

# Ready, Set, Enroll 2019

## Employee Benefit Guide



Superior Court of California, County of San Bernardino

**Benefits In Balance**

# 2019 Employee Benefits Guide

## Open Enrollment Tips

- Review the What's New & Different For Plan Year 2019
- Use the open enrollment benefits checklist
- Checkout the new benefit tool - Ask Alex
- Enroll or make changes using the Phoenix ESS online Open Enrollment option
- Select the right coverage level. Review the medical and dental plan highlights and comparison charts and life insurance information
- Enroll or re-enroll in the Flexible Spending Accounts (FSA) Health Care and/or Dependent Care
- A benefits calculator can be found on the Court's internet and intranet sites to assist with determining your out of pocket cost on premiums

Detailed benefit plan information and more can be found in this Guide or on the Court's Intranet site under Employee - Employee Benefits

**Open Enrollment is November 5 through November 20, 2018**

## Open Enrollment Benefits Checklist

- Read your Employee Benefit Guide
- Attend a benefit fair to get your questions answered
- Think about your needs and if you expect those needs to change in the year ahead
- Utilize Ask Alex
- Review and if necessary update your personal contact information in Phoenix ESS
- Review and if necessary add or update your beneficiaries and dependents in Phoenix ESS
- You must enroll or re-enroll in the Flexible Spending Account Health Care and/or Dependent Care if you wish to participate next year
- Print out a copy of your submitted selections for 2019 for your records
- Provide to the Human Resources Department required documentation, if adding any new eligible dependents

**You are encouraged to reference this guide throughout the year.**

## What's New & Different in 2019

The following is a quick summary of significant changes:



- 1. Why not Ask Alex?** - Use the new interactive digital benefit educational tool to assist you in making the best decisions based upon your individual circumstances. Alex is a tool that will guide you in the decision making process by asking a series of general questions to determine which plans will meet your needs. There are also characters that make this experience engaging. Check it out on the Court's Intranet Site: Employee>Human Resources>Employee Benefits>Ask Alex.
- 2. Blue Shield Medical Plans** - Blue Shield of California will begin pro-rating cost sharing for partial fill prescriptions for Schedule II controlled substances per AB 1048.
  - **Access+ HMO physician home visit** copay will decrease to \$10 per visit from \$25 per visit.
  - **Trio HMO+ specialist care office visit (self-referral) within the same medical group/ IPA as your PCP** for certain situations will decrease to \$10 per visit from \$20 per visit and the **physician home visit copy** will decrease to \$10 per visit from \$25 per visit.
- 3. Medical subsidy amounts are increasing!** - Please refer to your Memorandum of Understanding (MOU) or Compensation Plan.
- 4. No Changes? No Problem!** - You will not be required to use the Phoenix ESS online enrollment system if you are not making any changes to your medical, dental, vision, life insurance and/or accidental death & dismemberment (AD&D) insurances this year.
- 5. Physician Pre-Designation** - If you have previously submitted a Physician Pre-Designation form for treatment of a worker's compensation injury or illness, making a change of medical providers or plans during open enrollment may impact your choice and you may need to file a new form.
- 6. Flexible Spending Accounts (FSA)** - **You will need to enroll or re-enroll if you want to participate in the Flexible Spending Accounts (FSA) Health Care and/or Dependent Care plans in 2019.**

## Important Dates

IMPORTANT DATES	ACTION
November 5, 2018	Open Enrollment Begins
November 20, 2018	Open Enrollment Ends
December 14, 2018	Required Documentation Due to Human Resources
January 1, 2019	Effective Date of New Benefit Plan Year
January 1, 2019	FSA - Health Care/Dependent Care Plan Year Begins

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## You Have The Power To Choose

### Are You Ready?



#### IMPORTANT:

Please make your benefit selections carefully during this open enrollment. The next opportunity to make changes will be in late 2019, for an effective date of January 1, 2020, unless you experience a mid-year qualifying Change-in Status Event.

This Benefits Guide provides an overview of some of the benefit plans offered by the Superior Court of California, County of San Bernardino. Not all of the plan provisions, limitations and exclusions are described. You must consult each plan’s legal documents, insurance contracts or Evidence of Coverage booklets for a complete description of the benefits, limitations and exclusions. In the event of any difference between this Benefits Guide and the official plan documents, the provisions of the plan documents will govern. We encourage you to keep this guide as a reference throughout the year.

# Welcome to Benefits In Balance 2019

The Superior Court of California, County of San Bernardino offers eligible employees a comprehensive benefits program designed to help keep your life in balance. “Benefits In Balance” includes a variety of quality plans and coverage options to promote your good health, peace of mind and financial security.

This Guide is designed to help you understand your benefit enrollment choices for the 2019 plan year which will become effective January 1, 2019. Included you will find plan highlights, comparison charts for convenient at-a-glance referencing, and a directory of key contacts whom you may contact for more information. Please read your materials and choose the plan(s) that best meet your needs.

You are encouraged to use this Guide as a reference throughout the year. If you have questions, contact the Human Resources Department.

Choosing a health coverage option is an important decision. To help you make an informed selection, the insurance carriers make available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format.

The SBC's are available on the Court's intranet site. A paper copy is also available at no cost by calling Human Resources at 909.521.3700.

## 2019 Bi-Weekly Premium Rate Table

Coverage Effective January 1, 2019

MEDICAL	BLUE SHIELD HMO	BLUE SHIELD TRIO	BLUE SHIELD PPO	KAISER HMO	DENTAL	DELTACARE (DHMO) PLAN	DELTA DENTAL (DPPO) PLAN	EYEMED VISION (GENERAL EMPLOYEES)	
Employee	\$332.22	\$279.22	\$750.58	\$269.72	Employee	\$7.05	\$22.88	Employee	Court Paid
Employee +1	\$664.46	\$558.45	\$1,501.17	\$539.43	Employee +1	\$13.45	\$40.90	Employee + Spouse	\$5.74
Employee +2 or more	\$936.51	\$787.09	\$2,115.79	\$763.30	Employee +2 or more	\$20.94	\$67.82	Employee + Child(ren)	\$6.45
								Employee + Family	\$10.61

Note: These bi-weekly premiums do not include any medical/dental premium subsidies and/or benefit plan dollars you may be eligible for.



### IMPORTANT DISCLAIMER!

**Not all of the plan provisions, limitations and exclusions are described in this Guide. You must consult each plan's legal documents, insurance contracts or Evidence of Coverage booklets for a complete description of the benefits, limitations and exclusions. Telephone numbers and websites are listed on the back cover of this Guide. Plan documents can be viewed on the Court's intranet or by contacting Human Resources.**

### Benefits Calculator Available Online

The benefits calculator can help you determine how much bi-weekly out-of-pocket expense you will have and is available for use on the Human Resources intranet page. You can also access this calculator through the internet at [www.sb-court.org/Portals10/Documents/PDF/Human%20Resources/BenefitsCalculator2019.xls](http://www.sb-court.org/Portals10/Documents/PDF/Human%20Resources/BenefitsCalculator2019.xls).

## Eligibility & Enrollment

### Who Is Eligible?

#### Employee Eligibility

To be eligible for the benefits listed in this Guide, you must be an employee in a regular position with a minimum of forty (40) hours worked per pay period (or be on an approved leave pursuant to applicable law or MOU), and the benefit must be offered to you through a Memorandum of Understanding (MOU) or a Compensation Plan.

#### Dependent Eligibility

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

- Your legal spouse as recognized under applicable state law
- State Registered Domestic Partner
- Children\* to age 26
- Children of any age who are supported primarily by you and incapable of self-sustaining employment by reason of mental or physical disability, subject to carrier approval

\* 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 the birth of the grandchild. Coverage for the grandchild may continue as long as the dependent child is covered.)

Other benefit plans do not allow for coverage of grandchildren. Please consult with the applicable Evidence of Coverage or contact the benefit plan vendor directly for clarification before you submit your enrollment.

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 and spouse as parents)
- Photocopy of court documents for:
  - \*Adoption
  - \*Placement
  - \*Custody
  - \*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 ineligible. Send required documentation to Human Resources at 247 W. Third St., First Floor, San Bernardino, CA 92415-0312. You can also send the information to confidential fax 909.521.3644.



## Over Age Dependent (OAD)

DEPENDENT RELATIONSHIP TO SUBSCRIBER	BLUE SHIELD	KAISER	DELTA DENTAL HMO AND PPO	EYEMED VISION
<p>Disabled Dependent over the age of 26</p> <p>Defined as: Unmarried, dependent child who is primarily dependent upon the insured for support due to mental incapacity or physical handicap and if a Physician's written certification is submitted annually for as long as disability continues.</p>	<p><b>New Hires:</b> May enroll a disabled dependent within 60 days of hire.</p> <p>Subject to receipt and approval of Physician's certification</p>	<p><b>New Hires:</b> May enroll a disabled dependent within 60 days of hire.</p> <p>Subject to receipt and approval of Physician's certification</p>	<p><b>New Hires:</b> May enroll a disabled dependent within 60 days of hire.</p> <p>Subject to receipt and approval of Physician's certification</p>	<p><b>New Hires:</b> May enroll a disabled dependent within 60 days of hire.</p> <p>Subject to receipt and approval of Physician's certification</p>
	<p><b>Continued Enrollment:</b> Disabled dependents must be enrolled in the plan upon attaining the age of 26 in order to continue enrollment. If the disabled dependent discontinues enrollment at any time after attaining age 26, they will not be allowed to re-enroll for coverage (e.g. there must be no break in coverage).</p>	<p><b>Continued Enrollment:</b> No prior enrollment</p> <p>Subject to receipt and approval of Physician's certification.</p>	<p><b>Continued Enrollment:</b> Disabled dependents must be enrolled in the plan upon attaining the age of 26 in order to continue enrollment. If the disabled dependent discontinues enrollment at any time after attaining age 26, they will not be allowed to re-enroll for coverage (e.g. there must be no break in coverage).</p>	<p><b>Continued Enrollment:</b> Disabled dependents must be enrolled in the plan upon attaining the age of 26 in order to continue enrollment. If the disabled dependent discontinues enrollment at any time after attaining age 26, they will not be allowed to re-enroll for coverage (e.g. there must be no break in coverage).</p>

### About Enrollment

As a condition of Court employment, if you are an eligible employee, you must enroll in a Court-sponsored medical plan unless you have other employer-sponsored group medical. Enrollment in a Marketplace plan (e.g. Covered California) will also fulfill this requirement. Verification of other group coverage is required. The Court helps you pay for your medical and dental insurance by making payments directly to the carriers. These amounts, known as medical and dental subsidies, vary depending upon family size enrolled, plan selection, and the number of hours you work. For specific amounts, refer to the appropriate MOU or Compensation Plan. Premiums for Court-sponsored plans will be deducted from your paycheck.

If you are an active employee, enrolled in a Court-sponsored medical plan, and reach age 65, you will have the option of remaining on the Court-sponsored plan and delay enrolling in Medicare Parts A and B until you retire.

#### Opt-Out

If you have other employer-sponsored group health insurance that offers coverage comparable to a Court-sponsored plan, or are covered by a Marketplace plan or are covered by another Court employee, you may elect to Opt-Out of the Court-sponsored medical insurance.

If you are newly Opting-Out during this annual Open Enrollment, you must provide proof of group insurance to Human Resources. If you fail to provide the required documentation by 5:00 p.m., December 14, 2018, you will be automatically re-enrolled in your previous coverage, if available or the Blue Shield HMO option.

New employees and employees making mid-year changes must complete the Benefit Waiver form and submit it to Human Resources within sixty (60) days of the Qualifying Event.

#### 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, dental, and/or vision (based upon your MOU or Compensation Plan.) Human Resources must physically receive your enrollment information and supporting documentation within that sixty (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 Blue Shield HMO medical plan only 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 Internal Revenue Code (IRC) Change-in-Status Event.

### Medical and Dental Plan ID Cards

If enrolling for the first time in a plan within a month of the effective date of your coverage, you should receive identification (ID) cards from your medical and/or dental plans. You may begin using your medical, dental, or vision benefits before receiving your ID card on or after your coverage effective date. If you do not receive your ID card(s), or if you need replacement card(s), please refer to the back cover under “For More Information.” Dental ID cards are not required for services.

### Mid-Year Change-in-Status Events

The enrollment options you elect during the 2019 Open Enrollment period will remain in effect for the entire Plan Year. You will have to wait until the next Open Enrollment period to make changes **UNLESS** you experience an IRC Change-in-Status Event.

Your request to make a mid-year change must:

- Be consistent with the qualifying event.
- Meet the guidelines of Court contracts/agreements, plan documents and Internal Revenue Code Section 125.
- Be received by Human Resources within sixty (60) days of the qualifying event. *Submit your mid-year change paperwork within the 60 day time frame, even if you are waiting to receive official documents (e.g. birth certificate, marriage certificate).*

To view a summary of the most common Section 125 mid-year Change-in-Status events, please refer to the Section 125 Change-in-Status Matrix on the following pages.

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

1. Complete the applicable medical, dental, and/or vision form(s) available from Human Resources.
2. Complete a Premium Deduction Election form available from Human Resources.
3. If the Change-in-Status Event makes you eligible to Opt-Out of your Court-sponsored medical plan, complete the “Benefit Waiver” form available from Human Resources.
4. Attach documentation that verifies the reason for the mid-year change. Examples of acceptable documentation are:
  - \* Copies of birth, death, marriage, or State-Registered Domestic Partner certificates or equivalent out-of-state certificate.
  - \* Copies of court papers for divorce or adoption

- \* Copy of letter from employer verifying loss or gain of spouse's employment which results in a change of eligibility for medical, dental, and/or vision benefits.
- \* Verification of other employer-sponsored group health coverage if Opting-Out. Verification must show the coverage effective date.

### Effective Date of Mid-Year Changes

All elections made during the Plan Year shall become effective the first pay period that follows the date of receipt of proper conditions of coverage, including limitations and exclusions, please refer to your Plan Summaries, Evidence of Coverage booklets, and/or Plan Documents.

**FOR NEWBORN CHILDREN:** Newborn children must be enrolled in Court plan coverage to receive benefits under the plan. Failure to enroll your newborn in a Court plan will result in your newborn not having coverage from date/time of birth forward. Please note, should this occur you will be liable for any services and/or expenses incurred.

To enroll your newborn, submit completed mid-year change paperwork to Human Resources within 60 days of the newborn's date of birth. Please note pursuant to IRS regulations and the Court's plan document, newborn coverage is made effective the first pay period following the newborn's date of birth. You are encouraged to submit paperwork as soon as possible to avoid incurring multiple premiums as a result of retroactive coverage. Remember to submit your mid-year change paperwork within the 60 day timeframe even if you are waiting to receive the newborn's official birth certificate.

**Blue Shield Members:** The newborn will be assigned under the medical group to which the mother (parent) is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

**Kaiser Members:** The newborn will automatically be covered for 31 days from the date of birth.

If you need assistance or have questions regarding mid-year change paperwork to enroll a newborn, please contact your Human Resources Assistant.

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, the Court's Section 125 Premium Conversion Plan and the terms of the Group Benefit Plans. You will be charged 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.

**IRC Section 125 Premium Conversion Plan**

This plan allows employees to pay for their share of eligible benefit plan premiums before taxes are calculated. 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 taxes are calculated and the employee will be subject to all plan requirements and restrictions.

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

- Medical
- Dental
- Vision
- Accidental Death & Dismemberment (AD&D)
- Life Insurance

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.

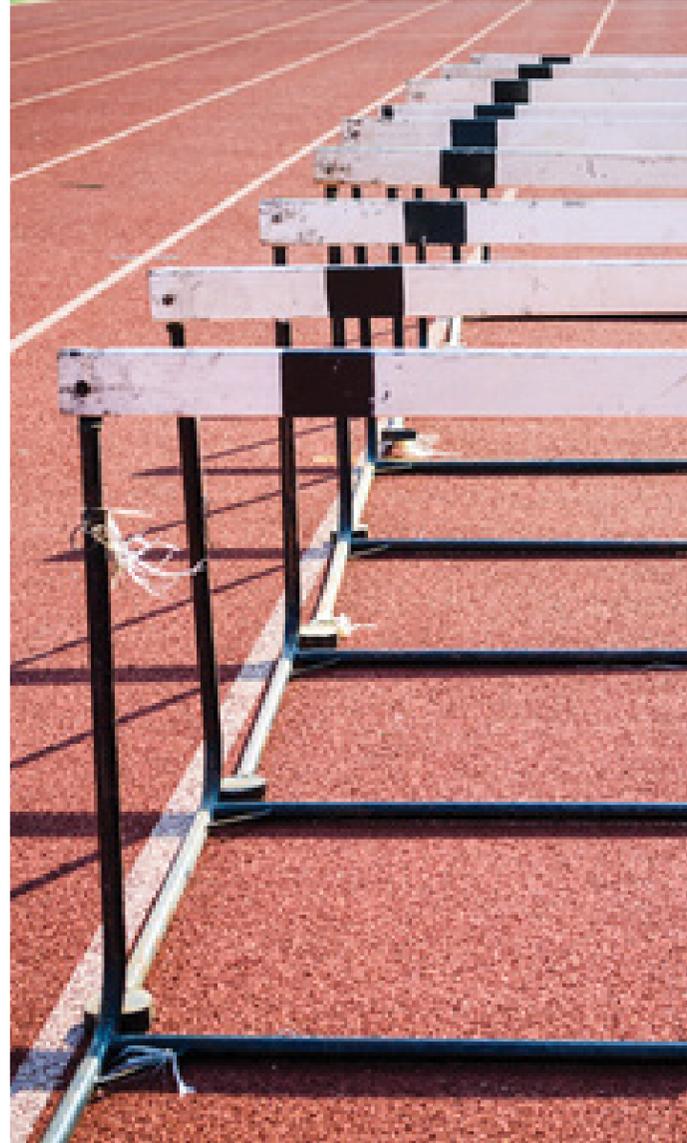
**Before-Tax**

This option is especially attractive as it can result in greater take home pay. It does, however, limit your mid-year changes to the Change-in-Status Events as specified in IRC Section 125 and the Court's Section 125 Premium Conversion Plan. Please note that Registered Domestic Partner coverage cost can only be offered on an after-tax basis.

**After-Tax**

This option can result in less take home pay. Changes during the Plan Year are still limited to those allowed by the Court's contract, agreements, and the terms of the Group Benefit Plans.

You must notify Human Resources of your choice to deduct eligible insurance premiums from your paycheck either before or after taxes are calculated. Plan elections are irrevocable for the Plan Year unless you have an IRC Change-in-Status Event. If you are making your election as a result of Change-in-Status Event, you must submit a completed Premium Deduction Election form within sixty (60) days of the applicable IRC qualifying event for medical, dental, and vision, and within thirty-one (31) days for AD&D and Life Insurance. If these time requirements are not satisfied, Human Resources cannot process your change.



IRC SECTION 125 CHANGE-IN-STATUS EVENT MATRIX			
QUALIFYING CHANGE-IN-STATUS EVENT	MID-YEAR CHANGE		DOCUMENTATION REQUIRED
	MEDICAL/DENTAL/VISION	FSA-HC	
Gain of Dependent <ul style="list-style-type: none"> <li>• Marriage</li> <li>• Birth/Adoption/Placement for Adoption</li> </ul>	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 – HC election amount, you must submit the following forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>• Premium Deduction Election Form</li> <li>• Health Care (FSA) Plan Enrollment Form*</li> <li>• Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>• Marriage Certificate and Birth Certificate(s) or hospital printout of birth</li> </ul>
Loss of Dependent <ul style="list-style-type: none"> <li>• Divorce or annulment</li> <li>• Death</li> </ul>	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-HC election amount, you must submit the following forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>• Premium Deduction Election Form</li> <li>• Health Care (FSA) Plan Enrollment Form*</li> <li>• Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>• Divorce, legal separation, or annulment</li> <li>• Death Certificate</li> <li>• Marriage/Birth Certificate(s)</li> </ul>
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 forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>• Premium Deduction Election Form</li> <li>• Health Care (FSA) Plan Enrollment Form*</li> <li>• Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>• Judgment, decree or order</li> <li>• Birth Certificate(s)</li> </ul>
Gain of coverage through spouse/registered domestic partner's employer or other change-in status that results in eligibility under spouses/registered domestic partner'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 – HC election amount, you must submit the following forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>• Premium Deduction Election Form</li> <li>• Health Care (FSA) Plan Enrollment Form*</li> <li>• Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>• Proof of spouse/registered domestic partner's employer-sponsored coverage that includes the effective date</li> <li>• Benefit Waiver form</li> </ul>
Loss of spouse's/registered domestic partner'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–HC election amount, you must submit the following forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>• Premium Deduction Election Form</li> <li>• Health Care (FSA) Plan Enrollment Form*</li> <li>• Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>• Proof of spouse's/registered domestic partner's employment and benefit plan loss that includes loss of coverage effective date</li> <li>• Marriage/Birth Certificate(s)</li> </ul>

\*within 30 days of the event

IRC SECTION 125 CHANGE-IN-STATUS EVENT MATRIX			
QUALIFYING CHANGE-IN-STATUS EVENT	MID-YEAR CHANGE		DOCUMENTATION REQUIRED
	MEDICAL/DENTAL/VISION	FSA-HC	
Change in Employment Status (i.e. part-time to full-time status)	Employee may elect to enroll self and dependent(s) 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-HC annual election amount you must submit the following forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Health Care (FSA) Plan Enrollment Form*</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>Proof of Employment Status change</li> <li>Marriage/Birth Certificate(s)</li> </ul>
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 forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Health Care (FSA) Plan Enrollment Form*</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>Proof of loss of eligibility (FSA only)</li> </ul>
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 you must submit the following forms (within 60 days of event), except as noted: <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Health Care (FSA) Plan Enrollment Form</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form(s) or Benefit Waiver form</li> <li>Marriage/Birth Certificate(s) (enroll only)</li> </ul>
Residence change results in gain or loss of eligibility	Employee may enroll or remove dependent(s)	No change is permissible	To remove dependent(s) from health benefits, you must submit the following forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form(s)</li> <li>Proof of residence change</li> <li>Marriage/Birth Certificate(s) (enroll only)</li> </ul>
Self or dependent becomes entitled or loses eligibility for Medicare or Medicaid	Employee may enroll or opt-out or enroll or remove dependent(s)	No change is permissible	To opt-out (self) or enroll/remove dependents from health benefits you must submit the following forms (within 60 days of event): <ul style="list-style-type: none"> <li>Premium Deduction Election Form</li> <li>Medical/Dental/Vision Plan Enrollment-Change Form(s) or Benefit Waiver form</li> <li>Proof of gain/loss of Medicare or Medicaid</li> <li>Marriage/Birth Certificate(s)</li> <li>Benefit Waiver form</li> </ul>

\*within 30 days of event

**Marketplace Coverage**

Employees may elect to prospectively commence or terminate the medical coverage if contributions are taken before-tax (dental, vision, and FSA coverage excluded) offered through the Court based upon the individual enrollment status in a Marketplace plan (eg. Covered California) under the following conditions:

1. The employee is eligible for a Special Enrollment Period to enroll in a Marketplace plan or the employee seeks to enroll in a Marketplace plan during the Marketplace’s annual open enrollment period; and
2. The revocation of the election of coverage under the Court’s group health plan corresponds to the simultaneous enrollment of the employee and any related individuals who cease coverage due to the revocation, in a Marketplace plan for new coverage that is effective beginning no later than the day immediately, following the last day of the original coverage that is revoked.

**Medical**

To promote your health and wellness, the Court offers eligible employees the choice of several medical plan options. You must enroll in a medical plan unless you provide Human Resources with proof that you have employer-sponsored group coverage elsewhere, such as through a spouse’s plan or are enrolled in a Marketplace plan.

The medical options cover similar healthcare treatments and services, but they differ in their deductibles, co-insurance, co-payments, and premiums. The plans also have different levels of provider choice. Take the time to learn how each plan works so you can select the option that best meets your needs and budget.

You must enroll or be enrolled in a medical plan unless you have proof of group coverage elsewhere and provide Human Resources with the necessary documentation as detailed in the “Opt-Out” section on page 4.



**KAISER PERMANENTE®**

**Kaiser Permanente**

This is a general summary of Kaiser Permanente Health Maintenance Organization (HMO) benefits. A more complete description of benefits and coverage, including limitations and exclusions, is contained in the plan documents and evidence of coverage document (EOC). 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. 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 team 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 additional cost. However, you must use Kaiser Permanente’s physicians, hospitals and other approved health care providers. Otherwise, you will not be eligible to receive benefits, except in a life-threatening situation such as an out-of-area urgent or emergency situation.

The \$10 co-payment is waived for preventive care services. For other services, co-payments may range from \$5 to \$100. You pay no deductible and your out-of-pocket annual expenses are limited to \$1,500 per person or \$3,000 per family. You do not have to file claim forms except for out-of-area urgent or emergency care.

**Kaiser Permanente Online Services ([www.kp.org](http://www.kp.org))**

Kaiser Permanente members have on-line access to:

- 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. This access to on-line services makes it easier for members to stay connected with their health.

**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. The Kaiser Permanente contract and EOC determines the exact terms, conditions, and applicable coverage exclusions for the Kaiser plan.

## How to Get in Touch with Kaiser Permanente

Kaiser Permanente's member services team is available twenty-four (24) hours, seven days a week, except holidays at 800.464.4000. You can also access their website at [www.kp.org](http://www.kp.org) for more information. To obtain assistance with disability and protected leaves paperwork, contact Kaiser's Release of Information Department in Fontana at 909.609.3232.



## Blue Shield HMO

**Blue Shield Access+ is a Health Maintenance Organization (HMO).**

### How the Plan Works

You must choose a Primary Care Physician, PCP and a Blue Shield Participating Physician Group (PPG) when you enroll. If you also enroll dependents, each dependent can choose their own Participating Physician Group and PCP. **You may not choose a specialist as a PCP.** If you do not select a PCP, one will be selected for you based on your home address zip code. Your PCP will treat you for many medical conditions, perform preventive care services, and coordinate all of

your health care, including making referrals to specialists and hospitals within your Participating Physician Group. The link to finding a provider is [blueshieldca.com/networkhmo](http://blueshieldca.com/networkhmo).

## Blue Shield Trio HMO

### What is Blue Shield Trio HMO?

The Trio ACO HMO plan is an innovation in health care: the accountable care organization (ACO). In an ACO, the focus is on you. Blue Shield works with a network of doctors and hospitals that share responsibility for coordinating care for you and your family.

The Blue Shield Trio HMO plan currently offers the same medical benefits (copays) as the Access+ HMO® plan. Effective January 1, 2019, the Trio+ specialist care office visit copay will decrease to \$10 per visit. This feature allows you to self-refer to a specialist within the same medical group or IPA as your Trio HMO primary care physician for certain conditions. In addition, Trio offers the following:

- **A lower employee premium contribution than the Access+ HMO®** - The Trio HMO plan will cost you less than the Access+ HMO plan.
- **A select network that focuses on coordinating your care** - The local doctors and hospitals in Trio's network work closely to coordinate your care. This helps to keep you healthy, avoid redundant processes, and reduce costs.
- **Access to Shield Concierge, a team of experts and dedicated customer service representatives** - With Shield Concierge, you call one toll-free number for help with all your questions about your medical coverage and care. The Shield Concierge team includes health advocates, registered nurses,



health coaches, clinical support coordinators, pharmacists, pharmacy technicians and dedicated customer service representatives. They can:

- \* Help you find a network provider
  - \* Work with you and your doctor to coordinate care across all providers
  - \* Help you manage a chronic condition, such as asthma, diabetes or coronary artery disease
  - \* Connect you with NurseHelp 24/7
  - \* Explain pharmacy benefits coverage, including formulary use
  - \* Assist you with claims, and much more
- **A complimentary Fitbit Zip® wireless activity tracker for Walkadoo®, a fun and social walking program** - With the Trio HMO plan, you get a complimentary Fitbit Zip if you enroll in the Walkadoo program. You can clip this device to your belt or hip pocket. It tracks steps taken, distance traveled, and calories burned. The Fitbit Zip includes a large tap display, so you can quickly see your daily stats.

### How the Plan Works

You and your eligible dependents must choose a PCP from the Trio HMO network when you enroll. Led by the PCP you pick, your care team will work with you to help keep you healthy or improve your health, better coordinate your care, spot problems and build personalized care plans, and encourage you to plan an active and informed role in your health and health care decisions. The direct link to find a Blue Shield Trio ACO HMO provider is: [blueshieldca.com/networktriohmo](http://blueshieldca.com/networktriohmo).

Becoming a Trio member has its advantages! Through the Walkadoo program, Trio members are eligible to receive a FitBit. There is also the Shield Concierge Customer Service which is a one stop number to assist with member questions including pre-enrollment assistance. You may call 855.829.3566 from 7:00 a.m. to 7:00 p.m. Monday through Friday.

## Blue Shield PPO

Blue Shield PPO is a preferred provider organization (PPO) style plan. This medical plan offers you a choice between in-network providers who offer their services at discounted rates and non-network providers without discounted rates. It lets you visit any doctor, anytime you need care. No referrals are needed and you don't need to select a Primary Care Physician or PCP.

## How the Plan Works

With Blue Shield's PPO plan, you may obtain care from an in-network or non-network provider. It's your choice. However, when you receive your medical care from in-network, or "Participating 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 seventy percent (70%) of the "maximum allowable charges" for the area. You will pay thirty percent (30%) of the "maximum allowable charges" and all charges above the "maximum allowable charges". 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 thirty percent (30%).

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

Blue Shield's PPO network is available nationwide. To locate in-network providers in your area go to [blueshieldca.com/networkppo](http://blueshieldca.com/networkppo) and select Find a Doctor or call the toll free number on your Blue Shield ID card. If you're not a Blue Shield member — or haven't received an ID card — call 855.599.2649.

Included with all Blue Shield medical plans is **NurseHelp 24/7**: Call NurseHelp 24/7 toll-free at 877.304.0504 and talk with a registered nurse anytime you have health-related questions. **Teladoc 24/7**: Teladoc a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many or your medical issues via phone or video consultant 24/7/365 by calling 800.Teladoc (800.835.2362). **LifeReferrals 24/7** - Access to support and advice from experienced professionals. Provides support in all areas of life from relationships, to child and elder carer, to financial and legal issues. Included are 3 face-to-face counseling sessions with licensed therapist in each six-month period. Call any time at 800.985.2405. **Wellness Discount Programs** including Diet and Exercise, Alternative Care, and Vision discounts.



## Medical Plan Highlights

The following chart provides highlights of the benefits available through the Blue Shield and Kaiser medical plans. For exact terms and conditions of coverage, including limitations and exclusions, please refer to your Blue Shield HMO, Blue Shield Trio, Kaiser HMO or Blue Shield PPO Evidence of Coverage booklet.

FEATURE	BLUE SHIELD HMO/ BLUE SHIELD TRIO	KAISER HMO	BLUE SHIELD PPO	
			In-Network	Non-Network
Calendar Year Deductible	None	None	\$250 each member \$750 family maximum combined In-Network/Non-Network (CY Deductible applies to all services except where noted)	
Calendar Year Out-of-Pocket Maximum (Calendar Year Deductible included on PPO plan)	\$3,500 each member \$7,000 employee plus two or family	\$1,500 each member <sup>1</sup> \$3,000 family maximum <sup>1</sup>	\$3,500 each member \$7,000 family maximum <sup>1</sup>	\$4,400 each member \$8,800 family maximum <sup>1</sup>
Physician Office Visits	You pay \$10 copay	You pay \$10 copay	You pay 20% (CY deductible waived)	You pay 30%
Preventive Care Exam	No charge	No charge	No charge (CY deductible waived)	Not covered
Allergy Testing	You pay \$10 copay	No charge	You pay 20%	You pay 30%
Well Woman (annual)	No charge	No charge	No charge (CY deductible waived)	Not covered
Hospital Care (inpatient)	No charge	No charge for approved services obtained in a Kaiser Permanente facility/approved facility	You pay 20%	You pay 30%, up to \$1,500 benefit per day; member pays 100% of excess charges.
Diagnostic X-rays and Lab Tests	No charge	No charge	You pay 20%	You pay 30%, if in facility 30% up to \$600 benefit per day; member is responsible for excess charges.
Outpatient Surgery	\$100 copay per surgery	\$10 copay per procedure	You pay 20%	30% up to \$600 benefit per day; member is responsible for excess charges.
Emergency Room (copay waived if admitted)	You pay \$50 copay	You pay \$50 copay	\$50 copay then 20% (CY deductible waived)	
Urgent Care	You pay \$10 copay	You pay \$10 copay	You pay 20% (CY deductible waived)	You pay 30%
Prescription Drugs (per fill) <sup>2</sup> (CY Deductible for outpatient prescription drugs)	<b>Pharmacy (up to a 30-day supply):</b> \$5 Tier 1 \$10 Tier 2 \$25 Tier 3 20%; \$200 copay maximum per prescription through Blue Shield Speciality Pharmacy network  <b>Mail Order (up to a 90-day supply):</b> \$10 Tier 1 \$20 Tier 2 \$50 Tier 3  Specialty drugs: not covered	<b>Pharmacy (up to 100-day supply):</b> \$15 generic \$15 brand Specialty drugs: 20% coinsurance (not to exceed \$100 per script) for up to a 30-day supply  <b>Mail Order (up to 100-day supply):</b> \$10 generic \$15 brand and compounded	<b>Pharmacy (up to a 30-day supply):</b> \$15 generic form \$30 brand name form \$45 non-formulary Specialty drugs: 30% for formulary and non-formulary drugs; maximum per prescription \$200 copay through Blue Shield Speciality Pharmacy network  <b>Mail Order (up to 90-day supply):</b> 2 times pharmacy co-pays Specialty drugs: 30% up to \$200 per prescription	<b>Pharmacy (up to a 30-day supply):</b> 25% of purchase price+\$15 per Rx 25% of purchase price+\$30 per Rx 25% of purchase price+\$45 per Rx Specialty drugs: not covered

<sup>1</sup>Some benefits do not count toward's the out-of-pocket maximum. Please refer to the certificate of insurance or evidence of coverage booklet for details.

<sup>2</sup>Some preventive drugs and women's contraceptives are covered at \$0 co-pay except for the Non-Network portion of the PPO plan.

Note on infertility treatment: The plans cover the diagnosis and treatment of the underlying medical condition but does not cover GIFT, ZIFT, and IVF. Kaiser does cover artificial insemination and certain infertility medications. Kaiser's infertility benefits are covered at 50% but do not count towards the calendar year out of pocket maximum.

**Blue Shield and Kaiser offer a Medical Transition of Care Benefit that may allow you to continue your current treatment plan due to a specific diagnosis for a specified time frame with your prior provider. This will not apply if your current provider participates in the Blue Shield or Kaiser medical option you elect and if the treatment is a covered benefit on the Blue Shield or Kaiser plans. If you have a transition care issue, please contact Blue Shield or Kaiser.**



## Dental

For your dental health, the Court offers two (2) quality dental plans, the DeltaCare USA DHMO or the Delta Dental DPPO.

### DeltaCare DHMO Plan-CA Only

The DeltaCare Plan is a prepaid "HMO-style" plan. The DeltaCare Plan covers a broad range of services. Here are some of the benefits to enrolling in the DeltaCare Dental Plan:

- No deductibles
- No claim forms
- No calendar year maximum benefit

You and your family members may choose different primary dentists if you wish. Your primary dentist will take care of your dental care needs, monitor your oral health and refer you to a specialist when needed. In order for your DeltaCare USA claims to be paid, you must obtain services through either your assigned Primary dentist or a specialist through a referral by your primary dentist. Any services obtained outside of the DeltaCare USA network without prior authorization will not be covered.

If needed, you and your covered family members have the ability to change your primary dentist by calling DeltaCare USA at 800.422.4234.

### Emergency Care

In the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than 50 miles from your home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by a dentist up to a maximum of \$100 for each emergency visit. You will need to provide the receipt or dental statement to obtain your reimbursement.

### How to Find A DHMO Dentist

To look for a DHMO dentist, type this link into your browser: [deltadentalins.com](http://deltadentalins.com). Please be sure to indicate the DHMO provider number if you would like to enroll in the DHMO plan. Double click on the dentist to find the corresponding provider ID number.

## Delta Dental DPPO Plan

The Delta Dental Preferred Plus Premier DPPO Plan works similar to the PPO medical plan. This plan allows you to visit any licensed dentist you wish. You will receive the highest level of benefits at the lowest out-of-pocket cost when you select a Delta Dental Preferred DPPO network provider. If you select a non-PPO provider, your share of the cost for services would include the applicable co-insurance (percentage) and could also include an additional amount which would be the difference between the payment the provider received from Delta Dental and the dentist's usual fee (referred to as balance billing). If you go to a Premier dentist, you will not be subject to balance billing for eligible dental expenses. The Delta Dental DPPO plan covers a wide range of services so that you and your family will be able to maintain good dental health and receive specialty care when needed.

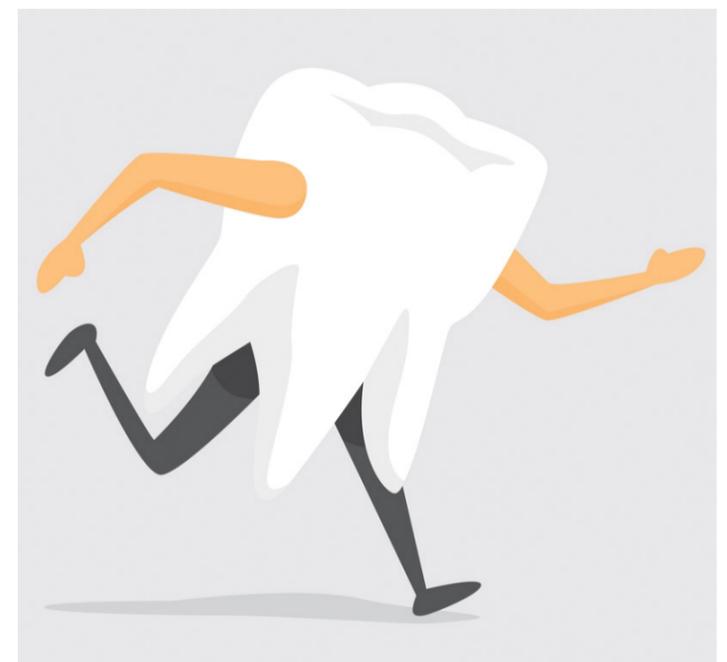
The additional cost or "balance billing" can vary by provider.

### Emergency Care

In an emergency, get the care you need. The plan will pay benefits based on whether your emergency care was received from a PPO or Non-PPO dentist. If possible, contact your regular dentist first as they may be able to direct you to another office if their's is not available.

### How to Find A Preferred or Premier DPPO Dentist

To look for a Preferred or Premier DPPO dentist, type this link into your browser: [deltadentalins.com](http://deltadentalins.com) or you can call Delta Dental customer service at 800.765.6003.



## Dental Plan Highlights

The following chart provides highlights of the dental benefits available through the DeltaCare USA DHMO and the Delta Dental DPPO Plans. For exact terms and conditions of coverage, including limitations and exclusions, please refer to your Plan Summaries, Evidence of Coverage booklets, and/or Plan Documents.

DENTAL PLAN HIGHLIGHTS			
Benefits/Services	DeltaCare DHMO Plan (You pay...)	Delta Dental DPPO Plan	
		Delta Dental PPO (You pay...)	Non-PPO (You pay... plus any costs over maximum allowance)
Dental Network Name	DeltaCare USA	Delta Dental Preferred	Delta Premier and Non-Delta
Annual Deductible	None	None	None
Calendar Year Maximum Benefit	Not applicable	\$1,700 per person (excluding orthodontia)	
Preventive Care	No charge No charge (every 24 months)	No charge No charge (every 36 months)	No charge No charge (every 36 months)
<ul style="list-style-type: none"> <li>Oral Exams*</li> <li>Full mouth X-rays - once every 24 months</li> <li>Emergency, palliative treatment</li> <li>Prophylaxis (cleanings*)</li> </ul>	\$5 No charge, 2 per CY	No charge No charge, up to 4 per CY	No charge No charge, up to 4 per CY
Adjunctive General Services	\$125 each	Not covered	Not covered
<ul style="list-style-type: none"> <li>External bleaching – self treatment with bleaching tray &amp; gel, limitation applies</li> <li>Occlusal guard (night guard), by report – limited to every 3 years</li> <li>Sealant per tooth (limited to molars)</li> <li>Fluoride (to age 19)</li> </ul>	\$95 No charge (to age 16) No charge	Not covered No charge (to age 15) No charge	Not covered No charge (to age 15) No charge
Restorative Dentistry (such as fillings and simple extractions)	Scheduled copays ranging from \$0 to \$75	No charge	10%
Periodontics (such as gingival flap, bone replacement graft, gum surgery)	Scheduled copays ranging from \$0 to \$175	No charge	10%
Endodontics (such as therapeutic puplotomy, root canals)	Scheduled copays ranging from \$0 to \$205	No charge	10%
Oral Surgery (such as biopsy, extraction, anesthesia (1st 30 minutes), removal of cyst or tumor)	Scheduled copays ranging from \$0 to \$170 (not covered for ages below 15)	No charge	10%
Dentures, Crowns, Onlays and Inlays	Scheduled copays ranging from \$0 to \$170	25%; predetermination recommended	30%; predetermination recommended
Implants	Not covered	25%; predetermination recommended	25%; predetermination recommended
Orthodontics			
<ul style="list-style-type: none"> <li>Orthodontic treatment fee (24 months treatment plan for comprehensive banding)</li> </ul>		50% up to \$1,700 lifetime maximum benefit	50% up to \$1,700 lifetime maximum benefit
- Adult	\$1,900		
- Child to age 19	\$1,700		
Note that start up and retention fees are not included in the copays.			

\* Please refer to Plan Summaries/Evidences of Coverage/Plan Documents for information on additional benefits available to expectant mothers and members with other health conditions.

### More to Know

- There are options for dual coverage for the DPPO plan.
- For costly treatments such as crowns, wisdom teeth extractions, bridges, dentures or periodontal surgery, a **Predetermination of Benefits** is recommended so that you know, before treatment begins, what Delta Dental will pay and what your share of the cost will be.



## Vision

To help keep your life in focus, the Court offers vision benefits through EyeMed Vision Care. EyeMed offers immediate savings as well as choice, quality and value on a variety of eye care products and services. Their extensive national network locations include, but are not limited to: LensCrafters, Sears Optical, Target Optical, participating Pearle Vision locations, JC Penney Optical, and select independent doctors of optometry. Plan highlights include:

- No eye exam deductibles
- Large network of vision care providers
- Freedom to see any provider you choose, noting that the greatest savings are achieved by going to an in-network provider
- In and out-of-network benefits
- Additional in-network discounts on frames (select frames only)
- Exams, frames, standard lenses and contact lenses every twelve (12) months
- On-line service features
- Customer Service Representatives available seven (7) days a week

To locate an EyeMed provider, visit [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) and use the “Find a Provider” tool. Choose the “Select” network, then enter your zip code.



## Flex Spending Accounts (FSAs)

To help you maximize tax savings and stretch your spending power, the Court offers FSAs. There are two types of plans: 1) Flex Spending Account – Health Care (FSA-HC); and 2) Flex Spending Account – Dependent Care (FSA-DCAP). The accounts are currently administered by TASC.

To participate or continue participation in either or both of these plans, you must make a new election each year. Unlike most of the Court’s benefits, FSA-HC and FSA-DCAP elections from a previous plan year will not automatically carry over into the next Plan Year if no election is made during the November Open Enrollment period. The plan year for both FSA plans is January 1, 2019 through December 31, 2019.

## Flex Spending Account – Health Care

This plan is offered to all eligible employees who are in a regular position with a minimum of forty (40) hours worked per pay period. If you participate in the FSA-HC, you can save money by paying for certain medical care expenses with pre-tax dollars.

### How the Plans Works

When you participate in the FSA-HC plan, you elect to set aside a portion of your bi-weekly 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 or other insurance. For example, these expenses might include amounts paid for hospital bills, doctor and dental bills or co-pays, eyeglasses and vision care, chiropractic care, and/or prescription drugs. Normally you would pay for these expenses with after-tax dollars. However, with the FSA-HC, you can be reimbursed from your account with pre-tax dollars.

### Minimum / Maximum Contribution Amounts

Contribution amounts for the FSA-HC are based on bargaining unit. Please refer to the appropriate MOU or Compensation Plan for the specific minimum contribution limits. The IRS maximum is **\$2,650**.

### Eligible Expenses

Expenses are generally considered eligible for reimbursement if the expenses are incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Over-the-counter medications without a prescription and expenses solely for cosmetic reasons (e.g. health spas, vitamins, etc.) are not considered eligible expenses for health care.

NOTE: Some over-the-counter health care products can be eligible without a prescription! Check out [www.fsastore.com](http://www.fsastore.com).

## Reimbursement

You may apply for reimbursement of qualifying medical care expenses by using your TASC Mastercard Debit Card or by submitting a completed claim form to TASC no later than ninety (90) days after the end of the Plan Year. Invoices, receipts, bills, or other statements from an independent third party showing the amount and date of the qualifying medical care expenses incurred must be attached to the claim form, together with proof that the expense was paid by you, and any other documentation that may be requested. Requests for reimbursement may be made as the expenses are incurred or at the end of the Plan Year.

**IMPORTANT NOTE:** Each time you seek service, you must request and keep a copy of your itemized statement of service, or obtain your insurance carrier Explanation of Benefits (EOB) statement as IRS rules require you to provide this information upon request. If this information is not provided, IRS rules require the card be temporarily inactivated until such time that the documentation is provided. The itemized statement must clearly show the provider name/address, patient name, date of service, description of service and dollar amount.

## Flex Spending Account – Dependent Care

This plan is offered to all eligible employees who are in a regular position with a minimum of forty (40) hours worked per pay period. The plan allows you to pay for work-related dependent care expenses on a pre-tax basis. The FSA-DCAP Open Enrollment period is in November of each year, and the FSA-DCAP Plan Year matches the calendar year (January through December).

### Eligibility

In order for dependent care expenses to be eligible, the expense must be work-related to enable the gainful employment of you and if married, your spouse, be paid on behalf of a qualified dependent, and be provided by an eligible care provider. Work-related also includes actively looking for work. A qualified dependent under the FSA-DCAP is a dependent whom you claim for Federal tax purposes and is either a child living with you under the age of 13; your spouse, a relative, or a child age 13 or over who is physically or mentally incapable of self-care and is living with you at least eight hours a day; any individual who qualifies as a dependent under any employer sponsored health care plan or insurance contract, and qualifies as a dependent under Section 152 of the Internal Revenue Code for purposes of pre-tax contributions or reimbursement on a pre-tax basis. See IRS Publication 503 for additional information.

Under the FSA-DCAP, eligible day care providers include a licensed day care center (if it cares for more than six children who don't live there), a private babysitter, a care center for the elderly or handicapped, or an attendant who comes to your home. Housekeeper expenses can be paid only if that person's services benefit the dependent. You must provide the name, address and Social Security number or the Tax Identification Number of your dependent care provider on all claims and also on your tax return. Expenses that are not eligible for reimbursement under the FSA-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.

### How the Plan Works

Each year during the FSA-DCAP Open Enrollment, you may enroll and authorize a bi-weekly deduction amount from your pay to be placed into your FSA-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 claim through the TASC Mobile App or complete a claim form and submit by fax, mail, or online and attach an itemized statement for services or use your TASC Debit card. **NOTE:** You are responsible for paying a bill by its due date, whether you have received reimbursement or not. **NOTE: Tax laws are complex and it is important that you seek professional tax advice before enrolling in the FSA-DCAP.**

### 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 FSA-DCAP, the annual maximum includes any benefits he or she received under the FSA-DCAP.

### Important IRS Rules on Flex Spending Account – Health Care (FSA-HC) and Flex Spending Account – Dependent Care (FSA-DCAP)

Plan very carefully! The IRS governs the terms of these plans, which means that your election to put money into the FSA-HC and/or FSA-DCAP is irrevocable. The FSAs are a year-to-year account so you should plan only for predictable and recurring expenses that you know you will have. Once you have made an election to participate, 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. Any requested change in your FSA-HC and/or FSA-DCAP election must be requested within 30 days of the event and be consistent with the Change-in-Status Event and is subject to approval by the plan sponsor.

The Plan Year for the FSA-HC and FSA-DCAP begins January 1 and ends December 31. The deadline to submit claims for 2018 is March 31, 2019.

Carry Over up to \$500! At the end of the Plan Year, if any balance remains, you can carry over up to \$500 for use in the following plan year! Any balance over this amount is forfeited. The carry over applies to the FSA-Health Care Account.



## Life Insurance

Life insurance provides your beneficiaries with valuable financial protection in the event of your death. The Court Life Insurance provider is Minnesota Life Insurance Company, a Securian Financial Group, Inc. affiliate.

### Basic Life Insurance

The Court pays the premium for a term life insurance policy for each employee according to the provisions set forth in their applicable MOU or Compensation Plan.

You must designate a beneficiary at the time of enrollment. If there is no eligible beneficiary, or if you do not name

one, Minnesota Life 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 for themselves and their spouse/registered domestic partner and/or child(ren) who are under age 26 through the Supplemental Life Insurance plan underwritten by Minnesota Life Insurance Company.

### MONTHLY PREMIUM COST PER \$1,000 OF COVERAGE

YOUR AGE	EMPLOYEE	SPOUSE	CHILD(REN)
Under 25	\$0.046	\$0.082	\$0.200
25-29	\$0.046	\$0.099	
30-34	\$0.061	\$0.131	
35-39	\$0.068	\$0.148	
40-44	\$0.076	\$0.164	
45-49	\$0.114	\$0.246	
50-54	\$0.174	\$0.378	
55-59	\$0.326	\$0.706	
60-64	\$0.501	\$1.084	
65-69	\$0.963	\$2.087	
70 & over*	\$1.563	\$3.385	

\* 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 provided in the Supplemental Life Insurance certificate that is available from Human Resources.

### Eligibility for Supplemental Life Insurance

Your MOU or Compensation Plan governs your eligibility for Supplemental Life Insurance.

Before you enroll in the plan or make changes to your elections during the annual Open Enrollment, you must work forty (40) 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 thirty-one (31) days of becoming eligible or during the annual Open Enrollment. After your initial enrollment, you may make changes in coverage only upon experiencing a qualifying mid-year change-in-status event, or during the annual open enrollment period.

### Coverage Options

- Employee: \$10,000 increments, up to \$700,000. Guaranteed coverage up to \$250,000.

- Spouse/Registered Domestic Partner: \$10,000 increments, up to \$100,000. Guaranteed coverage up to \$20,000.
- Child(ren): \$5,000 increments, up to \$20,000. All amounts are guaranteed.

**Please Note:** Your dependent’s coverage cannot exceed your total combined basic and supplemental life coverage of the maximum amount that the plan allows. In addition, spouse/registered domestic partner are not eligible if they are also eligible for employee coverage and child(ren) cannot have dual coverage if both parents are Court employees.

#### Evidence of Insurability (EOI) Requirements

EOI, commonly known as proof of good health, will be required if you elect employee coverage of more than \$250,000. For example, if you elect \$500,000 of coverage for yourself, 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 the guaranteed amount of \$250,000.

Your spouse/registered domestic partner may be subject to EOI requirements when they elect coverage more than \$20,000.

#### 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 Court deducts for your premium payment. If you have requested coverage above the guaranteed amount, your coverage date is subject to insurance company approval.

**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.

#### Variable Group Universal Life (VGUL)

##### Employee Eligibility for VGUL

Your MOU or Compensation Plan governs your eligibility for VGUL underwritten by Minnesota Life Insurance Company, a Securian Financial Group, Inc. affiliate. If you are interested in this coverage, please contact Human Resources for plan benefits and cost information. Note that guarantee issue for the supplemental life amount elected combined with VGUL cannot exceed \$250,000. Any amount in excess of the combined guarantee issue amount will be subject to evidence of insurability. The combined maximum is \$1,000,000.

#### Accidental Death & Dismemberment (AD&D)

##### Employee Eligibility for AD&D

Your MOU or Compensation Plan governs your eligibility for AD&D underwritten by Minnesota Life Insurance Company, a Securian Financial Group, Inc. affiliate.

##### Eligible Dependents for AD&D

- The insured employee’s lawful spouse who is not legally separated from the employee or the insured employee’s registered domestic partner who is: (a) not eligible as an employee under the group policy; and (b) under age 70 and
- The insured employee’s children who have not attained the age of 26 regardless of student status. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support prior to age 26 and are financially dependent on their certificate holder for more than one-half of their support and maintenance. “Children” includes the employee’s natural children, stepchildren, legally adopted children, and foster children, who are unmarried and dependent on the insured employee for financial support. Eligibility begins at live birth (unborn or stillborn children are not eligible).
- If both parents of a child qualify as eligible employees under this policy, the child shall be considered a dependent of only one parent for purposes of this benefit. If any child qualifies as an eligible employee under this policy, he or she is not eligible to be insured as a dependent child.

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

##### AD&D Plan and Coverage Options

Employee plus dependent coverage is governed by the type of dependents you intend to enroll/cover.

##### Coverage Options

1. **Employee-only coverage:** Coverage will be the amount listed in the Employee column on the 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 thirty-one (31) 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. Note that the AD&D benefit does not allow dual coverage under family coverage provisions.

##### 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

##### 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 Court deducts for 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 Benefit Plan qualified change in status/life event.

##### AD&D Premium Table

VOLUNTARY AD&D	
Employee only	\$0.020 per \$1,000 per month
Employee and family	\$0.030 per \$1,000 per month

#### More to Know about Supplemental Life Insurance and AD&D

- 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) siblings, (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 and/or AD&D Beneficiary Designation/Change form available from Human Resources.
- The Supplemental Life Insurance Plan includes a Waiver of Premium While Disabled, Accelerated Benefit Option and a Portability Benefit.
- The AD&D plan includes a Portability Benefit.
- Your Supplemental Life Insurance and/or AD&D coverage will terminate if:
  - \* You cancel your coverage during Open Enrollment or experience a Qualifying Event
  - \* 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 twelve (12) months excluding military leave



## Disability Insurance

### Eligibility

Your Memorandum of Understanding (MOU) or Compensation Plan governs your eligibility for participation in either State Disability Insurance (SDI), Short Term Disability (STD), and/or Long Term Disability (LTD).

### Short-Term Disability (STD)

The Court provides Short-Term Disability (STD) benefits in the event that a non-work-related illness or injury requires you to be off work for more than seven (7) consecutive calendar days. STD benefits provide partial income replacement while you are off work. These benefits may be integrated with your available leave accruals. STD benefits are paid for by the Court and administered by Standard Insurance Company (The Standard).

### Eligibility

Your Memorandum of Understanding (MOU) or Compensation Plan 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 eighteen (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, the minimum benefit of \$25 will be payable.

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 scheduled and working at least forty (40) hours per bi-weekly pay period; 2) Employee must have completed two pay periods of continuous service, each with a minimum of one-half of the scheduled hours of paid time; 3) Employee must be designated as a member of one of the groups covered by this Plan.

**Filing a Claim**

**No later than your fourth day of absence**, call The Standard directly at 800.378.2395 or complete a claim form online at [www.standard.com/employer/insurance/group-short-term-disability](http://www.standard.com/employer/insurance/group-short-term-disability). Proceed to click on “File A Claim”. You must also obtain and complete the Court required paperwork, which is available on the Court’s intranet under the employees’ leave section or by contacting Human Resources. Completed paperwork must be returned to Human Resources within fifteen (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. Your normal weekly benefit will not exceed fifty-five percent (55%) of your base salary to a maximum of \$987 per week for eligible Represented employees, or \$1,408 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:

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

The maximum benefit duration 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 duration of one hundred-eighty (180) days.

**NOTE:** STD Benefit payments will be made separately by The Standard and are paid as taxable income on a weekly basis.

**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. You may not receive more than 100% of your base salary. Employees who elect to fully integrate plan benefit payments with other paid time will receive benefits and accruals as specified in the applicable MOU or Compensation Plan 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 eligibility 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 or Compensation Plan.

**Long-Term Disability (LTD)**

Long-Term Disability is a Court-paid benefit administered by The Standard that provides partial income replacement for employees covered by a Compensation Plan who are unable to work due to a disability. The benefit pays sixty (60%) of monthly salary to a maximum of \$10,000 per month. Monthly payments begin after one hundred-eighty (180) consecutive days of disability and may NOT be fully or partially integrated with other paid time.

AGE WHEN DISABLED	MAXIMUM BENEFIT PERIOD
61 or younger	To age 65, or to SSNRA, or 3 year 6 months, whichever is longest
Age 62	To SSNRA, or 3 years 6 months, whichever is longer
Age 63	To SSNRA, or 3 years, whichever is longer
Age 64	To SSNRA, or 2 years 6 months, whichever is longer
Age 65	2 years
Age 66	1 year 9 months
Age 67	1 year 6 months
68	1 year 3 months
Age 69 or older	1 year

Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the Federal Social Security Act, as amended.



**Employee Assistance Program (EAP)**

The Court’s EAP (Employee Assistance Program), administered by ACI, is a voluntary and confidential program to help you and your family members resolve challenging issues that affect your personal lives at home and at work. Through the EAP, a team of dedicated counselors are available to provide guidance on a wide range of issues from everyday concerns to serious problems—such as relationship issues, legal/fraud, emotional well-being, and workplace challenges. Work/Life and Personal Services are also included in your EAP. Child care, elder care, and pet care are a few of the matters where resources and referrals are available.

When you call the EAP, you will be helped by healthcare professionals who will coordinate and arrange services, face-to-face assessment or consultation, and/or resources. Call 800.932.0034 any time, day or night, to connect with the people and resources you need to help keep your life in balance. For more information visit the Court’s intranet.



**Retirement Plan Highlights Eligibility**

Any employee working at least forty (40) hours per pay period in a retirement-eligible position is automatically a member of the San Bernardino County Employee’s Retirement Association (SBCERA). As a member of SBCERA, you make contributions each pay period for your retirement and survivor benefits by payroll deduction.

**Tier 1 Members** are those with a SBCERA membership date prior to January 1, 2013. They pay a percentage of their earnable compensation based on their entry age. Your entry age is your closest age when you began working for your employer permanently or your entry age from another public pension system with which you have previously established reciprocity.

If you are a Tier 1 Member that has left employment and you were rehired by an SBCERA-covered employer, your contribution rate will be based on your entry age from your earlier employment if: you are rehired within ninety (90) days and your contributions remain on deposit with SBCERA, you redeposit your contributions within one hundred eighty (180) days of being rehired, or if you are vested and left your funds on deposit with SBCERA when you left employment. If not, your entry age will be based on your birthday closest to your rehire date.

**Tier 2 Members** are those with a SBCERA membership date on or after January 1, 2013. They pay a fixed flat-rate percentage of their pensionable compensation. Contributions are not paid on compensation above the pensionable compensation cap, which is adjusted each year based on changes in the consumer price index.

**Refundable and Non-Refundable Retirement Options**

If you are a **Tier 1** SBCERA member, 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 Form. Elections will be effective pay-period 01/19 and you will see the election change on the pay warrant dated January 11, 2019.

For **Tier 2** members, refundable contributions is your only option.

**Refundable Retirement Contributions**

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



The information contained in the following Refundable vs. Non-refundable 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.

**Tier 1 Members**

GENERAL EMPLOYEES CONTRIBUTION RATE (%)		
Entry Age	Refundable (%)	Non-Refundable (%)
16	9.13	8.61
17	9.27	8.75
18	9.40	8.87
19	9.56	9.02
20	9.71	9.16
21	9.86	9.30
22	10.01	9.44
23	10.16	9.58
24	10.33	9.75
25	10.49	9.90
26	10.65	10.05
27	10.82	10.21
28	10.98	10.36
29	11.16	10.53
30	11.34	10.70
31	11.52	10.87
32	11.70	11.04
33	11.89	11.22
34	12.09	11.41
35	12.29	11.59
36	12.50	11.79
37	12.71	11.99
38	12.94	12.21
39	13.17	12.42
40	13.41	12.65
41	13.63	12.86
42	13.86	13.08
43	14.09	13.29
44	14.33	13.52
45	14.55	13.73
46	14.76	13.92
47	14.96	14.11
48	15.12	14.26
49	15.25	14.39
50	15.35	14.48
51	15.42	14.55
52	15.50	14.62
53	15.27	14.41
54 & Over	14.79	13.95

**Tier 2 members** – Refundable (%): 9.16%

**Non-Refundable Retirement Contributions**

If you designate your retirement contributions as non-refundable, 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. If you leave the Court without retiring, you may not withdraw this contribution from the SBCERA. If eligible, you may receive a retirement benefit.



**457(b) Deferred Compensation Plan**

The 457(b) is a voluntary supplemental retirement plan that allows employees to contribute a portion of their pre-tax (Traditional) or after-tax (Roth) salary, within certain Internal Revenue Service (IRS) limits, to a personal account currently maintained by VOYA. Employees may select from multiple mutual funds and a stable value account when investing their funds. Although the Court has their own plan account numbers, 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 Defined Contribution Plans and Retirement Medical Trust Plan Investment Policy Statement*.

**Eligibility**

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

**Contributions**

Contributions to the 457 may be deposited on a Pre-Tax basis (Traditional 457) or on an After-Tax basis (Roth 457). Participants can select either option or both for their contributions.

- For the Traditional 457 option, contributions and any earnings that accumulate are not taxed until the funds are withdrawn.
- For the Roth 457 option, contributions and any earnings that accumulate can be withdrawn tax-free in retirement if the requirements for a “qualified distribution” are met.

The IRS does impose restrictions on when these funds can be accessed. Upon complete separation from Court service, participants may choose to withdraw a portion or all of their 457(b) account balance. Federal and state taxes may apply on the amount withdrawn from Traditional 457 or Roth 457 if the Roth distribution does not meet qualified distribution criteria. To be a qualified tax-free distribution from Roth 457, you must have had the Roth 457 account for a minimum of five (5) years AND experience one of these events:

- Attainment of age 59½
- Disability
- Death
- Certain first-time home purchases

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 eligible employee who has questions, or who is interested in participating in the 457(b) Plan, should contact the local VOYA 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.

**401(k) Salary Savings Plan**

**Eligibility**

Exempt, Confidential and Executive Employees are eligible to participate in this voluntary 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 VOYA. Employees may enroll at any time and may select from multiple investment options including a stable value account when investing their funds.

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

**Roth 401(k):** Allows participating employees the opportunity to take tax-free distributions upon

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

**Withdrawal Period**

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

**In-Service Distributions**

In-service distributions are limited to loans and hardship withdrawals. Both options are subject to several restrictions. Employees should make themselves familiar with the loan and hardship provisions in the 401(k) Plan document before participating in the plan. Any eligible employee who has questions, or who is interested in participating in the 401(k) Plan, should contact the local VOYA 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.

**Retirement Medical Trust Fund**

Please refer to your MOU or Compensation Plan for specific information on participation eligibility.

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

All funds contributed to the Trust are maintained in individual accounts administered by TASC 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.

**Other Valuable Benefits**

**529 Education Savings Plan**

The 529 Education Savings Plan is offered by VOYA. This plan offers all Court employees a way to invest in their children’s and grandchildren’s education. Advantages include tax-deferred growth of any earnings and tax-

free withdrawals for qualified higher education expenses such as room, board, and tuition. The owner of a 529 plan controls the assets in the account, even after the beneficiary turns 18. The minimum bi-weekly deferral is \$25, which is deducted on an after-tax basis. You must contact VOYA directly to participate in the plan.

## Your Retiree Medical Benefits Upon Retirement

When you retire from the Court, you and your eligible dependents are eligible to participate in a Court-sponsored retiree medical plan. As a retiree or eligible dependent, you or your eligible dependent is responsible for paying 100% of the cost of premiums. For additional information see the Human Resources Benefits intranet page or contact Human Resources.

Retiree medical and dental options are also available as a SBCERA retiree through the County of San Bernardino. Contact the Employee Benefits Division of the County of San Bernardino at 909.387.5787.

Once you enroll in a County retiree medical plan, you may not enroll in a Court-sponsored medical plan at any future date.

**Please note:** Current retiree medical rates are blended with the active employee rates and are subject to change each year. Should rates be unblended in the future, retiree medical premium costs could increase significantly.

## Appeal Procedure General Information

The Court maintains and provides documents that explain the policies, requirements, and limits of coverage for all employee benefit programs. In the event that an employee or beneficiary believes that a request or claim for a benefit under a health and welfare, flexible spending account, or salary savings plan has been improperly denied, he or she may appeal the decision within the parameters set forth in the following procedure.

Appeals for claims that are denied solely by one of the Court's benefit carriers must be submitted to the Deputy CEO, Human Resources and Training within the guidelines established by that carrier. If requested to do so, Human Resources 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 to the Deputy CEO, Human Resources and Training within thirty (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 fifteen (15) calendar days of the date the appeal is received, the Deputy CEO, Human Resources and Training will review the facts and respond in writing with his or her findings. Should special circumstances require an extension of time for a decision on review, the review period may be extended by an additional fifteen (15) days. The Deputy CEO, Human Resources and Training will provide written notification if an extension is needed.

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

Upon timely delivery of the requested information, and within fifteen (15) calendar days, the Deputy CEO, Human Resources and Training must report his or her findings. Should the requested information not be received by the Deputy CEO, Human Resources and Training within the time specified, the Deputy CEO, Human Resources and Training will make a decision without it, in which case, the decision is final and is not eligible for re-appeal.

## Important Notices

### Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six [96] hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six [96] hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six [96] hours).

## Women's Health and Cancer Rights Act of 1998 (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of physical complications resulting from a mastectomy, including lymphedema. Call Human Resources at 909.521.3700 for more information.

## Patient Protection Disclosure

Blue Shield Access+ HMO/Trio ACO HMO generally requires the designation of a primary care provider (PCP). You have the right to designate any PCP who participates in Blue Shield Access+ HMO network and who is available to accept you or your family members. For the Blue Shield Trio ACO, the PCP must be part of the Trio ACO HMO network. Until you make this designation, Blue Shield of California designates one for you. For information on how to select a PCP, and for a list of the participating PCPs, go to the Blue Shield of California websites, [blueshieldca.com/networkhmo](http://blueshieldca.com/networkhmo) or [blueshieldca.com/networktriohmo](http://blueshieldca.com/networktriohmo)

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Shield of California or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, go to the Blue Shield of California website, [blueshieldca.com/networkhmo](http://blueshieldca.com/networkhmo) or [blueshieldca.com/networktriohmo](http://blueshieldca.com/networktriohmo).

## COBRA Continuation Coverage

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

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

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

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

- The death of the employee
- Voluntary or involuntary termination of the employee's employment (for reasons other than gross misconduct) or reduction in spouse's or domestic partner's hours of employment with the Court
- Divorce or dissolution of domestic partnership

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

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

Employees and qualified beneficiaries are eligible to continue health, dental and vision coverages for a maximum period of eighteen (18) months from the qualifying event date. The employee or qualified beneficiary is responsible for the full applicable premium plus a two percent (2%) administration fee.

**The information in this section is only a highlight of COBRA and does not include specific rights and responsibilities. It is your responsibility to notify Human Resources within sixty (60) days of Qualifying Events that impact you and your covered dependents. Failure to comply with this timeframe will jeopardize the ability to elect COBRA coverage. For more information or questions regarding COBRA, contact Human Resources.**

## Medi-Cal/Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medi-Cal/Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are NOT currently enrolled in Medi-Cal/Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medi-Cal/Medicaid or CHIP office or dial **877.KIDS.NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medi-Cal/Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan if you are not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within sixty (60) days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact your employer plan. You can also contact the Department of Labor/Employee Benefits Security Administration at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call 866.444.EBSA (3272).

To see if your State has added a premium assistance program, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
866.444.EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
877.267.2323

## Important Notice from the Superior Court of California, County of San Bernardino About Your Prescription Drug Coverage and Medicare – CREDITABLE COVERAGE

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see below for more details, and be sure to give this notice to your Medicare-eligible dependents covered under the Superior Court of California, County of San Bernardino group health plans.**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Superior Court of California, County of San Bernardino and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Superior Court of California, County of San Bernardino has determined that the prescription drug coverage offered by Blue Shield of California and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Superior Court of California, County of San Bernardino coverage will be affected. See the Human Resources Department listed at the end of this notice for an explanation of your plan benefits including the prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current Superior Court of California, County of San Bernardino coverage, be aware that you and your dependents will not be able to get this coverage back.

### When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Superior Court of California, County of San Bernardino and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

## PRIVACY NOTICE

### SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN BERNARDINO NOTICE OF PRIVACY PRACTICES - EFFECTIVE JANUARY 1, 2019

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

#### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the Human Resources Department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Superior Court of California, County of San Bernardino changes. You also may request a copy of this notice at any time.

#### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 14, 2018
Name of Entity/Sender:	Superior Court of California, County of San Bernardino
Contact--Position/Office:	Human Resources Department
Address:	247 W. Third Street, First Floor San Bernardino, CA 92415-0312
Phone Number:	909.521.3700

#### **Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

#### **Your Rights**

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

#### **Your Choices**

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

#### **Our Uses and Disclosures**

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

#### **Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

#### **Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### **Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

### **Our Uses and Disclosures**

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### **Help manage the health care treatment you receive**

- We can use your health information and share it with professionals who are treating you.
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

#### **Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- Example: We use health information about you to develop better services for you.

#### **Pay for your health services**

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

#### **Administer your plan**

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and we will mail a copy to you.

**Other Instructions for Privacy Practice Notice**

To: Participants in the Superior Court of California, County of San Bernardino Health Care Spending Account Plan  
 From: Kimberlie A. Turner, Privacy Officer, Deputy Court Executive Officer, Human Resources and Training  
 Re: Availability of Notice of Privacy Practices

The Health Care Spending Account Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Privacy Officer at 247 W. Third Street, 1st Floor; San Bernardino, CA 92415-0312; Phone: 909.521.3640.

**Health Insurance Marketplace Coverage Options and Your Health Coverage**

When key parts of the health care law took effective in 2014, there was a new way to buy health insurance: The **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins on November 1, 2018 for coverage starting as early as January 1, 2019.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% (as adjusted each year after 2014) of your household income for the 2019 year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.)

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

**How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact Susan Zenzen, Benefits and Payroll Administrator at [szenzen@sb-court.org](mailto:szenzen@sb-court.org) or phone 909.521.3700.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [www.HealthCare.gov](http://www.HealthCare.gov) for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Superior Court of California, County of San Bernardino		4. Employer Identification Number (EIN): 33-0939001	
5. Employer address: 247 West Third Street, 1st Floor		6. Employer phone number: 909.521.3700	
7. City: San Bernardino	8. State: CA	9. Zip code: 92415-0312	
10. Who can we contact about employee health coverage at this job? Susan Zenzen, Benefits and Payroll Administrator			
11. Phone number (if different from above): n/a		12. Email address: <a href="mailto:szenzen@sb-court.org">szenzen@sb-court.org</a>	

Form Approved  
 OMB No. 1210-0149  
 (expires 5-31-2020)



## For More Information

BENEFIT PLAN	TELEPHONE CONTACT	WEBSITE
<b>Medical</b> <ul style="list-style-type: none"> <li>Blue Shield HMO</li> <li>Blue Shield Trio ACO HMO</li> <li>Blue Shield PPO</li> <li>Kaiser HMO</li> </ul>	855.599.2649 855.829.3566 855.599.2649 800.900.3277	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>  <a href="http://www.kp.org">www.kp.org</a>
<b>Dental</b> <ul style="list-style-type: none"> <li>DeltaCare USA DHMO</li> <li>Delta Dental DPPO</li> </ul>	800.422.4234 800.765.6003	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
<b>Vision</b> EyeMed Vision Care	866.939.3633	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>
<b>EAP (Employee Assistance Program)</b> ACI	800.932.0034	<a href="http://sbcsc.acieap.com">http://sbcsc.acieap.com</a>
<b>Flex Spending Accounts (FSAs)</b> TASC <ul style="list-style-type: none"> <li>Flex Spending Account – Health Care (FSA-HC)</li> <li>Flex Spending Account – Dependent Care (FSA-DCAP)</li> </ul>	800.422.4661	<a href="http://www.tasconline.com">www.tasconline.com</a>
<b>Disability Insurance</b> Standard Group Insurance <ul style="list-style-type: none"> <li>Short-Term Disability (STD)</li> <li>Long-Term Disability (LTD)</li> </ul>	800.378.2395	<a href="http://www.standard.com">www.standard.com</a>
<b>Life Insurance</b> Minnesota Life (Securian) <ul style="list-style-type: none"> <li>Basic Life Insurance</li> <li>Supplemental Life Insurance</li> <li>Variable Group Universal Life (VGUL)</li> <li>AD&amp;D Insurance</li> </ul>	877.282.1752	<a href="http://www.securian.com">www.securian.com</a>
<b>Retirement Plans</b> VOYA <ul style="list-style-type: none"> <li>457(b) Deferred Compensation Plan</li> <li>401(k) Salary Savings Plan</li> <li>529 Educational Savings Plan</li> </ul>	909.748.6468 800.584.6001	<a href="http://voya.com">http://voya.com</a>
<b>San Bernardino County Retirement Association (SBCERA)</b>	909.885.7980 877.722.3721	<a href="http://www.sbcera.org">www.sbcera.org</a>

### IMPORTANT!

Not all of the plan provisions, limitations and exclusions are described in this Guide. You must consult each plan's legal documents, insurance contracts or Evidence of Coverage booklets for a complete description of the benefits, limitations and exclusions. Telephone numbers and websites are listed on the back cover of this Guide. Plan documents can be viewed on the Court's intranet or by contacting Human Resources.