Superior Court of California, County of San Bernardino

2021 Benefits Guide

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This brochure summarizes the benefit plans that are available to San Bernardino Superior Court eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Open Enrollment Tips

- Review the What's New & Different for Plan Year 2021
- Use the Open Enrollment benefits checklist
- Enroll or make changes using the Phoenix ES online Open Enrollment tile
- Select the right coverage level. Review the medical, dental and vision plan highlights, comparison charts and life insurance information
- Make sure your beneficiaries are up to date
- 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 - Human Resources - Benefits

Open Enrollment Benefits Checklist

- ☐ Read your Employee Benefit Guide
- ☐ Think about your needs and if you expect those needs to change in the year ahead
- ☐ Review and if necessary, update your beneficiaries and dependents in Phoenix ES
- ☐ You **must enroll or re-enroll** in the Flexible Spending Account Health Care and/or Dependent Care if you wish to participate in 2021
- ☐ Print out a copy of your submitted selections for 2021 for your records
- ☐ If adding any newly eligible dependents, provide the Human Resources Department required documentation by December 11, 2020

What's New & Different in 2021

The following is a quick summary of changes:

1. Medical subsidy amounts are increasing! Please refer to your Memorandum of Understanding (MOU) or Compensation Plan to see if you are eligible for increased amounts.
2. Telehealth services are now available to Blue Shield HMO and PPO members at no cost per visit beginning January 1, 2021.
3. Blue Shield Pharmacy Benefit: Tier 4 now includes Specialty Drugs. The HMO retail cost is 20% up to $250 per prescription and mail order is 20% up to $500 per prescription. For PPO retail cost is 30% up to $250 per prescription in-network. Out of network is 30% up to $250 plus 25% of the purchase price. Mail order is 30% up to $500 per prescription and there is no out of network benefit for mail order. Also, your acupuncture and chiropractic copays now count towards your calendar year deductible.
4. Kaiser is offering two (2) new apps for members. 1) myStrength - a self-service app for mental and behavioral health wellness, without the guidance of a provider, for ages 13 and up, and 2) Calm. To learn more visit www.kp.org/selfcareapps.
5. No Changes? No Problem! You will not be required to use the Phoenix ES 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.
6. 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.
7. Flexible Spending Accounts (FSA) – You **must enroll or re-enroll** if you want to participate in the Flexible Spending Accounts (FSA) Health Care and/or Dependent Care plans in 2021.

Important Dates

IMPORTANT DATES	ACTION
November 2, 2020	Open Enrollment Begins
November 17, 2020	Open Enrollment Ends
December 11, 2020	Required Documentation Due to Human Resources
January 1, 2021	Effective Date of New Benefit Plan Year
January 1, 2021	FSA - Health Care/ Dependent Care Plan Year Begins

IMPORTANT:

Please make your benefit elections carefully during this Open Enrollment. The next opportunity to make changes will be in late 2021, for an effective date of January 1, 2022, 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.

Goodbye 2020!!

As we have all experienced this year, life is not always predictable. That's why the Superior Court of California, County of San Bernardino is pleased to offer eligible employees a comprehensive benefits program. It 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 2021 plan year which will become effective January 1, 2021. 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.

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:

https://sb-court.org/sites/default/files/Employment/BenefitsCalculator2021.xlsx

2021 Bi-Weekly Premium Rate Table

Coverage Effective January 1, 2021

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	$368.76	$309.93	$833.13	$294.60	Employee	$7.05	$24.72	Employee	Court-paid
Employee+1	$737.54	$619.87	$1,666.28	$589.21	Employee+1	$13.45	$44.17	Employee+ Spouse	$5.74
Employee+2 or more	$1,039.51	$873.66	$2,348.50	$833.74	Employee+2 or more	$20.94	$73.25	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.

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
- California-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 provider 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
Disabled Dependent over the age of 26 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.	**New Hires:** May enroll a disabled dependent within 60 days of hire. Subject to receipt and approval of Physician's certification	**New Hires:** May enroll a disabled dependent within 60 days of hire. Subject to receipt and approval of Physician's certification	**New Hires:** May enroll a disabled dependent within 60 days of hire. Subject to receipt and approval of Physician's certification	**New Hires:** May enroll a disabled dependent within 60 days of hire. Subject to receipt and approval of Physician's certification
	Continued Enrollment: 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).	**Continued Enrollment:** No prior enrollment required Subject to receipt and approval of Physician's certification.	**Continued Enrollment:** 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).	**Continued Enrollment:** 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).

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 another employer-sponsored group medical plan. Enrollment in a Marketplace plan (e.g. Covered California), Medi-Cal or Medicare will also fulfill this requirement. Verification of another 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, without penalty.

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 11, 2020, you will be automatically re-enrolled in your previous coverage, if available, or the lowest cost HMO option based on your home zip code.

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 lowest cost Blue Shield HMO medical plan with employee only coverage. All 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, Dental and Vision Plan ID Cards

If enrolling for the first time in a medical or dental plan, you should receive identification (ID) cards within approximately one month of the effective date of your coverage. 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 and vision ID cards are not required for services.**

Mid-Year Change-in-Status Events

The enrollment options you elect during the 2021 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 IRC Section 125 Change-in-Status Event Matrix beginning on page 11.

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 certificate 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.

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)
- Supplemental 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 • Marriage • Birth/Adoption/ Placement for Adoption	Employee may enroll newly eligible dependent(s)	Employee may enroll or increase annual election amount	To enroll dependent in health benefits or enroll/increase annual FSA – HC election amount, you must submit the following forms (within 60 days of event), except as noted: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Marriage Certificate and Birth Certificate(s) or hospital printout of birth
Loss of Dependent • Divorce or annulment • Death	Employee must remove spouse; may enroll self and eligible dependent(s)	Employee may enroll, increase or decrease annual election	To remove spouse or enroll self/dependent(s) in health benefits or increase/decrease annual FSA-HC election amount, you must submit the following forms (within 60 days of event), except as noted: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Divorce, legal separation, or annulment • Death Certificate • Marriage/Birth Certificate(s)
Judgment, decree, or order resulting from divorce, annulment or change in legal custody that requires medical/ dental coverage for your dependent child(ren)	Employee may enroll dependent	Employee may increase annual election	To enroll dependent(s) in health benefits, you must submit the following forms (within 60 days of event), except as noted: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Judgment, decree or order • Birth Certificate(s)
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: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Proof of spouse/registered domestic partner's employer-sponsored coverage that includes the effective date • Benefit Waiver form
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: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Proof of spouse's/registered domestic partner's employment and benefit plan loss that includes loss of coverage effective date • Marriage/Birth Certificate(s)

*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: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Proof of Employment Status change • Marriage/Birth Certificate(s)
Dependent Ceases to Satisfy Plan Eligibility Requirements (i.e. Over age dependent)	Employee must remove dependent	Employee may decrease election	To remove dependent from health benefits or to decrease annual election amount you must submit the following forms (within 60 days of event), except as noted: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form* • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Proof of loss of eligibility (FSA only)
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: • Premium Deduction Election Form • Health Care (FSA) Plan Enrollment Form • Medical/Dental/Vision Plan Enrollment-Change Form(s) or Benefit Waiver form • Marriage/Birth Certificate(s) (enroll only)
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): • Premium Deduction Election Form • Medical/Dental/Vision Plan Enrollment-Change Form(s) • Proof of residence change • Marriage/Birth Certificate(s) (enroll only)
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): • Premium Deduction Election Form • Medical/Dental/Vision Plan Enrollment-Change Form(s) or Benefit Waiver form • Proof of gain/loss of Medicare or Medicaid • Marriage/Birth Certificate(s) • Benefit Waiver form

*within 30 days of the event.

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, Medi-Cal, or Medicare plan.

The medical options cover similar health care 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 8.

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 $50. 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**)**

Kaiser Permanente members have access on-line or via mobile application 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 those 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 Services 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 Services Department, toll free, Monday through Friday from 7:00 a.m. to 7:00 p.m. (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 in this Guide for a summary of covered expenses. Remember, this Guide only provides a summary of some 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 a day, seven days a week, except holidays at (800) 464-4000. You can also access their website at www.kp.org or use their mobile application for more information. To obtain assistance with disability and protected leaves paperwork, contact Kaiser's Release of Information Department in Fontana at (909) 609-3200.

Blue Shield Access+ 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 your health care, including making referrals to specialists and hospitals within your Participating Physician Group. The link to finding a provider is: www.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 most of the same medical benefits (copays) as the Access+ HMO® plan. Trio+ specialist care 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 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, including formulary use
- Assist you with claims, and much more

Free Features for Trio ACO HMO Members!

- **Heal** is an on-demand service that allows you to schedule the time and place to see a doctor. The first visit is $0!
- **Life Spring** is for individuals who qualify that have chronic conditions or nutritional needs;
- **Healthy Savings** is a card to help save on healthy items at select store locations;
- **Teladoc** is $0 copay;
- **Call the Car** is a car service for those who have a serious illness who need non-emergency medical transportation to their doctor appointments.

A case manager will inform you if you qualify. Flyers for these features are located on the Court's intranet.

How the Plan Works

You and your eligible dependents must choose a PCP from the Trio ACO 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 play 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: www.blueshieldca.com/networktriohmo.

Remember, becoming a Trio member has its advantages! There is Shield Concierge Customer Service which a one-stop number is 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 (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 non-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 non-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 non-network ("non-participating") provider.

Blue Shield's PPO network is available nationwide. To locate in-network providers in your area go to www.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 is 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 of 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 care, 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.

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.

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 ACCESS+HMO/BLUE SHIELD TRIO	KAISER HMO	BLUE SHIELD	
			In Network	Out-of-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 incl. on PPO)	$3,500 each member $7,000 employee plus two or family	$1,500 each member[1] $3,000 family maximum[1]	$3,500 each member $7,000 family maximum[1]	$4,400 each member $8,800 family maximum[1]
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 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 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 ded. waived)	You pay 30%
Prescription Drugs (per fill)[2]	**Pharmacy (up to a 30-day supply):** Contraceptive Drugs/Devices $0 Tier 1 Generic: $5 Tier 2 Brand-Name: $10 Tier 3 Non-Formulary: $25 Tier 4 & Specialty Drugs: 20%; up to $250 max copay/rx Drug Formulary: Plus Formulary; Pharmacy Network: Rx Ultra	**Pharmacy (up to 100-day supply):** Contraceptive Drugs/Devices: $0 Generic: $10 Formulary Brand: $15 Specialty Drugs: 20%; up to $100 per rx (30-day supply) Lifestyle and infertility drugs benefit is 50%	**Pharmacy (up to a 30-day supply):** Contraceptive Drugs/Devices: $0 Tier 1 Generic: $15 Tier 2 Brand-Name: $30 Tier 3 Non-Formulary: $45 Tier 4 & Specialty Drugs: 30% up to $250 max copay/rx Drug Formulary: Plus Formulary; Pharmacy Network: Rx Ultra	**Pharmacy (up to a 30-day supply):** Contraceptive Drugs and Devices: $0 Applicable Tier 1, 2 or 3 copay Tier 1 Generic: $15 + 25% of purchase price Tier 2 Brand-Name: $30 + 25% of purchase price Tier 3 Non-Formulary: $45 + 25% of purchase price Tier 4 & Specialty Drugs: 30% up to $250 max copay/rx + 25% of purchase price
	Mail Order (up to a 90-day supply): Contraceptive Drugs/Devices: $0 Tier 1 Generic: $10 Tier 2 Brand-Name: $20 Tier 3 Non-Formulary: $50 Tier 4 & Specialty Drugs: 20% up to $500 max copay/rx;	**Mail Order (up to 100-day supply):** Contraceptive Drugs/Devices: $0 Generic: $10 Formulary Brand: $15 Lifestyle and infertility drugs benefit is 50%	**Mail Order (up to 90-day supply):** Contraceptive Drugs/Devices: $0 Tier 1 Generic: $30 Tier 2 Brand-Name: $60 Tier 3 Non-Formulary: $90 Tier 4 & Specialty Drugs: 30% up to $500 max copay/rx	**Mail Order Drugs: Not covered**

[1]Some benefits do not count toward the out-of-pocket maximum. Please refer to the certificate of insurance or evidence of coverage booklet for details.

[2]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.

Dental

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

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, claim forms or calendar year maximums

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: www.deltadentalins.com and select "DeltaCare USA" network. 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 PPO Plus Premier Plan

The Delta Dental PPO Plus Premier 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 PPO 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 PPO 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 theirs is not available.

How to Find A Preferred or Premier PPO Dentist

To look for a PPO or Premier dentist, type this link into your browser: www.deltadentalins.com and select "Delta Dental PPO" network for PPO dentists or "Delta Dental Premier" network for Non-PPO dentists who are affiliated with Delta Dental. Premier dentists have an affiliation with Delta Dental, but they are considered Non-PPO providers. These dentists have filed fees with Delta Dental, but their discounts are not as great as PPO providers. The advantages of using a Premier versus a Non-Delta Dental affiliated dentist is their fees are discounted and there is no balance billing. You can call Delta Dental customer service at (800) 765-6003 for assistance in finding a provider or to ask your questions.

SmileWay® - A Dental Wellness for certain PPO Dental Plan Members!

There is a direct correlation between medical and dental health. SmileWay® wellness benefit is for PPO dental members who have been diagnosed with diabetes, heart disease, HIV/AIDS, rheumatoid arthritis or stroke. By opting into this program, members will have access to expanded services to help combat periodontal disease. These expanded services will replace the regular cleanings that are included in the plan. Every calendar year the member will receive a periodontal scaling and root planing and any combination of 4 services which can include prophylaxis, periodontal maintenance procedure, and/or scaling in presence of moderate to severe gingival inflammation. The services will be based upon your dentist's recommendations and will be covered at 100%!

To access SmileWay®, PPO members must first register on the Delta Dental portal at www.deltadentalins.com. Upon registering click on the "Optional Benefits" tab to the left of the screen then click "Opt In" next to the name of the family member who wants to enroll. Complete and submit the form then you'll be on your way. The next time you login the website you'll see a notation that you're enrolled in the SmileWay® program. This program is based upon the honor system and members will not need to provide medical documents.

Dental Plan Highlights

The following chart provides highlights of the dental benefits available through the DeltaCare USA DHMO and the Delta Dental PPO 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 PPO 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 • Oral Exams*	No charge	No charge	No charge
• Full mouth X-rays - once every 24 months	No charge (every 24 months)	No charge (every 36 months)	No charge (every 36 months)
• Emergency, palliative treatment • Prophylaxis (cleanings*)	$5	No charge	No charge
	No charge, 2 per CY	No charge, up to 2 per CY	No charge, up to 2 per CY
Adjunctive General Services • External bleaching – self-treatment with bleaching tray & gel, limitation applies	$125 each	Not covered	Not covered
• Occlusal guard (night guard), by report – limited to every 3 years	$95	Not covered	Not covered
• Sealant per tooth (limited to molars)	No charge (to age 16)	No charge (to age 15)	No charge (to age 15)
• Fluoride (to age 19)	No charge	No charge	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 pulpotomy, 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 • Orthodontic treatment fee (24 months treatment plan for comprehensive banding)		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 PPO 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, Target Optical, Pearle Vision and select independent Doctor 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 through Special Offers
- 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 and use the "Find an Eye Doctor" 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 administered by P&A.

To participate or continue participation in either or both of these plans, you **must enroll/re-enroll** to make a new election each year. The plan year for both FSA plans is January 1, 2021 through December 31, 2021.

Flex Spending Account – Health Care

This plan is offered to all eligible employees who are in a regular position and receiving a minimum of forty (40) hours per pay period or on an approved leave designated as FMLA. 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 or 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 for 2021 is **$2,750**.

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. All over the counter medications and feminine care products are now eligible expenses. Expenses solely for cosmetic reasons (e.g. health spas, vitamins, etc.) are not considered eligible expenses for health care.

Reimbursement

You may apply for reimbursement of qualifying medical care expenses using your Debit Card by QuikClaim, via the mobile application site, by secure online upload to www.padmin.com, by toll-free fax, or by submitting a completed claim form to P&A Group 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 and receiving a minimum of forty (40) hours per pay period or on an approved leave designated as FMLA. 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 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 Mobile App or complete a claim form and submit by fax, mail, or online and attach an itemized statement for services or use your 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) & 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 to P&A Group for 2020 is March 31, 2021.

Carry over up to $550! At the end of the Plan Year, if any balance remains, you can carry over up to $550 for use in the following plan year! Any balance over this amount is forfeited. The carry over applies to only 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	$0.110
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 $200,000. Guaranteed coverage up to $20,000 upon initial eligibility. All amounts elected after initial eligibility require evidence of insurability.
- 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 is 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. Coverage maximum is $1,000,000. 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.

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.

Employee 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 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.

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/payroll deduction authorization form 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
8	$350,000	$175,000	$25,000
9	$500,000	$250,000	$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	$0.013 per $1,000 per month
Employee and family	$0.022 per $1,000 per month

More about Supplemental Life 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 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 paid 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) 368-2859 or complete a claim form online at 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 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 for exempt employees, 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.

Critical Illness Voluntary Insurance

Critical Illness insurance provides cash when you are diagnosed with a serious illness. You can use the money for medical expenses like copays and deductibles during treatment or recovery. You can also put the money toward living costs like utilities, groceries and childcare. The benefits are paid in a lump sum directly to you for a covered illness; you can take them with you if you leave the Court; your children under age 26 are automatically covered under your plan at no additional cost; and there are 21 different Health Maintenance Screenings which pay additional benefits for each covered family member.

Please see the Critical Illness flyer and enrollment form on the Court's intranet for more details. There are no diagnosis waiting periods or lifetime benefit maximums, but employees and spouses must be under age 65 to enroll. Coverage is available until age 80.

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 at no cost to you. 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. Childcare, 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 or visit the website http://sbcsc.acieap.com/ 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 a 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 none of the above conditions are met, 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 01/21 and you will see the election change on the pay warrant dated January 8, 2021.

For **Tier 2** members, refundable contributions are 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

Entry Age	Refundable (%)	Non-Refundable (%)
6	9.15	8.62
17	9.29	8.75
18	9.43	8.89
19	9.58	9.03
20	9.73	9.17
21	9.88	9.31
22	10.04	9.46
23	10.19	9.60
24	10.35	9.75
25	10.52	9.92
26	10.68	10.07
27	10.85	10.23
28	11.01	10.38
29	11.19	10.55
30	11.37	10.71
31	11.56	10.89
32	11.73	11.06
33	11.92	11.24
34	12.13	11.42
35	12.33	11.61
36	12.53	11.81
37	12.75	12.01
38	12.96	12.23
39	13.20	12.44
40	13.44	12.67
41	13.67	12.88
42	13.90	13.09
43	14.13	13.31
44	14.37	13.54
45	14.60	13.75
46	14.80	13.94
47	15.00	14.13
48	15.17	14.29
49	15.29	14.41
50	15.39	14.50
51	15.47	14.58
52	15.55	14.65
53	15.32	14.43
54 & Over	14.84	13.98

Tier 2 Members

Employer	Refundable (%)
County General	9.11
Superior Court	9.11
SCAQMD	8.16
Other General	9.06

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:

Currently the Court offers retiree medical plans and the retiree rates are blended with the active employee rates. Both are subject change each year. Should either of these be changed in the future, you will be notified.

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 their 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 their 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 website: www.blueshieldca.com/networkhmo or www.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: www.blueshieldca.com/networkhmo or www.blueshieldca.com/networktriohmo.

Federal 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.

California "Cal-COBRA" Extension

Beginning July 1, 2004 (AB 1401), Federal COBRA participants may qualify for an extension of medical benefits through the insurance carrier. This extension allows all California residents the opportunity to continue their Federal COBRA coverage for an additional 18-months through Cal-COBRA, for a total of 36 months of medical continuation coverage. The insurance carrier may charge up to 110% of the cost for the additional 18-months.

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

If you or your children are eligible for Medi-Cal/Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medi-Cal/Medicaid or CHIP and you live in California, contact the State Medicaid office listed below to find out if premium assistance is available.

CALIFORNIA - Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 1-800-541-5555

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** 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 or call 1-(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
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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.

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
- 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, 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 20, 2020
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:	(909) 521-3700

PRIVACY NOTICE

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN BERNARDINO NOTICE OF PRIVACY PRACTICES - EFFECTIVE JANUARY 1, 2021

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/
- 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

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

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

Superior Court of California, County of San Bernardino Court Flexible Spending Account Administrator:

P&A Administrative Services, Inc.

Jaime Smith, IT Security Officer
Ph: (800) 688-2611 ext. 5434 / Fax: (716) 851-8923
smithj@padmin.com

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, 2020 for coverage starting as early as January 1, 2021.

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 9.83% (9.78% for the 2020 plan year) of your household income for the 2021 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 or by 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 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.

If you decide to shop for coverage in the Marketplace, http://www.healthcare.gov will guide you through the process. Below is the employer information you'll enter when you visit http://www.healthcare.gov to find out if you can get a tax credit to lower your monthly premiums. This information is numbered to correspond to the Marketplace application.

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

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: szenzen@sb-court.org	

Here is some basic information about health coverage offered by the Superior Court of California, County of San Bernardino (the Court):

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ■ Some employees. Eligible employees are:

  Employees in a regular position scheduled and paid for a minimum of forty (40) hours per pay period.
- With respect to dependents:
  - ■ We do offer coverage. Eligible dependents are: Legal Spouse as recognized under applicable state law, California State Registered Domestic Partner, Child to age 26, Children of any age who are supported primarily by the employee and spouse/California-State Registered Domestic Partner, who are incapable of self-sustaining employment by reason of mental or physical disability.
  - ☐ We do not offer coverage
- ■ If filled, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based upon employee wages.

**Even if the Court intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

NOTES:

For More Information

BENEFIT PLAN	TELEPHONE CONTACT	WEBSITE
Medical • Blue Shield Access+ HMO • Blue Shield Trio ACO HMO • Blue Shield PPO • Kaiser HMO	(855) 599-2649 (855) 829-3566 (855) 599-2649 (800) 464-4000	www.blueshieldca.com www.kp.org
Dental • DeltaCare USA DHMO • Delta Dental DPPO	(800) 422-4234 (888) 335-8227	www.deltadentalins.com
Vision • EyeMed Vision Care	(866) 939-3633	www.eyemedvisioncare.com
EAP (Employee Assistance Program) ACI	(800) 932-0034	http://sbcsc.acieap.com
Flex Spending Accounts (FSAs) P&A Group • Flex Spending Account – Health Care (FSA-HC) • Flex Spending Account – Dependent Care (FSA-DCAP)	(800) 688-2611	www.padmin.com
Disability Insurance Standard Group Insurance • Short-Term Disability (STD) • Long-Term Disability (LTD) • Critical Illness	(800) 368-2859 (866) 851-2429	www.standard.com www.standard.com
Life Insurance Securian • Basic Life Insurance • Supplemental Life Insurance • Variable Group Universal Life (VGUL) • AD&D Insurance	(877) 282-1752	www.securian.com
Retirement Plans VOYA • 457(b) Deferred Compensation Plan • 401(k) Salary Savings Plan • 529 Educational Savings Plan	(909) 748-6468 (800) 584-6001	http://voya.com
San Bernardino County Retirement Association (SBCERA)	(909) 885-7980 (877) 722-3721	www.sbcera.org

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. Plan documents can be viewed on the Court's intranet or by contacting Human Resources.