Absence Management
Frequently Asked Questions

County of San Bernardino

Reporting Absences and Filing For Short Term Disability Benefits

It feels good to be prepared. That's why we've developed the following guide to help you report an absence with Standard Insurance Company. Please use the steps outlined below should you become disabled or need to file for a leave of absence from work. They will enable you to access our in-house Absence Management Service Center (AMSC), online or via telephone.

When Should I Report An Absence?

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

- Your own serious health condition (including pregnancy)
- To care for your newborn child
- The placement of your adopted or foster child
- To provide care for a qualifying family member with a serious health condition
- To care for a covered service member injured in the line of duty
- For qualifying military exigency, allowing family members to take leave to prepare for or deal with issues that arise as a result of a family member being called to serve in the military

How Do I Notify The Standard About An Absence?

- Call the AMSC at **844-239-3560**; or
- Report it online:
  - Go to **www.standard.com** and choose **I am an individual**
  - On the next page, select **Report an Absence**
  - The next page, select Log in to Report an Absence
  - You will be asked to provide the following information:
    Company ID: County of San Bernardino
    Username: This is your last name + the last 4 digits of your SSN
    Password: If this is your first time reporting an absence, you will enter the word "password" as your password. You will then be prompted to choose a personal password.

What Are The Absence Management Service Center Operation Hours?

The AMSC is available Monday through Friday, between 4 a.m. – 5 p.m. Pacific Time.

When I Call To Request Leave Or Report My Absence, What Questions Will I Be Asked?

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

- Employer Name: **County of San Bernardino**
- Last day you were at work or are expected to be at work
- Reason leave is requested
- If you are planning to file a short term disability claim, we will ask you to provide your Physician's contact information (name, address, phone, and fax number)

When Should I Report an Intermittent Absence?

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

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

How Do I Report an Intermittent Absence?

When you miss time associated with an approved, open intermittent leave, you can quickly and easily report absences through The Standard's self-service phone system. When you call us, say "report an absence" when asked, and you can report your time off without needing to speak to a representative. This service is available any time of day or night.

To use the system you will need to provide:

- Your leave number. Your leave number is found on correspondence we sent you after we approved your intermittent leave.
- Your date of birth.
- The date of the absence. You may report multiple absences during one call. Dates can be today, or in the past or future, however each absence will be a separate entry during the same call.
- The type of absence. You will need to let the system know if your absence is related for your condition or is to attend a medical appointment.
- The number of hours you were scheduled to work, and the number of hours of leave taken, for each day you are reporting.
- A number where you can be reached. You will be asked to provide a call back number if we need to contact you for further information.

Once the automated intake is complete, you will receive a confirmation number to let you know that your absence report has been successfully submitted.

Don't forget to notify your manager and follow your department's usual call-in procedures.

Who Is Responsible For Notifying County of San Bernardino Of My Absence?

It is your responsibility to follow your department's usual call-in procedures.

Will I Receive Any Notification After I Initiate A Leave Or Claim?

After initiating a request for time off under Family Medical Leave and/or claim for Short Term Disability (STD), The Standard will send you a letter confirming receipt of your leave request. If you are filing for an STD claim, The Standard will fax an Attending Physician's Statement[2] to your physician to complete; an Authorization to Obtain Information will be mailed to you to sign and return. If you called to request a leave but did not initiate an STD claim, you will receive a Certification of Health Care Provider form. These forms should be returned to The Standard by the due date indicated in your letter. You will also receive letter about "Your Benefits While on Medical Leave of Absence", including "Continuation of Benefits Designation" form from the County. You are expected to read the information and return the Benefits Designation form to the County.

Where Do I Send The Completed Forms?

If you are required to submit paperwork, please send the completed forms to:

Standard Insurance Company
Employee Benefits Division
PO Box 3877
Portland OR 97208

Or you may fax completed forms to 866.751.5174.

How Long Does It Normally Take For An STD Claim Decision?

It will take approximately one week to make a claim decision (once your completed claim application is received). If we have not made a decision within one week, you will be notified as to why.

If My Claim For Short Term Disability Benefits Is Approved, How Long Will It Take To Receive My First Check?

After the Benefit Waiting Period of 7 days has been served and your STD claim has been approved, STD benefit payments are paid in arrears on a weekly basis. In most cases, checks are mailed on Wednesday of each week. STD benefit payments that are payable for retroactive claims will be mailed following claim approval. STD checks will be mailed directly to your home address listed in EMACS system.

Can I Receive My Benefit Payment via Direct Deposit?

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

Will FICA Taxes Be Deducted From My Benefit Payment?

FICA tax is composed of two parts, Social Security and Medicare. As a County employee, you will not contribute to Social Security tax, however, Medicare will be withheld under the following three circumstances:

1. During the first six complete calendar months after the individual ceases work due to disability.
2. During disability when the claimant returns to work with the policyholder.
3. During the first six complete calendar months after the employee ceases work again.

More Questions?

Call The Standard's Absence Management Service Center at **844-239-3560**.

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

LEAVE REQUEST FOR EXTENDED SICK AND SPECIAL LEAVE

Employees must contact The Standard no later than the 4th day of leave to initiate the leave process.[1]

Must print in Black or Blue ink ONLY — *Check box if applying for* **STD** ☐

Employee ID	Rcd No.	Last Name, First Name

Job Title	Department	Department ID

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

Home Address	City	State	Zip Code
Mailing Address (if different than Home)	**City**	**State**	**Zip Code**

Telephone Numbers:	Home	Work	Alternate

Type of Request

- ☐ New
- ☐ Continuation
- ☐ Revision

Reasons for Leave

- ☐ Own serious health condition (non-work related)
- ☐ Occupational injury/illness
- ☐ Indicate due date if pregnant :
- ☐ Care for child/spouse/domestic partner/parent for a serious health condition[2]
- ☐ Birth, placement or adoption of a child's other parent is a county employee, indicate name and employee ID:
- ☐ Care for other family member, including legal guardianship, for serious health condition
- ☐ Military leave, educational leave, or other leave not specified above

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

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

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

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

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

[4] Required for Leave WIth/Without Right to Return, Medical Leave of Absence, educational leave

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

Office Use Only

Payroll Specialist Name		Approved	Approved Pending Cert.	
Mail Code	**Reviewed By**	**Date**	**Keyed By**	**Date**

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

LEAVE INTEGRATION REQUEST

(STD, SDI and WORKERS' COMPENSATION)

Clear Form Fields

Notice: This form must immediately be submitted for processing based on the distribution choice below.
Integration choice will begin based on the date this form is received.
NO FUTURE OR RETRO PROCESSING WILL BE MADE

Must print in Black or Blue ink ONLY

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

Type of Request	Type of Integration	Type of Benefit Payments	Department Name
☐ New Request	☐ Full	☐ Short Term Disability (STD)	
☐ Revised	☐ No Integration	☐ Workers' Compensation	
Date of Injury/ Start of Leave	☐ Partial Integration - List number of hours per **pay period:** _____	☐ State Disability Insurance (SDI)	**Union Code**

Requested Order of Use

Default Order of Use - Check box if requesting to use leave in the order listed.
Requested Order of Use - Check box if requesting an order other than default, enter the requested order of leave to be used.
Sick Only - Check box if requesting to use sick leave only.
Note: Leaves will be used until exhausted, then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

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

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

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

Employee Signature *	Telephone	Date

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

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

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

Leave Integration Guidelines

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

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

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

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

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

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

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

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

PRELIMINARY FMLA DESIGNATION NOTIFICATION

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

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

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

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

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

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

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

Employment Development Department
State of California

Request for State Income Tax Withholding From Sick Pay

► **File this form with the payer of your sick pay.**

Type or Print Your Full Name | Your Social Security Number

Home Address (Number and Street or Rural Route)

City or Town, State, and ZIP Code

Claim or Identification Number (If Any) . . . . . .

I request income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment . . . . . **$**

Employee's Signature ► | Date ►

---------- Detach along this line. Give the top part of this form to the payer; keep the lower part for your records. ----------

General Instructions

The Information Practices Act Notice: Information collected is for the purpose of administering the Personal Income Tax law under the authority of Section 13028.6 of the California Unemployment Insurance Code and Section 4328.6-1 of Title 22, California Code of Regulations.

Purpose of Form: To request state income tax withholding from sick pay. File this form ONLY if the sick pay is received from a third party, such as an insurance company or trust. You do not have to file this form if you receive sick pay from your employer as you have previously submitted a withholding form.

You may not want to use the DE 4S form if you already have all your tax liability covered by estimated tax payments or other withholding.

Definition: Sick pay is a payment you receive:

(a) Under a plan your employer takes part in.

(b) In place of wages for any period when you are temporarily absent from work because of sickness or injury.

Amount to Be Withheld: Enter on this form the amount you want withheld from each payment. You can use the worksheet accompanying the state *Employee's Withholding Allowance Certificate* (DE 4) to estimate the amount of income tax you want withheld from each sick pay payment.

Sign This Form: The DE 4S is not valid unless you sign it.

Statement of Income Tax Withheld: After the end of the year, you will receive a Wage and Tax Statement (Form W-2) reporting the taxable sick pay paid and income tax withheld during the prior year. These amounts may be included on your Form W-2 with your other wages and withholding.

Changing Your Withholding: The DE 4S remains in effect until you change or cancel it. You can do this by giving a new DE 4S or a written notice to the payer of your sick pay.

Form **W-4S**

Department of the Treasury
Internal Revenue Service

Request for Federal Income Tax Withholding From Sick Pay

▶ **Give this form to the third-party payer of your sick pay.**

▶ **Go to *www.irs.gov/FormW4S* for the latest information.**

OMB No. 1545-0074

2019

Type or print your first name and middle initial	Last name	Your social security number

Home address (number and street or rural route)

City or town, state, and ZIP code

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

Employee's signature ▶ Date ▶

Separate here and give the top part of this form to the payer. Keep the lower part for your records.

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

1	Enter amount of adjusted gross income that you expect in 2019	**1**		
2	If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. See Pub. 505 for details. If you don't plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional standard deductions for age and blindness.) **Note:** There is no deduction for personal exemptions for 2019	**2**		
3	Subtract line 2 from line 1	**3**		
4	Tax. Figure your tax on line 3 by using the **2019** Tax Rate Schedule X, Y-1, Y-2, or Z on page 2. **Do not** use any tax tables, worksheets, or schedules in the 2018 Form 1040 instructions	**4**		
5	Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.) .	**5**		
6	Subtract line 5 from line 4	**6**		
7	Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2019 or paid or to be paid with 2019 estimated tax payments	**7**		
8	Subtract line 7 from line 6	**8**		
9	Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	**9**		
10	Divide line 8 by line 9. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under *Amount to be withheld* below. If it does, enter this amount on Form W-4S above	**10**		

General Instructions

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

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

Definition. Sick pay is a payment that you receive:

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

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

- Must be in whole dollars (for example, $35, not $34.50).
- Must be at least $4 per day, $20 per week, or $88 per month based on your payroll period.
- Must not reduce the net amount of each sick pay payment that you receive to less than $10.

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

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

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

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

(continued on back)

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

Specific Instructions for Worksheet

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

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

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

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

Line 2—Deductions

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

Standard deduction. For 2019, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying widow(er)	$24,400*
Head of household	$18,350*
Single or Married filing separately	$12,200*

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

Additional standard deduction for the elderly or blind. An additional standard deduction of $1,300 is allowed for a married individual (filing jointly or separately) or qualifying widow(er) who is 65 or older or blind, $2,600 if 65 or older **and** blind. If both spouses are 65 or older or blind, an additional $2,600 is allowed on a joint return ($2,600 on a separate return if your spouse is your dependent). If both spouses are 65 or older **and** blind, an additional $5,200 is allowed on a joint return ($5,200 on a separate return if your spouse is your dependent). An additional $1,650 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, $3,300 if 65 or older **and** blind. See Pub. 505, Worksheet 2-4.

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

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

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

Line 5—Credits

Include on this line any tax credits that you're entitled to claim, such as the child tax and higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled. See Pub. 505, Table 1-2, for credits.

Line 7—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2019 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

2019 Tax Rate Schedules

Schedule X—Single

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$9,700	**$0 + 10%**	**$0**
9,700	39,475	**970.00 + 12%**	**9,700**
39,475	84,200	**4,543.00 + 22%**	**39,475**
84,200	160,725	**14,382.50 + 24%**	**84,200**
160,725	204,100	**32,748.50 + 32%**	**160,725**
204,100	510,300	**46,628.50 + 35%**	**204,100**
510,300	and greater	**153,798.50 + 37%**	**510,300**

Schedule Z—Head of household

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$13,850	**$0 + 10%**	**$0**
13,850	52,850	**1,385 + 12%**	**13,850**
52,850	84,200	**6,065 + 22%**	**52,850**
84,200	160,700	**12,962 + 24%**	**84,200**
160,700	204,100	**31,322 + 32%**	**160,700**
204,100	510,300	**45,210 + 35%**	**204,100**
510,300	and greater	**152,380 + 37%**	**510,300**

Schedule Y-1—Married filing jointly or Qualifying widow(er)

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$19,400	**$0 + 10%**	**$0**
19,400	78,950	**1,940 + 12%**	**19,400**
78,950	168,400	**9,086 + 22%**	**78,950**
168,400	321,450	**28,765 + 24%**	**168,400**
321,450	408,200	**65,497 + 32%**	**321,450**
408,200	612,350	**93,257 + 35%**	**408,200**
612,350	and greater	**164,709.50 + 37%**	**612,350**

Schedule Y-2—Married filing separately

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$9,700	**$0 + 10%**	**$0**
9,700	39,475	**970.00 + 12%**	**9,700**
39,475	84,200	**4,543.00 + 22%**	**39,475**
84,200	160,725	**14,382.50 + 24%**	**84,200**
160,725	204,100	**32,748.50 + 32%**	**160,725**
204,100	306,175	**46,628.50 + 35%**	**204,100**
306,175	and greater	**82,354.75 + 37%**	**306,175**

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

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

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

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

157 W. 5th Street, San Bernardino, CA 92415 | Phone: 909.387.5787 Fax: 909.387.6075
www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources Department

Diane Rundles
Director

Mark DeBoer
Assistant Director

Dear County Employee:

SUBJECT: Your Benefits While on Medical Leave of Absence

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

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

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

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

Or

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

Or

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

Or

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

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

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

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

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

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

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

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

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

CONTINUATION OF BENEFITS DESIGNATION

Employee ID	Rcd No.	Last Name, First Name

Department	Contact Email	Department ID	Telephone

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

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

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

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

Benefit	Option		
	I **DO** want to continue this benefit and will pay for the applicable portion of the premium to continue the benefit	I do **NOT** want to continue this benefit, terminate my coverage immediately	***FMLA Only***: I want to **CHANGE** my benefit coverage level (drop dependent(s))
Medical	☐	☐	☐
Dental	☐	☐	☐
Vision	☐	☐	☐

Benefit Elections
(Unpaid Status/Under Minimum Hours Requirement)

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

Employee Signature	Date

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

Rev. 11/03/2014