>If you do not select a dentist, Cigna will assign one to you.</p> <p>You will be able to change your dentist by calling Cigna Customer Service at (800) 238-5834.</p>	For new Waive or Opt-Out elections, you MUST provide verification of the other group-sponsored health/dental coverage to EBSD by July 9, 2012

eBENEFITS INSTRUCTIONS *(continued)*

	Vision	FSA	Retirement Options
What you need to know/do	Select dependent coverage (applies to certain bargaining units)	Enrollment is voluntary, but you must enroll every year to continue participating	Decide between refundable and nonrefundable options
To enroll	Employee Only enrollment is automatic	Click the 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 2012-13 in the "Annual Pledge" box <ul style="list-style-type: none"> – Click "Worksheet" to calculate your per-pay-period contributions ✓ Click "Return" to go back to the <i>Flexible Spending Account</i> page 	To select a different option, click the button to the left of your "Plan Name"
Store	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page	Click "Store" to hold your choices. Click "OK" to return to <i>Enrollment Summary</i> page

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

BLUE SHIELD SIGNATURE HMO

This is a general summary of Blue Shield Signature HMO benefits. A more complete description of benefits and coverage, including limitations and exclusions, is contained in the plan documents and Evidence of Coverage. If there are any discrepancies between the information contained in this summary and the provisions of the plan documents, the provisions of the plan documents will prevail.

Blue Shield Signature HMO 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 Blue Shield Participating Physician Groups. The POS component gives you the option of seeking consultations and evaluations from any specialist within the Blue Shield Preferred Provider Organization (PPO) network without a referral from your PCP. The HMO provision is referred to as Level 1 and the POS provision as Level 2.

Under Level 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 Level 2 (the POS option), you are allowed consultations with a doctor outside of your Participating Physician Group, but within Blue Shield's PPO network, without a referral from your PCP.

How the Plan Works

When you enroll in the Shield Signature plan, you will need to choose a Personal Physician (primary care physician) for you and your enrolled dependents from the list of Personal Physicians in the Blue Shield HMO physician network.

You have the option to choose a different Personal Physician and medical group for yourself and each enrolled family member. If you choose a Personal Physician you have already seen, please let Blue Shield know that you are an existing patient. When enrolling in the Shield Signature plan, you will need your Personal Physician's Blue Shield provider number and medical group/IPA number, can be found by searching for the physician by name in the *Find a Provider* section of www.blueshieldca.com.

Signature Level 1 is your "HMO level" of benefits. Using your Signature Level 1 benefits provides you with the highest level of benefits – i.e., full plan benefits at the lowest out-of-pocket cost to you. However, you will only be covered under the Signature Level 1 when care is provided by your Personal Physician or any provider authorized by your Personal Physician. There is an exception: Under the Signature Level 1 benefits, women are allowed to self-refer for one annual OB/GYN appointment when they select an OB/GYN who is in the same medical group/IPA as their Personal Physician.

Using your Shield Signature Level 1 (HMO) benefits through your Personal Physician is the most cost-effective way to use your Shield Signature plan, for the lowest out-of-pocket-costs.

Signature Level 2 is your "PPO level" of benefits. Under your Signature Level 2 benefits you can see any doctor or specialist in the Blue Shield PPO network without a referral from your Personal Physician for selected outpatient services. When you use this option, your share of costs will be higher than with Signature Level 1 and you may have to file claim forms for certain services. Please note that while this additional PPO outpatient benefit enhances your range of covered services and gives you more choices, you will be responsible for applicable copayments, and non-covered charges, and you are still required



Under Blue
Shield
Signature
HMO,
you pay no
deductibles

to receive all inpatient care from a hospital or other inpatient facility, participating hospice agencies, and non-physician health care practitioners under your Signature Level 1 HMO coverage.

This direct access PPO feature for selected outpatient services only covers office visits, consultation, evaluation, and treatment – procedures that can be performed in the doctor’s office. To find a Level 2 Provider, go to blueshieldca.com/findaprovider. Choose “Select a plan,” under “Medical Plan,” choose Blue Shield of California PPO Network, then click “Set plan” and select the type of provider that you are searching for.

Note that services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your Personal Physician under your Shield Signature Level 1 benefits.

If you need a Blue Shield HMO or PPO Provider Directory, please call Blue Shield’s Customer Service at (800) 642-6155 or use Blue Shield’s web site at www.blueshieldca.com. The directory lists physicians and medical groups accepting new patients. If your current physician or medical group accepts Blue Shield but is not listed in the Directory, call Blue Shield’s Customer Service for assistance. Once enrolled in Blue Shield, you can also call Customer Service to change your PCP.

Copayment

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

Deductible

Under Blue Shield Signature HMO, you pay no deductibles.

Hospitalization

You are covered for all medically necessary hospitalization when admitted by your Primary Care Physician (PCP).

Emergency Care

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the “911” emergency response system where available. Members should go to the closest Plan Hospital for Emergency Services whenever possible.

If you obtain Emergency Services, you should notify your Personal Physician within 24 hours after care is received unless it was not reasonably possible to communicate with the Personal Physician within this time limit. In such case, notice should be given as soon as possible.

An emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the Member’s health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part.

If you receive nonauthorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

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

Out-of-Area Care

Outside of California: The Blue Shield Signature HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described below, can be more cost-effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement.

NOTE: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Out-of-Area Follow-up Care is covered and services may be received through the BlueCard Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the Personal Physician.

Within California: If you need urgent medical care but are outside of your Personal Physician Service Area, if possible you should call Blue Shield Member Services. You may also locate a Plan Provider by visiting our web site at www.blueshieldca.com. However, you are not required to use a Blue Shield of California Plan Provider to receive Urgent Services. You may use any provider.

NOTE: Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.

Follow-up care is also covered through a Blue Shield of California Plan Provider and may also be received from any provider. However, when outside your Personal Physician Service Area authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield HMO may direct the patient to receive the additional follow-up services from the Personal Physician.

If services are not received from a Blue Shield of California Plan Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield HMO. Claims for Urgent Services obtained outside of your Personal Physician Service Area within California will be reviewed retrospectively for coverage. When you receive covered Urgent Services outside your Personal Physician within California, the amount you pay, if not subject to a flat dollar copayment, is calculated on Blue Shield's Allowed Charges.

BlueCard Program: Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers.

Please obtain full details on the Blue Card Program from the current Blue Shield EOC for by calling Blue Shield's Customer Service at (800) 642-6155.



Claim Forms

Under the Blue Shield Signature HMO (Level 1) component you do not have to file claim forms. You may have to file claim forms when using Level 2 benefits, 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 family member are:

- ✓ 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 contact Blue Shield's Customer Service at (800) 642-6155 and ask for assistance with transition of care. Blue Shield will assign you a case manager to guide and assist you with your specific transition of care needs.

How to Enroll

New employees must enroll within 60 days of hire into an eligible position. 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 Blue Shield, 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 Blue Shield. The Blue Shield 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 Blue Shield Evidence of Coverage (EOC) or contact Blue Shield's Customer Service at (800) 642-6155 for additional information.

General Exclusions

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

Blue
Shield's
Customer
Service can
be reached at
(800) 642-
6155

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 Blue Shield

Call Blue Shield’s Customer Service at (800) 642-6155 any time between 7:00 a.m. and 7:00 p.m. Monday – Friday or visit Blue Shield’s web site at www.blueshieldca.com for more information.

BLUE SHIELD PPO & BLUE SHIELD NEEDLES PPO

Both the Blue Shield PPO and Blue Shield Needles PPO are preferred provider organizations (PPO). 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. Under a PPO plan, you may choose the level of benefits you receive based on the providers you use when you receive care.

How the Plan Works

With Blue Shield PPO and Blue Shield Needles 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 before the plan pays for certain services obtained from an in-network (“participating”) or out-of-network (“nonparticipating”) provider as follows:

- ✓ Shield PPO – \$250 per member, \$500 per family
- ✓ Shield Needles PPO – \$250 per member, \$500 per two-party, \$750 per family

Emergency Care

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the “911” emergency response system where available. Members should go to the closest Plan Hospital for Emergency Services whenever possible. Emergency Room visits not resulting in admission have a charge for services of \$50. When the member is admitted directly from the Emergency Room there are no charges for services. For more details please refer to your EOC or contact Blue Shield’s Customer Service at (800) 642-6155.

BlueCard Program

When temporarily traveling outside California or the United States, if possible, call the 24-hour toll-free number (800) 810-BLUE (2583) to obtain complete details and information on the Blue Card Program. When traveling Outside the United States, Urgent Services are available through the BlueCard Worldwide Network, but may be received from any provider.



Members before traveling abroad should call their local Member Services office for the most current listing of participating providers worldwide or they can go on line at www.bcbs.com and select the “Find a Doctor or Hospital” tab. However, a Member is not required to receive Urgent Services outside of the United States from the BlueCard Worldwide Network.

Please refer to your EOC under the ‘Blue Card Program’ in the How to Use Your Health Plan section for additional information or call your dedicated Blue Shield member services at (800) 642-6155.

How to Enroll

New employees must complete a County Medical Plan Enrollment/Change form within the first 60 days of hire into an eligible position, and return it to their Payroll Specialist. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this Guide for specific details.

Call Blue Shield 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 claim question

What’s Covered

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

What’s Not Covered

Exclusions and Limitations are subject to change. Please refer to the current Blue Shield PPO Evidence of Coverage or contact Blue Shield’s Customer Service at (800) 642-6155 for additional information.

General Exclusions

It is extremely important to read your EOC of Insurance before you obtain services in order to know what Blue Shield will and will not cover. Blue Shield 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 Blue Shield PPO or Blue Shield Needles PPO

Call Blue Shield’s Customer Service at (800) 642-6155 any time between 7:00 a.m. and 7:00 p.m. Monday – Friday or visit Blue Shield’s web site at www.blueshieldca.com for more information.



Blue Shield Needles PPO – Important Information

Employees who are assigned to work locations in Needles, Trona, and Baker are eligible for the Needles Subsidy.

It is the responsibility of the Employee to notify the Employee Benefits and Services Division (EBSD) if assigned to a Needles Subsidy eligible work location. Conversely, if an Employee is receiving the Needles Subsidy and their work location changes to a non-eligible location the employee must notify EBSD as soon as they are no longer assigned to a qualifying location.

To designate or change an election for the Needles Subsidy, Employees must complete and submit the Premium Deduction Election Form (found on EMACS Forms at <http://countyline/emacs/forms.asp>) to their Payroll Specialist or the EBSD.

If it is discovered that an employee has been receiving the Needles Subsidy in error, the County will collect, through payroll deduction, any amount of subsidy the Employee received but was not eligible.

For more information please refer to your applicable Memorandum of Understanding (MOU), Exempt Compensation Plan, Salary Ordinance or Contract which can be found on the County's Intranet at: <http://countyline/hr/employeerelations/>.



KAISER PERMANENTE

The Kaiser Permanente Health Maintenance Organization (HMO) is available only to employees and their eligible dependents living within the Kaiser Permanente service areas of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern and Ventura Counties. Certain outlying ZIP codes within the County are not eligible for coverage through Kaiser Permanente. Please contact Kaiser Permanente's Member Services at (800) 464-4000 if you wish 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 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.

Copayments

For most routine care, you pay a \$10 copay. For other services, copayments may range from \$5 to \$50.

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 (EOC) 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 60 days of hire into an eligible position. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this Guide (pages 12-17) for specific details.

*Kaiser
Permanente's
Member
Services can
be reached at
(800) 464-
4000*

Kaiser Permanente Online Services (www.kp.org):

Wherever you go, members can:

- ✓ Email their doctor's office or pharmacy
- ✓ Schedule, view and cancel appointments; order prescription refills
- ✓ Request a member identification (ID) card
- ✓ Use valuable online health calculators, information, discounted services and resources
- ✓ File a grievance

With a single click, members can check immunization records, details of past office visits, vital signs, certain test results, and diagnosed health conditions. So staying connected to your health is easier.

Helpful Information for New Members

If you make the decision to enroll in a Kaiser plan, please know that there is a **New Member Entry Department** that can help you:

- ✓ Find a Kaiser Permanente facility near you
- ✓ Choose your new doctor
- ✓ Transfer your prescriptions
- ✓ Schedule your first visit, and when possible "Fast Track" appointments with Specialists
- ✓ Learn about programs and resources to keep you healthy

Contact the New Member Entry Department, toll free, Monday through Friday from 7:00 a.m. to 7:00 p.m. at (888) 956-1616.

Transition of Care

If you are receiving care for a serious health issue, such as an acute condition, pending surgery or advanced pregnancy, you may be eligible for Kaiser's **Continuity of Care** program. This program can allow you to continue getting care from your current doctor or hospital. New members must meet certain criteria to qualify for Continuity of Care. As a new member, to apply for Continuity of Care, call (800) 464-4000, weekdays from 7:00 a.m. to 7:00 p.m. and weekends from 7:00 a.m. to 3:00 p.m.

What's Covered

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

What's Not Covered

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

New
Member
Entry
Department
can be
reached at
(888) 956-1616

General Exclusions

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

How to Get in Touch with Kaiser Permanente

Kaiser Permanente Member Services is available twenty four hours, seven days a week, except holidays at (800) 464-4000. You can also access their website at www.kp.org for more information.



Staying connected to your health has never been easier at www.kp.org

IMPORTANT NOTICE FROM THE COUNTY OF SAN BERNARDINO ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Certificate of Creditable Medicare Prescription Drug Coverage

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

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

MEDICAL PLAN COMPARISON CHART

	Kaiser	Blue Shield Signature HMO	
		Tier One	Tier Two
Providers, Deductibles, Maximums, PreExisting Conditions			
Choice of physician and other providers	Kaiser physicians and facilities only	Shield Signature HMO Network (includes Blue Card Program access)	Shield Signature Level II Network (includes providers in Shield PPO Network)
Calendar year Deductible combined PPO/OON	None		None
Hospital or Ambulatory Surgical Center deductible	None		None
Lifetime benefits maximum	None		None
Out-of-Pocket annual maximum	\$1,500 each member \$3,000 family maximum	\$1,500 each member \$3,000 family maximum	Not applicable
Preexisting condition	Fully covered		Fully covered
Office/Outpatient Care			
Office visits	You pay a \$10 copay	You pay a \$10 copay	You pay a \$30 copay
Periodic health exams / annual physicals	No charge	No charge	You pay a \$30 copay
Hearing screenings	No charge	No charge	You pay a \$30 copay
Immunizations	No charge	No charge	You pay a \$30 copay
Family planning Infertility services	You pay 50% excludes GIFT, ZIFT and IVF	You pay 50% excludes GIFT, ZIFT and IVF	Covered under Level 1 Benefit
Tubal ligation	You pay a \$10 copay	No charge	Covered under Level 1 Benefit
Vasectomy	You pay a \$10 copay	You pay a \$10 copay	Covered under Level 1 Benefit
Specialists	You pay a \$10 copay	You pay a \$10 copay	You pay a \$30 copay
Well baby/Well child care	No charge	No charge	You pay a \$30 copay
Well woman exam (annual)	No charge	No charge	You pay a \$30 copay
Emergency Medical Care			
Ambulance	No charge when medically necessary	No charge	No charge if medically necessary
Emergency room	You pay a \$50 copay (waived if admitted)	You pay a \$50 copay (waived if admitted)	Covered under Level 1 Benefit
Urgent care	You pay a \$10 copay		You pay a \$10 copay

Please note: This comparison chart only highlights benefits. The Evidence of Coverage (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this Comparison Chart and the official plan documents, the official plan documents will prevail.

Blue Shield PPO	
In-Network	Out-of-Network
Shield PPO Network (includes Blue Card Program access)	(includes Blue Card Program access)
\$250 per individual \$500 per family	
None	
None	
\$1,500 each member \$3,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)	\$2,000 each member \$4,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)
Fully covered	
You pay a \$10 copay [CY ded. waived]	You pay 30% after CY deductible
No charge [CY ded. waived]	You pay 30% after CY deductible
No charge [CY ded. waived]	You pay 30% after CY deductible
No charge [CY ded. waived]	You pay 30% after CY deductible
Not covered	Not covered
No charge [CY ded. waived]	You pay 50% after CY deductible (A facility charge may also apply)
You pay 30% after deductible	You pay 50% after deductible
You pay 20% [CY ded. waived]	You pay 30% after CY deductible
No charge [CY ded. waived]	You pay 30% after CY deductible
No charge [CY ded. waived]	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 20% after CY deductible
\$50 per visit + 20% after CY deductible (\$50 waived if admitted) ER Physician Services: You pay 20% after CY deductible	\$50 per visit + 20% after CY deductible (\$50 waived if admitted & treated as in-network benefit) ER Physician Services: You pay 20% after CY deductible
You pay a \$10 copay [CY ded. waived]	You pay 30% after CY deductible

	Kaiser	Blue Shield Signature HMO	
		Tier One	Tier Two
Diagnostic Services			
Laboratory and Pathology Tests	No charge	No charge	Covered only when performed in physician's office
Diagnostic Tests and X-Ray	No charge	No charge	Covered only when performed in physician's office For CT, MRI, MUGA, PET, and SPECT covered under Level 1 benefit
Diabetes Care			
Covered Diabetic drugs and testing supplies	See 'Prescription Drugs' Testing supplies no charge under formulary	See 'Prescription Drugs'	
Diabetes Self Management Training & Education	No charge	No charge	You pay a \$30 copay
Devices, Equipment, and Non-Testing Supplies	See Durable Medical Equipment	No charge	Covered under Level 1 Benefit
Maternity Care			
Prenatal and Postnatal office visits	No charge	No charge	Covered under Level 1 Benefit
Delivery	No charge	No charge	Covered under Level 1 Benefit
Newborn Care	Newborn covered 31 days; must enroll through County within 60 days	Newborn covered 30 days; must enroll through County within 60 days	Covered under Level 1 Benefit
Hospital Services			
Hospital care (Physician and Facility charges)	No charge for approved services obtained in a Kaiser Permanente or other approved facility	No charge	Covered under Level 1 Benefit
Surgical Services			
Hospital - In Patient Surgical Services	No charge (Facility and Physician services)	No charge (Facility and Physician services)	Covered under Level 1 Benefit
Outpatient/Ambulatory Surgery Center	No charge (Facility and Physician services)	No charge (Facility and Physician services)	Covered under Level 1 Benefit
Alternatives to Hospital Care			
Home health services	No charge when medically necessary; up to 100 visits per calendar year	No charge	Covered under Level 1 Benefit
Hospice Inpatient & outpatient	No charge when selected as alternative to traditional services covered by Kaiser Permanente	No charge	Covered under Level 1 Benefit
Skilled nursing facilities	No charge for authorized stays; maximum 100 days per benefit period in a plan skilled nursing facility	No charge	Covered under Level 1 Benefit

Blue Shield PPO	
In-Network	Out-of-Network
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
See 'Prescription Drugs'	
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% after CY deductible	You pay 30% after CY deductible
Newborn covered 30 days; must enroll through County within 60 days	Newborn covered 30 days; must enroll through County within 60 days
You pay 20% after CY deductible	You pay 30% after CY deductible
Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible
Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 30% after CY deductible Physician: You pay 30% after CY deductible
You pay 20% after CY deductible (100 visits per calendar year combined PPO/OoN maximum)	If preauthorized you pay 20% after deductible
You pay 20% after CY deductible	If preauthorized you pay 20% after CY deductible
You pay 20% after CY deductible	Freestanding: SNF if preauthorized You pay 20% after deductible 30% for OON skilled nursing unit of a hospital (100 visits per calendar year combined PPO/OoN maximum)

		Kaiser	Blue Shield Signature HMO	
			Tier One	Tier Two
Mental Health Care and Substance Abuse Treatment				
			MHSA Participating Provider	MHSA Non-Participating Provider
Non-severe mental disorders	Inpatient: No charge Outpatient: You pay a \$10 copay/\$5 copay group		Inpatient: No charge Outpatient: 1-3 visits – no charge \$10 per visit thereafter	Inpatient: Not covered Outpatient: 1-3 visits – no charge \$30 per visit thereafter
Severe mental disorders	Inpatient: No charge Outpatient: You pay a \$10 copay/\$5 copay group (Severe Mental Disorder defined in EOC)		MHSA Participating Provider	MHSA Non-Participating Provider
Substance abuse	Inpatient: No Charge Outpatient: \$10 copay individual, \$5 copay group		Inpatient: Inpatient Hospitalization Copay Applies Professional (Physician) Services- Outpatient Physician Visit (per calendar year): 1-3 visits- no charge \$10 per visit thereafter Professional (Physician) Services - Inpatient: No charge Partial Hospitalization/Day Treatment: No charge	Covered under Level 1 Benefit
Prescription Drugs				
Prescription drugs (per fill) Includes Diabetic drugs and testing supplies	Pharmacy (up to 100 day supply): generic - \$10 copay; brand \$15 copay; drugs prescribed for the treatment of sexual dysfunction disorders and infertility: 50% Coinsurance Mail Order is voluntary		Pharmacy (30-day supply): \$5 generic, \$10 brand name, \$25 non-formulary Specialty Pharmacies: \$10 per prescription (up to a 30-day supply) Mail Order is voluntary 90-day supply at discounted rate	Covered under Level 1 Benefit
Other Services				
Allergy testing	You pay a \$10 copay (serum covered)		You pay a \$10 copay (50% if serum purchased seperately)	You pay a \$30 copay (50% if serum purchased seperately)
Chiropractic care	Not covered		Not covered	
Durable medical equipment	No charge		No charge	Covered under Level 1 Benefit
Home visits (Physician)	No charge; only when medically necessary		You pay a \$10 copay	Covered under Level 1 Benefit

Blue Shield PPO	
In-Network	Out-of-Network
MHSA Participating Provider	MHSA Non-Participating Provider
Inpatient: You pay \$10 Outpatient: 1-3 visits – no charge 20% per visit thereafter (Not subject to the Calendar-Year Deductible)	Inpatient: 30% Outpatient: 30% per visit
MHSA Participating Provider	MHSA Non-Participating Provider
Inpatient: Inpatient Hospitalization Copay Applies Professional (Physician) Services - Outpatient Physician Visit (per calendar year): 1-3 visits- no charge \$10 per visit thereafter Professional (Physician) Services - Inpatient: 20% after CY deductible	Inpatient: Inpatient Hospitalization Copay Applies Professional (Physician) Services - Outpatient Physician Visit (per calendar year): 30% per visit Professional (Physician) Services - Inpatient: 30%
PARTICIPATING PHARMACY Pharmacy: \$15 generic formulary \$30 brand formulary \$30 non-formulary Specialty Pharmacies: \$15 per prescription (up to a 30-day supply) Mail Order is voluntary 90 day supply at discounted rate	NON-PARTICIPATING PHARMACY (Member pays 25% of billed amount plus copayment) Pharmacy: \$15 generic formulary, \$30 brand formulary, \$30 non-formulary Specialty Pharmacies: Not covered Mail Order not covered
Pharmacy (retail and mail order) copays do not apply toward the out-of- pocket maximum.	
Office Visit: You pay 20% (CY ded. waived) Allergy Injection Services(serum not included) \$15 visit (CY ded. waived)	Office Visit: You pay 30% Allergy Injection Services (serum not included) \$15 visit (CY ded. waived)
You pay 20% after CY deductible	You pay 30% after CY deductible
Up to 30 visits per calendar year combined PPO/OoN maximum	
You pay 20% after CY deductible	You pay 30% after CY deductible
You pay 20% (CY ded. waived)	You pay 30% after CY deductible

CIGNA DENTAL CARE (DHMO)

*With Cigna
Dental Care
(DHMO)
there are no
deductibles
and no claim
forms*

This is a general summary of Cigna Dental Care plan benefits. A more complete description of benefits and coverage, including limitations and exclusions, is contained in the Evidence of Coverage (EOC). If there are any discrepancies between the information contained in this summary and the provisions of the EOC, the plan document will prevail.

Cigna Dental Care is a prepaid "HMO-style" dental plan covering nationally more than 13,283 unique dentists and dental offices.

Based on research that showed an association between periodontal (gum) disease and certain medical conditions (cardiovascular disease, diabetes and maternity), Cigna developed two programs, Cigna Dental Oral Health Integration Program (OHIP) and Cigna Dental Oral Health Maternity Program (OHMP) which provide proactive care to members with such medical conditions. These programs provide enhanced dental coverage to participants enrolled in Cigna Dental plans. Participants may be eligible for additional cleanings per year.

How the Plan Works

When you enroll in Cigna Dental Care, you must select a Primary Care dentist for yourself and for your covered dependents. Each covered dependent can choose their own primary care dentist near their home or work.

You must utilize the selected primary care dentist for all of your dental services. If services are not obtained through the primary care dental office, or if Cigna Dental Care has not authorized the services, those services will not be covered. If you require specialty care, your network general dentist will refer you to a network specialist.

You may change your dental office for any reason. The change will become effective the first of the following month. To make the change, visit www.cigna.com or call (800) 238-5834 to speak with a customer service representative.

Copayments

For most basic and preventative services, you pay no copayment. For other services, you pay a small fee as described on your patient charge schedule.

Deductible

You pay no deductibles.

Claim Forms

You have no claim forms to file.

Orthodontia Coverage

You and your covered dependents may obtain comprehensive and/or limited orthodontic care from any Cigna Dental Care orthodontist of your choice. Pretreatment records and diagnostic services are covered at a \$620 copayment for any proposed treatment phase.

For comprehensive orthodontic treatment, you pay a \$490 startup (Bandings) fee along with a \$40 copayment per month for 24 months of usual and customary treatment.

The start up (banding) charges for limited and/or interceptive orthodontic treatment, is a copayment of \$230 for primary, transitional, and adolescent (to age 19) teeth, and \$430 for adult teeth, with a \$40 copayment per month which covers 24 months of usual and customary treatment.

Please note: The 24-month allowance for ortho treatment is not on a per-treatment basis; this allowance is based on the lifetime of the plan.

You can obtain a list of Cigna Dental Care orthodontists by calling Customer Services at (800) 238-5834 or www.cigna.com.

Out-of-State Dependent Coverage

If you have covered dependents living outside of California, contact EBSD for a list of covered states.

Emergency Care

If you need emergency services, call your primary care dental office. If your primary care dental office is unavailable, call Cigna Dental Care at (800) 238-5834 available 24 hours a day, 7 days a week.

Out-of-Area Care

If you need dental care away from home, call Cigna Dental Care at (800) 238-5834 for a listing of network dentists.

How to Enroll

New employees must complete a Dental Plan Enrollment/Change form within the first 60 days of hire into an eligible position and return it to their Payroll Specialist. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this Guide for specific details.

Cigna Dental Care (DHMO) 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 Cigna Dental Care (DHMO) if you:

- ✓ Need to select a new dentist
- ✓ Have a benefits question
- ✓ Need a provider directory
- ✓ Need a member ID card
- ✓ Have an eligibility question
- ✓ Have a claim question
- ✓ Would like to request predetermination of benefits

*Cigna
Dental's
Customer
Services can
be reached at
(800) 238-
5834*

Questions About Your Cigna Dental Coverage Before You Enroll?

Call the Cigna Enrollment Information Line toll free at (800) 238-5834, available 24 hours a day, 7 days a week.

After you enroll, register for myCigna.com and click the link to view your personalized dental plan information.

What's Covered

While covered under the Cigna Dental Care 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 for a comprehensive explanation of benefits.

What's Not Covered

It is extremely important to read your EOC before you obtain services in order to know what Cigna Dental will and will not cover. Exclusions and Limitations are subject to change, please refer to the Cigna Dental Care EOC or contact Cigna Dental Customer Services at (800) 238-5834 for additional information.

How to Get In Touch With Cigna Dental Care (DHMO)

For information about Cigna Dental Care, call (800) 238-5834 available 24 hours a day, 7 days a week or visit Cigna Dental Care's website at www.cigna.com.



Before enrolling, read the EOC to understand the Cigna Dental Care (DHMO) benefits

CIGNA DENTAL PPO

This is a general summary of Cigna Dental PPO benefits. A more complete description of benefits and coverage, including limitations and exclusions, is contained in the Evidence of Coverage (EOC). If there are any discrepancies between the information contained in this summary and the provisions of the EOC, the plan document will prevail.

Cigna Dental PPO allows you to choose to receive care from an in-network (Radius) dental provider or from an out-of-network provider. Whether you choose an in-network or out-of-network provider, your coverage includes a wide range of covered services.

Dual coverage is allowed between two County employees enrolled in a County-sponsored dental plan.

Based on research that showed an association between periodontal (gum) disease and certain medical conditions (cardiovascular disease, diabetes and maternity), Cigna developed two programs, Cigna Dental Oral Health Integration Program (OHIP) and Cigna Dental Oral Health Maternity Program (OHMP) which provide proactive care to members with such medical conditions. These programs provide enhanced dental coverage to participants enrolled in Cigna Dental plans. Participants may be eligible for additional cleanings per year.

How the Plan Works

In-Network

When you receive your dental care from a Cigna Dental PPO network dentist, you will pay a percent of the dentist's discounted Cigna Dental PPO rates (0% for preventive services, 0% for basic restorative services, and 25% for major restorative services).

To find out what your cost will be in advance, you may request a predetermination of benefits from Cigna.

To obtain a Cigna Dental PPO Preferred Provider Directory, please call Cigna Dental at (800) 238-5834 or visit Cigna's website at www.cigna.com.

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 Major restorative services) of Cigna Dental PPO's maximum allowance as established by Cigna Dental.

You will be responsible for the difference between the payment dental providers receive from Cigna Dental and their usual fees. 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 Cigna's maximum allowance for that service was \$100, then you would pay 10% of \$100 (\$10) plus the additional \$25 difference between Cigna'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 Cigna 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.)

With Cigna Dental PPO, you can choose an in-network or out-of-network provider

Under
Cigna
Dental
PPO, you
pay no
deductible

When you receive out-of-network services your out-of-pocket expenses will generally be higher as out-of-network dentists have not agreed to participate in Cigna's DPPO network in which discounted rates have been negotiated.

Co-insurance

Co-insurance 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 Cigna Dental PPO, you pay no deductible.

Emergency Care

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

Orthodontia Coverage

You and your covered dependents may obtain orthodontic care from any licensed orthodontist of your choice. The plan pays 50% of your orthodontia expenses up to a lifetime maximum of \$1,700.

Out-of-Area Care

If you need dental care away from home, call Cigna Dental at (800) 238-5834. If possible, you will be directed to an in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit, unless it's an emergency.

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 Cigna, you'll receive an estimate of your share of the cost and how much Cigna will pay before treatment begins.

To predetermine treatment, your dentist sends Cigna a proposed treatment plan, along with x-rays relevant to the case. Cigna then checks to be sure the services are covered by your dental program. Cigna also calculates how any coinsurance and dollar maximum limits might affect your share of the cost. Your dentist then receives an estimate of the amount Cigna will pay for approved services. Please call Cigna Dental at (800) 238-5834 to request a predetermination of benefits.

Claim Forms

Under Cigna Dental PPO, in-network dentists will submit a claim form directly to Cigna Dental.

If your dentist is not contracted (out of network) with Cigna Dental, you may have to file your own claims. It is your responsibility to pay your dentist for services rendered and to submit all necessary claim forms.

How to Enroll

New employees must complete a Dental Plan Enrollment/Change form within the first 60 days of hire into an eligible position, and return it to their Payroll Specialist. Please refer to the Eligibility, Enrollment, and Mid-Year Changes sections of this Guide for specific details.

Call Cigna Dental PPO at (800) 238-5834 if you:

- ✓ Have a benefits question
- ✓ Need a provider directory
- ✓ Need a member ID card
- ✓ Have an eligibility question
- ✓ Have a claim question
- ✓ Would like to request predetermination of benefits

Questions about your Cigna dental coverage before you enroll?

Call the Cigna Enrollment Information Line toll free at (800) 238-5834, available 24 hours a day, 7 days a week.

After you enroll register for myCigna.com and click the link to view your personalized dental plan information.

What's Covered

While covered under Cigna 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 on pages 48-51 of this Guide 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

It is extremely important to read your EOC before you obtain services in order to know what Cigna Dental will and will not cover. Exclusions and Limitations are subject to change. Please refer to the Cigna Dental PPO EOC or contact Cigna Dental Customer Services at (800) 238-5834 for additional information.

How To Get In Touch With Cigna Dental PPO

For information about Cigna Dental PPO, call Cigna Dental at (800) 238-5834 or visit Cigna's website at www.cigna.com.

*Cigna
Dental's
Customer
Services can
be reached at
(800) 238-
5834*



DENTAL PLAN COMPARISON CHART

			Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
					Calendar Year Maximum Benefit
			Not applicable	\$1,700 per person (excluding orthodontia)	\$1,700 per person (excluding orthodontia)
Category	Procedure Code	Description	(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Preventive Care	D0120	Periodic oral examination (2 per year)*	No Charge	No Charge	0%
	D0210	Full mouth X-ray (see frequency limitations)	No Charge	No Charge	0%
	D9110	Emergency, palliative treatment of dental pain	\$5.00	No Charge	0%
	D1203	Topical Fluoride (child) – see limitations	No Charge	No Charge	0%
	D1110 (Adult) D1120 (Child)	Prophylaxis (cleanings) (1 per 6-month period)*	No Charge	No Charge	0%
	D1351	Sealant (per tooth) limitations may apply	\$5.00	No Charge	0%
	D1352	Preventive resin restoration – permanent tooth	\$5.00	No Charge	0%
Adjunctive General Services	D9972	External bleaching – self-treatment with bleaching tray & gel	\$125.00 per arch	Not Covered	Not Covered
	D9940	Occlusal guard (night guard), by report – limited to 1 in 3 years	\$95.00	25%	30%
	D9951	Occlusal adjustment, limited	\$20.00	No Charge	10%
	D9952	Occlusal adjustment, complete	\$40.00	No Charge	10%
	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50.00	Benefit covered through Medical Plan/Cigna as secondary to medical	Benefit covered through Medical Plan/Cigna as secondary to medical
Restorative Dentistry	D2140 (1) D2150 (2) D2160 (3) D2161 (4)	Amalgam (“silver” fillings) on primary or permanent teeth: 1, 2, 3 or 4 surfaces	No Charge	No Charge	10%
	D2330 (1) D2331 (2) D2332 (3) D2335 (4)	Resin composite (white fillings), anterior (front) teeth: 1, 2, 3 or 4 surfaces	No Charge	No Charge	10%
	D2391 (1) D2392 (2) D2393 (3) D2394 (4)	Resin composite (white fillings), posterior (molars): 1, 2, 3 or 4 surfaces	\$45.00 \$55.00 \$65.00 \$75.00	No Charge	10%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Restorative Dentistry (continued)	D2510 (1) D2520 (2) D2530 (3 +)	Metallic Inlay – Up to 3+ surfaces	No Charge	25% upon review, predetermination recommended	30% upon review, predetermination recommended
	D2650 (1) D2651 (2) D2652 (3 +)	Composite resin inlay (white) – Up to 3+ surfaces	\$85.00 \$95.00 \$115.00	25% upon review, predetermination recommended	30% upon review, predetermination recommended
	D2610 (1) D2620 (2) D2630 (3 +)	Porcelain/ceramic inlay – Up to 3+ surfaces	\$135.00 \$150.00 \$160.00	25% upon review, predetermination recommended	30% upon review, predetermination recommended
Periodontics	D4241 (1-3) D4240 (4+) (# of teeth)	Gingival flap, per quadrant	\$75.00 \$75.00	10%	10%
	D4263	Bone replacement graft – first site in quadrant	\$195.00	10%	10%
	D4264	Bone replacement graft – each additional site in quadrant	\$60.00	10%	10%
	D4211 (1-3) D4210 (4+) (# of teeth)	Gingivectomy/gingivoplasty (gum surgery), per quadrant	\$15.00 \$75.00	10%	10%
Endodontics	D3220	Puplotomy	No Charge	No Charge	10%
	D3222	Partial pulpotomy for apexogenesis – permanent tooth	No Charge	No Charge	10%
	D3310	Root canal – Anterior (front) teeth	\$30.00	No Charge	10%
	D3320	Root canal – Bicuspid	\$60.00	No Charge	10%
	D3330	Root canal – Molar	\$90.00	No Charge	10%
Oral Surgery	D7286	Biopsy of soft oral tissue	No Charge	No Charge	10%
	D7140	Uncomplicated extraction, single tooth	No Charge	No Charge	10%
	D7220	Extraction – impacted soft tissue, per tooth	No Charge	No Charge	10%
	D7230	Extraction – impacted partially bony, per tooth	\$30.00	No Charge	10%
	D7240	Extraction – impacted completely bony, per tooth	\$40.00	No Charge	10%
	D9215	Local anesthesia	No Charge	No Charge	10%
	D9220	General anesthesia – first 30 minutes (only with oral surgery)	\$165.00	No Charge	10%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Radius)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Oral Surgery (continued)	D9221	General anesthesia – each additional 15 minutes (only with oral surgery)	\$80.00	No Charge	10%
	D7450/D7451	Removal of benign odontogenic cyst or tumor	No Charge	Benefit covered through Medical Plan / Cigna pays as secondary coverage under Basic Benefits	Benefit covered through Medical Plan / Cigna pays as secondary coverage under Basic Benefits
Crowns and Bridges	D2790	Crown – full cast high noble metal (gold)	\$160.00	25%	30%
	D6721	Crown –resin with predominantly base metal	\$60.00	25%, addt'l cost for porcelain on posterior teeth	30%, addt'l cost for porcelain on posterior teeth
	D6740	Crown – porcelain/ ceramic substrate	\$195.00	25% addt'l cost for porcelain on molar teeth	30% addt'l cost for porcelain on posterior teeth
	D6722	Crown – porcelain fused to noble metal	\$60.00	25%, addt'l cost for porcelain on posterior teeth	30%, addt'l cost for porcelain on posterior teeth
	D6930	Recement fixed partial denture	No Charge	25%	30%
	D2920	Recement crown	No Charge	25%	30%
	D6241	Pontic – porcelain fused to predominantly base metal (front teeth or molars)	\$60.00	25%, addt'l cost for porcelain on posterior teeth	30%, addt'l cost for porcelain on posterior teeth
	D6980	Fixed partial denture repair, by report	\$15.00	25%	30%
Prosthetics	D5110 (Upper) D5120 (Lower)	Complete upper or lower denture	\$75.00 for either upper or lower	25%	30%
	D5211 (Upper) D5212 (Lower)	Upper or lower partial denture – resin base	\$85.00 for either upper or lower	25%	30%
	D5670 (Upper) D5671 (Lower)	Replace all teeth (upper or lower) on cast metal framework	\$75.00 for either upper or lower	25%	30%
	D5510	Repair broken Complete Denture Base	\$15.00	25%	30%
	D5410 (Upper) D5411 (Lower)	Complete denture adjustment	No Charge for either upper or lower	25%	30%
	D5520	Replace broken tooth on denture	\$5.00	25%	30%
	D6010 D6012 D6040 D6050	Implants	Not Covered	25%, predetermination recommended	25%, predetermination recommended

*EyeMed
Vision is
the provider
of choice for
more than
120 million
members*

EYEMED VISION

The County of San Bernardino has contracted with EyeMed Vision to provide vision care benefits to its employees. EyeMed is one of the leading managed vision care organizations in the industry. Its unique relationship with recognized vision care providers and its corporate-owned optical retailers offer a vision care program that combines ultimate choice, quality, value and service for over 120 million members.

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

- ✓ No eye exam copayments
- ✓ 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 and items not covered by the plan
- ✓ Exams, frames, standard lenses or contact lenses every 12 months
- ✓ Online service features
- ✓ Customer service representatives available 7 days a week and evenings

EyeMed Vision Care features a full service website that will allow you to access and download valuable information about the company, view benefit details and claim status, locate providers and print ID cards. Register at their web address, <https://www.eyemedvisioncare.com>. To locate a provider near you, use the "locate a provider" tool. Choose the "Select" network, then enter your ZIP code.

Limitations and Exclusions

1. Charges for procedures, services or materials that are not included 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 (877) 406-4146. Service Representatives are available daily from 4:30 a.m. to 8:00 p.m. (PST).

*EyeMed
Vision's
Customer
Services can
be reached at
(877) 406-
4146*



COBRA CONTINUATION COVERAGE

General Information

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1985 to offer employees and their covered dependents the opportunity to elect a temporary continuation of their plan coverage in certain instances where coverage would otherwise end.

Upon notification that a qualifying event has occurred, EBSD will mail you additional information and the appropriate election notices at that time. The group health and welfare plans maintained by the County offer no greater COBRA rights than what the COBRA statute requires, and this summary should be construed accordingly.

Qualified Beneficiary

For purposes of COBRA, a qualified beneficiary is any individual who, on the day before qualifying event, is covered under the group health and welfare plans maintained by the County of San Bernardino by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee.

For purposes of COBRA, Domestic Partners are not considered to be qualified beneficiaries, but can be enrolled for COBRA coverage subject to election, eligibility and plan rules applicable to the qualified beneficiary.

Qualifying Events

If you are an employee of the County and are covered by the group health and welfare plans maintained by the County, you have the right to elect COBRA continuation coverage if you lose coverage under the plans due to any one of the following “qualifying events”:

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

If you are the spouse or domestic partner of an employee and are covered by the group health and welfare plans maintained by the County, you have the right to elect continuation coverage if you lose coverage under the plans 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 or dissolution of domestic partnership

In the case of an employee’s dependent child who is covered by the group health and welfare plans maintained by the County, he or she has the right to elect continuation coverage if group health coverage under the plans is lost due to any of the following “qualifying events”:

- ✓ The death of the employee (parent)
- ✓ Termination of the employee (parent) for reasons other than gross misconduct or reduction in the employee’s (parent’s) hours of employment with the County of San Bernardino
- ✓ Parent’s divorce or dissolution of domestic partnership
- ✓ The child ceases to be a “dependent child” under the terms of the Plan(s)

COBRA Rights and Obligations

Individual Election Rights and Eligibility

Each individual who was covered under the group health and welfare plans maintained by the County of San Bernardino on the day before the qualifying event is a “qualified beneficiary” and has independent election rights to continuation coverage. This means that each dependent who was covered can elect independently to continue coverage, even if the covered employee chooses not to continue coverage. However, continuation coverage is available to qualified beneficiaries subject to their continued eligibility. The Human Resources Benefits Chief, Employee Benefits and Services Division of the County of San Bernardino, or designee, reserves the right to verify eligibility status and terminate continuation coverage back to the original COBRA effective date, if it is determined that an individual is ineligible or coverage was obtained through a material misrepresentation of the facts.

County sponsored health plans are not “bundled” and are independent of one another. As such, under the provisions of COBRA, each qualified beneficiary can elect to continue all health and welfare plan coverages or any combination of the coverages in which they were enrolled in the day before the event. For instance, a qualified beneficiary could elect to continue their group medical coverage and waive the continuation of their group dental coverage. The applicable premiums will vary depending on the coverages elected.

Once an election of continuation coverage is made, the coverages may change if modifications are made to the coverages provided to similarly situated non-COBRA plan participants providing that the qualified beneficiary has a valid election for the affected plan or if the qualified beneficiary has a valid election during the Open Enrollment period they will be able to make changes to plans for which they are deemed a qualified beneficiary.

Once enrolled, if your marital status changes, if a covered dependent ceases to be eligible for coverage, or if the address of you or your spouse changes, you must notify EBSD immediately.

No Coverage During Election Period

You will not be covered under the plan(s) during the election period. However, if a COBRA election is made as described in the Notice of Right to Elect Continuation of Group Health and Welfare Plan (COBRA) Coverage and all applicable premiums are paid as detailed in the following section, then your health and welfare plan coverages selected will be retroactively reinstated back to your loss of coverage date in accordance with federal law.

Coverage Period

In general, qualified beneficiaries are eligible to continue health and dental coverage for a maximum consecutive period of eighteen (18) months from the qualifying event date.

Under California law, an extension of coverage is available for up to 18 additional consecutive months for medical coverage only (Dental and Vision coverage is excluded).

For additional information on specific coverage periods applicable to your situation, contact EBSD.

Notices and Election Period

Under COBRA, you (the employee) or a family member has the responsibility of notifying EBSD when a qualifying event has occurred.

If you have questions about COBRA, call EBSD at (909) 387-5552

If you or your dependents experience one of the COBRA qualifying events listed above, a sixty (60) day election period will be afforded during which you and/or your dependents can choose to elect or decline COBRA coverage from the date of notification.

If you choose not to elect COBRA coverage for one or all County sponsored medical, dental, and/or vision plans your eligibility and rights for COBRA coverage specific to the plans declined is considered “waived” based on the non-election made.

If you choose to elect COBRA, and submit your election within the 60 day election period, your coverage will be reinstated retroactive to the date that health care coverage would otherwise have been lost by reason of a qualifying event.

If you or a family member fails to provide this notice to EBSD during this 60-day notice period, then rights to continuation coverage will be forfeited.

Upon receipt of your Initial COBRA election notice, you will be provided with the details of your current coverage. You may elect any combination of coverage, in whole or in part, that meets your needs.

At the end of the COBRA coverage period, you will be notified of your option to continue coverage under Cal-COBRA if applicable.

Paying for COBRA

COBRA premiums are not paid for by the County, but rather are an out of pocket cost for the Employees and qualified beneficiaries. If you elect to continue your health plan coverages, as a qualified beneficiary you are responsible for the full applicable premium payment for the elected COBRA coverage. COBRA premiums reflect the total cost of County sponsored coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus an additional administrative fee of up to 2% (for a maximum total of 102%) as allowed under Federal law. For Cal-COBRA the cost may be up to 110% of the premium.

The initial premium payment must be made within 45 days after the date of the COBRA election. Premiums for successive periods of coverage are subject to a 30-day grace period from the premium due date. Premiums are billed in monthly increments and advance of the month of coverage.

After your election form is received by the Employee Benefits and Services Division, you will be sent a Confirmation of Election statement detailing your applicable election, premium amounts, and applicable due dates.

If premiums are not received or, if mailed, not postmarked within the required premium periods as described in the premium payment schedule, coverage will be retroactively cancelled back to the date for which coverage was paid and COBRA rights and protections will be forfeited.

COBRA: New Dependents and Open Enrollment

If, during the applicable period of COBRA coverage, an employee who elected continuation coverage acquires new dependents (such as through marriage), the new dependents may be added to the coverage according to the rules of the plan. However, the new dependents do not gain the status of a qualified beneficiary and will lose coverage if the qualified beneficiary who added them to the plan loses coverage.

Plan procedures for adding new dependents are available by calling EBSD. Premium rates will be adjusted at that time to the applicable rates.

In addition, should an Open Enrollment period occur during your COBRA continuation period, the County will notify you of your Open Enrollment rights. If an Open Enrollment period occurs, each qualified beneficiary will continue to have independent election rights to select any of the options or plans that are available to similarly situated non-COBRA plan participants.

If you have previously waived your COBRA entitlement in whole or in part (for specific plans), you will not be eligible to re-enroll in a plan for which you are not a qualified beneficiary. For example, if you elected COBRA continuation coverage for medical but not vision or dental you will have Open Enrollment rights for medical only and will not be able to re-enroll in dental or vision for COBRA coverage during the Open Enrollment period.

If you are currently enrolled in COBRA for any medical, dental, or vision benefits you may make changes to coverage as if you were still on regular coverage. This includes enrolling in coverage that you may not currently be enrolled in, provided that you do currently have a COBRA election and eligibility at the time that Open Enrollment is taking place.

Coverages added during Open Enrollment are subject to the initial Coverage Period for COBRA eligibility and do not entitle COBRA participants to a new or additional coverage period.

Cancellation of Continuation Coverage

COBRA continuation coverage can end prior to the exhaustion of the applicable maximum months of continuation coverage for any of the following reasons:

- ✓ A qualified beneficiary notifies the County they wish to cancel continuation coverage;
- ✓ The County ceases to provide any group health plan to any of its active employees;
- ✓ Any required premium for continuation coverage is not paid in a timely manner;
- ✓ A qualified beneficiary becomes, after the effective date of election, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of the Health Insurance Portability and Accountability Act (HIPAA) of 1996;
- ✓ A qualified beneficiary becomes, after the date of election, entitled to Medicare;
- ✓ For cause, on the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA participants.

Certificate of Creditable Coverage

Your Certificate of Creditable Coverage will be mailed separately to your home address. It will detail the amount of time you have been covered under the County's group health insurance plan(s). Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the time covered under the County's group health plan (including COBRA coverage, if elected) may be used to reduce a new health plan's pre-existing condition period. For example, if you were covered under the County's health plan for 10 months, including COBRA coverage, and your new health plan has a 12 month preexisting condition clause for new enrollees, the new plan would subtract 10 months from the 12 month pre-existing condition period. However, for your coverage under the County's plan to be counted under a new health plan, there must not be a break in coverage for more than 63 days from the time coverage under the County's plan (including COBRA coverage, if elected) ceases to the date of enrollment in your new plan.

Questions regarding a new health plan's pre-existing condition period and the impact HIPAA will have should be directed to your new health plan. If you obtain other insurance, present the Certificate of

Health Insurance Portability to your new health insurance plan and they will determine if any benefits are available to you in this matter. If you elect COBRA coverage, an updated Certificate of Health Insurance Portability will be sent to you when your COBRA coverage ceases. If you lose or do not receive the above-mentioned certificate, one can be requested up to 24 months from the date coverage (or COBRA coverage) ceases by calling (909) 387-5552.

COBRA Plan Administrator:

County of San Bernardino
Human Resources Department
Employee Benefits and Services Division
157 W. Fifth Street, First Floor
San Bernardino, CA 92415-0440

How to Get in Touch with a COBRA Representative

Call EBSD at (909) 387-5552.

COBRA rules and regulations are subject to changes in State or Federal law, if any provision contained in this benefit guide is found to be in conflict with the current laws, applicable State or Federal laws shall prevail.



MEDICAL EXPENSE REIMBURSEMENT PLAN (FSA)

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

How the Plan Works

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

Participants in the County's FSA Plan are required to make an election every year if they wish to continue to participate. Unlike most of the County's benefits, FSA elections from a previous Plan Year will not automatically carry over into the next Plan Year if no election is made during the Open Enrollment period.

Minimum/Maximum Contribution Amounts

Effective July 28, 2012, there will be a maximum annual contribution of \$2,500 pursuant to IRS regulations. This may affect your bargaining unit maximum allowable contribution.

Please refer to the appropriate Memorandum of Understanding, Exempt 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.

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://mybenefitsatwork>.

Reimbursement

You may apply for reimbursement of qualifying medical care expenses by submitting a completed Medical Expense Reimbursement claim form to EBSD, 157 West Fifth Street, First Floor, San Bernardino, CA 92415 (Interoffice Mail Code 0440) 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 billed amount, date, and nature of service, the name and address of the provider, and the name of the person who received the service for the qualifying medical care expenses incurred must be attached to the completed claim form, together with proof that the expense was paid by you and any other documentation that EBSD may request.

Participating in the FSA plan can be a welcome money saver when it comes to medical expenses

If you are requesting reimbursement for over-the-counter medications (OTC), your claim must include a legal prescription for the OTC medication. This prescription must include the date, patient name, medication name, required dosage, number of refills, provider's address and license number, a copy of the label, and a receipt stating the product name, price, and purchase date. Illegible receipts and prescriptions will not be accepted.

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 eligible claims received total \$25 or more.

Eligible expenses will be reimbursed by a check issued separately 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, contact EBSD at (909) 387-5648.

Important Rules on Medical Expense Reimbursement Plan (FSA)

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

Be as accurate as possible in your estimates of your total annual FSA contribution amount. Do not contribute more money into your account than you know you will use. 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. 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 incur 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 Plan (FSA), contact EBSD or go online to http://www.sbcounty.gov/hr/Benefits_Home.aspx or <http://mybenefitsatwork>.

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 hours per 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 eligible dependent care expenses on a pre-tax basis. The DCAP Open Enrollment period is in November of each year, and the DCAP Plan Year matches the calendar year.

Eligibility

In order for dependent care expenses to be eligible, the expense must enable the gainful employment of you or your spouse, be paid on behalf of a qualified dependent, and be 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 under age 13 living with you, 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 Section 152 of the IRC for purposes of pre-tax contributions or reimbursement on a pre-tax basis is also a dependent.

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. You must provide the name, address and Social Security number or the tax identification number of your dependent care provider on all claims and 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 or your spouse 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.

Participants in DCAP are required to make an election every year if they wish to continue to participate. Unlike most of the County's benefits, DCAP elections from a previous Plan Year will not automatically carry over into the next Plan Year if no election is made during the DCAP Open Enrollment period.

How the Plan Works

Each year during the DCAP Open Enrollment in November, you may enroll and authorize a biweekly deduction amount from your pay to be placed into your DCAP 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 and proof of payment for the expense. **If your claim is greater than your account balance, you will be paid the funds that are available.** As additional deposits are made to your account, subsequent check(s) will be issued automatically. 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 you have received reimbursement or not. For the 2012 DCAP Plan Year, you may file claims any time before January 31st following the end of the plan year.

NOTE: Tax laws are complex and it may benefit you to seek professional tax advice before enrolling in the DCAP.

DCAP allows the participant to pay for certain dependent care expenses with pre-tax dollars

Maximum Contribution

The maximum annual contribution for the calendar year is the lowest of either the participant or spouse'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 a conservative estimate as IRS regulations stipulate that your elections are irrevocable and you may only change your deduction amount during the plan year if 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 toward 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 of DCAP. For a full description of the plan, refer to the plan document. If any differences exist between this summary and the plan document, the plan document will prevail.

For more information on the DCAP, contact EBSD or go on line to http://www.sbcounty.gov/hr/Benefits_Home.aspx or <http://mybenefitsatwork>.



SHORT-TERM DISABILITY (STD)

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

Eligibility

Your Memorandum of Understanding (MOU), Exempt Compensation Plan, Salary Ordinance, or Contract governs your eligibility for STD.

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

However, employees who participated in SDI at any time within the 18 months immediately prior to filing an STD claim, or employees who have a second job that participates in SDI, may be eligible to receive SDI benefits. 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 40 hours or more per pay period; 2) Employee must have completed at least two pay periods of continuous service, each with a minimum of one-half plus one hour of scheduled hours of paid time; and 3) Employee must be designated as a member of one 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 40 hours or more per pay period; 2) Employee must have completed at least one 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

No later than your fourth day of absence, call Cigna directly at (800) 238-5834 or file online at www.myCigna.com.

You must also obtain the County required paperwork (RESSL and Leave Integration Request forms) from your Payroll Specialist or download the forms from the intranet at <http://countyline/emacs/forms.asp>. Your completed paperwork must be returned to your Payroll Specialist within 15 days after your initial disability date.

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 base salary, not to exceed \$1,011 per week for represented employees, or \$1,442 per week for Exempt employees. These amounts are subject to change. Benefits due for any partial weeks will be calculated at the daily amount of one-seventh (1/7) of the Normal Weekly Benefit. Your normal weekly benefit will be reduced by the amount you receive or are entitled to receive from:

*To File a Claim:
No later than your
fourth day of absence,
you must call Cigna
directly at (800) 238-
5834 or file online at
www.myCigna.com and
contact your Payroll
Specialist.*

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) weeks. Exempt employees may receive a maximum benefit amount of one-hundred eighty (180) days.

NOTE: STD Benefit payments will be made separately by Cigna, and are paid as taxable income.

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 base salary. 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.

For any questions or additional information regarding Short-Term Disability, contact EBSD at (909) 387-5787, Cigna at (800) 238-5834 or go online to http://www.sbcounty.gov/hr/Benefits_Home.aspx or <http://mybenefitsatwork>.

LONG-TERM DISABILITY (LTD)

Long-Term Disability is a County-paid benefit that provides partial income replacement for Exempt employees that are unable to work due to a non-work related disability. The benefit pays 60% of Monthly Salary but cannot exceed \$10,000.

Payments begin after 180 consecutive days of disability. Plan benefit payments may NOT be fully or partially integrated with other paid time. Benefits are subject to change pending Board of Supervisors approval. Maximum duration for which benefits may be paid is as follows:

Age When Disabled	Benefits Payable
Prior to Age 60	To Age 65
Ages 60 – 64	60 months
Ages 65 – 67	To Age 70
Age 68 and over	24 months

For further information contact EBSD at (909) 387-5787. To file a claim, contact Cigna at (800) 238-5834, or visit their website at www.myCigna.com.

STD benefit payments are taxable income

PLAN SUMMARIES

LTD payments begin after 180 consecutive days of disability

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 Physician's Statement verifying the medical requirement to be off work 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 for 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
- ✓ Release of Medical Information

You can obtain MEL forms from your department's Payroll Specialist or download the forms from the intranet at <http://countyline/emacs/forms.asp>. No MEL Benefits will be paid until all completed forms have been received by EBSD. MEL is not a retroactive benefit.

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

For further information contact EBSD at (909) 387-5787.

*Medical
Emergency
Leave is not
available to those
receiving Worker's
Compensation
benefits*

LIFE INSURANCE

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

Basic Life Insurance

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

Your life insurance becomes effective on the same date as your medical and dental benefits. You must designate a beneficiary at the time of enrollment. Benefits will be paid according to your instructions. If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit using the order of eligibility listed in the Certificate of Insurance provided by Minnesota Life Insurance Company.

Supplemental Life Insurance

Eligible employees may purchase additional life insurance through the supplemental life insurance plan.

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

** The Supplemental 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 Supplemental Life Insurance effective date. Reduction amounts are available in the Supplemental Life Insurance booklet that is available from your Payroll Specialist.*

Eligibility

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

- ✓ Per Diem Nurses
- ✓ Certain Contract Positions (please refer to your contract for eligibility)

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

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

You may enroll within 60 days of becoming eligible, or during the annual Open Enrollment. After your initial enrollment, you may make changes in coverage only during the annual Open Enrollment.

Plan Options

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

Beneficiary for Supplemental Life Insurance

If you do not designate a beneficiary, benefits will be paid automatically to your beneficiaries in the following order: (1) surviving lawful 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 designate a beneficiary, you must complete the Supplemental Life Insurance Beneficiary Designation/Change form through eBenefits (during the Open Enrollment period only) or through your Payroll Specialist at any time throughout the year.

NOTE: Premiums for life insurance coverage in excess of \$50,000 (including employer-paid life insurance) must be paid on an after-tax basis per IRS regulations.

Payroll Deductions and Effective Date of Coverage

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

Waiver of Premium While Disabled

Waiver of premium is a provision which allows for continued participation in the life insurance plan without payment of premium while you are disabled.

If you return to work for the County and want to continue coverage, you must contact your Payroll Specialist or EBSD at (909) 387-5537 within 60 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 into an individual plan under the same terms as a terminating County employee.

Accelerated Benefits Option

The Accelerated Death Benefit, or "living benefit option," provides you with an advanced benefit if you are diagnosed with a terminal illness and have less than 12 months to live. You may be eligible for up to 100 percent of your life insurance benefits (\$1 million maximum). Upon death, the balance of the life insurance benefit, if any, will be paid to the named beneficiaries. The minimum policy face value amount to be eligible for this benefit is \$10,000. Please refer to the County's Certificate of Insurance at www.sbcounty.gov/hr/Benefits_Home.aspx or <http://mybenefitsatwork> for further details.

Termination of Coverage

Your Supplemental 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

Portability or Conversion of Coverage

When you are no longer eligible for life insurance coverage through the County's group plan, you may be eligible to continue your coverage through the portability or conversion process. You can obtain more information on this subject by contacting EBSD at (909) 387-5537 or Minnesota Life at (866) 293-6047.

How To Get In Touch With the Supplemental Life Insurance Plan

For questions about plan design, claim status/payments, medical underwriting and eligibility, call Minnesota Life at (866) 293-6047. For questions about enrollment, current coverage or to request claim paperwork, call EBSD at (909) 387-5537.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Employee Eligibility

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

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

Eligible Dependents for AD&D Coverage

- ✓ Lawful Spouse
- ✓ State-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. You must be enrolled to enroll your dependents.

Plan and Coverage Options

You have two coverage options and seven AD&D plans from which to choose. For benefit levels, please refer to the Group Benefit Plans at www.sbcounty.gov/hr/Benefits_Home.aspx or <http://mybenefitsatwork>.

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 coverage level you select.

- 2. Employee plus family:** Coverage amounts will be the amounts listed in the Employee column, the Spouse or Domestic Partner column and Each Child column, as applicable to your family.

If you marry or enter into a state-registered domestic partnership after enrolling for AD&D coverage, you may add your new spouse or domestic partner by submitting new enrollment and payroll deduction authorization forms within 60 days of the date of marriage or commencement of domestic partnership. Once family coverage is in force, all newly eligible dependents (such as a newborn) are enrolled automatically.

AD&D Plan Options Table

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

Beneficiary for AD&D

If you do not designate a beneficiary, insurance benefits will be automatically paid to your beneficiaries in the following order: (1) surviving lawful 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 designate a beneficiary you must complete the beneficiary designation form.

Payroll Deductions and Effective Date of Coverage

Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium payment. Before-tax payroll deductions for AD&D premiums are available. If before-tax dollars are used to pay the premiums, you may cancel the plan only when you have a 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

Portability Benefit

The portability benefit provides for continuation of your group accidental death and dismemberment insurance if you no longer meet the eligibility requirements of the County's group plan. To continue coverage under this provision, you must make a written request and make the

first premium payment within 60 days after the AD&D coverage ends with the County. For more information on this benefit, you can contact EBSD at (909) 387-5537.

How To Get In Touch With an AD&D Representative

For questions about plan design, claim status/payments, medical underwriting and eligibility, call Minnesota Life Insurance Company at (866) 293-6047. For questions about enrollment, current coverage or to request claim paperwork, call EBSD at (909) 387-5537.

AD&D Premium Table

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

HEALTH CLUB MEMBERSHIP

County employees are eligible for a health club membership at a reduced rate at 24-Hour Fitness and LA Fitness. 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 or LA Fitness are eligible to have monthly dues reduced to the County's rate.

24-Hour Fitness

Employees may enroll at any 24-Hour Fitness club location for a One Club or All Sports Club membership valid at over 140 club locations. Super and Ultra-Sport club memberships are also available. The County has paid processing and initiation fees, and has negotiated the following discounted monthly membership dues:

	Initiation and Processing Fee	Monthly Fee for One Club Access	Monthly Fee for All Club Sport Access	Monthly Fee for All-Club Super Sport Access
Employee Only	\$0	\$23.00	\$27.00	\$41.99
Each Additional Member	\$0	N/A	\$24.99	\$39.99

Upon initial enrollment, employees will be responsible for immediate payment of first and last months' dues. Monthly dues are paid thereafter by electronic fund transfer (EFT) directly from the employee's checking or savings account. Payroll deduction is not available. Additional members must be the employee's spouse, State-registered domestic partner, or child (12-18 years of age) and live at the same address as the employee to be eligible. Employees must provide proof of County

A healthy lifestyle is the best investment one can make

employment. Please note that employees may cancel their 24-Hour Fitness membership at any time without penalty. Contact 24-Hour Fitness at (800) 204-2400 or e-mail tbohannon@24hourfit.com.

LA Fitness

Employees may enroll at any LA Fitness club location after receiving a promotional code (e-voucher) from the Employee Benefits and Services Division for a membership valid at all LA Fitness clubs, except Signature Clubs. The County has negotiated the discounted monthly membership dues of \$29.99 with no initiation fee. Racquetball court usage may be added at an additional amount of \$5 per month.

Upon initial enrollment, employees will be responsible for immediate payment of first and last months' dues. Monthly dues are paid thereafter by pre-authorized direct debit or credit card payment. Payroll deduction is not available. Please note that employees may cancel their LA Fitness membership at any time without penalty.

	Initiation and Processing Fee	Monthly Fee for One Club Access
Employee Only	\$0	\$29.99
Each Additional Member	\$0	\$29.99



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 30, 2012. The survivor benefit premiums will decrease from \$0.89 to \$0.77 per pay period. The following Contribution Rate Table details the latest refundable and nonrefundable rates for both General and Safety employees.

Employee Retirement Contribution Rate Table

General Employees Contribution Rate (%)			Safety Employees Contribution Rate (%)		
Entry Age	Refundable	Non-Refundable	Entry Age	Refundable	Non-Refundable
16	7.77	7.06	16	10.11	9.82
17	7.90	7.18	17	10.29	9.99
18	8.04	7.31	18	10.47	10.17
19	8.17	7.43	19	10.65	10.34
20	8.32	7.56	20	10.83	10.51
21	8.45	7.68	21	11.03	10.71
22	8.60	7.82	22	11.22	10.89
23	8.75	7.95	23	11.42	11.09
24	8.91	8.10	24	11.61	11.27
25	9.05	8.23	25	11.82	11.48
26	9.21	8.37	26	12.02	11.67
27	9.36	8.51	27	12.25	11.89
28	9.53	8.66	28	12.47	12.11
29	9.69	8.81	29	12.69	12.32
30	9.85	8.95	30	12.92	12.54
31	10.02	9.11	31	13.16	12.78
32	10.19	9.26	32	13.38	12.99
33	10.38	9.44	33	13.63	13.23
34	10.56	9.60	34	13.86	13.46
35	10.74	9.76	35	14.10	13.69
36	10.93	9.94	36	14.35	13.93
37	11.12	10.11	37	14.60	14.17
38	11.33	10.30	38	14.86	14.43
39	11.54	10.49	39	15.12	14.68
40	11.75	10.68	40	15.40	14.95
41	11.97	10.88	41	15.68	15.22
42	12.20	11.09	42	15.91	15.45
43	12.42	11.29	43	16.09	15.62
44	12.66	11.51	44	16.23	15.76
45	12.91	11.74	45	16.33	15.85
46	13.15	11.95	46	16.44	15.96
47	13.40	12.18	47	16.54	16.06
48	13.59	12.35	48	16.37	15.89
49	13.74	12.49	49 & Over	15.93	15.47
50	13.85	12.59			
51	13.95	12.68			
52	14.03	12.75			
53	13.89	12.63			
54 & Over	13.51	12.28			

The refundability factors are 1.10 for General and 1.03 for Safety.

The information contained in the Refundable vs. Nonrefundable Table is a summary of information provided by SBCERA. In the event of any discrepancy between information contained in this summary and the California Government Code, SBCERA By-Laws, and SBCERA policies, the Code provisions, By-Laws, and policies will govern.

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 17 and you will see the election change on the pay warrant you receive on or about August 8, 2012.

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 these refundable contributions plus earned interest in one lump-sum payment from 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 \$1.03 required. If you leave the County without retiring, you may not withdraw these nonrefundable contributions from SBCERA. If eligible, you may receive a retirement benefit.



Refundable vs. Nonrefundable Table

The following table outlines the refundable and nonrefundable retirement options.

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 \$1.03 required.
Termination before five (5) years of service credit	You <u>can</u> refund or rollover all of your refundable contributions in a lump-sum payment plus interest; or, you may choose to leave your contributions "on deposit" with SBCERA to earn the applicable member deposit interest rate as determined by the Board of Retirement.	You <u>cannot</u> refund or rollover any nonrefundable contributions. Note: If you made contributions under both the refundable and nonrefundable options, only the refundable contributions can be refunded to you.
Termination after five (5) years of service credit	You can choose between a deferred retirement OR receive a lump-sum payment of all refundable contributions in your retirement account.	You can choose between a deferred retirement OR a refund of any refundable contributions in your account. Your nonrefundable contributions will not be refunded.
Nonservice-related death before five (5) years of service credit	Lump-Sum Payment: Your spouse, registered domestic partner, dependent minor children and/or other named beneficiary will receive a lump-sum payment of your refundable contributions and interest, plus one month's compensation for each completed year of service credit up to a maximum of six months' compensation.	Lump-Sum Payment: Your spouse, registered domestic partner, dependent minor children and/or other named beneficiary will receive one month's compensation for each completed year of service credit up to a maximum of six months' compensation. Note: Nonrefundable contributions will not be refunded. Only refundable contributions can be refunded.
Nonservice-related death after five (5) years of service credit	Optional Death Allowance: Your eligible spouse, registered domestic partner or dependent minor children will receive a monthly payment equal to 60% of the amount awarded in a nonservice-connected disability retirement or a service retirement (if eligible at the time of your death), whichever is greater.	Same as Refundable Option
Your beneficiary or beneficiaries may be able choose between each of the following options:	Modified Optional Death Allowance: Your eligible spouse or registered domestic partner will receive a lump-sum payment of one month's compensation for each completed year of service credit up to a maximum of six months' compensation; plus a reduced monthly benefit that would depend on the age of the beneficiary.	Same as Refundable Option
	Lump-Sum Payment: Your spouse, registered domestic partner, dependent minor children and/or another named beneficiary will receive a lump-sum payment of any refundable contributions and interest, plus one month's compensation for each completed year of service credit up to a maximum of six months' compensation.	Lump-Sum Payment: Your spouse, registered domestic partner, dependent minor children and/or another named beneficiary will receive one month's compensation for each completed year of service credit, up to a maximum of six months' compensation. Note: Nonrefundable contributions will not be refunded. Only refundable contributions can be refunded.
General Member death after 18 months of continuous SBCERA membership This is an additional monthly benefit available to eligible beneficiaries.	Survivor Benefit: Your spouse, registered domestic partner or dependent minor children may also be entitled to an additional monthly survivor benefit amount.	Same as Refundable Option

MY HEALTH MATTERS!

Take a step to becoming a new, healthier you with My Health Matters! (MHM!), the County's wellness program. MHM! offers a wealth of resources to help you in your journey of wellness. Whether you are making the first step towards wellness or are looking for ways to enhance your already established regimen, we encourage you to visit the MHM! web page on the intranet at <http://mybenefitsatwork> or on the internet at http://www.sbcounty.gov/hr/Benefits_MyHlth.aspx

Steps to Success, the MHM! web-based activity portal, is a great way to track your physical activities, manage your calorie intake, participate in a challenge, and receive incentives along the way.

Take advantage of the variety of worksite wellness programs offered through MHM! By participating in a wellness class, you can learn tips to reduce stress, discover ways to incorporate healthy food choices in your diet, and much more!

So, start making healthier choices today! For more information regarding MHM!

- ✓ Visit <http://mybenefitsatwork>
- ✓ Call your Department Wellness Advocate. View the directory posted on the MHM! webpage
- ✓ Contact EBSD staff via email at mhm@hr.sbcounty.gov or via phone at (909) 387-5787

457(b) DEFERRED COMPENSATION PLAN

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

Reminder: To receive a County match, you must be enrolled in and contributing to a 457(b) Plan.

Eligibility

All general employees in regular positions, and other employees that are granted this benefit through an employment contract or Exempt Compensation plan, are eligible to participate in the County's 457(b) Deferred Compensation Plan and can enroll at any time. In addition, certain bargaining units have added a County match if the employee is participating in the 457(b) Plan. Check your MOU to determine if you are eligible for this benefit. If you are eligible for the County match, all County contributions will be deferred to a 401(a) Defined Contribution Plan.

Contributions

Contributions to this account and any earnings that accumulate are not taxed until the funds are withdrawn. 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 with most 401(k) plans, there is no penalty for withdrawals made from a 457(b) Plan prior to the participant's attainment of age 59½.

In-Service Distributions

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship provisions in the 457(b) Plan document before participating in the plan.

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

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

401(k) DEFINED CONTRIBUTION PLAN

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

Roth 401(k): Allows participating employees the opportunity to take tax-free distributions upon retirement, as long as the participant meets certain qualifications, by paying taxes on their contributions up front. Unlike the Traditional 401(k), the Roth 401(k) offers the participant the potential for tax-free retirement income later by investing on an after-tax basis now.

Eligibility

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

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

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

Withdrawal Period

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

In-Service Distributions

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship provisions in the 401(k) Plan document before participating in the plan.

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

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

RETIREMENT MEDICAL TRUST FUND

The Retirement Medical Trust Fund Plan was implemented by the County of San Bernardino to assist eligible retirees and their dependents with the high cost of health related expenses. It provides a method for eligible participants to pay, on a nontaxable basis, for qualified expenses including medical, dental and long term care premiums (as defined in IRC 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 or unused sick leave accruals and County contributions.

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

529 EDUCATION SAVINGS PLAN

A 529 Education Savings Plan is offered by Fidelity Investments. This plan offers all County employees a way to invest in their children's and grandchildren's education. The minimum biweekly deferral is \$25 and is deducted on an after-tax basis. You must contact ING to participate in the plan.

Potential Tax Advantages

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

Control and Flexibility

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

Additional Advantages

The advantages to the Fidelity 529 Education Savings Plan are its:

- ✓ Ability to accept biweekly payroll deductions
- ✓ Low investment management fees
- ✓ Low annual account fees
- ✓ Quality and quantity of investment options

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

COMMUTER SERVICES

Human Resources – Commuter Services (HR-CS) administers the County's Rideshare Program and assists employees with finding alternatives to driving to work alone. HR-CS offers a variety of programs including: vanpool, carpool, hybrid vehicle carpool, transit bus pass, walk and bike to work. HR-CS can help you:

- ✓ Join or form a vanpool or carpool
- ✓ Obtain information about public transportation options
- ✓ Take advantage of tax benefits such as pre-tax payroll deductions for vanpool rates and transit pass purchases (up to \$125 per month through December 2012)
- ✓ Register and submit a RideMatch Request for a list of potential carpool partners, who share a similar commute and schedule – and are interested in sharing the ride
- ✓ Find information on topics pertaining to improving air quality, reducing traffic congestion, and saving money through newsletters, payroll stuffers, and e-mails
- ✓ Save money and reduce your carbon foot print

Examples of incentives and rewards include:

- ✓ \$2 Per Day Start Up Incentive – Eligible ridesharing employees can receive \$2 per day for the

first three months of participation in any of the County's Rideshare Programs

- ✓ Membership in the Rideshare Plus Rewards Club provides discounts to more than 135,000 merchants in the Inland Empire and in the United States
- ✓ Earn gas cards or Big 5 gift cards every six months for participation
- ✓ Monthly drawings for \$25 gift cards for employees who track rideshare participation with HR-CS each month
- ✓ Invitation to the Annual Commuter Services Rideshare luncheon

This year, HR-CS will sponsor Brown Bag Luncheon events at locations across the county as part of the "Rideshare Road Show." Attendees will learn about various rideshare programs, incentives for participating, environmentally friendly tips for work and home, and much more.

For Road Show event information, or if you are interested in sponsoring a Road Show event at your location, call HR-CS at (909) 387-9640 or (909) 387-9639. Also, visit the HR – CS Intranet site at <http://countyline.sbcounty.gov/commuterservices/> to learn more about different rideshare options and for information on how participating in the County's rideshare program can benefit you.

SICK LEAVE CONVERSION

Employees in certain bargaining units 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. This benefit only applies to certain bargaining units. Check your MOU for details and 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. This benefit only applies to certain bargaining units. Check your MOU for details and 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 online application at www.edd.ca.gov
2. File by telephone using the toll-free number to contact the call center at (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 fax the application to (866) 215-9159 or mail it to EDD #019, P.O. Box 1041, Atwood, CA 92811-1041.

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. The exception to this would be if you experienced a mid-year qualifying event. At the time you meet with a Retirement Specialist at the SBCERA, you will be instructed to contact EBSD for an appointment to discuss your medical and dental enrollment options.

APPEAL PROCEDURE

General Information

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. EBSD, if requested to do so, will act as an advocate and will assist to ensure that the appeal receives due consideration.

Timeframes

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

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

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

Notification

Notice of the appeal decision will include the following:

1. The EBSD Appeal Unit's decision;
2. The specific reason(s) for the appeal determination;
3. A reference to the specific Plan provision(s) on which the determination is based;
4. A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on when adverse determination has been made;
5. With the exception of appeals processed without the necessary information as described above, a statement outlining the second appeal process will be included in the letter. If the appellant disagrees with the EBSD Appeal Unit's decision and there is additional information that was not included in the first appeal which supports the position, a second appeal can be made to the attention of the EBSD Benefits Chief, whose decision will be final. Such appeals must be received within 15 calendar days of the first appeal decision notice.

Please contact EBSD with questions or concerns about the Appeals Process by calling (909) 387-5787.

Patient Protection and Affordable Care Act (PPACA)

~ *Required Notices* ~

Grandfathered Health Plans

The County of San Bernardino believes all of its medical insurance plans are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your medical plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Human Resources-Employee Benefits and Services.

The Women’s Health and Cancer Rights Act (WHCRA) of 1998 **Annual Notice**

As required by the Women’s Health and Cancer Rights Act (WHRA) of 1998, the medical plans provide coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

For more information regarding the above notices, contact the plan administrator, Human Resources-Employee Benefits and Services at (909) 387-5787.



Discrimination and Harassment in Employment are Prohibited by Law

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

- **Race**
- **Color**
- **Religion**
- **Sex** (includes pregnancy, childbirth, and related medical conditions)
- **Gender, gender identity, and gender expression**
- **Sexual orientation**
- **Marital status**
- **National origin** (includes language use restrictions)
- **Ancestry**
- **Disability** (mental and physical, including HIV and AIDS)
- **Medical condition** (cancer, or a record or history of cancer)
- **Genetic information**
- **Age** (40 and above)
- **Denial of family and medical care leave**
- **Denial of pregnancy disability leave or reasonable accommodation**

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

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

ployee or job applicant's religious beliefs and practices.

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

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

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

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

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

For more information contact (800) 884-1684; TTY (800) 700-2320; Videophone for the Deaf (916) 226-5285; contact.center@dfeh.ca.gov; or www.dfeh.ca.gov.

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

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

DFEH 162 (11/11)

Equal Employment Opportunity is THE LAW

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

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

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

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

DISABILITY

Title I and Title V of the Americans with Disabilities Act of 1990, as amended, protect qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship.

AGE

The Age Discrimination in Employment Act of 1967, as amended, protects applicants and employees 40 years of age or older from discrimination based on age in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment.

SEX (WAGES)

In addition to sex discrimination prohibited by Title VII of the Civil Rights Act, as amended, the Equal Pay Act of 1963, as amended, prohibits sex discrimination in the payment of wages to women and men performing substantially equal work, in jobs that require equal skill, effort, and responsibility, under similar working conditions, in the same establishment.

GENETICS

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

RETALIATION

All of these Federal laws prohibit covered entities from retaliating against a person who files a charge of discrimination, participates in a discrimination proceeding, or otherwise opposes an unlawful employment practice.

WHAT TO DO IF YOU BELIEVE DISCRIMINATION HAS OCCURRED

There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected:

The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Employers Holding Federal Contracts or Subcontracts

Applicants to and employees of companies with a Federal government contract or subcontract are protected under Federal law from discrimination on the following bases:

RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN

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

INDIVIDUALS WITH DISABILITIES

Section 503 of the Rehabilitation Act of 1973, as amended, protects qualified individuals from discrimination on the basis of disability in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. Disability discrimination includes not making reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, barring undue hardship. Section 503 also requires that Federal contractors take affirmative action to employ and advance in employment qualified individuals with disabilities at all levels of employment, including the executive level.

DISABLED, RECENTLY SEPARATED, OTHER PROTECTED, AND ARMED FORCES SERVICE MEDAL VETERANS

The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, prohibits job discrimination and requires affirmative action to employ and advance in employment disabled veterans, recently separated veterans (within

three years of discharge or release from active duty), other protected veterans (veterans who served during a war or in a campaign or expedition for which a campaign badge has been authorized), and Armed Forces service medal veterans (veterans who, while on active duty, participated in a U.S. military operation for which an Armed Forces service medal was awarded).

RETALIATION

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

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

The Office of Federal Contract Compliance Programs (OFCCP), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210, 1-800-397-6251 (toll-free) or (202) 693-1337 (TTY). OFCCP may also be contacted by e-mail at OFCCP-Public@dol.gov, or by calling an OFCCP regional or district office, listed in most telephone directories under U.S. Government, Department of Labor.

Programs or Activities Receiving Federal Financial Assistance

RACE, COLOR, NATIONAL ORIGIN, SEX

In addition to the protections of Title VII of the Civil Rights Act of 1964, as amended, Title VI of the Civil Rights Act of 1964, as amended, prohibits discrimination on the basis of race, color or national origin in programs or activities receiving Federal financial assistance. Employment discrimination is covered by Title VI if the primary objective of the financial assistance is provision of employment, or where employment discrimination causes or may cause discrimination in providing services under such programs. Title IX of the Education Amendments of 1972 prohibits employment discrimination on the basis of sex in educational programs or activities which receive Federal financial assistance.

INDIVIDUALS WITH DISABILITIES

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

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



“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. The CFRA prohibits us from denying, interfering with, or restraining your exercise of these rights.
- 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 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

Employer's Contact Person

(909) 387-5787

Telephone Number

Notice to Employees:



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

UI

Unemployment Insurance

(funded entirely by employers' taxes)

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

Internet

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

Telephone

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

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

Mail or Fax

File by mailing or faxing a UI Application (DE 11011), by accessing the paper application on-line at www.edd.ca.gov. Print out the application, hand write your answers, and mail or fax it to EDD for processing.

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

DI

Disability Insurance

(funded entirely by employees' contributions)

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

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

Claim Forms

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

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

PFL

Paid Family Leave

(funded entirely by employees' contributions)

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

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

Claim Forms

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

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

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

STATE GOVERNMENT EMPLOYEES SHOULD CALL 1-877-945-4747

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

NOTICE TO EMPLOYEES **UNEMPLOYMENT INSURANCE BENEFITS**

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

If you are:

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

You may be eligible to receive unemployment insurance benefits.

Employees of Educational Institutions:

Unemployment Insurance benefits based on wages earned while employed by a public or nonprofit 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 a public or nonprofit 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

Spanish 1-800-326-8937

Cantonese 1-800-547-3506

Mandarin 1-866-303-0706

Vietnamese 1-800-547-2058

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.

COUNTY OF SAN BERNARDINO
Medical Expense Reimbursement Plans
NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: August 1, 2009

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by the plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the County of San Bernardino's Medical Expense Reimbursement Plan(s). The plans covered by this notice may share health information with each other to carry out Treatment, Payment or Health Care Operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer.

How the Plan(s) may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as authorization) for purposes of health care Treatment, Payment activities, and/or Health Care Operations. Here are some examples of what this might entail:

- **Treatment**. While the Plan generally does not use or disclose your PHI to health care providers for treatment, the Plan is permitted to do so if necessary.
- **Payment**. The Plan may use or disclose your PHI to administer the Plan, which includes reimbursing you for eligible health care expenses for you and your dependents that are not reimbursed by insurance. The Plan may use your information to determine your eligibility for enrollment and for reimbursement and other services, including responding to complaints, appeals and external review requests.
- **Health Plan Operations**. For example, the Plan may use or disclose your PHI to perform its functions as a flexible spending account (FSA) plan. This may include: quality assessment and improvement activities, internal grievance resolution, fraud and abuse compliance programs, authorizing business associates to perform data aggregation services; and managing, planning or developing the Plan's business including conducting or arranging for legal, billing, auditing, compliance and other administrative support functions and/or services.
- **To Business Associates**. The Plan may disclose your PHI to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide you with information about other flexible spending account benefits and services that may be of interest to you.

COUNTY OF SAN BERNARDINO, Medical Expense Reimbursement Plans, Notice of Privacy

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How the Plan may share your health information with the County of San Bernardino

The Plan may disclose your health information without your written authorization to The County of San Bernardino for plan administration purposes. The County of San Bernardino may need your health information to administer benefits under the Plan. The County of San Bernardino agrees not to use or disclose your health information other than as permitted or required by the Plan document and by law. The staff of the Human Resources Department, Employee Benefits and Services Division (EBSD) are the only County employees who will have access to your health information for plan administration functions.

Please be aware that The County of San Bernardino cannot and will not use health information obtained from the Plan for any employment-related actions.

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' Compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonable able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonable believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public Health activities	Disclosures authorized by law to person who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you will be notified of the Plan's disclosure if informing you would not put you at further risk).
Judicial and Administrative Proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
Law Enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials

COUNTY OF SAN BERNARDINO, Medical Expense Reimbursement Plans, Notice of Privacy

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	about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HSS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can not revoke your authorization if the Plan has taken action pursuant to it. In other words, you can not revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

- **Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse.** You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

- **Right to receive confidential communications of your health information.** If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

- **Right to inspect and copy your health information.** With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

1. The access or copies you requested;
2. A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
3. A written statement that the time period for reviewing your request will be extended by no more than 30 days, along with the reasons for the delay and the date by which the Plan expects to address your request.

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The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

- **Right to amend your health information that is inaccurate or incomplete.** With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g. psychotherapy notes or information compiled for civil, criminal or administrative proceedings.)

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

1. Make the amendment as requested;
2. Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
3. Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

- **Right to receive an accounting of disclosure of your health information.** You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an “accounting of disclosures.” You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosure made:

1. For Treatment, Payment or Health Care Operations;
2. To you about your own health information;
3. Incidental to other permitted or required disclosures;
4. Where authorization was provided;
5. To family members or friends involved in your care (where disclosure is permitted without authorization);
6. For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstance; or
7. As part of a “limited data set” (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no

COUNTY OF SAN BERNARDINO, Medical Expense Reimbursement Plans, Notice of Privacy

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cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

- **Right to obtain a paper copy of this notice from the Plan upon request.** You have the right obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on August 1, 2009. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised Privacy Notice either electronically or on paper. If you receive this Notice electronically, you may also request a paper copy at no charge. This Notice is also posted on the County of San Bernardino, Human Resources Department website (http://www.sbcounty.gov/hr/Benefits_Home.aspx).

Our right to check your identity

For your protection, we may check your identity whenever you have questions about your specific enrollment Plan activities. We will check your identity whenever you submit requests to look at, copy or amend your records or to obtain a list of disclosures of your health information.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan or to the County of San Bernardino, Office of Compliance and Ethics at the addresses listed below. Alternatively you may complain to the Secretary of the U.S. Department of Health and Human Services, at the regional office that handles your area, generally within 180 days of when the act or omission occurred. You will not be retaliated against for filing a complaint.

<p>To file a complaint with the Plan as administered by the County Human Resources Department, contact:</p>	<p>To file a complaint with the County of San Bernardino, Office of Compliance and Ethics:</p>
<p>Benefits Chief, Department of Human Resources Employee Benefits and Services 157 W. Fifth Street, First Floor San Bernardino, CA 92415-0440</p>	<p>HIPAA Complaints Official 157 W. Fifth Street, First Floor San Bernardino, CA 92415-0440</p>
<p>Phone # (909) 387-5787 Fax # (909) 387-5566 Email: ebds@hr.sbcounty.gov</p>	<p>Phone # (909) 387-4500 Fax # (909) 387-8950 Email: HIPAAComplaints@cao.sbcounty.gov</p>

For more information on the Plan’s privacy policies or your rights under HIPAA, contact:

HIPAA Benefits Analyst
County of San Bernardino, Human Resources Department
Employee Benefits and Services
157 W. Fifth Street, First Floor
San Bernardino, CA 92415-0440

Phone # (909) 387-5787
Fax # (909) 387-5566

Plans that will follow this Notice include the following:

- County of San Bernardino, Medical Expense Reimbursement Plan
- County of San Bernardino, Exempt Medical Expense Reimbursement Plan

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

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

Benefits and Protections

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

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

Eligibility Requirements

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

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

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

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

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

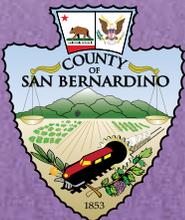


For additional information:
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U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division

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