

COUNTY OF COLUSA NOTICE OF APPOINTMENT

Employee Information

IMPORTANT – ALL ITEMS MUST BE COMPLETED

EMPLOYEE NAME (Must be same as shown on Social Security Card): _____

U.S. CITIZEN: Yes / No (Circle one)

SOCIAL SECURITY #: _____

DRIVERS LICENSE #: _____

ADDRESS: _____

STATE: _____

CITY, STATE, ZIP: _____

SEX: Male / Female (Circle one)

MAIN CONTACT PHONE #: _____

MARITAL STATUS: _____

DATE OF BIRTH: _____

ARE YOU A FORMER COLUSA COUNTY EMPLOYEE? Yes / No (Circle one) WHEN: _____

HAVE YOU EVER BEEN A MEMBER OF A CALPERS RETIREMENT AGENCY?

IF YES, ENTER NAME OF AGENCY (IES): _____

DO YOU HAVE ANY OTHER PREVIOUS PUBLIC EMPLOYMENT IN CALIFORNIA NOT COVERED BY CALPERS?
Yes / No (Circle one)

IF YES, ENTER NAME OF AGENCY (IES): _____

CONFIDENTIAL

This data is for use for Notice of Appointment purposes only. Please shred once Notice of Appointment has been completed. Thank you!

EMPLOYEE ONBOARDING CHECKLIST



NEW HIRE PACKET INSTRUCTIONS

Please fill out all of the forms and **return the completed documents on your first day of employment.**

- Fill out both copies of the Designation of Person Authorized to Receive Warrants form, as we will need two originals. Do not make any corrections or changes to the form or it will not be valid. Extra copies are available in Human Resources if need.
- CalPERS health benefit insurance: if you have other health coverage and would like to decline County-sponsored coverage, please make sure the Health Plan Coverage Waiver form is completed.
- Vision and life insurance are mandatory for all permanent employees unless the employee can provide proof of other coverage. If you have other dental coverage and would like to decline County-sponsored coverage, please complete the Dental Plan Coverage Waiver form.
- Dental coverage is required for all permanent employees unless the employee can provide proof of other coverage. If you have other dental coverage and would like to decline County-sponsored coverage, please complete the Dental Plan Coverage Waiver form.
- If you are married and are enrolling your spouse in County-sponsored Health/Dental/Vision insurance, we will need a copy of your marriage certificate. See Benefits Enrollment Required Documentation sheet in New Hire Packet for a complete list of required items for insurance enrollment.
- If you have any questions or need assistance in completing any forms, please feel free to contact us at (530) 458-0420.
- On the reverse side of this form is a checklist of the forms and documents that need to be returned. **Please make sure that all forms are filled out completely on your first day of employment.**



EMPLOYEE HIRING CHECKLIST



PLEASE BE SURE ALL OF THE FOLLOWING DOCUMENTS ARE COMPLETED AND RETURNED TO HUMAN RESOURCES ON YOUR FIRST DAY OF EMPLOYMENT:

- ☐ W-4 (Federal Withholding form)
- ☐ DE-4 (State Withholding form)
- ☐ Direct Deposit Form (Lime Green)
- ☐ Warrant Designation Form (2 Originals)
- ☐ *CalPERS HBD-12 (Health Insurance Form) OR HBD-12 form completed with declined box checked in section 17 and health Plan Coverage Waiver form completed + Proof of other coverage
- ☐ *Health Reimbursement Arrangement Proof of Alternate Coverage form (To be eligible for your contribution during your 1st month of employment) OR Health Reimbursement Arrangement Waiver of Participation Form Coverage form
- ☐ *Vision Insurance form
- ☐ *Dental Insurance form OR completed with declined box checked and Dental Plan Coverage Waiver form completed + proof of other coverage
- ☐ Life Insurance form
- ☐ CalPERS Reciprocal Self-Certification form
- ☐ County Policies Signature Pages
- ☐ Employee Association form (CCEA/CCDSA/MGMT)
- ☐ Information Requirement Notice

***Please refer to Benefits Enrollment Required Documentation sheet for list of items needed for enrollment in County-sponsored medical, dental and/or vision insurance plans.**



BENEFITS ENROLLMENT REQUIRED DOCUMENTATION COUNTY OF COLUSA

If you plan to **enroll yourself and/or your eligible dependents** into medical, dental and/or vision plans please provide the following documents:

EMPLOYEE

- Copy of your birth Certificate
and
- Copy of your Social Security Card

SPOUSE OR REGISTERED DOMESTIC PARTNER

- Copy of Marriage Certificate or Copy of the Declaration of Domestic Partnership registered with the Secretary of State
and
- Copy of Spouse's Social Security Card

CHILDREN UNDER THE AGE OF 26

(Natural born, adopted or step (by traditional marriage or domestic partnership))

- Copy of birth certificate or adoption papers
and
- Copy of Child's Social Security Card

CERTIFIED "PARENT-CHILD RELATIONSHIP" CHILDREN

- Affidavit of Parent-Child Relationship (CalPERS form HBD-40)
and
- Copy of Child's Social Security Card

CERTIFIED DISABLED DEPENDENT OVER AGE OF 26

- Member Questionnaire for the Disabled Dependent Benefit (CalPERS form HBD 98)
and
- Medical Report for the CalPERS Disabled Dependent Benefits (CalPERS form HBD 34)
and
- Copy of Child's Social Security Card

If you have any questions please contact Human Resources at 530-458-0420.

Employee's Withholding Certificate

OMB No. 1545-0074

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**Give Form W-4 to your employer.****Your withholding is subject to review by the IRS.****2023****Step 1:
Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

**Step 2:
Multiple Jobs
or Spouse
Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Reserved for future use.
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	Multiply the number of other dependents by \$500 \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$ _____

**Step 5:
Sign
Here**

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.)

Date

**Employers
Only**

Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter:

• \$27,700 if you're married filing jointly or a qualifying surviving spouse • \$20,800 if you're head of household • \$13,850 if you're single or married filing separately	}	
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2 \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City, State, and ZIP Code	Filing Status Single or Married (with two or more incomes) Married (one income) Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.

- 1a. Number of Regular Withholding Allowances (Worksheet A) _____
 1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.) _____
 1c. Total Number of Allowances you are claiming _____

2. Additional amount, if any, you want withheld each pay period (if employer agrees), (**Worksheet C**) _____
 OR

Exemption from Withholding

3. I claim exemption from withholding for 2022, and I certify I meet both of the conditions for exemption. (Check box here)

OR

4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here)

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number
--	--

Purpose: This certificate, DE 4, is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California PIT withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

- (i) Your spouse is a member of the armed forces present in California in compliance with military orders;
- (ii) You are present in California solely to be with your spouse; and
- (iii) You maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The *California Employer's Guide (DE 44)* (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return (FTB Form 540)*, visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined \$500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:

- Do you claim allowances for dependents or blindness?
- Will you itemize your deductions?
- Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box “SINGLE or MARRIED (with two or more incomes).” Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the “Head of Household” marital status box if you meet all of the following tests:

- (1) Your spouse will not live with you **at any time** during the year;
- (2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
- (3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual’s personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A

Regular Withholding Allowances

- | | |
|--|-----|
| (A) Allowance for yourself — enter 1 | (A) |
| (B) Allowance for your spouse (if not separately claimed by your spouse) — enter 1 | (B) |
| (C) Allowance for blindness — yourself — enter 1 | (C) |
| (D) Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1 | (D) |
| (E) Allowance(s) for dependent(s) — do not include yourself or your spouse | (E) |
| (F) Total — add lines (A) through (E) above and enter on line 1a of the DE 4 | (F) |

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year’s FTB Form 540 as a model to calculate this year’s withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each \$1,000, or fraction of \$1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B

Estimated Deductions

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

- | | |
|---|------|
| 1. Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540 | 1. |
| 2. Enter \$9,606 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or \$4,803 if single or married filing separately, dual income married, or married with multiple employers | 2. |
| 3. Subtract line 2 from line 1, enter difference | = 3. |
| 4. Enter an estimate of your adjustments to income (alimony payments, IRA deposits) | + 4. |
| 5. Add line 4 to line 3, enter sum | = 5. |
| 6. Enter an estimate of your nonwage income (dividends, interest income, alimony receipts) | – 6. |
| 7. If line 5 is greater than line 6 (if less, see below [go to line 9]);
Subtract line 6 from line 5, enter difference | = 7. |
| 8. Divide the amount on line 7 by \$1,000, round any fraction to the nearest whole number
enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise stop here . | 8. |
| 9. If line 6 is greater than line 5;
Enter amount from line 6 (nonwage income) | 9. |
| 10. Enter amount from line 5 (deductions) | 10. |
| 11. Subtract line 10 from line 9, enter difference. Then, complete Worksheet C. | 11. |

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C

Additional Tax Withholding and Estimated Tax

1. Enter estimate of total wages for tax year 2022. 1.
2. Enter estimate of nonwage income (line 6 of Worksheet B). 2.
3. Add line 1 and line 2. Enter sum. 3.
4. Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest). 4.
5. Enter adjustments to income (line 4 of Worksheet B). 5.
6. Add line 4 and line 5. Enter sum. 6.
7. Subtract line 6 from line 3. Enter difference. 7.
8. Figure your tax liability for the amount on line 7 by using the 2022 tax rate schedules below. 8.
9. Enter personal exemptions (line F of Worksheet A x \$141.90). 9.
10. Subtract line 9 from line 8. Enter difference. 10.
11. Enter any tax credits. (See FTB Form 540). 11.
12. Subtract line 11 from line 10. Enter difference. This is your total tax liability. 12.
13. Calculate the tax withheld and estimated to be withheld during 2022. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2022. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2022. 13.
14. Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld. 14.
15. Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4. 15.

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2022 Only

**Single Persons, Dual Income
Married With Multiple Employers**

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$9,325	1.100%	\$0	\$0.00
\$9,325	\$22,107	2.200%	\$9,325	\$102.58
\$22,107	\$34,892	4.400%	\$22,107	\$383.78
\$34,892	\$48,435	6.600%	\$34,892	\$946.32
\$48,435	\$61,214	8.800%	\$48,435	\$1,840.16
\$61,214	\$312,686	10.230%	\$61,214	\$2,964.71
\$312,686	\$375,221	11.330%	\$312,686	\$28,690.30
\$375,221	\$625,369	12.430%	\$375,221	\$35,775.52
\$625,369	\$1,000,000	13.530%	\$625,369	\$66,868.92
\$1,000,000	and over	14.630%	\$1,000,000	\$117,556.49

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$18,650	1.100%	\$0	\$0.00
\$18,650	\$44,214	2.200%	\$18,650	\$205.15
\$44,214	\$69,784	4.400%	\$44,214	\$767.56
\$69,784	\$96,870	6.600%	\$69,784	\$1,892.64
\$96,870	\$122,428	8.800%	\$96,870	\$3,680.32
\$122,428	\$625,372	10.230%	\$122,428	\$5,929.42
\$625,372	\$750,442	11.330%	\$625,372	\$57,380.59
\$750,442	\$1,000,000	12.430%	\$750,442	\$71,551.02
\$1,000,000	\$1,250,738	13.530%	\$1,000,000	\$102,571.08
\$1,250,738	and over	14.630%	\$1,250,738	\$136,495.93

Unmarried Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...	PLUS	
\$0	\$18,663	1.100%	\$0	\$0.00
\$18,663	\$44,217	2.200%	\$18,663	\$205.29
\$44,217	\$56,999	4.400%	\$44,217	\$767.48
\$56,999	\$70,542	6.600%	\$56,999	\$1,329.89
\$70,542	\$83,324	8.800%	\$70,542	\$2,223.73
\$83,324	\$425,251	10.230%	\$83,324	\$3,348.55
\$425,251	\$510,303	11.330%	\$425,251	\$38,327.68
\$510,303	\$850,503	12.430%	\$510,303	\$47,964.07
\$850,503	\$1,000,000	13.530%	\$850,503	\$90,250.93
\$1,000,000	and over	14.630%	\$1,000,000	\$110,477.87

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit [FTB](https://ftb.ca.gov) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

COLUSA COUNTY

HUMAN RESOURCES DEPARTMENT



DAR RHODES
Human Resources Director

250 5th Street
Colusa, CA 95932
(530) 458-0420
(530) 458-0425 fax

Information Requirements Notice

Pursuant to the current Memorandums of Understanding, the Human Resources Department is required to provide the following information to the Colusa County Employees' Association (CCEA):

- Name
- Job Title
- Work Location
- Personal telephone number (may be home or cellular as provided by the employee)
- Home address

Optional:

- Personal email address if provided by the employee and on file with the County (new hires only)

We are required to share your personal email address unless you request to the County and CCEA to withhold disclosure of your email address.

Please indicate below if you give your consent for your personal email address to be disclosed.

- ☐ Yes, I consent for my personal email address to be disclosed.
- ☐ No, I do not consent for my personal email address to be disclosed. *Note: provide this completed form to the CCEA.*

The above information will be provided on a monthly basis, except that the County is not required to provide personal telephone numbers, home addresses or personal email addresses unless requested by CCEA.

Name: _____ Email: _____

Signature: _____ Date: _____

COUNTY OF COLUSA
DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS
(Government Code Section 53245)

Check One:

- ☐ **NEW DESIGNATION**
☐ **REPLACES PREVIOUS DESIGNATION**
☐ **DECLINES TO DESIGNATE A DESIGNEE - DO NOT COMPLETE SECTION 2**
(Failure to designate an individual or trust will result in payroll money due at time of death being administered under the California Probate Code, which will delay distribution of funds for at least forty days.)

SECTION 1 – EMPLOYEE INFORMATION

Name – Last First M.I. Social Security Number

--

Mailing Address – Street Address/P.O. Box City State Zip

--

SECTION 2 – DESIGNEE INFORMATION

NOTE- THIS DESIGNATION DOES NOT APPLY TO RETIREMENT BENEFITS

Under the provisions of Section 53245 of the Government Code in the event of my death, I hereby designate the following person to be entitled to receive all payroll warrants payable to me by the County of Colusa had I survived:

Name – Last First M.I. Social Security Number Phone Number

--

Mailing Address – Street Address/P.O. Box City State Zip

--

SECTION 3 – EMPLOYEE APPROVAL

This designation cancels and replaces any previously signed by me for this purpose and shall remain in effect until canceled in writing by me. It is expressly understood that the County of Colusa is not obliged to deliver said warrant to the person designated herein unless said designated person, within one year after the date of said warrant or warrants, claims said warrants from the Auditor/Controller of the County of Colusa and provides to said Auditor/Controller sufficient proof to identify pursuant to the provisions of Section 53245 of the California Government Code.

EMPLOYEE SIGNATURE

DATE

ORIGINALS (2): PAYROLL, HUMAN RESOURCES

07/2017

EMPLOYEE INSTRUCTIONS

Purpose of this form-

This form is used to designate the person you want to receive any payroll money (also called “warrants”) owed to you in the event of your death. Doing this makes it easier for the person you designate to receive pay owned to you after your death.

If you don't wish to designate someone you must still fill out the form. Payroll money due at the time of death must then be administered under the California Probate Code, which will delay distribution of funds for at least forty days.

NOTE: This form affects payroll money only; it does not affect retirement benefits.

How to fill out this form-

Top of the form: Make sure you check one of the boxes at the top

- New Designation- check this box when and if you first wish to designate someone
- Replaces Previous Designation- check this box if you have already designated someone you wish to designate a different person
- Declines To Designate A Designee- check this box if you do not wish to designate anyone

Section 1: This section must be filled out even if you are not designating anyone

Section 2: To designate someone, print their full name (i.e. Mary Jane Smith, not Mrs. John E. Smith), Social Security number, phone number, and complete mailing address. (You may designate only one person.)

Section 3: Be sure to sign and date the form in ink (whether you are designating someone or not).

Submitting the form-

Submit two signed originals of this form to the Human Resources (HR) Department. The documents will be kept in you personnel and payroll files.

Verify that the form is complete and correct. **No erasures or corrections may be made in the writing of the name of the designee. If any error has been made, complete a new set of forms.**

You may change your designation at any time by completing two new forms with the HR Department. Inform the HR Department when a change in your designee's address occurs, so that new forms can be completed.

You may wish to file a new designation upon any change in your marital status.

COUNTY OF COLUSA
DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS
(Government Code Section 53245)

Check One:

- ☐ **NEW DESIGNATION**
- ☐ **REPLACES PREVIOUS DESIGNATION**
- ☐ **DECLINES TO DESIGNATE A DESIGNEE - DO NOT COMPLETE SECTION 2**
(Failure to designate an individual or trust will result in payroll money due at time of death being administered under the California Probate Code, which will delay distribution of funds for at least forty days.)

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Name – Last First M.I. Social Security Number

--

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NOTE- THIS DESIGNATION DOES NOT APPLY TO RETIREMENT BENEFITS

Under the provisions of Section 53245 of the Government Code in the event of my death, I hereby designate the following person to be entitled to receive all payroll warrants payable to me by the County of Colusa had I survived:

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--

Mailing Address – Street Address/P.O. Box City State Zip

--

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This designation cancels and replaces any previously signed by me for this purpose and shall remain in effect until canceled in writing by me. It is expressly understood that the County of Colusa is not obliged to deliver said warrant to the person designated herein unless said designated person, within one year after the date of said warrant or warrants, claims said warrants from the Auditor/Controller of the County of Colusa and provides to said Auditor/Controller sufficient proof to identify pursuant to the provisions of Section 53245 of the California Government Code.

EMPLOYEE SIGNATURE

DATE

ORIGINALS (2): PAYROLL, HUMAN RESOURCES

EMPLOYEE INSTRUCTIONS

Purpose of this form-

This form is used to designate the person you want to receive any payroll money (also called “warrants”) owed to you in the event of your death. Doing this makes it easier for the person you designate to receive pay owned to you after your death.

If you don't wish to designate someone you must still fill out the form. Payroll money due at the time of death must then be administered under the California Probate Code, which will delay distribution of funds for at least forty days.

NOTE: This form affects payroll money only; it does not affect retirement benefits.

How to fill out this form-

Top of the form: Make sure you check one of the boxes at the top

- New Designation- check this box when and if you first wish to designate someone
- Replaces Previous Designation- check this box if you have already designated someone you wish to designate a different person
- Declines To Designate A Designee- check this box if you do not wish to designate anyone

Section 1: This section must be filled out even if you are not designating anyone

Section 2: To designate someone, print their full name (i.e. Mary Jane Smith, not Mrs. John E. Smith), Social Security number, phone number, and complete mailing address. (You may designate only one person.)

Section 3: Be sure to sign and date the form in ink (whether you are designating someone or not).

Submitting the form-

Submit two signed originals of this form to the Human Resources (HR) Department. The documents will be kept in your personnel and payroll files.

Verify that the form is complete and correct. **No erasures or corrections may be made in the writing of the name of the designee. If any error has been made, complete a new set of forms.**

You may change your designation at any time by completing two new forms with the HR Department. Inform the HR Department when a change in your designee's address occurs, so that new forms can be completed.

You may wish to file a new designation upon any change in your marital status.



California Public Employees' Retirement System
P.O. Box 942709 Sacramento, CA 94229-2709
888 CalPERS (or 888-225-7377)
TTY: (877) 249-7442 | Fax: (916) 795-4166
www.calpers.ca.gov

Employer Account Management Division

Dear Member,

The California Public Employees' Retirement System (CalPERS) requires all members hired after January 1, 2013 complete the ***Reciprocal Self-Certification Form (PERS-EAMD-801)*** to provide essential information that will be used by your employer to enroll you in CalPERS membership.

This form obtains information regarding your membership in other qualifying public retirement systems and *must be returned to your employer within 10 business days of receipt*. Use the instructions provided on the back of the form and reference the List of Qualifying Public Retirement Systems for assistance. Information regarding your membership in a defined benefit plan for any of the listed qualifying public retirement system must be provided. **However, information related to CalPERS membership should not be included when completing this form, as this data is already stored in the CalPERS system.**

It is your responsibility to ensure the accuracy and completeness of the information you provide. Inaccurate information may result in adjustments to your account which could lead to adverse impacts such as incurring financial obligations that you and your employer will be responsible to fulfill.

For more information regarding the ***Reciprocal Self-Certification Form***, please visit our website at www.calpers.ca.gov.

Please note: The completion of the ***Reciprocal Self-Certification Form*** does not establish [reciprocity](#), nor is it a request to establish reciprocity. To request that reciprocity be established, download the **When You Change Retirement Systems (PUB 16)** publication to obtain the **Confirmation of Intent to Establish Reciprocity When Changing Retirement Systems (PERS-CASD-255)** form. This publication is available at www.calpers.ca.gov.

Sincerely,

Membership Services

Enclosures: List of Qualifying Public Retirement Systems in California, ***Reciprocal Self-Certification Form***, and Directions for Completing Reciprocal Self-Certification Form

List of Qualifying Public Retirement Systems in California

Name of Public Retirement System	Qualifications:
Alameda County Employees' Retirement Association [^]	
City and County of San Francisco Employees' Retirement System*	
City of Concord Retirement System*	
City of Costa Mesa Public Retirement System*	Safety only
City of Fresno Retirement System	
City of Pasadena Fire and Police Retirement System	Fire and police only
City of San Clemente*	Non-safety (miscellaneous) only
Contra Costa County Employees' Retirement Association [^]	
Contra Costa Water District	
East Bay Municipal Utility District	
East Bay Regional Park District	Safety only
Fresno County Employees' Retirement Association [^]	
Imperial County Employees' Retirement Association [^]	
Judges Retirement System II	
Kern County Employees' Retirement System [^]	
Legislators' Retirement System	
Los Angeles City Employees' Retirement System	Non-safety (miscellaneous) only; L.A. Fire and Police Pension System and L.A. Water and Power Employees' Retirement System not eligible
Los Angeles County Employees' Retirement Association [^]	
Los Angeles County Metropolitan Transportation Authority	Non-contract Employees' Retirement Income Plan, formerly Southern California Rapid Transit District
Marin County Employees' Retirement Association [^]	
Mendocino County Employees' Retirement Association [^]	
Merced County Employees' Retirement Association [^]	
Oakland Municipal Employees' Retirement System (City of Oakland)	Non-safety (miscellaneous) only
Orange County Employees' Retirement System [^]	
Sacramento City Employees' Retirement System*	
Sacramento County Employees' Retirement System [^]	Defined benefit plan only; cash balance plans not eligible
San Bernardino County Retirement Association [^]	
San Diego City Employees' Retirement System	Defined benefit plan only; cash balance plans not eligible
San Diego County Employees' Retirement Association [^]	
San Joaquin County Employees' Retirement Association [^]	
San Jose Federated City Employees' Retirement System	
San Luis Obispo County Pension Trust	
San Mateo County Employees' Retirement Association [^]	
Santa Barbara County Employees' Retirement System [^]	
Sonoma County Employees' Retirement Association [^]	
Stanislaus County Employees' Retirement Association [^]	
State Teachers' Retirement System	Defined benefit plan only; cash balance plans not eligible
Tulare County Employees' Retirement Association [^]	
University of California Retirement Program	Defined benefit plan only; cash balance plans not eligible
Ventura County Employees' Retirement Association [^]	
*=Also CalPERS-covered agency	[^] =1937 Act Counties



California Public Employees' Retirement System
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TTY: (877) 249-7442 | Fax: (916) 795-4166
www.calpers.ca.gov

Reciprocal Self-Certification Form

Complete the following information and return this form to your personnel office **within 10 business days**. To ensure this form is completed correctly, please reference the enclosed List of Qualifying Public Retirement Systems and instructions.

Section 1. Member Information	
Member Name:	(Last) (First) (Middle)
Date of Birth:	CalPERS ID:
Membership Status in Qualifying Public Retirement Systems: ☐ I have not been a member of a qualifying public retirement system in California. (skip to section 3) ☐ I have membership in a defined benefit plan under a qualifying public retirement system in California other than CalPERS. (complete section 2 with membership information for each qualifying public retirement system)	

Section 2. Qualifying Reciprocal Membership Information			
Name of Most Recent Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐ Retired* or ☐ Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐ Retired* or ☐ Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐ Retired* or ☐ Refunded* Date: / /

**Please provide dates, if applicable. Not all sections may be applicable for each Public Retirement System.*

Section 3. Sign and Certify
I understand that by accepting employment in a qualified public retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form is not a request to establish reciprocity.
I hereby certify that the foregoing information has been verified with the qualifying public retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.
Member Signature: _____ Date: _____

Section 4. To Be Completed by Employer Only	
Name of CalPERS Agency:	
CalPERS Business Partner ID:	Member's Enrollment Eligibility Date:
Designee of Employer: (print name)	Designees' Title:
Designee Signature: _____	Date: _____
The employer must retain this form in the member's file for auditing purposes.	
<i>For more direction regarding how to process the Reciprocal Self-Certification Form, please refer to our employer reference guides.</i>	

Instructions for Completing the Reciprocal Self-Certification Form

Section 1. Member Information	• Complete the required fields with your name, date of birth, and CalPERS ID. • Check one of the appropriate boxes to indicate if you have had membership in a defined benefit plan in one of the qualifying public retirement systems named on the enclosed list. – If you have not been a member of any of the qualifying public retirement systems, mark the first box and skip to section 3. – If you have membership in a defined benefit plan of any of the qualifying public retirement systems on the enclosed list, mark the second box and continue to section 2. – This form is to obtain information regarding your membership in <u>other</u> qualifying public retirement systems; do not include CalPERS membership on this form.
Section 2. Qualifying Reciprocal Membership Information	• In the first column, titled “Name of Public Retirement System,” list the name of any qualifying public retirement systems you are a member of a defined benefit plan. – If you are a member of multiple qualifying public retirement systems, please provide the name of each system beginning with the most recent in descending order. – Please reference the enclosed List of Qualifying Public Retirement Systems in California. Only systems named on this list should be provided on the Reciprocal Self-Certification Form. • In the second column, titled “Membership Date,” list your membership date in the qualifying public retirement system. – You must provide a full date, including month, date, and year, which corresponds to each qualifying public retirement system listed. – If you are unsure of your membership date, please contact the qualifying public retirement system to confirm information prior to completing the form. • In the third column, titled “Separation Date,” list your separation date from the qualifying public retirement system. – This section may not be applicable for all qualifying public retirement systems. If you have not separated from the qualifying public retirement system, leave this field blank. – If you have separated from the qualifying public retirement system, you must provide a full date including month, date, and year. – If you are unsure of your separation date, please contact the qualifying public retirement system to confirm information prior to completing the form. • In the fourth column, titled “Retired or Refunded,” indicate if you have retired or refunded from the qualifying public retirement system. – This section may not be applicable for all qualifying public retirement systems. If you have not retired or refunded from the qualifying public retirement system, leave this field blank. – If you have retired or refunded from the qualifying public retirement system, mark the appropriate box and provide a full date including month, date, and year. – Retired: You have separated from the qualifying public retirement system and receive a monthly retirement allowance. – Refunded: You have terminated your membership in the qualifying public retirement system by withdrawing your contributions.
Section 3. Sign and Certify	• Please read the statement. Then, sign your name and date the document before returning it to your personnel office.

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at **888 CalPERS** (or 888-225-7377).



Health Benefits Plan Enrollment for Active Employees (HBD-12)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or 888-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

SECTION A: Applicant Information

1. Employee Name: (First) (M.I.) (Last)			2. Hire Date: (mm/dd/yyyy)	
3. CalPERS ID or Social Security Number:		4. Date of Birth: (mm/dd/yyyy)		5. Gender: ☐ Male ☐ Female ☐ Nonbinary
6. Physical Address: (Street) (City) (State) (ZIP) (County)				
7. Mailing Address (If different): (Street) (City) (State) (ZIP) (County)				
8. Use Work ZIP Code for Health Eligibility: ☐ Yes ☐ No If yes, enter zip code here: (ZIP)				
9. E-mail Address:		10. Primary Phone: Alternate:		

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date (mm/dd/yyyy): ☐ Open Enrollment ☐ Move	
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/Adoption ☐ Other:	
13. Permitting Event Date: (mm/dd/yyyy)	14. Name of Health Plan: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15. Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 Relationship Codes: S - Spouse DP - Domestic Partner NC - Natural Child SC - Step Child AC - Adopted Child DPC - Domestic Partner Child PCR - Parent Child Relationship

SECTION E: Enrollment

16. To enroll, carefully review the information in this section and check the box: ☐ I ELECT TO ENROLL in (or MAKE CHANGES TO) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. I CERTIFY that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act. I VOLUNTARILY enroll into the selected Health Plan. I AGREE to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan. I UNDERSTAND that enrolling in certain health plans requires binding arbitration and that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.	
17. To decline, carefully review the information in this section and check the box: ☐ I DECLINE ENROLLMENT into the CalPERS Health Program for myself and my dependents. I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.	
18. Employee Signature:	19. Date: (mm/dd/yyyy)

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers

6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the system. For questions about this notice, our [Privacy Policy](#), or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. Agency Name: County of Colusa	21. Date of Hire: (mm/dd/yyyy)	22. Retirement System: ☒ CalPERS ☐ CalSTRS ☐ Other
23. CalPERS Employer ID:	24. Division ID:	25. Employee Bargaining Unit/Employee Group:
26. Payroll Office: ☐ State Controller's Office ☒ Public Agency Billing	27. Date Received by Employer:	28. Effective Date: (mm/dd/yyyy)
I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.		
29. Health Benefits Officer: (Print name)	30. Signature:	31. Date: (mm/dd/yyyy)
32. Phone Number:		
33. Remarks:		

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

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**COUNTY OF COLUSA
HEALTH PLAN COVERAGE WAIVER FORM**

The County of Colusa provides its employees with health insurance coverage through the CalPERS Health Insurance Program and has several HMO and PPO options available. County health plan enrollment is not mandatory as long as employees can provide proof of alternative coverage from another source. Employees who possess other non-individual market coverage (e.g., other group health plan coverage, Tricare, Veterans Affairs, Medicare) for themselves and for all individuals that they expect to claim a deduction for in the taxable year (tax family), may elect to waive the County health plan coverage and earn a cash in-lieu benefit if they can provide proof that the coverage was not obtained through the Covered California Exchange or other Affordable Care Act Marketplace plan and which provides Affordable Care Act minimum essential coverage. The amount of the cash in-lieu benefit depends on the employee's benefit resolution or memorandum of understanding.

This waiver form is to be used by an employee who wishes to waive County provided health coverage and can provide proof of alternative coverage from another source. Please complete this form and submit it along with confirmation of existing coverage to the Human Resources Department. **This form along with proof of coverage will be required annually.**

EMPLOYEE INFORMATION:

Last Name

First Name

Mailing Address

City

Zip Code

EXISTING HEALTH COVERAGE INFORMATION:

I have existing alternative coverage from another source and wish to waive the County provided health plan coverage.

Proof of coverage that states employee's name must be attached.

Subscriber's Name

Coverage is through subscriber's employer: ☐ Yes ☐ No

Group No.

ID No(s).

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:

I wish to decline the County provided health plan coverage as I have alternative coverage from another source. I acknowledge that as a result of this waiver, I forfeit all rights to coverage otherwise available to me under the County health plan. I realize that I will not be able to enroll in a County health plan option until the next Open Enrollment period. If I cease to be covered by my existing plan outside of Open Enrollment, I must provide proof that my other health coverage has ended and enroll in the County health plan coverage within 60 days of the qualifying event. I understand that in order to qualify for the cash in-lieu benefit I must provide proof of non-individual market coverage for myself that is non-individual market coverage which was not obtained through the Covered California Exchange or other Affordable Care Act Marketplace plan, nor is Medi-Cal, and that provides Affordable Care Act defined minimum essential coverage. Furthermore, I verify that the attached alternative coverage includes all individuals in my expected tax family.

I understand that the information provided above is a requirement if I want to waive the County health plan coverage. I certify that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Human Resources Department has received and approved my waiver application. I understand that the waiver form and proof of health coverage will be required annually to qualify for the waiver and that if I do not provide the required documentation I will not receive the cash in-lieu benefit and will be enrolled in the lowest cost County health plan at the employee only level.

Employee signature

Print Name

Date

Human Resources Office Use Only: Processing Date: _____ Processed by: _____

Eligible for cash in-lieu: ☐ Yes ☐ No

COUNTY OF COLUSA HEALTH PLAN COVERAGE WAIVER FACTS

Qualification:

- **Health Plan Waiver:** In order to qualify for a County health plan coverage waiver, an employee must demonstrate that he/she has alternative coverage from another source. Evidence of such coverage must be provided by the employee.
- **Cash In-Lieu:** In order to qualify for the cash in-lieu benefit, an employee must meet the waiver requirements above and also provide proof that the plan that he/she currently has is non-individual market coverage that was not obtained through the Covered California Exchange or other Affordable Care Act Marketplace plan, nor is Medi-Cal, and which provides Affordable Care Act defined minimum essential coverage. Additionally, the alternative coverage must include all individuals in the employee's expected tax family.

Annual Recertification:

Employees receiving the health plan coverage waiver must recertify annually during the County's Open Enrollment period. Recertification consists of the completion of the appropriate County forms and evidence of coverage. If the required documentation is not received during this period, the waiver and cash in-lieu benefits will be discontinued and the employee will be enrolled in the lowest cost County health plan at the employee only level effective January 1.

Notice of Enrollment Rights:

This waiver of coverage must be completed during your initial eligibility period and annually during Open Enrollment. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

You may also be eligible to enroll in a County health plan if your other health coverage terminates as a result of any of the following:

- Termination of employment;
- Change in employment status;
- Employer no longer offers health plan coverage;
- Employer ceases premium contribution toward coverage;
- Divorce, legal separation, or death of the person (subscriber) through whom you (or your family members) are covered as a dependent; or
- Exhaustion of COBRA continuation of coverage.

DOCUMENTATION VERIFYING ALL CHANGES LISTED ABOVE WILL BE REQUIRED.



ENROLLMENT/CHANGE FORM - CA DUAL CHOICE

Delta Dental of California

deltadentalins.com

Select a Plan:

Fee-For-Service

OR

DeltaCare® USA¹

P.O. Box 429086
San Francisco, CA 94142-9086

P.O. Box 1803
Alpharetta, GA 30023

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information

☐ New Enrollment	☐ Address Change	☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received
☐ Add/Delete Dependent	☐ Terminate Enrollee Coverage	
☐ Marital Status Change	☐ Change Dental Plans*	

*Enrollees can change plans only during open enrollment or due to a qualifying status change unless allowed by the group contract.

Change Dental Plan*

- ☐ Fee-For-Service - Cancel
- ☐ DeltaCare USA - Cancel

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

Enrollee Classification

☐ Full-Time ☐ Hourly ☐ Certified
☐ Part-Time ☐ Salaried ☐ Classified
☐ Retired ☐ Member/Other

COBRA (if applicable)

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce/Legal Separation**
- ☐ Widowed/Surviving Dependent**
- ☐ Dependent Child No Longer Eligible**

Indicate qualifying date: ____/____/____

****If a dependent is enrolling under his/her social security number, the SSN currently enrolled under must be provided.**

Primary Enrollee Information

Social Security Number				Enrollee ID Number (if applicable)												Date of Birth			Gender		Marital Status	
																			☐ Male	☐ Female	☐ Single	☐ Married
First Name										Last Name										Middle Initial		
Mailing Address (Street)										City					State			Zip Code				
E-mail Address (internal use only)										Phone Number () -							Phone Type Cell ☐ Work ☐ Home ☐					
Network Facility Name (DeltaCare USA only)															Network Facility Number (DeltaCare USA only)							
Name of Other Dental Carrier										Policy Holder Name (first/last)										Date of Birth		
Effective Date of Other Policy												City				State			Zip Code			

Dependent Information

Relationship	Dependent First Name (last name only if different from enrollee)	Add / Term	Social Security Number			Date of Birth	Male / Female	Student / Disabled***		Name of School (coverage student)***	Network Facility Number ‡ (DeltaCare USA only)
Spouse/Partner		☐ ☐				/ /	☐ ☐	☐ ☐			
Dependent		☐ ☐				/ /	☐ ☐	☐ ☐			
Dependent		☐ ☐				/ /	☐ ☐	☐ ☐			
Dependent		☐ ☐				/ /	☐ ☐	☐ ☐			

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. ***Additional documentation will be required for disabled and student status. #Maximum of three facilities per family.

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

☐ I decline coverage at this time.

Signature of Enrollee _____ Date _____ / _____ / _____

¹DeltaCare USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment.

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to receive this document in Spanish or Chinese. For free help, please call Delta Dental:

Delta Dental Premier®
and Delta Dental PPOSM: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

IMPORTANTE: ¿Pueda leer este documento? Si no, podemos ayudarle. También puede recibir este documento en español o chino. Para obtener ayuda gratis, llame a Delta Dental al:

Delta Dental Premier®
and Delta Dental PPOSM: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

重要通知： 您能讀這份文件嗎？如有問題，我們可請他人協助您。您也能取得這份文件的西班牙文或中文譯本。如需免費協助，請電 Delta Dental。

Delta Dental Premier®
and Delta Dental PPOSM: 1-800-765-6003
DeltaCare® USA: 1-800-422-4234

**COUNTY OF COLUSA
DENTAL PLAN COVERAGE WAIVER FORM**

The County of Colusa requires its employees to enroll in County-sponsored dental coverage unless they can show proof of alternative coverage from another source. In order to qualify for cash in-lieu benefits, this proof of alternative coverage must be provided during the employee's initial eligibility period and annually during Open Enrollment. The amount of the cash in-lieu benefit depends on the employee's benefits resolution or memorandum of understanding and is available for employees hired before January 1, 2013.

This waiver form is to be used by an employee who wishes to waive County provided dental coverage and can provide proof of alternative coverage from another source. Please complete this form and submit it along with confirmation of existing coverage to the Human Resources Department. **This form along with proof of coverage will be required annually.**

EMPLOYEE INFORMATION:

Last Name

First Name

Mailing Address

City

Zip Code

EXISTING DENTAL COVERAGE INFORMATION:

I have existing dental coverage and wish to waive the County provided dental plan coverage. **Proof of coverage that states employee's name must be attached.**

Subscriber's Name

Group No.

ID No(s).

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:

I wish to decline the County provided dental plan coverage. I acknowledge that as a result of this waiver, I forfeit all rights to coverage otherwise available to me under the County dental plan. I realize that I will not be able to enroll in a County dental plan option until the next Open Enrollment period. If I cease to be covered by my existing plan outside of Open Enrollment, I must provide proof that my other dental coverage has ended and enroll in the County dental plan coverage within 60 days of the qualifying event.

I understand that the information provided above is a requirement if I want to waive the County dental plan coverage. I certify that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Human Resources Department has received and approved my waiver application. I understand that the waiver form and proof of dental coverage will be required annually to qualify for the waiver, and that if I do not provide the required documentation I will not receive the cash in-lieu benefit and will be enrolled in the County-sponsored dental plan at the employee only level.

Employee signature

Print Name

Date

Human Resources Office Use Only: Processing Date: _____ Processed By: _____

Eligible for cash in-lieu: ☐ Yes (DOH pre 1/1/2013) ☐ No (DOH post 12/31/12)

COUNTY OF COLUSA DENTAL PLAN COVERAGE WAIVER FACTS

Qualification:

In order to qualify for a County dental plan coverage waiver, an employee must demonstrate that he/she has alternative coverage from another source. Evidence of such coverage must be provided by the employee.

Annual Recertification:

Employees receiving the dental plan coverage waiver must recertify annually during the County's Open Enrollment period. Recertification consists of the completion of the appropriate County forms and evidence of coverage. If the required documentation is not received during this period, the waiver and cash in-lieu benefits will be discontinued and the employee will be enrolled in the County-sponsored dental plan at the employee only level effective January 1.

Notice of Enrollment Rights:

This waiver of coverage must be completed during your initial eligibility period or during Open Enrollment. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption or placement for adoption.

You may also be eligible to enroll in a County dental plan if your other health coverage terminates as a result of any of the following:

- Termination of employment;
- Change in employment status;
- Employer no longer offers dental plan coverage;
- Employer ceases premium contribution toward coverage;
- Divorce, legal separation, or death of the person (subscriber) through whom you (or your family members) are covered as a dependent; or
- Exhaustion of COBRA continuation of coverage.

DOCUMENTATION VERIFYING ALL CHANGES LISTED ABOVE WILL BE REQUIRED.

enrollment/change/waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338



Policy and Div. # 010- _____ Cert. # _____	COBRA: If individual is a continuee: _____	Qualifying Event _____	Date of Event _____
--	---	------------------------	---------------------

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____ ☐ Male ☐ Female Full time date of hire _____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week _____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address _____ City _____ State _____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **eye care** insurance plan? **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first, MI)	Eye Care		Relationship	Sex	Date of birth	Social Security no.	College student?
	add	drop					
1 _____	☐	☐					☐
2 _____	☐	☐					☐
3 _____	☐	☐					☐
4 _____	☐	☐					☐
5 _____	☐	☐					☐

Please Sign (employee/policyholder) The certificate provides eye care benefits only. Review your certificate carefully.

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ **X** _____
Employee Signature (do not print) Date Policyholder Signature (do not print) Date

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date _____	Effective Date	Class	Dep. Code
Dependent late entrant date _____			

2 to change

☐ **Name Change** New Name _____ Old Name _____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage? _____ ☐ If due to birth/adoption, what is the date of event? _____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain: _____

☐ **Drop Dependent Coverage** Number of dependents still covered: _____ Effective date of drop: _____

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ myself (does not apply to TRUST policies) ☐ spouse/domestic partner ☐ child(ren) only ☐ spouse/domestic partner and child(ren)

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Note for Florida Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Note for Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Maryland Insureds: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Note for New Mexico and Rhode Island Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number** – to make sure plan members are added to the correct group.
- **Department/Division Numbers** – so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers** – the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date** – needed so the correct effective date is calculated for new members.
- **Class Number** – needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a “life event” or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

- 1) submit clear, legible enrollment forms.
- 2) underline or circle important information.
- 3) use blue or black ink.

Don't:

- 1) submit dark copies as they appear black on imaging.
- 2) highlight, which blackens the area so it cannot be read.
- 3) write on the top or bottom margins. This information is not always captured on the image system.

Health Reimbursement Arrangement
Proof of Alternate Coverage in Another Qualifying Health Plan

New hires who possess other qualifying health coverage may qualify for the Colusa County Health Reimbursement Arrangement (HRA) benefit for the month in which they were hired if their health coverage provides Affordable Care Act minimum essential coverage.

Please complete this form and submit it along with confirmation of coverage to the Human Resources Department as soon as possible.

EMPLOYEE INFORMATION:

Last Name

First Name

HEALTH COVERAGE INFORMATION:

I had alternative coverage from another source during my first month of hire. **Proof of coverage that states employee's name must be attached.**

Subscriber's Name

Group No.

ID No(s).

I understand that in order to qualify for the HRA benefit during the first month in which I was hired I must provide proof of health coverage that provides minimum essential coverage as defined by the Affordable Care Act.

I understand that the information provided above is a requirement if I want to receive the HRA funds for the first month in which I was hired. I certify that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Human Resources Department has received and approved this form. I understand that if I do not provide the required documentation I will not receive the HRA benefit for the first month in which I was hired and that I will become eligible for the HRA benefit when the County-sponsored health insurance becomes effective.

Employee Signature

Print Name

Date

WAIVER OF PARTICIPATION

This form must be returned no later than: _____

The County of Colusa Health Reimbursement Arrangement (the "Plan") provides that a Plan participant may irrevocably waive participation in the Plan.

I hereby waive participation in the Plan.

☐ For the _____ Plan Year

☐ Permanently

In making this waiver I understand and represent that:

1. I am giving up a valuable benefit.
2. My waiver of this benefit is irrevocable. Even if I change my mind I will not be allowed to participate in the Plan [at any time during the _____ Plan Year].
3. I am making this waiver before I first become eligible under the Plan.
4. I have been given ample time to read and consider this waiver.
5. I am giving this waiver freely and no one has pressured me into signing the waiver.

Dated _____, 2023.

Participant Signature

Print Participant Name

Group Term Life Insurance

Enrollment at a Glance

Convenient, affordable life insurance, offering financial protection for your loved ones.

For the employees of:
Public Risk Innovation, Solutions and Management (PRISM)
County of Colusa, Account 006

What is Group Term Life Insurance?

Group Term Life Insurance is offered through your employer and pays a benefit to your beneficiary if you pass away during a specific period of time (known as a “term”). The term of this coverage is generally one year, renewing on an annual basis with your other employer-offered benefits. Your employer offers Basic Life Insurance and Accidental Death and Dismemberment Insurance, which is the amount they provide at no cost to you. You also have the option to elect additional coverage called Supplemental Life and Accidental Death and Dismemberment Insurance.

What is Accidental Death and Dismemberment (AD&D) Insurance?

AD&D Insurance pays a benefit to you or your beneficiary, separate from the life insurance benefit, if you are severely injured or die as the result of a covered accident. This coverage is part of the Group Term Life Insurance offered through your employer.

How can life insurance help?

Below are a few examples of how your life insurance benefit could be used (coverage amounts may vary):

- Pay off any remaining medical bills, funeral costs and debts
- Provide ongoing financial support to your family
- Keep your family in your home by paying off the mortgage
- Fund your children's education

Who is eligible for life insurance?

- You—all active employees working 20+ hours per week.
- Your spouse*— Coverage is available only if Employee Supplemental Life Insurance is elected.
- Your children—birth to age 26. Coverage is available only if Employee Supplemental Life Insurance is elected. If both you and your spouse are covered under the policy as employees, then only one, but not both, may cover the same children under the children's rider/benefit. If the parent who is covering the children stops being insured as an employee, then the other parent may apply for children's coverage.

**The use of “spouse” in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

ReliaStar Life Insurance Company, a member of the Voya® family of companies

What amount of coverage am I eligible for?

- For you
 - Your employer provides you with Basic Life Insurance and Basic AD&D Insurance of \$50,000. There is no cost to you for this insurance.
 - Eligible employees may elect Supplemental Life and AD&D Insurance of \$20,000 to \$500,000 in \$10,000 increments.
- For your spouse*
 - Eligible employees may elect Spouse Supplemental Life and AD&D Insurance of \$20,000 to \$500,000 in \$10,000 increments.
- For your children
 - Eligible employees may elect Children Supplemental Life Insurance of \$2,000 to \$10,000 in \$2,000 increments.

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

Meet the Wilsons

Mark and Jodi Wilson had a busy life filled with work, sports and their three children. Mark was the breadwinner of the family and worked as a construction manager. Jodi had quit her job to stay home with the children when their second child was born. Mark had been suffering from recurring headaches and, after seeing many doctors, was diagnosed with an inoperable brain tumor. Fortunately for the Wilson family, Mark had elected Group Term Life Insurance coverage through his employer. When Mark passed away, Jodi was able to use the life insurance proceeds to pay off the remaining home mortgage and cover Mark's funeral. There was even enough money to support the family while she transitioned from being a stay-at-home mother to a working single parent.

Expenses covered by Mark's Life Insurance Proceeds:

\$180,000	Total Life Insurance Proceeds
-\$8,000	Funeral Costs
<u>-\$75,000</u>	Remaining Mortgage
\$97,000	Everyday Expenses (utilities, car, groceries, etc.)

The amounts shown are an example only. Actual costs/results may vary.

What does my life insurance include?

The benefits listed below are included with your life insurance coverage.

- **Accelerated Death Benefit:** If are diagnosed with a terminal illness with a limited life expectancy, you may receive a portion of your death benefit while still living.
- **Accidental Death and Dismemberment (AD&D) Insurance:** Pays a benefit to you or your beneficiary, separate from the life insurance benefit, if you are severely injured or die as the result of a covered accident. The proceeds can be used however you or your beneficiary would like. Coverage on your spouse is available if they are enrolled for life insurance.
- **Continuation:** If on an approved absence from work, you may continue your life insurance coverage under the employer's group policy for a set amount of time. Premiums must be paid during this time.
- **Conversion:** You, your spouse and/or your children may convert life insurance coverage to an individual whole life insurance policy when you leave your employer or due to loss of eligibility under the employer's group policy.
- **Portability:** You may apply to continue your Supplemental coverage when you leave your current employer, and pay premiums to the insurance company directly.
- **Waiver of Premium:** If you become unable to work due to total disability, your Basic and Supplemental Life Insurance can be continued without premium payment.
- **Convenient Payroll Deductions:** Premium deductions for Supplemental coverages are taken directly from your paycheck, so you never have to worry about late payments or lapse notices.

How much does my life insurance cost?

Basic Life Insurance and Basic AD&D Insurance are provided by your employer at no cost to you. The cost for Supplemental Life is calculated based on the age of the employee at the start of the plan's current policy year.

Rates shown are guaranteed until June 30, 2023.

Employee and Spouse Supplemental Life Insurance Rates

Employee Age	Monthly Rate per \$1,000 of Coverage
Under 25	\$0.050
25-29	\$0.060
30-34	\$0.080
35-39	\$0.098
40-44	\$0.143
45-49	\$0.210
50-54	\$0.360
55-59	\$0.600
60-64	\$0.915
65-69	\$1.763
70 +	\$2.865

The rates are per individual.

Supplemental Accidental Death and Dismemberment (AD&D) Insurance Rates

Coverage Type	Monthly Rate per \$1,000 of Coverage
Employee Supplemental AD&D	\$0.02
Spouse Supplemental AD&D	\$0.02

Children Supplemental Life Insurance Rates

Coverage Levels	Monthly Cost
\$2,000	\$0.42
\$4,000	\$0.84
\$6,000	\$1.26
\$8,000	\$1.68
\$10,000	\$2.10

Monthly cost for all eligible children.

Use the steps below to calculate your premium for you and your spouse based on the amount of insurance you elected:

Step 1: Enter the rate per \$1,000 based on age: _____

Step 2: Take the amount of insurance and divide it by 1,000: _____

(Example: For \$150,000 of coverage, enter "150")

Step 3: Multiply lines 1 and 2 (this is your monthly cost): _____

Monthly cost for your children: (covers all eligible children)

Enter the monthly cost for the amount of coverage from the table above: _____

Do I need to provide evidence of insurability (answer health questions) to be covered?

New Hires

- For you—You may elect up to \$150,000 of Supplemental Life Insurance without providing evidence of insurability.
- For your spouse*—You may elect up to \$50,000 of Supplemental Life Insurance on your spouse without providing evidence of insurability.
- For your children—You may elect up to \$10,000 of Supplemental Life Insurance on your children without providing evidence of insurability.
- If you elect higher amount(s), you will need to submit evidence of insurability to the insurance company for approval before coverage becomes effective.

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

Will my benefits decrease as I get older?

- For you – Basic Insurance amount(s) reduce to 50% of original coverage at age 70 and after.
- For you – Supplemental Insurance amount(s) reduce to 65% of original coverage at age 65, to 50% of original coverage at age 70, and to 30% of original coverage at age 75 and after.
- For your spouse* - Benefit amount(s) reduce to 65% of original coverage at spouse age 65, to 50% of original coverage at age 70, and to 30% of original coverage at age 75 and after.
- Your payroll deductions will be adjusted to pay premium based on the new benefit amount(s).

**The use of "spouse" in this document means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the group policy. Please contact your employer for more information.*

Exclusions and Limitations

Supplemental Life Insurance coverages have a two year suicide exclusion from the effective date of coverage or an increase in coverage.

AD&D Insurance has exclusions that are described in the certificate of insurance or rider.

Are there additional non-insurance services available?

- Funeral Planning and Concierge Services: You have the support of a team of independent professionals ready to assist with funeral planning for you and eligible family members.

Funeral Planning and Concierge Services are provided by Everest Funeral Package, LLC, Houston, TX.

- Employee Assistance Program: You have access to ComPsych GuidanceResources®, which provides support, resources and information for personal and work-life issues.

Employee Assistance Program (EAP) services are provided by ComPsych® Corporation, Chicago, IL.

- Travel Assistance: When traveling more than 100 miles from home, Voya Travel Assistance offers enhanced security for your leisure and business trips. You and your dependents can take advantage of four types of services: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

Who do I contact with questions?

For more information, contact your human resource representative.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy form ICC LP14GP or LP00GP (may vary by state).

CN0203-21788-0217

Public Risk Innovation, Solutions and Management (PRISM), Group #31640-7, Acct #006 Date Prepared: 06/22/2020

172501-02/10/2016

ReliaStar Life Insurance Company, a member of the Voya® family of companies

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN

Telephone: 800-955-7736

A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life coverage or **any** increases in Life coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name CSAC – EIA Effective Date of Coverage or Change _____

Group/Plan Number 316407 Account Number/Location Acct 6: County of Colusa

Class/Occupation _____

Date of Hire _____ Annual Salary \$ _____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This change is due to (Check all that apply):

☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant ¹ ☐ Other _____

¹ A late entrant is an individual who is first enrolling after the initial available opportunity.

EMPLOYEE INFORMATION

Employee Name (First, Middle Initial, Last) _____

Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female

Employee ID Number _____ Work Phone (_____) _____ Home Phone (_____) _____

Address _____ City _____ State _____ ZIP _____

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election

☒ Employee Only—Elect Coverage (Note: Basic Life insurance is employer provided.)

Supplemental Life / AD&D Insurance

Guaranteed Issue (GI) Limit = \$150,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage up to \$500,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company. Minimum amount of coverage is \$20,000.

Supplemental Life Insurance Election

☐ I currently have supplemental life coverage of: \$ _____.

☐ I am applying for additional supplemental life coverage of: \$ _____ (\$10,000 increments)

☐ Total supplemental life coverage (current plus additional): \$ _____.

☐ Waive coverage.

Supplemental AD&D Insurance Election

☐ Amount equal to supplemental life insurance.

☐ Waive coverage.

BENEFICIARY INFORMATION (Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name (First, MI, Last)	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ()			
2			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ()			
3			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ()			

SPOUSE LIFE INSURANCE *(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)*

When you are initially eligible for Spouse coverage, you can elect up to \$50,000 in coverage without evidence of insurability. Total Spouse coverage up to \$500,000 is available if Spouse completes an Evidence of Insurability form subject to approval by the insurance company. Minimum amount of coverage is \$20,000.

Spouse Name *(First, Middle Initial, Last)* _____ Birth Date _____

Spouse Life Insurance Election

- ☐ I currently have spouse life coverage of: \$ _____.
- ☐ I am applying for additional spouse life coverage of: \$ _____ (\$10,000 increments)
- ☐ Total spouse life coverage (current plus additional): \$ _____.
- ☐ Waive coverage.

Spouse AD&D Insurance Election

- ☐ Amount equal to spouse life coverage up to \$500,000
- ☐ Waive coverage.

Note: The employee is the beneficiary for any Spouse insurance coverage.

CHILDREN LIFE INSURANCE

Coverage of \$2,000 to \$10,000 is available.

Children Life Insurance Election

- ☐ Elect: \$ _____ (\$2,000 increments)
- ☐ Waive coverage.

Note: The employee is the beneficiary for any Children insurance coverage.

SPOUSE AND CHILDREN INFORMATION

Enter information below. If additional space is required please attach a separate document.

	Spouse Name <i>(First, MI, Last)</i>	DOB	Gender	SSN
			☐ M ☐ F	
	Address			Phone ()

	Child Name <i>(First, MI, Last)</i>	DOB	Gender	SSN
1			☐ M ☐ F	
	Address			Phone ()
2			☐ M ☐ F	
	Address			Phone ()
3			☐ M ☐ F	
	Address			Phone ()

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

 Employee Signature _____ Date _____

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

COUNTY OF COLUSA

EMPLOYEE POLICIES AND RULES

The *Colusa County Personnel Rules* can be viewed & downloaded at:

<https://www.countyofcolusa.org/DocumentCenter/View/16486/Colusa-County-Personnel-Rules-FINAL-BOS-041123?bidId=>

The following County Policies can be viewed & downloaded at:

<https://www.countyofcolusa.org/639/Policies-Procedures>

Anti-Harassment and Discrimination Policy (Number 301)

Alcohol and Drug Abuse Policy (Number 302)

Family Care Leave Policy (Number 308)

Equal Employment Opportunity (Number 309)

Workplace Violence Prevention Policy (Number 313)

Nepotism Policy (Number 320)

Military Leave (Number 322)

Discipline (Number 323)

Reclassification Policy (Number 324)

Colusa County Driving Policy (Number 501.1)

Social Media Policy (Number 109)

I have received and read the policies listed above:

Signature

Print Name

Department

Date

COLUSA COUNTY

HUMAN RESOURCES DEPARTMENT



DAR RHODES
Human Resources Director

250 5th Street
Colusa, CA 95932
(530) 458-0420
(530) 458-0425 fax

2023 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To view the SBCs and glossary online, visit www.calpers.ca.gov on the **Plans & Rates** page¹ (subsection **Health Plans**), or visit any of the health plan websites below. To request a free paper copy of the SBC and glossary, contact each health plan directly.

Anthem Blue Cross HMO & EPO

(855) 839-4524

www.anthem.com/ca/calpers

Kaiser Permanente

(800) 464-4000

www.kp.org/calpers

Blue Shield of California

(800) 334-5847

www.blueshieldca.com/calpers

Peace Officers Research Association of California**

(800) 288-6928

<http://ibtporac.org>

California Association of Highway Patrolmen**

(800) 734-2247

www.thecahp.org

PERS Gold & PERS Platinum

(877) 737-7776

www.anthem.com/ca/calpers

California Correctional Peace Officers Association**

(800) 257-6213

www.ccpoabt.org

Sharp Health Plan

(855) 995-5004

www.sharphealthplan.com/calpers

Health Net of California

(888) 926-4921

www.healthnet.com/calpers

UnitedHealthcare

(877) 359-3714

www.uhc.com/calpers

Western Health Advantage

(888) 942-7377

www.westernhealth.com/calpers

* <https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates>

** To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

County of Colusa
Deferred Compensation 457 Plan Providers
For New Account Enrollment
As of November 25, 2020

CalPERS

CalPERS 457 Representative – Darren Wagerman
Darren.Wagerman@voya.com
888-713-8244 Ext. 5

CalPERS 457 Administration: 1-800-696-3907

CalPERS online enrollment materials:
http://www.calpers-sip.com/PDF_documents/CP457_Enroll_Kit.pdf

MetLife

MetLife Representative – Valerie Bevan
vbevan@financialguide.com
916-437-1713

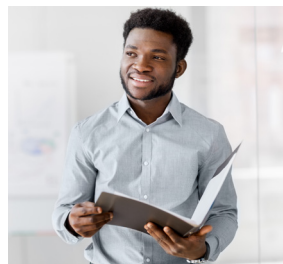
Brighthouse Financial **Annuity** (formerly MetLife Annuity)
Group #'s: 6500593 & 6500577
Customer Service #: 800-560-5001
Online information: www.eservice.metlife.com

MetLife **Mutual Fund** (formerly Copeland/CitiStreet)
Group #: 1013394-01
Customer Service #: 800-543-2520
Online information: www.mlr.metlife.com



Health Reimbursement Arrangement

Eligible Expense Guide



Understanding Your HRA

Health Reimbursement Arrangement (HRA) eligible expenses can vary depending on your plan's unique design. To help you better understand what type of HRA you have and, most importantly, which expenses are eligible, we've created this eligible expense guide for you.



Identify Your HRA

Simply log into your plan at www.myMidAmericaJourney.com. If it's your first time logging in, select **Create Your New Username and Password** from the login screen. Once logged in, locate the **Accounts** section from your homepage. From here, you can identify the type of HRA you have. You can also contact our Participant Services team at healthaccountservices@myMidAmerica.com or (855) 329-0095.



Understanding the Account Types

Below is a description of each account type as well as the expenses eligible within each. Pages 2–4 provide additional details on common eligible and ineligible expenses.

Account Types in MidAmerica Journey

Depending on your unique plan design, one or more of the below account types will display in the Accounts section of your Journey homepage once you log in.

Available: Full Medical or Available: Medical and Post-Tax Premiums



Once logged into MidAmerica Journey, if your account is named **Available: Full Medical** or **Available: Medical and Post-Tax Premiums**, your eligible expenses include:

- Full 213(d) Expenses
- Post-Tax Premiums

Available: Premiums



Once logged into MidAmerica Journey, if your account is named **Available: Premiums**, your eligible expenses include:

- Post-Tax Premiums

Available: Medical (No Premiums)



Once logged into MidAmerica Journey, if your account is named **Available: Medical (No Premiums)**, your eligible expenses include:

- Full 213(d) Expenses

Unavailable

An Unavailable account means that you currently do not have access to funds based on either your plan's vesting schedule, your employment status, or a combination of the two. For additional details on your plan design, contact our Participant Services team at (855) 329-0095 or email us at healthaccountservices@myMidAmerica.com.



Full 213(d) Eligible Medical Expenses

A Partial Listing

Qualified HRA expenses and premiums are outlined in Internal Revenue Code Section 213(d). To help you, we have created a partial listing of the IRS Section 213(d) expenses inquired about most frequently. For a full listing of eligible expenses, go to www.irs.gov/pub/irs-pdf/p502.pdf.

Most Common Expenses

- Over-the-Counter Drugs, such as pain relievers, sleep aids, digestive aids, and cold medicines
- Office Visit Copays
- Physician Service Copays
- Prescription Copays
- Insurance Plan Deductibles
- Insurance Plan Co-Insurance
- Menstrual Care Products

Other Services & Fees

- Anesthetist
- Chiropractor
- Christian Science
- Dentist
- Exam, physical
- Eye Exam
- Fertility Treatments
- Gynecologist
- Healing Services
- Hospital
- Laboratory
- Osteopath
- Physician
- Physiotherapist
- Psychiatrist
- Sex Therapist
- Specialists
- Surgeons

Military Retiree Coverage (TRICARE formerly known as CHAMPUS)

- Copays
- Deductibles
- Office Visits
- Vision
- EXTRA Premiums
- Medicare Part B Premiums
- PRIME (HMO) Premiums
- PRIME Supplement Premiums
- Retiree Dental Premiums
- Standard Premiums

Misc. Expenses

- Adoption (medical expenses incurred before adoption is finalized)
- Air conditioning and air filters used for alleviating illness
- Alcoholism and Drug Treatment Center Costs
- Ambulance Hire
- Artificial Limbs and Teeth
- Automobile Modifications (hand controls, special equipment, mechanical lifts)
- Birth Control Pills
- Braille Books &

- Magazines
- Breast Pumps
- Childbirth Classes (birth preparation, not child rearing)
- Contact Lenses
- Dental Treatments
- Eye Exam
- Eyeglasses
- Fertility Treatments
- Food & Beverages for specific diseases
- Genetic Testing (to determine possible defects)
- Hearing Aids & Batteries
- Immunizations
- Infertility Treatment
- Laser Eye Surgery
- Lead-Based Paint Removal
- Learning Disability (school or educator for learning disabled children recommended by doctor)
- Lifetime Care at Medical Facility
- Lodging for Medical Care or Treatment (subject to \$50/day per person)
- Medical Supplies & Equipment
- Norplant Insertion or Removal
- Obstetrical Expense
- Operations
- Optometrist
- Oral Surgery

- Organ Transplants
- Orthodontia
- Physical Therapy
- Prescription Medicines
- Private Hospital Room
- Retirement Home Fees, costs allocable to medical care
- Seeing-Eye Dog
- Speech Training for Child with Dyslexia or other Learning Disability
- Sterilization
- Stop-Smoking Programs
- Student Health Fees
- Support for Corrective Devices
- Telephone for Deaf
- Therapy Treatments ***
- Transportation Expense Relative to Illness (subject to IRS limits)
- Vaccines
- Vasectomy
- Viagra
- Vitamins (subject to doctor's verification)
- Weight Loss Program (to treat an existing disease)
- Wheelchair
- X-Rays

*Subject to annual maximum limits

*** IRS Section 213(d) has indicated that therapy provided for the general improvement of mental health, relief of stress, or personal enjoyment, is not an eligible expense reimbursable from your HRA or Flexible Spending Account. Therapy used to treat a specific medical need remains eligible. Therefore, this type of expense will require a doctor's note, with a diagnosis, to state the medical need for eligibility to be determined.



Premium Only Eligible Expenses

A Partial Listing

The following is a partial listing of eligible reimbursable expenses. A Health Reimbursement Arrangement (HRA) participant may request a reimbursement by properly submitting their claim online or by completing, signing, and returning a MidAmerica Claim Form along with proof of their claim. Qualified premiums are outlined in Internal Revenue Code Section 213(d).

Insurance premiums paid by an employer or through a pre-tax Section 125 cafeteria plan are not eligible for reimbursement. If you are a current participant in a Section 125 Health Care Flexible Spending Account (FSA), you must exhaust the FSA benefits before you may file an eligible HRA claim.

Common Qualified Claims

- Premiums paid by the former employee to a subsequent employer's group health plan.
- Premiums on an individual health insurance policy purchased by the former employee, including those purchased from the health care exchange.*
- Premiums on a Medicare supplemental health insurance policy purchased by the former employee.
- Reimbursement for Medicare Part B premiums paid by the former employee.
- Once Medicare Part D is implemented, Medicare Part D premiums paid by the former employee.
- Additional contributions the former employee's spouse pays to enroll the former employee as a dependent in the spouse's employer's group health plan (as long as these additional premiums were not paid by the spouse with pre-tax payroll deductions).
- Premiums for separate dental, vision, or prescription drug insurance policies.
- Premiums paid by the former employee for long-term care coverage. Long-term care premium reimbursements are subject to the following Internal Revenue Service limitations for the year 2021. Any premium amounts for the year above these limits are not considered to be an eligible medical expense.

Long-Term Care Premium Reimbursements: IRS 2021 Limitations

Attained age before the close of the taxable year	Maximum Deduction for 2021
40 or less	\$450
More than 40 but not more than 50	\$850
More than 50 but not more than 60	\$1,690
More than 60 but not more than 70	\$4,520
More than 70	\$5,640



Common Ineligible Expenses

A Partial Listing

The IRS does not allow the following to be reimbursed under your Health Reimbursement Arrangement as expenses to promote general health are not eligible. This is not an inclusive listing.

-
- Babysitting and Child Care
 - Calcium Supplements
 - Cancer, Indemnity, and Long-Term Disability Insurance
 - Canceled Appointment Fees
 - Contact Lens Insurance
 - Cosmetic Surgery/Procedures
 - Custom Fit-overs (clip-ons)
 - Dancing Lessons
 - Dental Discount Programs
 - Diaper Service
 - Discounted Fees/Write-offs
 - Electrolysis
 - Exercise Equipment*
 - Eyeglass Insurance
 - Fitness Programs*
 - Hair Loss Medication
 - Hair Transplant
 - Health Club Dues
 - Treatment Program (at a Health Club)*
 - Herbs & Herbal Medicines
 - Homeopathic Drugs
 - Illegal Operation or Treatment
 - Insurance Premium Interest Charge
 - Lamaze Class***
 - Marriage Counseling
 - Massage Therapy**
 - Maternity Clothes
 - Personal Trainer
 - Prescription Drug Discount
 - Pre-Tax Insurance Premiums
 - Retin-A*
 - Rogaine*
 - Special Foods*
 - (cost difference of common product)
 - Student Health Fee
 - Swimming Lessons
 - Tattoo Removal
 - Teeth Whitening/Bleaching
 - Toiletries, Toothpaste, etc.
 - Varicose Vein Treatment*
 - Veneers
 - Vision Discount Programs
 - Vitamins*
 - Weight Loss Programs and/or Drugs*

**Eligible only with Doctor's certification identifying the medical condition and length of treatment program.*

***IRS Section 213(d) has indicated that therapy provided for the general improvement of mental health, relief of stress, or personal enjoyment, is not an eligible expense reimbursable from your HRA or FSA account. Therapy used to treat a specific medical need remains eligible. Therefore, this type of expense will require a doctor's note, with a diagnosis, to state the medical need for eligibility to be determined.*

****Eligible expenses are limited to the mother's instruction related to birth.*

Please be aware that the Internal Revenue Service looks to the reasonableness of the cost of the treatment.

Questions?

If you have questions on eligible medical expenses, please call us at (855) 329-0095 or email us at healthaccounts@myMidAmerica.com.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mymidamericajourney.com or by calling 1-800-430-7999. This summary describes the coverage provided by the Health Reimbursement Arrangement (HRA); which is intended to supplement your other major medical coverage. This summary only describes the coverage offered under the HRA and does not reflect any coverage that may be offered by your major medical coverage. See the summary for your major medical coverage for more information regarding your major medical coverage.

Important Questions	Answers	Why this matters:
What is the overall deductible?	N/A	See the chart starting on page 2 for your costs for services this plan covers. The HRA may be used to offset all or a portion of expenses not covered by your major medical plan. See the summary for your major medical coverage for more details regarding expenses covered by your major medical coverage.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. The HRA may be used to offset all or a portion of expenses not covered by your major medical plan. See the summary for your major medical coverage for more details regarding expenses covered by your major medical coverage.
Is there an <u>out-of-pocket limit</u> on my expenses?	No	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the <u>out-of-pocket limit</u> ?	This plan has no out-of-pocket limit .	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	Yes, based on vested account value as provided by the employer contribution to your account.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above your account balance.
Does this plan use a <u>network of providers</u> ?	No	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above your account balance.

Questions: Call 1-800-430-7999 or visit us at www.mymidamericajourney.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <https://www.mymidamerica.com/sbcglossary> or call 1-800-430-7999 to request a copy.

HRA-Class A: County of Colusa

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2022 – 12/31/2022

Coverage for: Single&Family | Plan Type: HRA

Important Questions	Answers	Why this Matters:
Do I need a referral to see a <u>specialist</u> ?	No	You can see the specialist you choose without permission from this plan. However, the HRA will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above your account balance.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .



- This HRA generally covers expenses that (i) qualify as “medical care” by the Internal Revenue Code under Section 213(d), (ii) are not covered by other medical insurance, and (iii) satisfy any additional requirements imposed by the HRA plan document.
- Expenses not covered by health insurance may be submitted for reimbursement using the **Submit a Claim** option on the MidAmerica Journey website (www.myMidAmericaJourney.com), the MidAmerica Journey mobile app, or by submitting a claim form found at www.myMidAmerica.com.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Specialist visit	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Other practitioner office visit	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Preventive care/screening/immunization	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If you have a test	Diagnostic test (x-ray, blood work)	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Imaging (CT/PET scans, MRIs)	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.

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HRA-Class A: County of Colusa

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2022 – 12/31/2022

Coverage for: Single&Family | Plan Type: HRA

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.midamerica.biz .	Generic drugs	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Preferred brand drugs	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Non-preferred brand drugs	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Specialty drugs	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Physician/surgeon fees	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If you need immediate medical attention	Emergency room services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Emergency medical transportation	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Urgent care	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If you have a hospital stay	Facility fee (e.g., hospital room)	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Physician/surgeon fee	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.

Questions: Call 1-800-430-7999 or visit us at www.mymidamericajourney.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <https://www.mymidamerica.com/sbcglossary> or call 1-800-430-7999 to request a copy.

HRA-Class A: County of Colusa

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2022 – 12/31/2022

Coverage for: Single&Family | Plan Type: HRA

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Mental/Behavioral health inpatient services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Substance use disorder outpatient services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Substance use disorder inpatient services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If you are pregnant	Prenatal and postnatal care	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Delivery and all inpatient services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If you need help recovering or have other special health needs	Home health care	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Rehabilitation services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Habilitation services	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Skilled nursing care	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Durable medical equipment	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Hospice service	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
If your child needs dental or eye care	Eye Exam	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Glasses	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.
	Dental Check-up	Reimbursable	Expenses not covered by medical insurance may be eligible for reimbursement subject to your account balance.

Questions: Call 1-800-430-7999 or visit us at www.mymidamericajourney.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <https://www.mymidamerica.com/sbcglossary> or call 1-800-430-7999 to request a copy.

Excluded Services & Other Covered Services:**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic Surgery
- Over-the counter medication without a prescription
- Services not considered "medical care" under IRS Code Section 213(d)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Dental care
- Hearing aids
- Infertility treatment
- Medical care outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs
- Any other services considered "medical care" under IRS Code Section 213(d)

Your Rights to Continue Coverage:

COBRA coverage shall be available upon payment of the applicable COBRA premium and is limited in duration. As an alternative to COBRA continuation coverage, you may choose to continue to access the account via coverage in lieu of COBRA. No additional contributions will be made to the account during the coverage in lieu of COBRA period and no premium will be charged for the coverage.

For more information on your rights to continue coverage, contact your employer. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: MidAmerica toll-free at 800-430-7999 or visit our website at www.midamerica.biz.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-430-7999.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-800-430-7999 or visit us at www.mymidamericajourney.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <https://www.mymidamerica.com/sbcglossary> or call 1-800-430-7999 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** Eligible amounts not covered by major medical insurance, not to exceed HRA account value
- **Patient pays:** Amounts not covered by major medical insurance that exceed HRA account value

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	Per major medical insurance
Copays	Per major medical insurance
Coinsurance	Per major medical insurance
Limits or exclusions	Expenses not covered by major medical insurance may be eligible for reimbursement
Total	Dependent on HRA Account Value

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** Eligible amounts not covered by major medical insurance, not to exceed HRA account value
- **Patient pays:** Amounts not covered by major medical insurance that exceed HRA account value

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	Per major medical insurance
Copays	Per major medical insurance
Coinsurance	Per major medical insurance
Limits or exclusions	Expenses not covered by major medical insurance may be eligible for reimbursement
Total	Dependent on HRA Account Value

Questions: Call 1-800-430-7999 or visit us at www.mymidamericajourney.com If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <https://www.mymidamerica.com/sbcglossary> or call 1-800-430-7999 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples in this HRA Summary to compare plans?

- ✓ **No.** HRAs are designed to supplement other health insurance. Thus the coverage examples in this HRA summary can only help you understand how your costs under other plans may be impacted



Enrollment Kit



Flexible Spending Account



Paying for medical expenses made easy.

What you'll find in your Enrollment Kit



Meet MidAmerica2

Getting Started3

- Understanding Your Plan
- MidAmerica Journey
- Journey Benefits Card
- The Journey Mobile App

Online Enrollment4

Debit Card FAQ5

Attachments:

FSA Worksheet

FSA Eligible Expense Guide

HRA/FSA/HSA Interaction

Dear Employee,

Our goal at MidAmerica is to make your life easier by ensuring your benefits plan is administered properly, and that you have the resources you need to take full advantage of it.

Your employer has placed the administration of your benefits in our hands, and this is not a responsibility we take lightly. It's our promise to you that no matter where you're at in life—actively working, nearing retirement or retired—we will dedicate the time and effort to simplify how you access and manage your benefits.

This Enrollment Kit was developed to help you get started, but as you dive deeper into your benefits, you may find that you still have questions. Don't worry. We are here to help. If you need additional materials, further explanation or guidance, don't hesitate to contact us at (855) 329-0095 or healthaccountservices@myMidAmerica.com.

Welcome to your new benefits plan. We're happy you're here.

Sincerely,

MidAmerica Administrative & Retirement Solutions

Getting Started

An **introduction** to your plan.



Understanding Your Plan

Your employer has established a Flexible Spending Account (FSA) with MidAmerica to allow you to set aside money on a pre-tax basis to pay for eligible medical expenses. Enrolling in the plan gives you a tax-free way to pay for your eligible medical expenses throughout the year! You can control how much or how little you contribute. For more information on how your FSA operates, please review your **Plan Highlights**.



MidAmerica Journey

You can access your account online through MidAmerica Journey at www.myMidAmericaJourney.com. The Journey portal is an interactive website that gives you around-the-clock access to plan details, online claims submission, forms, system guides and much more. If it's your first time accessing the portal select **Get Started**. Next, simply input the prompted information to establish your login credentials.



Journey Benefits Card

You will receive a debit card to pay for eligible medical expenses, reducing the need for claim forms. Hold on to your documentation, though! When you swipe your card at the point of sale, any transaction with eligible, plan-established Merchant Category Codes (MCC) will be approved; however, we may still ask for documentation to verify its eligibility under your plan design. For more information on your Journey Benefits Card, please review the Debit Card FAQ on page 5.



The Journey Mobile App

You are encouraged to download the Journey mobile app, a powerful, on-the-go mobile app that gives you the freedom to submit your claims, ask a question or view your account anywhere at any time. To download, go to your Apple or GooglePlay app store and search **MidAmerica Journey**.



Debit Card FAQ

Common Questions about Required Documentation

How do I know if documentation is required?

Your debit card purchase may be auto-approved. However, if documentation is needed to substantiate your purchase, we will send a request via email, if we have an email address on file, or USPS.

Why was my expense approved at the point of sale if I still have to provide documentation?

The purpose of your debit card is to prevent out-of-pocket payments, which means no waiting around to get your reimbursement! Documentation may be required, however, per IRS regulations.

What documentation is required?

Documentation should always include the name of the service provider, patient name, date of service, description of the services rendered, and your out-of-pocket costs. Some examples include:

- **Explanation of Benefits (EOB):** An EOB returned to you from the insurance carrier indicating the amount for which you are responsible.
- **If there is no insurance for the health care expense, request an Itemized Receipt:** Be sure to request an itemized receipt every time you use your Journey Benefits Card.
- **If an Itemized Receipt is Not Available:** Request documentation on the letterhead of the licensed health care provider that details the service(s) provided and the cost per service. Be sure to include this with your transaction receipt.
- **Pro Tip!:** Keep your medical documentation in a safe location so they're easy to locate if needed.

How do I submit documentation?

- **Online:** Upload your receipt through MidAmerica Journey by visiting www.myMidAmericaJourney.com.
- **From Your Phone:** Download the Journey mobile app, snap a picture of your documentation with your phone and upload it right from the app! To download, go to your Apple or GooglePlay app store and search "MidAmerica Journey."
- **Email:** Email your receipt to claims@myMidAmerica.com.
- **Mail:** Mail it to PO Box 24927, Lakeland, FL 33802
- **Fax:** Fax it to (863) 577-4460

If we do not receive the requested documentation within 30 days, we will send a 2nd notice via USPS. If we do not receive the documentation after an additional 60 days, the card will be temporarily suspended until documentation is submitted.

How can I make sure my purchase is auto-approved?

- **Establish a Recurring Claim**
The first time you use your card to pay for a recurring expense, you will be asked for supporting documentation such as a statement or itemized invoice from the insurer, or a receipt. Once this has been provided, all purchases for the same dollar amount at the same merchant (or at another merchant with the same MCC) will be automatically approved throughout the plan year.
- **Shop at IIAS Merchants**
Many major pharmacies are registered as Inventory Information Approval System (IIAS) certified. This means you may see an F or FSA next to eligible items on your receipt. The pharmacy's IIAS system allows them to differentiate between eligible and ineligible expenses, making it possible for eligible HRA and FSA products to be automatically approved at the point of purchase.
- **Ask if Copayments Have Been Established Under the Plan**
Copayments that have been established under your employer's Group Health Plan can be used as a substantiation method. For example, if we have on file that there is a pharmacy copay of \$30 and you use your card to make a \$30 copay payment at a pharmacy, the transaction would be automatically approved.

Does my card remain in effect from year to year?

Yes. Your Journey Benefits Card will carry whatever funds are rolled over or contributed.

Questions?

(855) 329-0095

healthaccountservices@myMidAmerica.com

Customer Service Hours

Monday through Thursday, 8:30 a.m.–8 p.m. ET

Friday, 8:30 a.m.–6 p.m. ET



PO Box 24927 Lakeland, FL 33802-4927 • (855) 329-0095 • Fax (863) 577-4460 • www.myMidAmericaJourney.com

Flexible Spending Account Worksheet

Estimate your expenses

We want you to make a smart annual FSA election. To help you do this, we've put together a worksheet you can use to estimate your expenses and savings.

Your total estimated costs will help you determine what election amount makes sense for you.

Take it a step further by calculating your estimated tax savings using your total projected expenses!

Projected Uninsured Plan Year Expenses

Medical and dental deductible	\$ _____
Medical insurance co-payments and coinsurance.	\$ _____
Dental insurance co-payments and coinsurance.	\$ _____
Immunizations, injections and vaccinations	\$ _____
Routine examinations	\$ _____
Dental and orthodontic expenses.	\$ _____
Prescription drugs or co-payments.	\$ _____
Eye examinations, glasses and contacts	\$ _____
Hearing examinations	\$ _____
Transportation to and from medical provider	\$ _____
Medically necessary elective surgery	\$ _____
Other expenses	\$ _____
Total expenses	\$ _____

The above items are some common expenses. Please see the FSA List of Eligible and Ineligible Expenses for a more comprehensive list.

Calculate your savings

Estimated Tax Savings

Desired FSA Plan Year Election	\$ _____
Multiply the number above by 25% (estimated tax savings)	x _____ .25
Estimated tax savings for the year	\$ _____



Understanding Your FSA

Depending on your unique Flexible Spending Account (FSA) type, the expenses that are eligible for reimbursement can vary. To help you better understand what type of FSA you have and, most importantly, which expenses are eligible, we've created this eligible expense guide just for you.



Identify Your FSA

Simply log into your plan at **www.myMidAmericaJourney.com**. If it's your first time logging in, select **Get Started** from the login screen. Once logged in, locate the **Accounts** section from your homepage. From here, you can identify the type of FSA you have. You can also contact our Participant Services team at healthaccountservices@myMidAmerica.com or (855) 329-0095.



Understanding the Account Types

Below is a description of each account type as well as the expenses eligible within each. Pages 2–5 provide additional details on common eligible and ineligible expenses.

Flexible Spending



Includes:

- FSA Eligible Medical Expenses

Dependent Care



Includes:

- Dependent Care Account Expenses

Flexible Spending: Limited Purpose



Includes:

- Limited Purpose Medical Care Expenses

Questions?

If you have questions on FSA eligible expenses, simply email us at healthaccountservices@myMidAmerica.com or call us at (855) 329-0095.



FSA Eligible Medical Care Expenses

A Partial Listing

What are medical care expenses?

The IRS defines these expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

With that in mind, we have created a list of medical expenses inquired about most frequently. For a full listing of eligible expenses, we encourage you to download the IRS Publication 502 Medical and Dental Expenses from IRS.gov.*

Dental Services

Crowns/Bridges
Dental X-Rays
Dentures
Exams/Teeth
Cleaning
Extractions
Fillings
Gum Treatment
Oral Surgery
Orthodontia/Braces

Insurance-Related Items

Co-pay Amounts
Deductibles
Preexisting condition expenses (medical)
Private Hospital Room
Differential

Lab Exams/Tests

Blood Tests
Cardiographs
Diagnostic
Laboratory Fees
Metabolism Tests
Spinal Fluid Tests
Urine/Stool Analysis
X-Rays

Medications

Aspirin, if plan allows
Insulin
Nicotine Gum or Patches, if plan allows
OTC Medicines, such as pain relievers, sleep aids, digestive aids, and cold

medicines
Prescribed Birth Control
Prescribed Vitamins (to treat specific disease)
Prescription Drugs

Obstetric Services

Midwife Expenses
OB/GYN Exams
OB/GYN Prepaid
Maternity Fees (reimbursable after date of birth)
Post-Natal/Pre-Natal Treatment
Pre-Natal Vitamins

Practitioners

Allergist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Osteopath
Physician
Psychiatrist
Psychologist

Other Medical Treatments/Procedures

Acupuncture
Alcoholism (inpatient treatment)
Cosmetic Surgery (if medically necessary)
Drug Addiction
Hearing Exams

Hospital Services
Infertility
In-Vitro Fertilization
Norplant Insertion or Removal
Patterning Exercises
Physical Examination (not employment related)
Physical Therapy
Pregnancy Tests
Rolfing
Smoking Cessation Programs
Speech Therapy
Sterilization
Transplants (includes organ donor)
Treatment for Handicapped
Vaccinations/Immunizations
Vasectomy
Well-Baby Care

Other Medical Equipment, Supplies and Services

Abdominal/Back Supports
Ambulance Services
Arches/Orthopedic Shoes
Contraceptives
Counseling
Crutches
Guide Dog (for visually/hearing impaired person)
Hearing Aids &

Batteries
Breast Pumps
Hospital Bed
Learning Disability (special school/teacher)
Medic Alert Bracelet or Necklace
Menstrual Care Products
Oxygen Equipment
Prescribed Medical and Exercise Equipment
Prosthesis
Splints/Casts
Support Hose (if medically necessary)
Syringes
Transportation Expenses (essential to medical care)
Tuition Fee at Special School for Disabled Child
Wheelchair
Wigs (hair loss due to disease)

Vision Services

Artificial Eyes
Contact Lenses
Contact Lens Solution
Eye Examinations
Eyeglasses
Laser Eye Surgeries
Ophthalmologist
Optometrist
Prescription
Sunglasses
Radial Keratotomy



Dependent Care Account Expenses

How it can work for you

A Dependent Care Account (DCA) is a type of FSA that allows you to pay for eligible dependent care expenses with pre-tax dollars throughout the year, eliminating the need to take the annual Federal Tax Credit. The amount you contribute to your DCA is not subject to Federal, State or FICA taxes, which generally means a tax savings of 15% to 40%, depending on your tax bracket.

Who is considered a qualified dependent?

Dependents are defined as children under 13 years of age, or children 13 and over who are physically or mentally unable to care for themselves. A spouse or an elderly parent residing in your home who is physically or mentally unable to live independently also qualifies.

Eligible Providers

You are able to use any provider you choose; however, they cannot be your own child if they are under 19 and still claimed as a dependent. An example of this may be paying your 16-year-old to babysit your 10-year-old. You cannot be reimbursed for the amount you paid the 16-year-old for babysitting. However, a provider can be as informal as a neighbor who watches your children after school, as long as they claim the money received for the services as income when determining their taxes at the end of the year. Note: you will need to obtain the provider's Federal Identification / Social Security Number for inclusion on your tax filing.

Eligible DCA Expenses

Expenses which allow you (and your spouse, if married) to work, look for work or attend school as a full-time student are eligible. Below are expenses that would qualify for reimbursement from your DCA:

- Day care facility fees (including transportation, lunches, educational services)
- Before-school and after-school care
- Local day camp
- In-home babysitting fees (income must be claimed by your care provider)
- Nursery school and preschool (preschool expenses are eligible if the amount you pay for schooling cannot be separated from the cost of care.)



Common Ineligible Expenses

A Partial Listing

Common Ineligible FSA Expenses

The IRS does not allow the following to be reimbursed under your Flexible Spending Account as expenses to promote general health are not eligible. This is not an inclusive listing.

Babysitting and Child Care	Treatment Program (at a Health Club)****	Special Foods**** (cost difference of common product)
Calcium Supplements	Herbs & Herbal Medicines	Student Health Fee
Canceled Appointment Fees	Homeopathic Drugs	Swimming Lessons
Contact Lens Insurance	Illegal Operation or Treatment	Tattoo Removal
Cosmetic Surgery/Procedures	Insurance Premium Interest Charge	Teeth Whitening/Bleaching
Custom Fit-overs (clip-ons)	Insurance Premiums	Toiletries, Toothpaste, etc.
Dancing Lessons	Lamaze Class*****	Varicose Vein Treatment****
Diaper Service	Marriage Counseling	Veneers
Discounted Fees/Write-offs	Massage Therapy*****	Vision Discount Program Premiums
Electrolysis	Maternity Clothes	Vitamins****
Exercise Equipment****	Personal Trainer	Weight Loss Programs &/or Drugs****
Eyeglass Insurance	Prescription Drug Discount	
Fitness Programs****	Program Premiums	
Hair Loss Medication	Retin-A****	
Hair Transplant	Rogaine****	
Health Club Dues		

Common Ineligible DCA Expenses

Dependent care expenses are not considered incurred until the child care is actually provided.

Reimbursement may not exceed your year-to-date deductions. Divorced parents should be aware that the Dependent Care Reimbursement Account is only available to the custodial parent, as it can only be used to allow the parent to be gainfully employed. The following are examples of common ineligible expenses:

- Diaper changing fees
- Fees for lessons (e.g., dance, piano, swim, etc.)
- Field trips
- Household services (housekeeper, maid, cook)
- Kindergarten
- Lunches/food
- Maternity Leave (if you or your spouse are on maternity leave and you place your other children in day care, those expenses are not eligible)
- Overnight camp expenses (this is not considered a work-related expense)
- Transportation for day care

* There are two exceptions to be aware of: 1) Insurance premiums are not reimbursable under a Health Care Reimbursement Account / Flexible Spending Account, and 2) the reimbursement is based only upon when the expense was incurred. For example, the date of service, not the date paid.

** There are two exceptions to be aware of: 1) Insurance premiums are not reimbursable under a Health Care Reimbursement Account / Flexible Spending Account, and 2) the reimbursement is based only upon when the expense was incurred. For example, the date of service, not the date paid.

*** Based on the definition described in Section 223(c)(2)(C).

**** Eligible only with Doctor's certification identifying the medical condition and length of treatment program.

***** IRS Section 213(d) has indicated that therapy provided for the general improvement of mental health, relief of stress, or personal enjoyment, is not an eligible expense reimbursable from your HRA or FSA account. Therapy used to treat a specific medical need remains eligible. Therefore, this type of expense will require a doctor's note, with a diagnosis, to state the medical need for eligibility to be determined.

*****Eligible expenses are limited to the mother's instruction related to birth.

The Interaction Among HRAs, FSAs, & HSAs

Helping you understand how these plans work together.

Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)	Health Savings Account (HSA)
An account funded by employer contributions which participants in eligible employee classes may use to reimburse eligible medical expenses as specified in the plan document for each class. Unused funds in the account at the end of the plan year typically carry over to the following plan year.	An account funded by elected employee pre-tax payroll deductions that participants may use for certain health care and dependent care expenses. Unused funds in the account at the end of the plan year will forfeit after the runout period. If the plan design permits, unused health care funds not exceeding IRS limits may be carried over to the following year. To view current carryover maximums, visit www.myMidAmerica.com/fsalimits	An account available to employees enrolled in a qualifying High Deductible Health Plan and funded by elected employee pre-tax payroll deductions that participants may use to pay for qualified medical expenses. Unused funds in the account carry over to the following year.

If you have...

An HRA and HSA

If during the HRA plan year, you or your employer, or your spouse or spouse's employer, contributes to an HSA, your HRA must be restricted for the plan year. While restricted, you can only seek reimbursement for dental, vision, preventive care, post-deductible, and premium expenses from your HRA.

An FSA and HSA

If you, your employer, your spouse or your spouse's employer are contributing to an HSA, your FSA must be a limited purpose FSA, meaning reimbursements are limited to dental and vision expenses.

An HRA and FSA

If both the FSA and HRA provide coverage for the same medical expenses, reimbursements are processed based on the ordering rules established in the plan. For example, if the plan identifies that the FSA "pay first," your expense will be applied to the FSA until the balance is depleted and then reimburse from the HRA. However, if the HRA is limited purpose or premium only, then the HRA and FSA accounts can be accessed concurrently for different expenses.

County of Colusa

Colonial Benefits Booklet



A Building Blocks Benefit Advisor will assist you with your enrollment via a Screen Share Enrollment Session which requires access to a computer and internet.



Receive membership to the **WellCard Savings Program!**

After completing your enrollment session with a Building Blocks Benefit Advisor, you will receive your membership login information to the WellCard Savings Program!

You and your family will have access to receive discounts on Medical, Pharmacy, Vision & Dental Care, Health & Wellness, Pet Discounts, and more!



The Following Benefits are Now Available!

-  **Accident**
For a covered accident, policyholders receive cash benefits for use as they see fit.
 -  **Cancer**
The cancer plan is designed to pay cash benefits that can be used to help offset cancer-related expenses.
 -  **Critical Illness**
Helps with medical expenses related to a covered serious health event.
 -  **Short-Term Disability**
In the case of an illness or injury, it helps you maintain your standard of living and helps you pay your bills.
 -  **Medical Bridge/Hospital Confinement**
Pays cash amounts to help with the non-covered expenses of a hospital stay.
 -  **Life Insurance**
Helps you get the peace of mind knowing your family is taken care of.
-  *All benefits with this symbol have
Guaranteed Issue available for New Enrollees!*

Contact a Building Blocks representative to
schedule your enrollment session today!



Call: 775-382-1287



Email: scheduling@bbforb.com

Accident 1.0

Colonial Life’s voluntary accident insurance policy is a medical indemnity plan that provides employees and their families with hospital, doctor, accidental death and catastrophic accident benefits in the event of a covered accident. Sample CA Rates shown at the bottom represent On/Offjob coverage with Health Screening. Accident coverage is pre-tax eligible.

Base Policy Benefits	Basic	Preferred	Premier
Accident Emergency Treatment For treatment in a doctor’s office, urgent care facility or emergency room within the first 72 hours of the accident. If initially treated after 72 hours, please see Accident Follow-up Doctor’s Visit	\$75	\$125	\$125
Accident Follow-Up Doctor Visit	\$50/visit up to 2 visits per accident	\$50/visit up to 3 visits per accident	\$50/visit up to 4 visits per accident
Accidental Death	\$20,000 Employee \$20,000 Spouse \$4,000 Child(ren)	\$25,000 Employee \$25,000 Spouse \$5,000 Child(ren)	\$50,000 Employee \$50,000 Spouse \$10,000 Child(ren)
Accidental Death: Common Carrier	\$80,000 Employee \$80,000 Spouse \$16,000 Child(ren)	\$100,000 Employee \$100,000 Spouse \$20,000 Child(ren)	\$200,000 Employee \$200,000 Spouse \$40,000 Child(ren)
Accidental Dismemberment: (Loss of Finger/Toe/Hand/Foot or Sight)	\$600- \$12,000	\$750- \$15,000	\$1,200-\$24,000
Ambulance - Air	\$1,200	\$2,000	\$2,000
Ambulance - Ground	\$120	\$200	\$200
Appliances (such as wheelchair, crutches)	\$75	\$100	\$100
Blood/Plasma/Platelets	\$300	\$300	\$300
Burns (based on size and degree)	\$1,000- \$12,000	\$1,000- \$12,000	\$1,000- \$12,000
Burns - Skin Graft	50% of burn benefit	50% of burn benefit	50% of burn benefit
Catastrophic Accident – prior to 65 (For severe injuries that result in the total and irrevocable: loss of one hand and one foot; loss of both hands or both feet; loss of sight in both eyes; loss of hearing of both ears; loss of the ability to speak.) 365 day elimination period Amounts reduced for covered persons over age 65	\$10,000 EE/SP \$5,000 CH	\$25,000 EE/SP \$12,500 CH	\$25,000 EE/SP \$12,500 CH
Coma (duration of at least 7 days)	\$7,500	\$10,000	\$12,500
Concussion	\$60	\$60	\$60
Dislocation (Based on joint and if repaired by open or closed reduction)	\$90-\$3,600	\$110 - \$4,400	\$120 - \$4,800
Emergency Dental Work	\$200 (crown, implant or denture) or \$50 (extract)	\$300 (crown, implant or denture) or \$75 (extract)	\$400 (crown, implant or denture) or \$100 (extract)
Eye Injury	\$200	\$300	\$300
Fractures (Based on bone and if repaired by open or closed reduction)	\$90 - \$4,500	\$110 - \$5,500	\$120 - \$6,000
Hospital Admission*	\$750/accident	\$1,000/accident	\$1,250/accident
Hospital Confinement (Per day up to 365 days)	\$175	\$225	\$250
Hospital ICU Admission*	\$1,500/accident	\$2,000/accident	\$2,500/accident
Hospital ICU Confinement (Up to 15 days per accident)	\$350	\$450	\$500

Knee Cartilage - Torn	\$500	\$500	\$750
Laceration (based on size and repair)	\$30-\$500	\$30-\$500	\$30-\$500
Lodging (Companion)	\$100 per day up to 30 days	\$125 per day up to 30 days	\$150 per day up to 30 days
Medical Imaging Study Limit one accident per year	\$100 per accident	\$150 per accident	\$200 per accident
Prosthetic Device/Artificial Limb	\$500 (1); \$1,000 (2 or more)	\$500 (1); \$1,000 (2 or more)	\$750 (1); \$1,500 (2 or more)
Rehabilitation Unit Confinement Up to 15 days per confinement per covered accident. Maximum of 30 days per calendar year.	\$100/day	\$100/day	\$150/day
Ruptured Disc	\$500	\$500	\$750
Surgery-Cranial, Open Abdominal, Thoracic	\$1,000:	\$1,500	\$1,500
Surgery- Hernia	\$100	\$150	\$150
Surgery – Exploratory or Arthroscopic	\$150	\$200	\$200
Tendon/Ligament/Rotator Cuff	\$500 (1); \$1,000 (2 or more)	\$500 (1); \$1,000 (2 or more)	\$750 (1); \$1,500 (2 or more)
Therapy - Occupational and Physical Therapy Benefit	\$25 per day (10 visits/accident)	\$25 per day (10 visits/accident)	\$35 per day (10 visits/accident)
Transportation up to 3 trips per accident	\$400 per trip	\$500 per trip	\$600 per trip
X-Ray Benefit	\$20	\$30	\$40
Health Screening Benefit Per covered person per calendar year	\$50	\$50	\$50
Mammography Benefit	\$200	\$200	\$200
* We will pay either the Hospital Admission or Hospital ICU Admission benefit, but not both.			

MONTHLY RATES (12 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Basic	17-64	\$21.11	\$29.87	\$29.73	\$38.50
Preferred	17-64	\$25.67	\$35.91	\$37.19	\$47.42
Premier	17-64	\$31.03	\$43.26	\$44.22	\$56.44
11THLY RATES (11 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Basic	17-64	\$23.03	\$32.59	\$32.43	\$42.00
Preferred	17-64	\$28.00	\$39.17	\$40.57	\$51.73
Premier	17-64	\$33.85	\$47.19	\$48.24	\$61.57
10THLY RATES (10 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Basic	17-64	\$25.33	\$35.84	\$35.68	\$46.20
Preferred	17-64	\$30.80	\$43.09	\$44.63	\$56.90
Premier	17-64	\$37.24	\$51.91	\$53.06	\$67.73
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Basic	17-64	\$10.56	\$14.94	\$14.87	\$19.25
Preferred	17-64	\$12.84	\$17.96	\$18.60	\$23.71
Premier	17-64	\$15.52	\$21.63	\$22.11	\$28.22
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Basic	17-64	\$9.74	\$13.79	\$13.72	\$17.77
Preferred	17-64	\$11.85	\$16.57	\$17.16	\$21.89
Premier	17-64	\$14.32	\$19.97	\$20.41	\$26.05

Cancer Assist

Colonial Life's individual cancer insurance product helps to provide valuable financial protection for America's workers and their families in times of need, when medical bills and other expenses related to cancer diagnosis and treatment may limit their ability to focus on what's most important - getting well. Sample CA Rates shown at the bottom includes \$100 Health Screening. Cancer coverage is pre-tax eligible.

Benefits	Level 1	Level 2	Level 3	Level 4
Air Ambulance, <i>per trip</i>	\$2,000	\$2,000	\$2,000	\$2,000
<i>Maximum trips per confinement</i>	2	2	2	2
Ambulance, <i>per trip</i>	\$250	\$250	\$250	\$250
<i>Maximum trips per confinement</i>	2	2	2	2
Anesthesia, General	25% of Surgical Procedures Benefit			
Anesthesia, Local, <i>per procedure</i>	\$25	\$30	\$40	\$50
Anti-Nausea Medication, <i>per day</i>	\$25	\$40	\$50	\$60
<i>Maximum per month</i>	\$100	\$160	\$200	\$240
Blood/Plasma/Platelets/Immunoglobulins, <i>per day</i>	\$150	\$150	\$175	\$250
<i>Maximum per calendar year</i>	\$10,000	\$10,000	\$10,000	\$10,000
Bone Marrow or Peripheral Stem Cell Donation, <i>per donation, maximum one per lifetime</i>	\$500	\$500	\$750	\$1,000
Bone Marrow Stem Cell Transplant, <i>per transplant</i>	\$3,500	\$4,000	\$7,000	\$10,000
Peripheral Stem Cell Transplant, <i>per transplant</i>	\$3,500	\$4,000	\$7,000	\$10,000
<i>Maximum transplants per lifetime</i>	2	2	2	2
Companion Transportation, <i>per mile</i>	\$0.50	\$0.50	\$0.50	\$0.50
<i>Maximum per round trip</i>	\$1,000	\$1,000	\$1,200	\$1,500
Egg (s) Extraction or Harvesting or Sperm Collection, <i>one per lifetime</i>	\$500	\$700	\$1,000	\$1,500
Egg (s) or Sperm Storage, <i>one per lifetime</i>	\$175	\$200	\$350	\$500
Experimental Treatment, <i>per day</i>	\$200	\$250	\$300	\$300
<i>Maximum per lifetime</i>	\$10,000	\$12,500	\$15,000	\$15,000
Family Care, <i>per day</i>	\$30	\$40	\$50	\$60
<i>Maximum per calendar year</i>	\$1,500	\$2,000	\$2,500	\$3,000
Hair/External Breast/Voice Box Prosthesis, <i>per calendar year</i>	\$200	\$200	\$350	\$500
Home Health Care Services, <i>per day</i>	\$50	\$75	\$100	\$150
<i>Maximum per calendar year</i> <i>Examples include: physical therapy, occupational therapy, speech therapy, and audiology, prosthesis and orthopedic appliances and rental or purchase of medical equipment.</i>	30 days or twice the days confined			
Hospice, Initial	\$1,000	\$1,000	\$1,000	\$1,000
Hospice, Daily	\$50	\$50	\$50	\$50
<i>Maximum combined Initial and Daily per lifetime</i>	\$15,000	\$15,000	\$15,000	\$15,000
Hospital Confinement, 30 days or less, <i>per day</i>	\$100	\$150	\$250	\$350
Hospital Confinement, 31 days or more, <i>per day</i>	\$200	\$300	\$500	\$700
Lodging, <i>per day</i>	\$50	\$50	\$75	\$80
<i>Maximum days per calendar year</i>	70	70	70	70
Medical Imaging Studies, <i>per study</i>	\$75	\$125	\$175	\$225
<i>Maximum per calendar year</i>	\$150	\$250	\$350	\$450
Outpatient Surgical Center, <i>per day</i>	\$100	\$200	\$300	\$400
<i>Maximum per calendar year</i>	\$300	\$600	\$900	\$1,200
Private Full-time Nursing Services, <i>per day</i>	\$50	\$75	\$125	\$150
Prosthetic Device/Artificial Limb, <i>per device or limb</i>	\$1,000	\$1,500	\$2,000	\$3,000
<i>Maximum per lifetime</i>	\$2,000	\$3,000	\$4,000	\$6,000

Radiation/Chemotherapy				
Injected chemotherapy by medical personnel, one per week	\$250	\$500	\$750	\$1,000
Radiation delivered by medical personnel, one per week	\$250	\$500	\$750	\$1,000
Self-Injected Chemotherapy, one per month	\$150	\$200	\$300	\$400
Pump Chemotherapy, one per month	\$150	\$200	\$300	\$400
Topical Chemotherapy, one per month	\$150	\$200	\$300	\$400
Oral Hormonal Chemotherapy (1-24 months), one per month	\$150	\$200	\$300	\$400
Oral Hormonal Chemotherapy (25+ months), one per month	\$75	\$100	\$150	\$200
Oral Non-Hormonal Chemotherapy, one per month	\$150	\$200	\$300	\$400
Reconstructive Surgery, per surgical unit	\$40	\$40	\$60	\$60
Maximum per procedure, including 25% for general anesthesia	\$2,500	\$2,500	\$3,000	\$3,000
Second Medical Opinion, one per lifetime	\$150	\$200	\$300	\$300
Skilled Nursing Care Facility, Per day up to the number of days for hospital confinement	\$75	\$100	\$100	\$150
Skin Cancer Initial Diagnosis one per lifetime	\$300	\$300	\$400	\$600
Supportive/Protective Care Drugs/Colony Stimulating Factors, per day	\$50	\$100	\$150	\$200
Maximum per calendar year	\$400	\$800	\$1,200	\$1,600
Surgical Procedures, per unit	\$40	\$50	\$60	\$70
Maximum per procedure	\$2,500	\$3,000	\$5,000	\$6,000
Transportation, per mile	\$0.50	\$0.50	\$0.50	\$0.50
Maximum per roundtrip	\$1,000	\$1,000	\$1,200	\$1,500
Additional Benefits	Level 1	Level 2	Level 3	Level 4
Bone Marrow Donor Screening Maximum of one per lifetime	\$50	\$50	\$50	\$50
Cancer Vaccine Benefit Maximum of one per lifetime	\$50	\$50	\$50	\$50
Waiver of Premium	Yes	Yes	Yes	Yes
Health Screening Benefit Per covered person per calendar year	\$100	\$100	\$100	\$100

MONTHLY RATES (12 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$18.65	\$29.45	\$18.80	\$29.60
Level 2	17-75	\$22.30	\$34.85	\$22.60	\$35.15
Level 3	17-75	\$27.45	\$45.70	\$27.90	\$46.15
Level 4	17-75	\$36.65	\$61.15	\$37.25	\$61.75
11THLY RATES (11 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$20.35	\$32.13	\$20.51	\$32.29
Level 2	17-75	\$24.33	\$38.02	\$24.65	\$38.35
Level 3	17-75	\$29.95	\$49.85	\$30.44	\$50.35
Level 4	17-75	\$39.98	\$66.71	\$40.64	\$67.36
10THLY RATES (10 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$22.38	\$35.34	\$22.56	\$35.52
Level 2	17-75	\$26.76	\$41.82	\$27.12	\$42.18
Level 3	17-75	\$32.94	\$54.84	\$33.48	\$55.38
Level 4	17-75	\$43.98	\$73.38	\$44.70	\$74.10
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$9.33	\$14.73	\$9.40	\$14.80
Level 2	17-75	\$11.15	\$17.43	\$11.30	\$17.58
Level 3	17-75	\$13.73	\$22.85	\$13.95	\$23.08
Level 4	17-75	\$18.33	\$30.58	\$18.63	\$30.88
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$8.61	\$13.59	\$8.68	\$13.66
Level 2	17-75	\$10.29	\$16.08	\$10.43	\$16.22
Level 3	17-75	\$12.67	\$21.09	\$12.88	\$21.30
Level 4	17-75	\$16.92	\$28.22	\$17.19	\$28.50

Critical Illness 1.0

Colonial Life's individual Specified Critical Illness 1.0 insurance helps you and your family maintain financial security during the lengthy, expensive recovery period of a critical illness. It provides a lump sum benefit to help with the out-of-pocket medical and non-medical expenses of employees who suffer a critical illness. Sample CA Rates shown at the bottom includes Subsequent Diagnosis & Health Screening Benefits. Rates are based off non-tobacco. Critical Illness coverage is post-tax.

Benefits:	Description:
Face Amount:	Can choose anywhere from \$5,000 face amount up to \$30,000. <i>Spouse receives 50% of employee's face amount. Children receive 25% of the employee's face amount.</i>
For the diagnosis of this covered critical illness condition:	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Permanent paralysis due to a covered accident	100%
Coma	100%
Blindness	100%
Coronary artery bypass graft surgery/disease	25%
Additional Benefits:	Description:
Subsequent Diagnosis Of A Critical Illness	If you receive a benefit for a specified critical illness, and later you are diagnosed with a different specified critical illness, the original percentage of the face amount is payable for that particular specified critical illness. If you receive a benefit for a specified critical illness, and later you are diagnosed with the same specified critical illness, 25% of the original face amount is payable
Maximum Benefit Amount	3x the face amount for the named insured for all covered persons combined. The policy will terminate when the maximum benefit amount for specified critical illness has been paid.
Health Screening Benefit <i>Per covered person per calendar year</i>	\$50
Mammography Benefit	\$200
Cervical Cancer Screening Test Benefit	\$70

MONTHLY RATES (12 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$15,000	25-29	\$9.30	\$14.30	\$9.30	\$14.30
	30-34	\$10.50	\$16.25	\$10.50	\$16.25
	35-39	\$14.10	\$21.65	\$14.10	\$21.65
	40-44	\$16.50	\$25.25	\$16.50	\$25.25
	45-49	\$21.00	\$32.15	\$21.00	\$32.15
	50-54	\$26.40	\$40.55	\$26.40	\$40.55
11THLY RATES (11 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$15,000	25-29	\$10.15	\$15.60	\$10.15	\$15.60
	30-34	\$11.45	\$17.73	\$11.45	\$17.73
	35-39	\$15.38	\$23.62	\$15.38	\$23.62
	40-44	\$18.00	\$27.55	\$18.00	\$27.55
	45-49	\$22.91	\$35.07	\$22.91	\$35.07
	50-54	\$28.80	\$44.24	\$28.80	\$44.24
10THLY RATES (10 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$15,000	25-29	\$11.16	\$17.16	\$11.16	\$17.16
	30-34	\$12.60	\$19.50	\$12.60	\$19.50
	35-39	\$16.92	\$25.98	\$16.92	\$25.98
	40-44	\$19.80	\$30.30	\$19.80	\$30.30
	45-49	\$25.20	\$38.58	\$25.20	\$38.58
	50-54	\$31.68	\$48.66	\$31.68	\$48.66
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$15,000	25-29	\$4.65	\$7.15	\$4.65	\$7.15
	30-34	\$5.25	\$8.13	\$5.25	\$8.13
	35-39	\$7.05	\$10.83	\$7.05	\$10.83
	40-44	\$8.25	\$12.63	\$8.25	\$12.63
	45-49	\$10.50	\$16.08	\$10.50	\$16.08
	50-54	\$13.20	\$20.28	\$13.20	\$20.28
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$15,000	25-29	\$4.29	\$6.60	\$4.29	\$6.60
	30-34	\$4.85	\$7.50	\$4.85	\$7.50
	35-39	\$6.51	\$9.99	\$6.51	\$9.99
	40-44	\$7.62	\$11.65	\$7.62	\$11.65
	45-49	\$9.69	\$14.84	\$9.69	\$14.84
	50-54	\$12.18	\$18.72	\$12.18	\$18.72

Individual Dental Fee Schedule

Colonial Life's dental fee schedule covers a wide range of treatments, from routine cleanings to root canals and pays a fixed benefit amount for any covered dental procedure, making it a great fit for individuals and families.

Benefit Categories	Waiting Periods	Level 1	Level 2	Level 3	Level 4
Dental Wellness* Maximum of two visits per calendar year per person, separated by 150 days.	None	\$25	\$50	\$50	\$75
Radiographic Image Procedure (X-Ray)* Maximum of one X-Ray per calendar year per person.	None	\$15	\$35	\$35	\$35
Fillings and Basic Services	3 months	\$10-\$225	\$15-\$250	\$15-\$275	\$20-\$375
Pain Management and Adjunctive Services	3 months	\$25-\$120	\$30-\$130	\$35-\$140	\$45-\$175
Other Preventive Services	6 months	\$15-\$100	\$20-\$110	\$20-\$120	\$35-\$150
Oral Surgery, Gum Treatments, and Prosthetic Repair	6 months	\$20-\$1,000	\$30-\$1,200	\$30-\$1,400	\$45-\$1,600
Crowns and Major Services	12 months	\$10-\$350	\$15-\$375	\$20-\$425	\$30-\$520
Major Prosthetic Services	24 months	\$75-\$1,000	\$90-\$1,200	\$110-\$1,400	\$160-\$1,600
Orthodontic Benefit Rider – Optional Pays \$500 for the initial treatment. After the initial treatment, pays \$50 for treatment involving a covered orthodontic procedure		- Maximum payment of one treatment per month for up to 18 treatments - Maximum: \$1,400 lifetime maximum per covered person and a calendar year maximum \$2,800 for all covered persons 24 month waiting period			
Vision Rider – Optional Pays \$50 benefit for eye exam and pays \$50 for materials		- Maximum of one benefit for eye exam and one benefit for vision correction materials per covered person per calendar year 30 day waiting period			
*The Calendar Year Maximum does not apply to Dental Wellness and Radiographic Image Procedure (X-Ray) benefits. - Each benefit category (except for Dental Wellness and Radiographic Image Procedure (X-Ray)) has a waiting period. Insureds must satisfy the waiting period before they are eligible for benefits. Procedures performed prior to satisfying the waiting period, if any, are not covered.					

Sample Deductions

MONTHLY RATES (12 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$23.95	\$44.35	\$47.65	\$68.05
Level 2	17-75	\$31.25	\$63.45	\$68.40	\$100.60
Level 3	17-75	\$38.25	\$74.80	\$78.35	\$114.90
Level 4	17-75	\$49.80	\$98.50	\$103.70	\$152.40
11THLY RATES (11 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$26.13	\$48.38	\$51.98	\$74.24
Level 2	17-75	\$34.09	\$69.22	\$74.62	\$109.75
Level 3	17-75	\$41.73	\$81.60	\$85.47	\$125.35
Level 4	17-75	\$54.33	\$107.45	\$113.13	\$166.25
10THLY RATES (10 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$28.74	\$53.22	\$57.18	\$81.66
Level 2	17-75	\$37.50	\$76.14	\$82.08	\$120.72
Level 3	17-75	\$45.90	\$89.76	\$94.02	\$137.88
Level 4	17-75	\$59.76	\$118.20	\$124.44	\$182.88
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$11.98	\$22.18	\$23.83	\$34.03
Level 2	17-75	\$15.63	\$31.73	\$34.20	\$50.30
Level 3	17-75	\$19.13	\$37.40	\$39.18	\$57.45
Level 4	17-75	\$24.90	\$49.25	\$51.85	\$76.20
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
Level 1	17-75	\$11.05	\$20.47	\$21.99	\$31.41
Level 2	17-75	\$14.42	\$29.28	\$31.57	\$46.43
Level 3	17-75	\$17.65	\$34.52	\$36.16	\$53.03
Level 4	17-75	\$22.98	\$45.46	\$47.86	\$70.34

Individual Short-Term Disability 3000

Colonial Life's voluntary short-term disability insurance policy is an individual plan that is sold via payroll deduction at the workplace. It insures you employee's paycheck by replacing a portion of you employee's income if he becomes disabled because of a covered accidental injury or covered sickness. Sample CARates shown at the bottom represents Off-Job Injury & Sickness/Maternity with Health Screening & 1st Day Hospital. Rates are based off AARisk Classification & 6 month benefit period.

Benefits:	Description:
Monthly Benefit Amount <i>Amounts vary based on income, offered in \$100 increments</i>	Available up to \$4,000 in monthly benefits for up to 40% of income
Benefit Periods <i>Refers to the maximum length of time benefits may be payable for a covered disability</i>	6 months and 12 months are available
Elimination Periods <i>Elimination periods vary by benefit period selected, the first number represents accident elimination period, the second number represents sickness elimination period</i>	0/7, 7/7, 7/14, 0/14, 14/14, 0/30, 30/30 60/60, 90/90, and 180/180
Total Disability and Partial Disability Benefits <i>Partial disability pays 50% of the total disability benefit and for up to 3 months</i>	Included
Pregnancy Benefits <i>The usual recovery period is six weeks (vaginal delivery) or eight weeks (cesarean delivery), subject to elimination periods, subject to Giving Birth Limitation</i>	Included
Additional Benefits:	Description:
Additional Disability Benefits Riders <i>Provides policyholders the ability to purchase additional disability coverage on a guarantee issue basis after their initial enrollment, Policyholders can purchase a maximum of two riders, at two separate intervals</i>	\$100 or \$200 monthly
Health Screening Rider <i>Per calendar year</i>	\$50

MONTHLY RATES (12 PAYPERIODS)	ISSUE AGE	\$500/mo	\$1,000/mo	\$1,500/mo	\$2,000/mo	\$2,500/mo
Elimination 0 days Injury / 7 days Sickness	17-49	\$29.25	\$55.60	\$81.95	\$108.30	\$134.65
	50-64	\$39.90	\$76.90	\$113.90	\$150.90	\$187.90
	65-74	\$47.70	\$92.50	\$137.30	\$182.10	\$226.90
Elimination 0 days Injury / 14 days Sickness	17-49	\$23.65	\$44.40	\$65.15	\$85.90	\$106.65
	50-64	\$31.00	\$59.10	\$87.20	\$115.30	\$143.40
	65-74	\$36.90	\$70.90	\$104.90	\$138.90	\$172.90
11THLY RATES (11 PAYPERIODS)	ISSUE AGE	\$500/mo	\$1,000/mo	\$1,500/mo	\$2,000/mo	\$2,500/mo
Elimination 0 days Injury / 7 days Sickness	17-49	\$31.91	\$60.65	\$89.40	\$118.15	\$146.89
	50-64	\$43.53	\$83.89	\$124.25	\$164.62	\$204.98
	65-74	\$52.04	\$100.91	\$149.78	\$198.65	\$247.53
Elimination 0 days Injury / 14 days Sickness	17-49	\$25.80	\$48.44	\$71.07	\$93.71	\$116.35
	50-64	\$33.82	\$64.47	\$95.13	\$125.78	\$156.44
	65-74	\$40.25	\$77.35	\$114.44	\$151.53	\$188.62
10THLY RATES (10 PAYPERIODS)	ISSUE AGE	\$500/mo	\$1,000/mo	\$1,500/mo	\$2,000/mo	\$2,500/mo
Elimination 0 days Injury / 7 days Sickness	17-49	\$35.10	\$66.72	\$98.34	\$129.96	\$161.58
	50-64	\$47.88	\$92.28	\$136.68	\$181.08	\$225.48
	65-74	\$57.24	\$111.00	\$164.76	\$218.52	\$272.28
Elimination 0 days Injury / 14 days Sickness	17-49	\$28.38	\$53.28	\$78.18	\$103.08	\$127.98
	50-64	\$37.20	\$70.92	\$104.64	\$138.36	\$172.08
	65-74	\$44.28	\$85.08	\$125.88	\$166.68	\$207.48
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	\$500/mo	\$1,000/mo	\$1,500/mo	\$2,000/mo	\$2,500/mo
Elimination 0 days Injury / 7 days Sickness	17-49	\$14.63	\$27.80	\$40.98	\$54.15	\$67.33
	50-64	\$19.95	\$38.45	\$56.95	\$75.45	\$93.95
	65-74	\$23.85	\$46.25	\$68.65	\$91.05	\$113.45
Elimination 0 days Injury / 14 days Sickness	17-49	\$11.83	\$22.20	\$32.58	\$42.95	\$53.33
	50-64	\$15.50	\$29.55	\$43.60	\$57.65	\$71.70
	65-74	\$18.45	\$35.45	\$52.45	\$69.45	\$86.45
BI-WEEKLY (26 PAYPERIODS)	ISSUE AGE	\$500/mo	\$1,000/mo	\$1,500/mo	\$2,000/mo	\$2,500/mo
Elimination 0 days Injury / 7 days Sickness	17-49	\$13.50	\$25.66	\$37.82	\$49.98	\$62.15
	50-64	\$18.42	\$35.49	\$52.57	\$69.65	\$86.72
	65-74	\$22.02	\$42.69	\$63.37	\$84.05	\$104.72
Elimination 0 days Injury / 14 days Sickness	17-49	\$10.92	\$20.49	\$30.07	\$39.65	\$49.22
	50-64	\$14.31	\$27.28	\$40.25	\$53.22	\$66.18
	65-74	\$17.03	\$32.72	\$48.42	\$64.11	\$79.80

Individual Medical Bridge 7000

Colonial Life’s Individual Medical Bridge insurance can help with medical costs that yourhealth insurance maynot cover. These benefits are available for you,yourspouse and eligible dependent children. Sample CA Rates shown at the bottomincludes \$100 Health Screening & \$2,500 Outpatient Surgery Benefit. Individual Medical Bridge coverage is pre-tax eligible.

Benefits:	Description:
Hospital Confinement <i>Maximum of one benefit per covered person per calendaryear</i>	Can choose \$500 or \$1,000
Observation Room Visit <i>Maximum of two visits per covered person per calendaryear</i>	\$100 per visit
Rehabilitation Unit Confinement <i>Maximum of 15 days per confinement with a 30-day maximum per covered person per year</i>	\$100 per day
Waiver of Premium <i>Available after 30 continuous days of a covered hospital confinement of the named insured</i>	Included
Outpatient Surgery - Tier1 <i>Examples: Colonoscopy, Hemorrhoidectomy, Laparoscopic hernia repair, Tonsillectomy, Pacemaker insertion, Foot surgery (bunionectomy, exostectomy, arthroplasty, hammertoe repair), Removal of tendonlesion</i>	\$500
Outpatient Surgery - Tier2 <i>Examples: Breast reconstruction, Breast reduction, Angioplasty, Cardiac catherization, Exploratory laparoscopy, Ethmoidectomy, Cataract surgery, Glaucoma surgery, Hysterectomy, Myomectomy, Arthroscopic knee surgery with meniscectomy (knee cartilage repair), Dislocations & Fractures (open reduction with internal fixation), Tendon/ligament repair</i>	\$1,000
Maximum Outpatient SurgeryBenefit <i>Per covered person per calendar year for all covered</i>	\$1,500
Health ScreeningBenefit	\$100
Additional Benefits:	Description:
Daily Hospital Confinement <i>Per covered person day of hospital confinement, maximum of 365 days per confinement</i>	\$100 per day
Enhanced Intensive Care Unit Confinement <i>Per covered person per day of intensive care unit confinement, maximum of 30 days per confinement</i>	\$500 per day

MONTHLYRATES (12 PAY PERIODS)	ISSUE AGE	EMPLOYEE	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$1,000 Hospital Confinement	17-49	\$25.50	\$47.25	\$32.00	\$53.75
	50-59	\$33.60	\$62.60	\$40.10	\$69.10
	60-64	\$42.10	\$78.75	\$48.60	\$85.25
	65-75	\$52.20	\$97.90	\$58.70	\$104.40
11THLY RATES (11 PAYPERIODS)	ISSUE AGE	EMPLOYEE	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$1,000 Hospital Confinement	17-49	\$27.82	\$51.55	\$34.91	\$58.64
	50-59	\$36.65	\$68.29	\$43.75	\$75.38
	60-64	\$45.93	\$85.91	\$53.02	\$93.00
	65-75	\$56.95	\$106.80	\$64.04	\$113.89
10THLY RATES (10 PAYPERIODS)	ISSUE AGE	EMPLOYEE	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$1,000 Hospital Confinement	17-49	\$30.60	\$56.70	\$38.40	\$64.50
	50-59	\$40.32	\$75.12	\$48.12	\$82.92
	60-64	\$50.52	\$94.50	\$58.32	\$102.30
	65-75	\$62.64	\$117.48	\$70.44	\$125.28
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	EMPLOYEE	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$1,000 Hospital Confinement	17-49	\$12.75	\$23.63	\$16.00	\$26.88
	50-59	\$16.80	\$31.30	\$20.05	\$34.55
	60-64	\$21.05	\$39.38	\$24.30	\$42.63
	65-75	\$26.10	\$48.95	\$29.35	\$52.20
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	EMPLOYEE	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$1,000 Hospital Confinement	17-49	\$11.77	\$21.81	\$14.77	\$24.81
	50-59	\$15.51	\$28.89	\$18.51	\$31.89
	60-64	\$19.43	\$36.35	\$22.43	\$39.35
	65-75	\$24.09	\$45.18	\$27.09	\$48.18

TermLife 5000

Colonial Life's Term Life insurance plan offers life insurance protection where the benefit remains the same through the life of the policy. At the end of the term period selected by the employee (10-, 15-, 20-, or 30-years), the policy may be continued on a yearly renewable basis, without proof of good health. Sample Rates shown at the bottom are based off non-tobacco rates. Term Life coverage is post-tax.

<u>Benefits:</u>	<u>Description:</u>
Death Benefit <i>Amounts available vary by age</i>	Range from \$10,000 to \$250,000
Term Levels <i>Varies by age, provides coverage for set amount of years with guaranteed level premiums and may be renewed annually thereafter without evidence of insurability</i>	10, 15, 20, and 30-year terms available
Terminal Illness Accelerated Death Benefit <i>Automatically included in the base policy at no additional premium, allows policyowner to receive an advance of up to 75% of face amount, up to a maximum of \$150,000 (in most states)</i>	Can request up to 75% of death benefit if diagnosed with a terminal illness has a life expectancy of 12 months or less
<u>Additional Benefits:</u>	<u>Description:</u>
Spouse Term Rider <i>Spouse signature not required, may convert to a cash value policy</i>	Death benefits range from \$10,000 to \$50,000, 10 and 20-year term options available
Children's Term Rider <i>Covers all dependent children for one level premium, may convert to a cash value policy</i>	Death benefits range from \$1,000 to \$20,000
Accidental Death Benefit Rider <i>Up to a maximum of \$150,000</i>	Doubles benefit amount if insured dies as a result of an accident before age 70
Waiver of Premium Benefit Rider <i>Total disability is considered permanent when the total disability continues with no interruptions for at least six consecutive months.</i>	Waives all premiums due on the base policy & attached riders during the total and permanent disability of the primary insured before age 65

TermLife 5000

Colonial Life’s Term Life insurance plan offers life insurance protection where the benefit remains the same through the life of the policy. At the end of the term periodselected by the employee (10-, 15-, 20-, or 30-years), the policy maybe continued ona yearly renewable basis, withoutproof of goodhealth. Sample Rates shown at the bottomare based off non-tobaccorates. Term Life coverage is post-tax.

Sample Monthly Deductions

Non-Tobacco Rates		10 Year Term			
MONTHLY RATES (12 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$11.65	\$10.21	\$13.31	\$16.42
	40	\$13.96	\$14.04	\$19.06	\$24.08
	50	\$23.29	\$25.58	\$36.37	\$47.16
SEMI-MONTHLY RATES (24 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$5.83	\$5.11	\$6.66	\$8.21
	40	\$6.98	\$7.02	\$9.53	\$12.04
	50	\$11.65	\$12.79	\$18.19	\$23.58
BI-WEEKLY (26 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$5.38	\$4.71	\$6.14	\$7.58
	40	\$6.44	\$6.48	\$8.80	\$11.11
	50	\$10.75	\$11.81	\$16.79	\$21.77
WEEKLY (52 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$2.69	\$2.36	\$3.07	\$3.79
	40	\$3.22	\$3.24	\$4.40	\$5.56
	50	\$5.37	\$5.90	\$8.39	\$10.88
Non-Tobacco Rates		20 Year Term			
MONTHLY RATES (12 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$11.81	\$10.54	\$13.81	\$17.08
	40	\$14.58	\$15.42	\$21.12	\$26.83
	50	\$25.69	\$31.58	\$45.37	\$59.16
SEMI-MONTHLY RATES (24 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$5.91	\$5.27	\$6.91	\$8.54
	40	\$7.29	\$7.71	\$10.56	\$13.42
	50	\$12.85	\$15.79	\$22.69	\$29.58
BI-WEEKLY (26 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$5.45	\$4.86	\$6.37	\$7.88
	40	\$6.73	\$7.12	\$9.75	\$12.38
	50	\$11.86	\$14.58	\$20.94	\$27.30
WEEKLY (52 PAYPERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$2.73	\$2.43	\$3.19	\$3.94
	40	\$3.36	\$3.56	\$4.87	\$6.19
	50	\$5.93	\$7.29	\$10.47	\$13.65

Whole Life 5000

Colonial Life's WholeLife insurance plan is individually owned, with guaranteed level premiums, guaranteed cash values and a guaranteed death benefit. Coverage is permanent and is guaranteed for the life of the policy (to age 100), provided premiums are paid when due. Sample Rates shown below are based off non-tobacco. Both Paid up at age 70 and Paid up at age 100 are represented.

<u>Benefits:</u>	<u>Description:</u>
Death Benefit <i>Amounts available vary by age</i>	\$5,000 to \$500,000
Two Plan Options <i>The policy is paid-up at the original face amount when the insured reaches the specified age, with no additional premiums due</i>	Paid-Up at Age 70 & Paid-Up at Age 100
Guaranteed Cash Value <i>In addition to death benefit coverage, it also provides a guaranteed cash value accumulation that grows taxdeferred.</i>	4.5%
Terminal Illness Accelerated Death Benefit Provision <i>Automatically included in the base policy at no additional premium, up to a maximum of \$150,000 (in most states)</i>	Can request up to 75% of death benefit if diagnosed with a terminal illness and has a life expectancy of 12 months or less
<u>Additional Benefits:</u>	<u>Description:</u>
Guaranteed Purchase Option <i>Provides the policyowner the right to buy additional insurance on the life of the insured without providing evidence of insurability if the policy is purchased before age 55.</i>	Available on the second, fifth, and eight anniversary dates.
Juvenile Whole Life Plan <i>Employees can purchase this for children or grandchildren without purchasing coverage of themselves</i>	A juvenile whole life plan is available for eligible dependents.
Spouse Term Rider <i>Spouse signature not required, may convert to a cash value policy</i>	Face amounts range from \$5,000 to \$50,000, 10 and 20-year term options available
Children's Term Rider <i>Covers all dependent children for one level premium, may convert to a cash value policy</i>	Face amounts range from \$1,000 to \$20,000
Accidental Death Benefit Rider <i>Up to a maximum of \$150,000</i>	Doubles benefit amount if insured dies as a result of an accident before age 70
Waiver of Premium Benefit Rider <i>Total disability is considered permanent when the total disability continues with no interruptions for at least six consecutive months.</i>	Waives all premiums due on the base policy & attached riders during the total and permanent disability of the primary insured before age 65

Whole Life 5000

Colonial Life’s WholeLife insurance plan is individually owned, with guaranteed level premiums, guaranteed cash values and a guaranteed death benefit. Coverage is permanent and is guaranteed for the life of the policy (to age 100), provided premiums are paid when due. Sample Rates shown below are based off non-tobacco. Both Paid up at age 70 and Paid up at age 100 are represented.

Non-Tobacco Rates	Paid up at Age 70				
MONTHLY RATES (12 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$27.75	\$47.46	\$69.68	\$91.91
	40	\$42.10	\$76.33	\$113.00	\$149.66
	45	\$70.50	\$135.83	\$202.24	\$268.66
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$13.88	\$23.73	\$34.84	\$45.96
	40	\$21.05	\$38.17	\$56.50	\$74.83
	45	\$35.25	\$67.92	\$101.12	\$134.33
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$12.81	\$21.90	\$32.16	\$42.42
	40	\$19.43	\$35.23	\$52.15	\$69.07
	45	\$32.54	\$62.69	\$93.34	\$124.00
WEEKLY (52 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$6.40	\$10.95	\$16.08	\$21.21
	40	\$9.72	\$17.61	\$26.08	\$34.54
	45	\$16.27	\$31.35	\$46.67	\$62.00
Non-Tobacco Rates	Paid up at Age 100				
MONTHLY RATES (12 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$25.00	\$42.24	\$61.81	\$81.41
	40	\$35.75	\$63.37	\$93.56	\$123.75
	45	\$55.52	\$98.25	\$145.87	\$193.49
SEMI-MONTHLY RATES (24 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$12.50	\$21.12	\$30.91	\$40.71
	40	\$17.88	\$31.69	\$46.78	\$61.88
	45	\$27.76	\$49.13	\$72.94	\$96.75
BI-WEEKLY (26 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$11.54	\$19.50	\$28.53	\$37.57
	40	\$16.50	\$29.25	\$43.18	\$57.12
	45	\$25.62	\$45.35	\$67.32	\$89.30
WEEKLY (52 PAY PERIODS)	ISSUE AGE	\$25,000.00	\$50,000.00	\$75,000.00	\$100,000.00
	30	\$5.77	\$9.75	\$14.26	\$18.79
	40	\$8.25	\$14.62	\$21.59	\$28.56
	45	\$12.81	\$22.67	\$33.66	\$44.65

Frequently Asked Questions by Employees

Question	Answer
Q: How do the Colonial Life plans work with my Health Insurance?	<i>A: The Colonial Life plans are indemnity-based benefits, meaning the plans do NOT coordinate with other insurance plans. The plans pay cash benefits directly to you to help offset direct and indirect costs related to covered events (varies by plan).</i>
Q: What if I have a pre-existing condition? Can I still get coverage?	<i>A: Yes! Guaranteed Issue is available on certain plans! Health questions may apply for certain benefits. Please check with your Building Blocks Benefit Advisor to learn more!</i> <i>A Pre-existing Condition is a sickness or physical condition for which a covered person was diagnosed or treated before the coverage effective date. The pre-existing condition period varies by policy type.</i>
Q: Can I keep the plans if I move or retire?	<i>A: Yes! All plans are portable!</i>
Q: Can I cover my family?	<i>A: Yes! You can cover eligible dependents (i.e. spouse and children) on this plan!</i>
Q: How long are my children covered?	<i>A: Children younger than the age of 26 are considered eligible dependent children.</i>
Q: How do I file a claim?	<i>A: You can file a claim online by registering as a policyholder at https://www.coloniallife.com/ or by using the mobile app! If you require any assistance, please contact the Building Blocks service team by emailing westservice@bbforb.com.</i>
Q: How do I enroll or make changes?	<i>A: Your employer will establish a defined enrollment period (the timeframe) in which you can enroll. Please reference the instructions provided by your District on how to login to your personal BenefitBridge portal. To schedule a personal one-on-one session with a Building Blocks Benefit Advisor, reference the instructions on Page 1 of this document.</i>
Q: What if I have a question outside of open enrollment?	<i>A: We are here for you year-round! Simply email westservice@bbforb.com whenever you have a question. You can view your policies by registering at https://www.coloniallife.com and downloading the My Colonial Life mobile app.</i>
Q: Do I still have coverage if I am traveling outside of the country?	<i>A: There may be global coverage available. Please check with your Building Blocks Benefit Advisor to learn more!</i>



Start saving today with WellCard Savings!

WellCard discounts include:



Prescription Discounts



Pet Discounts



Dental Care



Vision Care



Fitness



Family & Entertainment

Get Started Today!

Gain access to value-added programs that can save you money every time you use pharmacies, vision care providers, hearing care specialists, prepaid lab tests, prepaid imaging tests, patient advocacy services and more.

You are eligible to receive a FREE membership to the WellCard Savings Program! After completing your personal enrollment session with a Building Blocks Benefit Advisor, you will receive an email with instructions on how to gain access to the WellCard Savings Discount Program.



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Keep Smiling

Delta Dental PPOSM

Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your

plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁴ You can find this date by logging in to Online Services.

Newly covered?

Visit deltadentalins.com/welcome.

Save with a PPO dentist



¹ In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

Plan Benefit Highlights for: County of Colusa

Group No: 08189

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	PPO dentists: None			
	None PPO dentists: \$25 per person/ \$50 per family each calendar year			
Maximums D & P counts toward maximum?	PPO dentists: Not applicable			
	Non-PPO dentists: Yes			
Waiting Period(s)	\$2,500 per person each calendar year			
	PPO dentists: No			
Waiting Period(s)	Non-PPO dentists: Yes			
	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions and sealants	80 %	80 %
Endodontics (root canals)	80 %	80 %
Periodontics (gum treatment)	80 %	80 %
Oral Surgery	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges and dentures	80 %	80 %
Orthodontic Benefits Dependent children	50 %	50 %
Orthodontic Maximum	\$1,000 Lifetime	\$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Keep Smiling

DeltaCare[®] USA

provided by
Delta Dental of California



Dental benefits made easy!

When you enroll in a DeltaCare USA¹ plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.²

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums³ for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan:
deltadentalins.com/about/legal/index-enrollee.html

¹ DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Delta Dental is a registered trademark of Delta Dental Plans Association.

² Verify your selected DeltaCare USA primary care dentist before each appointment.

³ Plans with an Accidental Injury Rider have a \$1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.



deltadentalins.com/enrollees

Frequently Asked Questions

What you need to know about your DeltaCare USA plan

Getting started

- 1. How do I enroll in a DeltaCare USA plan?**
Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.
- 2. How do I get started using my DeltaCare USA plan?**
Once we process your enrollment, we'll mail you welcome materials that will include:
 - **The name, address and phone number of your selected primary care dentist.** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
 - **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
 - **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.
- 3. How long will it take to get an appointment with my primary care dentist?**
Two to four weeks¹ is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time slot, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

- 4. How much will my dental treatments cost? How do I pay?**

With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

- 5. How do I select my primary care dentist?**
When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at deltadentalins.com and select the DeltaCare USA network. If you do not select a dentist when you enroll, we will choose one for you.
- 6. Does everyone in my family have to choose the same primary care dentist?**
No. Each family member can select his or her own primary care network dentist.²
- 7. Can I change my primary care dentist?**
Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or contact Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

¹ In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.

² In MA, you cannot select more than three primary care dentist facilities per family.

8. **My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists. You must visit your selected primary care network dentist to receive benefits under this plan.
9. **What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

10. **If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles from your primary care dentist. Your out-of-area emergency benefit (typically limited to \$100 per person) is for services to relieve pain until you can return to your primary care network dentist.³ Standard plan limitations, exclusions and copayments may apply.
11. **Can I access my plan online?**
Yes. Visit deltadentalins.com to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

12. **Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress⁴), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.
13. **Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.
14. **Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.
15. **What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

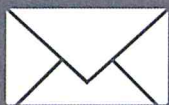
³ In TX, there is no limit on the number of miles or on the dollar amount per emergency.

⁴ In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

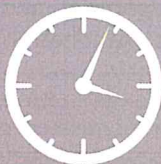
We make it easy for you!



Select a
DeltaCare USA
dentist



Receive your
welcome materials



Schedule an
appointment



Receive
dental care



Pay only your
share to dentist

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in *italics* below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2020 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	\$5.00
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 3 years</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 3 years</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 3 years</i>	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost
D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (<i>within the 6 month period</i>)	\$45.00

D1120	Prophylaxis <i>cleaning</i> - child - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child (within the 6 month period)	\$35.00
D1206	Topical application of fluoride varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1208	Topical application of fluoride - excluding varnish - <i>child to age 19; 1 D1206 or D1208 per 6 month period</i>	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	\$5.00
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	\$5.00
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	\$5.00
D1354	Interim caries arresting medicament application - per tooth - <i>child to age 19; 1 per 6 month period</i>	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	\$10.00
D1516	Space maintainer - fixed - bilateral, maxillary	\$10.00
D1517	Space maintainer - fixed - bilateral, mandibular	\$10.00
D1520	Space maintainer - removable - unilateral - per quadrant	\$10.00
D1526	Space maintainer - removable - bilateral, maxillary	\$10.00
D1527	Space maintainer - removable - bilateral, mandibular	\$10.00
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i>	\$10.00

D2000-D2999**III. RESTORATIVE**

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$100.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	\$45.00
D2392	Resin-based composite - two surfaces, posterior	\$55.00
D2393	Resin-based composite - three surfaces, posterior	\$65.00
D2394	Resin-based composite - four or more surfaces, posterior	\$75.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface	\$135.00
D2620	Inlay - porcelain/ceramic - two surfaces	\$150.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	\$160.00
D2642	Onlay - porcelain/ceramic - two surfaces	\$150.00
D2643	Onlay - porcelain/ceramic - three surfaces	\$165.00
D2644	Onlay - porcelain/ceramic - four or more surfaces	\$175.00
D2650	Inlay - resin-based composite - one surface	\$85.00

D2651	Inlay - resin-based composite - two surfaces	\$95.00
D2652	Inlay - resin-based composite - three or more surfaces	\$115.00
D2662	Onlay - resin-based composite - two surfaces	\$110.00
D2663	Onlay - resin-based composite - three surfaces	\$120.00
D2664	Onlay - resin-based composite - four or more surfaces	\$145.00
D2710	Crown - resin-based composite (indirect)	\$35.00
D2712	Crown - 3/4 resin-based composite (indirect)	\$35.00
D2720	Crown - resin with high noble metal	\$155.00
D2721	Crown - resin with predominantly base metal	\$55.00
D2722	Crown - resin with noble metal	\$95.00
D2740	Crown - porcelain/ceramic	\$195.00
D2750	Crown - porcelain fused to high noble metal	\$195.00
D2751	Crown - porcelain fused to predominantly base metal	\$95.00
D2752	Crown - porcelain fused to noble metal	\$135.00
D2753	Crown - porcelain fused to titanium and titanium alloys	\$195.00
D2780	Crown - 3/4 cast high noble metal	\$170.00
D2781	Crown - 3/4 cast predominantly base metal	\$70.00
D2782	Crown - 3/4 cast noble metal	\$110.00
D2783	Crown - 3/4 porcelain/ceramic	\$195.00
D2790	Crown - full cast high noble metal	\$170.00
D2791	Crown - full cast predominantly base metal	\$70.00
D2792	Crown - full cast noble metal	\$110.00
D2794	Crown - titanium and titanium alloys	\$195.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	\$10.00
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	\$15.00
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	\$10.00
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework	\$19.00
D2980	Crown repair necessitated by restorative material failure	\$10.00
D2981	Inlay repair necessitated by restorative material failure	\$10.00
D2982	Onlay repair necessitated by restorative material failure	\$10.00
D2983	Veneer repair necessitated by restorative material failure	\$10.00
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i> .	\$5.00

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	\$5.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$5.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$5.00

Plan CA10A	DeltaCare USA	Description of Benefits and Copayments
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D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	\$45.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	\$90.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	\$205.00
D3331	Treatment of root canal obstruction; non-surgical access	\$45.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$45.00
D3333	Internal root repair of perforation defects	\$45.00
D3346	Retreatment of previous root canal therapy - anterior	\$60.00
D3347	Retreatment of previous root canal therapy - premolar	\$105.00
D3348	Retreatment of previous root canal therapy - molar	\$220.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$70.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	\$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$80.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$50.00
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$50.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$80.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$50.00
D4245	Apically positioned flap	\$75.00
D4249	Clinical crown lengthening - hard tissue	\$75.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$175.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$140.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$195.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$60.00
D4270	Pedicle soft tissue graft procedure	\$195.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	\$45.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$195.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$195.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	No Cost

D4910	Additional periodontal maintenance (within the 6 month period)	\$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	\$100.00
D5120	Complete denture - mandibular	\$100.00
D5130	Immediate denture - maxillary	\$120.00
D5140	Immediate denture - mandibular	\$120.00
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$80.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	\$120.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	\$120.00
D5221	Immediate maxillary partial denture - resin base (including any retentive/clasping materials, rests and teeth)	\$80.00
D5222	Immediate mandibular partial denture - resin base (including any retentive/clasping materials, rests and teeth)	\$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	\$120.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any retentive/clasping materials, rests and teeth)	\$120.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$170.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$170.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	\$15.00
D5512	Repair broken complete denture base, maxillary	\$15.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$5.00
D5611	Repair resin partial denture base, mandibular	\$15.00
D5612	Repair resin partial denture base, maxillary	\$15.00
D5621	Repair cast partial framework, mandibular	\$15.00
D5622	Repair cast partial framework, maxillary	\$15.00
D5630	Repair or replace broken retentive/clasping materials - per tooth	\$15.00
D5640	Replace broken teeth - per tooth	\$5.00
D5650	Add tooth to existing partial denture	\$5.00
D5660	Add clasp to existing partial denture - per tooth	\$5.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$75.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$75.00
D5710	Rebase complete maxillary denture	\$35.00
D5711	Rebase complete mandibular denture	\$35.00
D5720	Rebase maxillary partial denture	\$35.00
D5721	Rebase mandibular partial denture	\$35.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	\$35.00
D5751	Reline complete mandibular denture (laboratory)	\$35.00
D5760	Reline maxillary partial denture (laboratory)	\$35.00
D5761	Reline mandibular partial denture (laboratory)	\$35.00

D5820	Interim partial denture (maxillary) - <i>limited to 1 in any 12 consecutive months</i>	\$45.00
D5821	Interim partial denture (mandibular) - <i>limited to 1 in any 12 consecutive months</i>	\$45.00
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$100.00 per unit, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

D6210	Pontic - cast high noble metal	\$170.00
D6211	Pontic - cast predominantly base metal	\$70.00
D6212	Pontic - cast noble metal	\$110.00
D6240	Pontic - porcelain fused to high noble metal	\$195.00
D6241	Pontic - porcelain fused to predominantly base metal	\$95.00
D6242	Pontic - porcelain fused to noble metal	\$135.00
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$135.00
D6245	Pontic - porcelain/ceramic	\$195.00
D6250	Pontic - resin with high noble metal	\$155.00
D6251	Pontic - resin with predominantly base metal	\$55.00
D6252	Pontic - resin with noble metal	\$95.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$150.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$160.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$100.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$100.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	\$40.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$40.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$150.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$165.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$100.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$100.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	\$40.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$40.00
D6720	Retainer crown - resin with high noble metal	\$155.00
D6721	Retainer crown - resin with predominantly base metal	\$55.00
D6722	Retainer crown - resin with noble metal	\$95.00
D6740	Retainer crown - porcelain/ceramic	\$195.00
D6750	Retainer crown - porcelain fused to high noble metal	\$195.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$95.00
D6752	Retainer crown - porcelain fused to noble metal	\$135.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$195.00
D6780	Retainer crown - 3/4 cast high noble metal	\$170.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$70.00
D6782	Retainer crown - 3/4 cast noble metal	\$110.00
D6783	Retainer crown - 3/4 porcelain/ceramic	\$195.00
D6784	Retainer crown 3/4 - titanium and titanium alloys	\$170.00
D6790	Retainer crown - full cast high noble metal	\$170.00
D6791	Retainer crown - full cast predominantly base metal	\$70.00
D6792	Retainer crown - full cast noble metal	\$110.00
D6930	Re-cement or re-bond fixed partial denture	No Cost

D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	\$10.00

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$15.00
D7220	Removal of impacted tooth - soft tissue	\$25.00
D7230	Removal of impacted tooth - partially bony	\$50.00
D7240	Removal of impacted tooth - completely bony	\$70.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$90.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$90.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$50.00
D7280	Exposure of an unerupted tooth	\$85.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$85.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7320	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	\$50.00
D7971	Excision of pericoronal gingiva	\$50.00

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply.

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: \$200.00

D0210	Intraoral - complete series of radiographic images
D0322	Tomographic survey
D0330	Panoramic radiographic image
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis
D0350	2D oral/facial photographic images obtained intraorally or extraorally
D0351	3D photographic image
D0470	Diagnostic casts

The benefit for post-treatment records includes: \$70.00

D0210	Intraoral - complete series of radiographic images
D0470	Diagnostic casts

D8010	Limited orthodontic treatment of the primary dentition	\$950.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$950.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$950.00

D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$1,150.00
D8050	Interceptive orthodontic treatment of the primary dentition	\$950.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$950.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> ..	\$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	\$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$100.00

D9000-D9999**XII. ADJUNCTIVE GENERAL SERVICES**

D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$5.00
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$5.00
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$95.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$95.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$95.00
D9951	Occlusal adjustment, limited	\$20.00
D9952	Occlusal adjustment, complete	\$40.00
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review ..	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments*.
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional \$100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.

9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Useful information at your fingertips

Boost your wellness IQ

Find oral health resources, including articles, quizzes, videos and a subscription to Grin!, our free dental wellness e-magazine at deltadentalins.com/wellness.

Find a network dentist near you

Use our convenient “Find a Dentist” tool and select DeltaCare USA as your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Sign up for an online account

Use your mobile device or desktop to sign up for a free, secure online account.

- Review your plan benefits
- Access your ID card

Contact us

Need help? Let us know.

Online: Visit deltadentalins.com/contact and choose the “DeltaCare USA Customer Service” form.

Write to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234

Customer Service agents are available Monday through Friday, 8 am to 9 pm, Eastern time. Or, use our automated phone system, available 24/7.

Underwritten by:

Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.

This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the “Description of Benefits and Copayments” and “Limitations and Exclusions of Benefits” in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.



Your Smile, Your Choice

Delta Dental PPO™ & DeltaCare® USA



You can choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks and affordable preventive care. Your options are:

Delta Dental PPO¹

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.² Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles.³

Turn the page for more details to help you choose the best plan for your needs.

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

³ Refer to your plan booklet for more information about covered services, deductibles and maximums.

Compare plan features

Delta Dental PPO		DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits. ²
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at low or no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has low or no copayments.
Are there deductibles and maximums?	Yes, most plans have an annual deductible and maximum.	No, there are no annual deductibles or maximums. ⁴
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date. ⁵ Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral. ⁶
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting us.	You can change your selected or assigned primary care dentist online or by telephone. ⁷
Do I need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non-Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan. ⁸

⁴ In AK, CT, ND and SD, you have an out-of-network calendar year maximum of \$500 when you visit an out-of-network dentist.

⁵ Except in Texas; please refer to your plan booklet for details.

⁶ Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by an in-network specialist. Refer to your plan booklet for details.

⁷ In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

⁸ You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA — Delta Dental of California; PA, MD — Delta Dental of Pennsylvania; NY — Delta Dental of New York, Inc.; DE — Delta Dental of Delaware, Inc.; WV — Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

EVIDENCE OF INSURABILITY (EOI) INSTRUCTIONS WHEN YOU NEED MORE LIFE INSURANCE.

By completing the Evidence of Insurability (EOI) form, you are providing the additional information needed to review your request. Any Guaranteed Issue amount available to you will be provided regardless of your EOI application.

1. Getting Started:

- Know how much insurance you need.
- Know how much insurance you already have through your employer, what type of insurance it is, and how much you are eligible for.
- Know your/your spouse's primary health practitioner contact info.

2. Completing the EOI:

- Complete all other sections of this form.
- If you do not require underwriting for your spouse or children, you do not need to complete those sections.
- OPTION section is for Voya Employee Benefits (Voya EB) use only. Do not complete.
- The privacy and security of your personal contact and health information is critically important to us.
- We will not share your information with your employer or anyone not directly involved in the underwriting process per attached privacy statement.
- Your signature and date are required.
- Your spouse's signature is only required if applying for spouse coverage.

3. Submitting your EOI Application:

- Make a copy of your EOI form for your records.
- Submit your EOI form directly to Voya EB for fast and confidential handling via one of the methods below:

Fax to: 1-612-467-8721

Or

Mail to:
ReliaStar Life Insurance Company
PO Box 20, Mail Stop 5-E, Minneapolis, MN 55440

4. Questions:

- Call your Benefits Department to verify your current amount of coverage or any Guaranteed Issue amount you may be eligible for.
- Call Medical Underwriting at 1-800-537-5024, Option 4 if you have questions on how to complete this form or the status of your submitted EOI.

FORM EXAMPLE AND DEFINITIONS

(A) This is the total amount of insurance protection you desire, listed by type of insurance. (NOTE: Coverage available is dependent on the plan offered by your employer.)

(B) This is the amount of insurance you already have, listed by type of insurance. If you don't have current coverage in force, enter "0".

(C) This is the amount your plan allows you to have at this time without submitting the evidence of insurability form. This amount may be your guaranteed issue amount as a *new hire* or it may be an amount offered *during an annual enrollment*. If there is no additional guaranteed issue amount available, enter "0".

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) – (B) – (C) = Amount To Be Underwritten
☒ Employee Supplemental Life	\$ 500,000	\$ 0	\$ 100,000	\$ 400,000
☒ Spouse Supplemental Life	\$ 50,000	\$ 10,000	\$ 0	\$ 40,000

Definitions:

Employee Supplemental Life Insurance is typically paid for by the employee. It is often chosen as additional coverage when more insurance is needed.

Spouse Supplemental Life can be purchased as additional protection, if allowed by your plan. It is typically paid for by the employee.

Group #316407, 06/15/2020

EVIDENCE OF INSURABILITY (CA)

ReliaStar Life Insurance Company, Minneapolis, MN
A member of the Voya family of companies
PO Box 20, Mail Stop 5-E, Minneapolis, MN 55440
Phone: 612.342.7262 Fax: 612.467.8721



Use this form to apply for insurance coverage in addition to coverage you may already have through this plan.

Group Number 3 16 4 0 7 Account Number 0 0 0 6 Employer Name PRIS M

Location County of Colusa Option 2 _____ Option 3 _____ Option 4 _____

A. EMPLOYEE INFORMATION

Employee Name (First, MI, Last) _____ Gender: ☐ Male ☐ Female

SSN _____ Personal E-mail Address _____ Birth Date _____

Address _____ City _____ State _____ ZIP _____

Home Phone (_____) _____ Cell Phone (_____) _____

Hire Date _____ Salary \$ _____ Occupation _____

Primary Health Practitioner _____ Practitioner Phone (_____) _____

Practitioner Address _____ City _____ State _____ ZIP _____

B. INSURANCE DETAILS (Complete this table based only on the coverage you have through this plan.)

Are you completing this form due to a Family Status Change (Marriage, Divorce, Birth, Adoption, etc.)? ☐ Yes ☐ No

Coverage Type	(A) Total Amount Desired	(B) Current Amount	(C) Guaranteed Issue Amount	(A) - (B) - (C) = Amount To Be Underwritten
☐ Employee Supplemental Life	\$ _____	\$ _____	\$ _____	\$ _____
☐ Spouse Supplemental Life	\$ _____	\$ _____	\$ _____	\$ _____

C. SPOUSE INFORMATION

Spouse Name (First, MI, Last) _____ Gender: ☐ Male ☐ Female

SSN _____ Personal E-mail Address _____ Birth Date _____

Home Phone (_____) _____ Cell Phone (_____) _____

☐ Same Primary Health Practitioner as Employee (See information above.)

Primary Health Practitioner _____ Practitioner Phone (_____) _____

Practitioner Address _____ City _____ State _____ ZIP _____

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Employee Name _____ SSN (Last 4 digits only) _____

D. EMPLOYEE AND SPOUSE HEALTH QUESTIONS (Must be answered for coverage that is not Guaranteed Issue.)

Employee (EE)		Spouse (SP)		
Yes	No	Yes	No	
☐	☐	☐	☐	1. Within the last 5 years have you been treated for or been diagnosed by a member of the medical profession or health practitioner as having AIDS (Acquired Immunodeficiency Syndrome)?
☐	☐	☐	☐	2. Within the last 5 years have you been treated for, any of the following: insulin dependent diabetes, heart attack, coronary bypass/angioplasty, heart valve repair/replacement, stroke, metastatic cancer, emphysema or been an organ transplant recipient?
Complete for EE and SP. ---->				3. Employee: Height _____ ft. _____ in. Weight _____ lbs. Spouse: Height _____ ft. _____ in. Weight _____ lbs.
☐	☐	☐	☐	4. In the past 5 years have you been diagnosed or treated by a health practitioner, or taken medication for any of the following:
☐	☐	☐	☐	a. Any disease or abnormality of the heart or blood vessels (excluding controlled high blood pressure), or any heart rhythm abnormality?
☐	☐	☐	☐	b. Any disease of the lung (excluding asthma), liver (excluding hepatitis A), pancreas or intestine?
☐	☐	☐	☐	c. Non-insulin dependent diabetes, impaired glucose tolerance, or pre-diabetes?
☐	☐	☐	☐	d. Cancer or tumor, rheumatoid arthritis, connective tissue disease, neurological disease (excluding headaches), autoimmune disease or any disease of the blood cells or serum including, but not limited to, anemia, polycythemia, or bleeding or clotting disorder?
☐	☐	☐	☐	e. Depression, psychosis, suicide attempt, drug or alcohol abuse or addiction?
☐	☐	☐	☐	f. Polycystic kidney disease or kidney failure?
☐	☐	☐	☐	5. Within the last 5 years have you been diagnosed or treated by a physician or other health practitioner for:
☐	☐	☐	☐	a. Chest pain, heart trouble or circulatory condition?
☐	☐	☐	☐	b. Anemia or leukemia?
☐	☐	☐	☐	c. Sleep apnea, asthma or other respiratory disease?
☐	☐	☐	☐	d. Colitis, Crohn's disease, ulcerative colitis or any other intestinal disease?
☐	☐	☐	☐	e. Stomach disease?
☐	☐	☐	☐	f. Brain or seizure disorder?
☐	☐	☐	☐	g. Mental or nervous disorder?
☐	☐	☐	☐	h. Arthritis, paralysis or any muscle weakness impacting your ability to perform daily activities?
☐	☐	☐	☐	i. Abnormal urine specimen or urinary tract disorder?
☐	☐	☐	☐	j. Prostate or other reproductive organ disorder?
☐	☐	☐	☐	6. Are you pregnant? Due Date _____ Pre-pregnancy weight _____ lbs
☐	☐	☐	☐	7. Are you currently taking any medication prescribed or provided by a physician or other health practitioner for any disorder, condition, or disease not shown above?
☐	☐	☐	☐	8. Within the last 5 years have you received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a health practitioner to discontinue the use of such substances?

For every "Yes" answer, to any question in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Question Number	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Fully Recovered?	Health Practitioner Name, Full Address (Street, City, State, ZIP), Phone
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	
	☐ EE ☐ SP				☐ Yes ☐ No	

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Employee Name _____ SSN (Last 4 digits only) _____

E. AUTHORIZATION AND ACKNOWLEDGMENT (Please read and sign below)

For underwriting and claim purposes, I give my permission to any physician or other medical practitioner, hospital, clinic, rehabilitation facility, insurance or reinsuring company, MIB, Inc. (MIB), any consumer reporting agency to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below). This includes but may not be limited to: (a) findings on medical care, psychiatric or psychological care or examination, or surgery, as they apply to me; and (b) any non-medical information as it applies to me. I give my permission to ReliaStar Life to obtain consumer or investigative consumer reports about me.

I give my permission to ReliaStar Life and other insurance companies affiliated with ReliaStar Life to obtain any and all medical record information for the purposes described in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations—42 CFR Part 2. I may revoke this permission as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it. I specifically consent to the re-disclosure of medical record information as set forth in this form. In connection with any application for life insurance, or other insurance transaction that I may have with ReliaStar Life or any of its affiliated companies, I understand that I may request that this information not be communicated to companies affiliated with ReliaStar Life.

I authorize ReliaStar Life, or its reinsurers, to disclose personal health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection programs.

I understand that my further written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not before specified. My further consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have a right to receive a copy of this form. I certify that I have, will print, or will otherwise have access to a copy of all pages of this Evidence Form to keep for my records. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the latest date shown below.

I acknowledge that I have been given ReliaStar Life's: Consumer Privacy Notice and Insurance Information Practices Notice.

IMPORTANT! Please carefully read the next section. Then sign and date below.

I declare that all of the statements and answers, as they pertain to me and to my child(ren), if applicable, on all pages of this Evidence Form are complete and true to the best of my knowledge and belief.

I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid.

➡ Employee Signature _____ Date _____

➡ Spouse Signature _____ Date _____

Submit your EOI form directly to the insurer for fast and confidential handling via one of the methods below:

Fax to: 1-612-467-8721

Or

Mail to: ReliaStar Life Insurance Company, PO Box 20, Mail Stop 5-E, Minneapolis, MN 55440

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CONSUMER PRIVACY NOTICE AND INSURANCE INFORMATION PRACTICES NOTICE

ReliaStar Life Insurance Company, Minneapolis, MN
ReliaStar Life Insurance Company of New York, Woodbury, NY
Members of the Voya® family of companies



We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB's phone number is 866-692-6901 (TTY 866 346-3642). We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

**YOUR
GROUP
LIFE INSURANCE
PLAN**

For Employees of

COUNTY OF COLUSA

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IF YOU HAVE A QUESTION ABOUT YOUR POLICY, IF YOU NEED ASSISTANCE WITH A PROBLEM, OR IF YOU HAVE QUESTIONS ABOUT A CLAIM, YOU MAY WRITE OR CALL US AT:

**ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440
Telephone Number: (800) 955-7736**

YOU WILL NEED TO PROVIDE YOUR POLICY NUMBER WITH ANY COMMUNICATION.

IF YOU DO NOT REACH A SATISFACTORY RESOLUTION AFTER HAVING DISCUSSIONS WITH US, OR OUR AGENT OR REPRESENTATIVE, OR BOTH, YOU MAY CONTACT THE FOLLOWING UNIT WITHIN THE DEPARTMENT OF INSURANCE THAT DEALS WITH CONSUMER AFFAIRS:

**California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921**

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota 55440

ReliaStar Life Insurance Company (ReliaStar Life) certifies that it has issued the Group Policy listed below to the Policyholder. All benefits are controlled by the terms and conditions of the Group Policy.

The Group Policy is on file in the Policyholder's office. You may look at the Group Policy there.

ReliaStar Life also certifies that the person named below is insured under the Group Policy.*

31640-7GAT
CSAC Excess Insurance Authority

*If you are actively at work on the effective date. If you are not, your insurance is effective on the date you return to active work.

The insurance included in this certificate applies to you only if you have elected and are insured for it.

The Dependent's Insurance part of this certificate applies to you only if you are insured for it.

Your beneficiary is the last beneficiary you named, according to the records on file in ReliaStar Life's Home Office or on file with the Plan Administrator, if applicable. You may change your beneficiary any time, according to the terms of the Group Policy.

The certificate summarizes and explains the parts of the Group Policy which apply to you. This certificate is not an insurance policy. In any case of differences or errors, the Group Policy rules.

This certificate replaces any other certificates ReliaStar Life may have given you under the Group Policy.

A handwritten signature in black ink that reads "Julie Nelson". The signature is written in a cursive, flowing style. Below the signature is a horizontal line.

Registrar

SCHEDULE OF BENEFITS

Basic Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance

Class	Amount of Life Insurance*	Full Amount of AD&D Insurance*
All Eligible Employees	\$50,000	\$50,000

*Your amount of Basic Insurance will decrease to 50% on your 70th birthday.

Supplemental Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance

Class	Amount of Life Insurance**	Full Amount of AD&D Insurance**
All Eligible Employees	\$20,000 to \$500,000 in \$10,000 increments	If elected, equal to the amount of Supplemental Life Insurance

**Beginning on and after your 65th birthday, ReliaStar Life decreases the amount of your Supplemental Insurance. ReliaStar Life pays a percentage of the amount otherwise payable as follows:

- From your 65th birthday to age 70, ReliaStar Life pays 65%,
- From your 70th birthday to age 75, ReliaStar Life pays 50%,
- From your 75th birthday and after, ReliaStar Life pays 30%.

Accelerated Death Benefit

This benefit is equal to 50% of your amount of Life Insurance in force, or \$100,000, whichever is less. This benefit is available to employees only. Employees must have at least \$10,000 in Life Insurance coverage in force to qualify for this benefit.

Dependent Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance

Class	Amount of Life Insurance	Full Amount of AD&D Insurance
Spouse or Domestic Partner	\$20,000 to \$500,000 in \$10,000 increments	If elected, equal to the amount of Spouse Life Insurance
Child (each)	\$2,000 to \$10,000 in \$2,000 increments	NONE

The amount of insurance for a dependent can be no more than your Life Insurance amount.

Beginning on and after your spouse's or domestic partner's 65th birthday, ReliaStar Life decreases the amount of dependent's insurance on your spouse or domestic partner. ReliaStar Life pays a percentage of the amount otherwise payable as follows:

- From the 65th birthday to age 70, ReliaStar Life pays 65%,
- From the 70th birthday to age 75, ReliaStar Life pays 50%.
- From the 75th birthday and after, ReliaStar Life pays 30%.

SCHEDULE OF BENEFITS

Proof of Good Health

Proof of good health is required for amounts in excess of the limits described below. Coverage is subject to the Group Policy's proof of good health requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Group Policy's proof of good health requirements that are in force on the effective date of the increase. For proof of good health, a completed Evidence of Insurability form must be submitted to ReliaStar Life for approval.

Employee-Basic Life Insurance

Limit without Proof

- Initial eligibility...

\$50,000

Employee-Supplemental Life Insurance

Limit without Proof

- All applications for new coverage within 31 days after the date you become eligible for insurance...

\$150,000

- All applications for new coverage more than 31 days after the date you become eligible for insurance...

None. Proof of good health is required.

- All applications for an increase to existing supplemental coverage...

None. Proof of good health is required.

Dependent Life Insurance

Limit without Proof

- All applications for new dependent coverage within 31 days after the date you become eligible for dependent's insurance...

\$50,000 on your spouse or domestic partner, and
\$10,000 on your child(ren).

- All applications for new dependent coverage more than 31 days after the date you become eligible for dependent's insurance...

None. Proof of good health is required.

- All applications for an increase to existing dependent coverage...

None. Proof of good health is required.

Supplemental Life and AD&D Insurance Continued under the Portability Option

The amount of your Supplemental Life Insurance that can be continued is limited to the lesser of the amount of your Supplemental Life Insurance on the date you elect portability or \$500,000. You may elect to continue a lesser amount based on the amounts available to active employees.

The amount of your Supplemental AD&D Insurance that can be continued is limited to the lesser of the amount of your Supplemental Life Insurance that is continued or \$250,000. You must elect portability of your Supplemental Life Insurance in order to continue your Supplemental AD&D Insurance.

Any reductions in coverage due to age will apply to all coverage continued under the portability option.

Dependent Life and AD&D Insurance Continued under the Portability Option

The amount of Dependent Life and AD&D Insurance that may be continued for each dependent is limited to the lesser of the amount of your Dependent Life and AD&D Insurance on the date you elect portability, or the amount of your Life and AD&D Insurance that is continued. You must elect portability of your Supplemental Life and AD&D Insurance in order to continue your Dependent Life and AD&D Insurance.

Any reductions in coverage due to age will apply to all coverage continued under the portability option.

EMPLOYEE'S INSURANCE

Eligibility

You are eligible on the first day of the month after the date you start continuous service with the Employer.

You must meet the following conditions to become insured:

- Be eligible for the insurance.
- Be actively at work.
- Apply for the insurance, if you have to pay any part of the premium.
- Give to ReliaStar Life proof of good health, which it approves, as required on the Schedule of Benefits.

Effective Date of Employee's Insurance

Your insurance starts on the latest of the following dates:

- The date you become eligible.
- The date you return to active work if you are not actively at work on the date insurance would otherwise start. **Exception:** Your insurance starts on a nonworking day if you were actively at work on your last scheduled working day before the nonworking day.
- The date you apply for insurance, if you have to pay any part of the premium.
- The date ReliaStar Life approves your proof of good health, if proof is required.

Effective Date of Change in Amount of Insurance

If there is an increase in the amount of your insurance, the increase will take effect on:

- The first day of the month on or after the date of the increase, if you are actively at work on the date of the increase.
- The date you return to active work if you are not actively at work on the first day of the month on or after the date of the increase.
- The first day of the month on or after the date of the increase, if the first day of the month is a nonworking day and you were actively at work on your last scheduled working day before the nonworking day.

If proof of good health is required, the increase will take effect on the later of the dates indicated above or the date ReliaStar Life approves your proof of good health.

The amount of your insurance decreases on the date of change in your class or earnings. If you elect to decrease your insurance, the decrease will take effect on the first day of the month on or after the date of the elected decrease.

Termination of Insurance

Your insurance stops on the earliest of the following dates:

- For coverage not continued under the portability option, the last day of the month during which you were last actively at work for the Employer.
- For coverage not continued under the portability option, the last day of the month during which you are no longer eligible for insurance under the Group Policy.
- For coverage not continued under the portability option, the last day of the month during which you retire.
- For coverage continued under the portability option, the date you attain age 70.
- The date the Policyholder replaces the Supplemental Life Insurance under this plan with a similar life insurance plan through another insurance carrier, if you are actively at work for the Employer on that date.
- The date the Group Policy stops.
- The end of the period for which you paid premiums, if you do not make the next required premium contribution when due.
- For Accelerated Death Benefit, the date your Life Insurance stops.
- For AD&D Insurance, the date your Life Insurance stops or the date Life Insurance premiums are waived under the Waiver of Life Insurance Premium Disability Benefit.

ReliaStar Life stops providing a specific benefit to you on the date that benefit is no longer provided under the Group Policy.

EMPLOYEE'S INSURANCE

Family and Medical Leave Act of 1993

Certain employers are subject to the FMLA. If you have a leave from active work certified by your employer, then for purposes of eligibility and termination of coverage you will be considered to be actively at work. Your coverage will remain in force so long as you continue to meet the requirements as set forth in the FMLA.

Extension of Insurance

If you are no longer eligible for insurance because you stop active work, the Policyholder may continue your insurance. Premiums must be paid. Your insurance is continued subject to all other terms of the Group Policy.

If you stop active work because of a medical or non-medical leave of absence, temporary layoff, or the Employer suspending operations, the Policyholder may continue your insurance in accordance with the employer's documented personnel practices and precluding individual selection among employees.

Portability

Portability means you have the option to continue your Supplemental Life and AD&D Insurance if certain conditions are met. You must elect portability before you reach age 70.

To continue your insurance, you must elect portability within 31 days of the date your Supplemental Life and AD&D Insurance terminates due to the following:

- You retire or terminate employment with the Employer, if coverage is in effect for active employees under the Group Policy; or
- The Policyholder terminates coverage for active employees under the Group Policy and does not replace it with a similar life insurance plan; or
- You are no longer eligible for insurance under the Group Policy; or
- All other continuation under the Group Policy ends.

In all cases, you must pay premiums directly to ReliaStar Life beginning on the first day of the month following the date you elect portability.

If your Supplemental Life and AD&D Insurance reduces due to age or a change in employment status, this is not considered a termination of insurance. Please refer to the **Conversion Rights** section for more information about conversion following reductions in coverage.

If you continued coverage under the portability option and then later become eligible for Supplemental/Optional/Voluntary Life Insurance as an active employee under a Group Policy issued by ReliaStar Life, then your amount of coverage continued under the portability option will be reduced by your amount of Supplemental/Optional/Voluntary insurance as an active employee.

Reinstatement

ReliaStar Life will reinstate your insurance not eligible for portability if you stop work and then return to work within 12 months. You will be eligible for insurance on the date you return to active work with the Employer.

DEPENDENT'S INSURANCE

NOTE: YOUR DOMESTIC PARTNER AND YOUR DOMESTIC PARTNER'S CHILDREN MAY BE ELIGIBLE FOR INSURANCE UNDER THIS PLAN, AS DEFINED UNDER DEFINITIONS OF DEPENDENT AND DOMESTIC PARTNER AND CHILD. YOU SHOULD CONSULT WITH YOUR PERSONAL TAX ADVISER TO ASSESS POSSIBLE TAX IMPLICATIONS.

Eligibility

You are eligible for Dependent's Insurance on the later of the following dates:

- The date you are eligible for Employee's Supplemental Life Insurance.
- The date you first acquire a dependent as defined.

You must meet all of the following conditions to become insured for Dependent's Insurance:

- Be insured for Employee's Supplemental Life Insurance.
- Apply for Dependent's Insurance, if you must pay any part of the premium. You must apply for all dependents you have within 31 days of the date you are initially eligible for Dependent's Insurance.
- Give ReliaStar Life proof of good health for your dependent, which it approves, as required on the Schedule of Benefits.

If you and your spouse or domestic partner are insured as employees under the Group Policy, either you or your spouse or domestic partner, but not both, can apply for Dependent's Insurance. If the spouse or domestic partner carrying the Dependent's Insurance stops being insured as an employee, the other spouse or domestic partner may become insured for Dependent's Insurance by applying within 31 days.

Any person eligible for insurance as an employee under the Group Policy is not considered an eligible dependent for Dependent's Insurance.

Effective Date of Dependent's Insurance

Your dependent's insurance starts on the latest of the following dates:

- The date you become eligible for Dependent's Insurance.
- The date your dependent is no longer confined at home or in any facility for care and treatment of sickness or accidental injury, for any dependent, other than a newborn, who is confined at home or in such facility on the date your dependent's insurance starts.
- The date ReliaStar Life approves your dependent's proof of good health, if ReliaStar Life requires proof.
- The date you apply for Dependent's Insurance, if you have to pay any part of the premium.

If you acquire a new dependent and additional premium is required, you must apply within 31 days of acquiring the new dependent. If you acquire a new dependent while insured for Dependent's Insurance, and no additional premium is required, you should complete an enrollment form.

A newborn child will be covered from the date of eligibility. A foster or adopted child will be covered from the date of placement in the home.

Effective Date of Change in Amount of Insurance

If there is an increase in the amount of your dependent's insurance, the increase will take effect on the latest of the following dates:

- The first day of the month on or after the date you are eligible to increase Dependent's Insurance.
- The date your dependent is no longer confined at home or in any facility for care and treatment of sickness or accidental injury, if your dependent is so confined on the first day of the month on or after the date of the increase.
- The date ReliaStar Life approves your dependent's proof of good health, if proof is required.

If you elect to decrease your insured dependent's insurance, the decrease will take effect on the first day of the month on or after the date of the elected decrease. All other decreases will take effect on the date of the decrease.

Termination of Insurance

Your dependent's insurance stops on the earliest of the following dates:

- The date the Dependent's Insurance part of the Group Policy stops.
- The date the Group Policy terminates.
- The end of the period for which you made your last premium contribution for Dependent's Insurance if you do not make the next required contribution when due.
- The date your insurance stops.

DEPENDENT'S INSURANCE

- The date you retire.
- The date your dependent's insurance is converted under the Conversion Right.
- The last day of the month during which your insured dependent is no longer a dependent as defined.
- The date your Life Insurance premiums are waived under the Waiver of Life Insurance Premium Disability Benefit provision of the Group Policy.

ReliaStar Life stops providing a specific benefit under your dependent's insurance on the date that benefit is no longer provided under the Group Policy.

Family and Medical Leave Act of 1993

If your coverage remains in force due to a certified leave under the FMLA, then your dependents' coverage will also remain in force so long as you continue to meet the requirements as set forth in the FMLA.

Continuation of Insurance

Your insured dependent's insurance may be continued. Premiums must be paid. Your insured dependent's insurance stops at the end of the period for which the last premium was paid if the next premium is not paid on time. Your insured dependent's continuation is subject to all other terms of the Group Policy.

You Stop Active Work

If you stop active work and your insurance is being continued, your dependent's insurance will also be continued as shown in the Employee's Insurance part of this certificate.

Incapacitated Dependent Child

If your insured dependent child has an intellectual disability or physical handicap and reaches the maximum age for Dependent's Insurance, you may continue this child's insurance as long as all required premiums are paid. You must give ReliaStar Life proof that:

- The child is incapable of self-sustaining employment due to an intellectual disability or physical handicap.
- The child became incapacitated before reaching the maximum age for Dependent's Insurance.
- The child is chiefly dependent on you for support and maintenance.

Proof must be given within 31 days after the date the child reaches the maximum age for insurance. Before granting a continuation of this child's insurance, ReliaStar Life may require that a doctor examine the child. ReliaStar Life will specify the doctor and pay the fee for all exams ReliaStar Life requires. During the 2 years after the child reaches the maximum age, ReliaStar Life may ask for regular proof of the child's continued incapacity. After the 2 year period, ReliaStar Life will not ask for proof, including doctor's exams, more often than once a year.

This incapacitated child's continuation stops on the **earliest** of the following dates:

- The date the child becomes covered under any other group plan.
- The date the child is no longer incapacitated.
- The date you do not give ReliaStar Life proof of the child's incapacity when requested.
- The end of the period for which you paid premiums for this continuation, if you do not make the next required premium contribution when due.
- The date your Dependent's Insurance would otherwise stop under the Group Policy.

The Conversion Right will be available to your insured dependent child when all continuation is exhausted.

Portability

You may continue your Dependent Life Insurance if you elected portability of your Supplemental Life Insurance. You may continue your Dependent AD&D Insurance if Dependent Life Insurance and your Supplemental AD&D Insurance are continued under the portability option.

If you elected portability of Dependent's Insurance and then later become eligible as an active employee for Dependent's Insurance under a Group Policy issued by ReliaStar Life, then your amount of Dependent's Insurance continued under the portability option will be reduced by your amount of Dependent's Insurance as an active employee.

LIFE INSURANCE

Employee's Life Insurance

ReliaStar Life pays a death benefit to your beneficiary if written proof is received that you have died while this insurance is in force. The death benefit is the amount of Life Insurance for your class shown on the Schedule of Benefits in effect on the date of your death.

ReliaStar Life pays the death benefit for all causes of death. However, for Supplemental Life Insurance, if you commit suicide, while sane or insane, within 2 years of the date your insurance starts, ReliaStar Life will refund the amount of premiums paid for your Supplemental Life Insurance under the Group Policy instead of paying a death benefit.

Beneficiary

The beneficiary is named to receive the proceeds to be paid at your death. You may name more than one beneficiary. The Policyholder or the Employer cannot be the beneficiary.

You may name, add or change beneficiaries by written request as described below. You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

You may name, add or change beneficiaries by written request if all of the following conditions are met:

- Your coverage is in force.
- ReliaStar Life has written consent of all irrevocable beneficiaries.
- You have not assigned the ownership of your insurance. The rights of an assignee are described in the Assignment section.

All requests are subject to the approval of ReliaStar Life. A change will take effect as of the date it is signed but will not affect any payment ReliaStar Life makes or action it takes before receiving your notice.

Payment of Proceeds

ReliaStar Life pays proceeds to the beneficiary. If there is more than one beneficiary, each receives an equal share, unless you have requested otherwise, in writing. To receive proceeds, a beneficiary must be living on the earlier of the following dates:

- The date ReliaStar Life receives proof of your death.
- The tenth day after your death.

If there is no eligible beneficiary or if you did not name one, ReliaStar Life pays the proceeds in the following order:

1. Your spouse or domestic partner.
2. Your natural and adopted children.
3. Your parents.
4. Your estate.

The person must be living on the tenth day after your death.

Settlement Options

Settlement options are alternative ways of paying the proceeds under the Group Policy. Proceeds is the amount of each benefit ReliaStar Life pays when you die or when you receive a lump sum amount under the Accelerated Death Benefit. To find out more about settlement options, please contact the Policyholder.

Waiver of Life Insurance Premium Disability Benefit

ReliaStar Life waives your Life Insurance premium that becomes due while you are totally disabled. The premium will be waived if you satisfy certain conditions. When ReliaStar Life waives a premium, the amount of Life Insurance equals the amount that would have been provided if you had not become totally disabled. That amount will reduce or stop according to the Schedule of Benefits in effect on the date total disability begins.

When ReliaStar Life waives a premium it includes Life Insurance, Accelerated Death Benefit, and Waiver of Premium. It does not include AD&D Insurance, Dependent's Insurance, or any other benefits as elected under this certificate which were effective at the time of disability.

LIFE INSURANCE

Conditions, Notice and Proof of Total Disability

ReliaStar Life requires written notice of claim and proof of total disability to waive your premium. All of the following conditions must also be met:

- Total disability must begin before your 60th birthday.
- You are insured for the Waiver of Life Insurance Premium Disability Benefit on the date you become totally disabled.
- You continue to be totally disabled.
- Your insurance is in force when you suffer the sickness or accidental injury causing the total disability.
- All premiums are paid up to the date total disability begins.

ReliaStar Life needs written notice of claim before it waives any premium. This notice must be received –

- while you are living,
- while you are totally disabled, and
- within one year from the date the last premium payment was made.

If you cannot give ReliaStar Life notice within one year, your claim is still valid if you show you gave ReliaStar Life notice as soon as reasonably possible.

ReliaStar Life needs proof of your total disability before any premiums can be waived. ReliaStar Life may require you to have a physical exam by a doctor it chooses. ReliaStar Life pays for that exam. ReliaStar Life can only require one exam a year after premiums have been waived for 2 full years.

When ReliaStar Life approves your proof of total disability, premiums are waived as of the date you became totally disabled. ReliaStar Life refunds, to the Policyholder, any premium paid for a period during which you were totally disabled. It is the Policyholder's responsibility to refund to you any part of the premium you paid.

Termination of Waiver of Premium

ReliaStar Life stops waiving premiums on the earliest of the following dates:

- The date you are no longer totally disabled.
- The date you do not give ReliaStar Life proof of total disability when asked.
- The date you attain age 70.

If ReliaStar Life stops waiving your premiums, your Life Insurance will stay in force only if all of the following conditions are met:

- The Life Insurance under the Group Policy is still in force.
- You are eligible for Employee's Insurance under the Group Policy.
- Your premium payments are resumed.

The amount of Life Insurance that stays in force will be the amount shown on the Schedule of Benefits in effect on the date your premium payments are resumed.

You will not be eligible to continue insurance under the portability option when ReliaStar Life stops waiving your premiums.

If you buy an individual policy under the Conversion Right of the Group Policy during the first year of your total disability, your Life Insurance may be restored. ReliaStar Life will cancel the individual policy as of its issue date if within 12 months of the date you become totally disabled you –

- file a claim under this provision and ReliaStar Life approves it, and
- surrender the individual policy without claim, except for refund of premium.

When ReliaStar Life cancels your individual policy, ReliaStar Life –

- refunds all premiums paid for the individual policy.
- restores your Life Insurance under the Group Policy.
- retains the beneficiary named under the individual policy as beneficiary under the Group Policy, unless you ask ReliaStar Life to change the beneficiary in writing.

LIFE INSURANCE

Accelerated Death Benefit

NOTE: AT THIS TIME IT IS UNCLEAR WHETHER YOU WILL BE REQUIRED TO PAY TAX ON ACCELERATED DEATH BENEFIT PROCEEDS. YOU SHOULD CONSULT WITH YOUR PERSONAL TAX ADVISER TO ASSESS POSSIBLE TAX IMPLICATIONS.

ReliaStar Life pays this benefit if it has been determined that you have a terminal condition. Accelerated Death Benefit proceeds is the amount ReliaStar Life pays to you or your legal representative while you are living when it has been determined that you have a terminal condition. The Accelerated Death Benefit proceeds are paid in one lump sum and are paid only once. This lump sum payout is the only Settlement Option available to you prior to your death.

The Accelerated Death Benefit is the amount of the Accelerated Death Benefit shown on the Schedule of Benefits in effect on the date you apply for Accelerated Death Benefit proceeds. You will not be able to increase your contributory Life Insurance benefit after the time you apply for the Accelerated Death Benefit, unless you are determined to be ineligible to receive Accelerated Death Benefit proceeds.

To receive the Accelerated Death Benefit, **all** of the following conditions must be met. You must:

- request this benefit in writing while you are living. If you are unable to request this benefit yourself, your legal representative may request it for you.
- be insured as an employee for Life Insurance benefits.
- have Life Insurance benefits of at least \$10,000 as shown on the Schedule of Benefits.
- provide to ReliaStar Life a doctor's statement which gives the diagnosis of your medical condition; and states that because of the nature and severity of such condition, your life expectancy is no more than 6 months. ReliaStar Life may require that you be examined by a doctor of its choosing. If ReliaStar Life requires this, ReliaStar Life pays for the exam.
- provide to ReliaStar Life written consent from any irrevocable beneficiary, assignee, and, in community property states, from your spouse.

Benefit Payment

ReliaStar Life pays the Accelerated Death Benefit proceeds to you unless both of the following are true:

- It is shown, to the satisfaction of ReliaStar Life, that you are physically and mentally incapable of receiving and cashing the lump sum payment.
- A representative appointed by the courts to act on your behalf does not make a claim for the payment.

If ReliaStar Life does not pay you because the two above conditions apply, payments instead will be made to one of the following:

- A person who takes care of you.
- An institution that takes care of you.
- Any other person ReliaStar Life considers entitled to receive the payments as your trustee.

Accelerated Death Benefit Exclusions

ReliaStar Life does not pay benefits for a terminal condition if either of the following apply:

- the required Accelerated Death Benefit premium or Life Insurance premium is due and unpaid.
- the terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted injury, whether sane or insane.

Effects on Coverage

When ReliaStar Life pays out this benefit, your coverage is affected in the following ways:

- Your total available Life Insurance benefit equals your amount of Life Insurance shown on the Schedule of Benefits at the time you apply for the Accelerated Death Benefit.
- Your Life Insurance benefit is reduced by the Accelerated Death Benefit proceeds paid out under this provision.
- Your Life Insurance benefit amount which you may convert is reduced by the Accelerated Death Benefit proceeds paid out under this provision.
- You will not be able to increase your Life Insurance benefit after ReliaStar Life approves you to receive the Accelerated Death Benefit.
- Your premium is based upon the Life Insurance benefit amount in force prior to any proceeds paid under this Accelerated Death Benefit provision. Such premium must be paid, unless waived, to keep the Life Insurance coverage in force.
- Your remaining Life Insurance benefit is subject to future age reductions, if any, as shown on the Schedule of Benefits.

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- You will not be able to reinstate your coverage to its full amount in the event of a recovery from a terminal condition.
- Your dependents' Life Insurance coverage will be unaffected by Accelerated Death Benefit proceeds paid to you, provided all required premiums are paid.
- Your receipt of Accelerated Death Benefit proceeds does not affect your Accidental Death and Dismemberment Insurance. Thus, if you should die in an accident after receiving Accelerated Death Benefit Proceeds, your Accidental Death and Dismemberment Insurance will be based on your Life Insurance in force prior to the Accelerated Death Benefit payout, provided your premium is not being waived.

Accidental Death & Dismemberment (AD&D) Insurance

ReliaStar Life pays this benefit if you suffer a covered loss due to a covered accident. All of the following conditions must be met:

- You are covered for AD&D Insurance on the date of the accident.
- Loss occurs within 180 days of the date of the accident.
- The cause of the loss is not excluded.

ReliaStar Life pays the benefit shown below if you suffer any of the losses listed. The Full Amount is shown on the Schedule of Benefits. ReliaStar Life pays only one Full Amount while the Group Policy is in effect. If you have a loss for which ReliaStar Life paid 1/2 of the Full Amount, ReliaStar Life pays no more than 1/2 of the Full Amount for the next loss.

For:

The benefit is:

Loss of life	Full Amount
Loss of both hands, both feet or sight of both eyes	Full Amount
Loss of one hand and one foot	Full Amount
Loss of speech and hearing in both ears	Full Amount
Loss of one hand or one foot and sight of one eye	Full Amount
Loss of one hand or one foot or sight of one eye	1/2 Full Amount
Loss of speech	1/4 Full Amount
Loss of hearing in both ears	1/4 Full Amount
Loss of thumb and index finger of same hand	1/4 Full Amount
Quadriplegia	Full Amount
Paraplegia	1/2 Full Amount
Hemiplegia	1/2 Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Quadriplegia means total paralysis of all four limbs. **Paraplegia** means total paralysis of both lower limbs. **Hemiplegia** means paralysis of one arm and one leg on the same side of the body.

Paralysis must be the result of a spinal cord injury which is due to an accident. ReliaStar Life does not pay an AD&D benefit for any paralysis caused by a stroke. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

ReliaStar Life does not pay a benefit for loss of use of the hand or foot or thumb and index finger.

Death benefits are paid to your beneficiary. All other benefits are paid to you.

Exposure and Disappearance Benefit

ReliaStar Life pays an **Exposure** benefit if:

- the loss is from injury caused by exposure to the elements, and
- is the result of a covered accident.

ReliaStar Life pays a **Disappearance** benefit if:

- you are in a conveyance, including but not limited to an automobile, airplane, ship or train, that disappears, sinks or wrecks; and
- you disappear and your body is not found, and the disappearance is the result of a covered accident; and

LIFE INSURANCE

- a reasonable period of time, but no more than one year, has lapsed since the accident, and
- ReliaStar Life has reviewed all evidence and there is no reason to believe that you are living.

The amount payable for the Exposure benefit is contained in the table above. The amount payable for the Disappearance benefit is the AD&D benefit for loss of life. If benefits are paid for Exposure or Disappearance, no other AD&D benefits will be payable under the Group Policy.

Exposure benefits are paid to you if living, otherwise to your beneficiary. Disappearance benefits are paid to your beneficiary.

If ReliaStar Life pays the Disappearance benefit and it is later found you are alive, the amount of benefits paid must be refunded to ReliaStar Life.

Safe Driver Benefit

ReliaStar Life pays a **Safe Driver** benefit in addition to the AD&D benefit and subject to the exclusions listed below if you were:

- killed due to an automobile accident, and
- wearing a properly fastened safety belt at the time of the accident.

An additional amount will be paid if you were also driving in or riding in an automobile equipped with a factory installed airbag that operated properly upon impact.

For loss of:

The benefit is:

Life (with safety belt only) An additional 50% of Full Amount
of AD&D Insurance
up to a maximum of \$25,000

Life (with safety belt and airbag) An additional 55% of Full Amount
of AD&D Insurance
up to a maximum of \$40,000

Automobile means any self-propelled private passenger vehicle which has four or more tires and which is not being used for commercial purposes. **Safety belt** means a passenger restraint system properly installed in the vehicle in which you were riding. **Airbag** means an additional restraint system which inflates for added protection to the head and chest areas.

ReliaStar Life will not pay the Safe Driver benefit if the loss of life was in consequence of your being intoxicated or under the influence of any controlled substance unless administered on the advice of a doctor.

Safe Driver benefits are paid to your beneficiary.

Coma Benefit

ReliaStar Life pays a **Coma** benefit if, due to an accident, you are in a coma. Coma benefit payments will stop when you are no longer in a coma or when maximum benefits have been paid, whichever comes first.

In the event of:

The benefit is:

Coma An additional 2% of Full Amount
of AD&D Insurance
per month for up to 12 months
to a total maximum of \$24,000

Coma means that you remain unresponsive to any stimuli and speechless for a period of time not less than 30 days, as determined by a competent medical authority.

If you are physically and mentally incapable of receiving and cashing Coma benefit payments, then the payments instead will be made to a person legally authorized to receive the payments on your behalf.

LIFE INSURANCE

Education Benefit

ReliaStar Life pays an **Education** benefit in addition to the AD&D benefit and subject to the conditions below if you die due to an accident. This benefit will be paid at the end of each annual period following your death to your dependent who is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of your death. Benefit payments will stop if either of the following is true during the preceding annual period –

- the student's full-time school attendance is less than 6 months; or
- the student would no longer be considered your eligible dependent under the definition of dependent in the policy.

For:

The benefit is:

Education An additional 5% of Full Amount
of AD&D Insurance
per year for up to 4 years
to a maximum of \$3,000 per year

Education benefits are paid to each eligible dependent student, or to the dependent's legal guardian.

Transportation Benefit

ReliaStar Life pays a **Transportation** benefit in addition to the AD&D benefit if you die due to an accident that occurs at least 75 miles from your primary residence.

For:

The benefit is:

Transportation An additional 2% of Full Amount
of AD&D Insurance
up to a maximum of \$2,000

Transportation benefits are paid to your beneficiary.

Child Care Benefit

ReliaStar Life pays a **Child Care** benefit in addition to the AD&D benefit if you die due to an accident, and your dependent child under age 13 years is enrolled in a licensed day care center within 90 days of your death. This benefit is paid on behalf of each eligible dependent child at the end of each annual period following your death. Benefit payments will stop if either of the following is true during the preceding annual period –

- your dependent child does not attend a licensed day care center for at least 1000 hours; or
- your dependent child is not under age 13 years for any part of that year.

For:

The benefit is:

Child Care An additional 3% of Full Amount
of AD&D Insurance
per year for up to 6 years
to a maximum of \$2,000 per year

Child Care benefits are paid to the person who has incurred the cost of day care expenses for your eligible dependent child.

Common Carrier Benefit

ReliaStar Life pays a **Common Carrier** benefit in addition to the AD&D benefit if you suffer a covered loss due to an accident, and the loss occurs while traveling:

- as a fare paying passenger,
- in or on or entering into or alighting from a public conveyance, and
- the public conveyance is operated by a licensed common carrier for passenger service.

LIFE INSURANCE

For:

The benefit is:

Common Carrier An additional AD&D Amount equal to
50% of the AD&D amount
otherwise payable for this loss
up to a maximum of \$50,000

Common Carrier benefits are paid to you if living, otherwise to your beneficiary.

Occupational Assault Benefit

ReliaStar Life pays an **Occupational Assault** benefit in addition to the AD&D benefit if you suffer a covered loss due to an accident, **and**:

- the loss is due to an intentional and unlawful act of physical violence directed at you by another person,
- you are actively at work, performing assigned duties on behalf of the Employer at the time of the assault, and
- a report of criminal activity has been filed on your behalf with the appropriate law enforcement authority within 48 hours of the assault.

For loss due to:

The benefit is:

Occupational Assault An additional AD&D Amount equal to
the AD&D amount
otherwise payable for this loss
up to a maximum of \$10,000

Occupational Assault benefits are paid to you if living, otherwise to your beneficiary.

Brain Damage Benefit

ReliaStar Life pays a **Brain Damage** benefit if, due to an accident, you sustain an injury which, independently of all other causes, directly results in traumatic brain injury causing brain damage.

The benefit will be payable if:

- the brain damage begins within 365 days of the accident; and
- the brain damage continues for 12 consecutive months; and
- you are hospitalized for at least 7 days within the first 365 days following the accident for treatment related to the accident; and
- a qualified doctor certifies that the brain damage is permanent and irreversible at the end of the 12 consecutive months, and the certification is deemed satisfactory to ReliaStar Life.

In the event of:

The benefit is:

Brain Damage An additional 2% of Full Amount
of AD&D Insurance
per month for up to 50 months

Brain Damage means physical assault to the brain tissue to the extent that you are considered to be in a vegetative state, as determined by a competent medical authority.

Payment of this benefit, plus any other benefits payable as a result of the same accident, will not exceed the full AD&D benefit you are eligible to receive under the Group Policy.

If you are physically and mentally incapable of receiving and cashing Brain Damage benefit payments, then the payments instead will be made to a person legally authorized to receive the payments on your behalf.

Line of Duty Benefit

ReliaStar Life pays a **Line of Duty** benefit in addition to the AD&D benefit if you die or suffer a covered loss as the result of a covered accident that occurred while you were performing in your own occupation and while in the line of duty.

Line of Duty means any action that you are authorized or obligated to perform by law, rule, regulation or condition of employment or service.

LIFE INSURANCE

For:

The benefit is:

Line of Duty An additional 50% of the amount
of AD&D Insurance
otherwise payable for this loss
up to a maximum of \$50,000

Accidental Death and Dismemberment Exclusions

ReliaStar Life does not pay benefits for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs when you commit or attempt to commit a felony.
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

ReliaStar Life does not pay benefits for loss sustained or contracted in consequence of your being under the influence of any controlled substance unless administered on the advice of a doctor.

Dependent's Life Insurance

ReliaStar Life pays a death benefit in the amount of the Dependent's Life Insurance shown on the Schedule of Benefits. ReliaStar Life pays according to the Schedule of Benefits in effect on the date your insured dependent dies.

ReliaStar Life pays the death benefit for all causes of death. However, if your insured dependent, while sane or insane, commits suicide within 2 years from the date his or her coverage starts, ReliaStar Life will refund the amount of premiums already paid for Dependent Life Insurance instead of paying a death benefit.

ReliaStar Life requires that proof of your insured dependent's death be mailed to ReliaStar Life at its Home Office.

ReliaStar Life pays benefits for your insured dependent's death to you, if you are living on the earlier of the following:

- The date ReliaStar Life receives proof of your insured dependent's death at its Home Office.
- The tenth day after your insured dependent's death.

If you are not living on either of these dates, ReliaStar Life pays the proceeds to the following in the order listed:

1. Your spouse or domestic partner, if living.
2. Your estate.

Dependent's Accidental Death & Dismemberment (AD&D) Insurance

ReliaStar Life pays this benefit if your insured dependent suffers a covered loss due to a covered accident. All of the following conditions must be met:

- Your insured dependent is covered for AD&D Insurance on the date of the accident.
- Loss occurs within 180 days of the accident.
- The cause of the loss is not excluded.

ReliaStar Life pays the benefit shown below if your insured dependent suffers any of the losses listed. The Full Amount is shown on the Schedule of Benefits. ReliaStar Life pays only one Full Amount while the Group Policy is in effect. If your insured dependent has a loss for which ReliaStar Life paid 1/2 of the Full Amount, ReliaStar Life pays no more than 1/2 of the Full Amount for the next loss.

For:

The benefit is:

Loss of life	Full Amount
Loss of both hands, both feet or sight of both eyes	Full Amount
Loss of one hand and one foot	Full Amount

LIFE INSURANCE

Loss of speech and hearing in both ears	Full Amount
Loss of one hand or one foot and sight of one eye	Full Amount
Loss of one hand or one foot or sight of one eye	1/2 Full Amount
Loss of speech	1/4 Full Amount
Loss of hearing in both ears	1/4 Full Amount
Loss of thumb and index finger of same hand	1/4 Full Amount
Quadriplegia	Full Amount
Paraplegia	1/2 Full Amount
Hemiplegia	1/2 Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Quadriplegia means total paralysis of all four limbs. **Paraplegia** means total paralysis of both lower limbs. **Hemiplegia** means paralysis of one arm and one leg on the same side of the body.

Paralysis must be the result of a spinal cord injury which is due to an accident. ReliaStar Life does not pay an AD&D benefit for any paralysis caused by a stroke. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

ReliaStar Life does not pay a benefit for loss of use of the hand or foot or thumb and index finger.

ReliaStar Life pays all dismemberment and paralysis benefits for your insured dependent to you.

Exposure and Disappearance Benefit

ReliaStar Life pays an **Exposure** benefit if:

- your insured dependent's loss is from injury caused by exposure to the elements, and
- is the result of a covered accident.

ReliaStar Life pays a **Disappearance** benefit if:

- your insured dependent is in a conveyance, including but not limited to an automobile, airplane, ship or train, that disappears, sinks or wrecks; and
- your insured dependent disappears and your insured dependent's body is not found, and the disappearance is the result of a covered accident; and
- a reasonable period of time, but no more than one year, has lapsed since the accident, and
- ReliaStar Life has reviewed all evidence and there is no reason to believe that your insured dependent is living.

The amount payable for the Exposure benefit is contained in the table above. The amount payable for the Disappearance benefit is the AD&D benefit for loss of life. If benefits are paid for Exposure or Disappearance, no other AD&D benefits will be payable under the Group Policy.

Exposure and Disappearance benefits for your insured dependent are paid to you.

If ReliaStar Life pays the Disappearance benefit and it is later found your insured dependent is alive, the amount of benefits paid must be refunded to ReliaStar Life.

Safe Driver Benefit

ReliaStar Life pays a **Safe Driver** benefit in addition to the AD&D benefit and subject to the exclusions listed below if your insured dependent was:

- killed due to an automobile accident, and
- wearing a properly fastened safety belt at the time of the accident.

An additional amount will be paid if your insured dependent was also driving in or riding in an automobile equipped with a factory installed airbag that operated properly upon impact.

Your dependent must be insured for at least \$25,000 Dependent AD&D Insurance as shown on the Schedule of Benefits in order to be eligible for a Safe Driver benefit.

LIFE INSURANCE

For loss of:

The benefit is:

Life (with safety belt only)	An additional 50% of Full Amount of Dependent AD&D Insurance up to a maximum of \$25,000
Life (with safety belt and airbag)	An additional 55% of Full Amount of Dependent AD&D Insurance up to a maximum of \$40,000

Automobile means any self-propelled private passenger vehicle which has four or more tires and which is not being used for commercial purposes. **Safety belt** means a passenger restraint system properly installed in the vehicle in which your insured dependent was riding. **Airbag** means an additional restraint system which inflates for added protection to the head and chest areas.

ReliaStar Life will not pay the Safe Driver benefit if the loss of life was in consequence of your insured dependent being intoxicated or under the influence of any controlled substance unless administered on the advice of a doctor.

Coma Benefit

ReliaStar Life pays a **Coma** benefit if, due to an accident, your insured dependent is in a coma. Coma benefit payments will stop when your insured dependent is no longer in a coma or when maximum benefits have been paid, whichever comes first. Your dependent must be insured for at least \$25,000 Dependent AD&D Insurance as shown on the Schedule of Benefits in order to be eligible for a Coma benefit.

In the event of:

The benefit is:

Coma	An additional 2% of Full Amount of Dependent AD&D Insurance per month for up to 12 months to a total maximum of \$24,000
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Coma means that your insured dependent remains unresponsive to any stimuli and speechless for a period of time not less than 30 days, as determined by a competent medical authority.

Coma benefits for your insured dependent are paid to you.

Education Benefit

ReliaStar Life pays an **Education** benefit in addition to the AD&D benefit and subject to the conditions below if your insured dependent spouse or domestic partner dies due to an accident. This benefit will be paid at the end of each annual period following your dependent spouse's or domestic partner's death to your spouse's or domestic partner's dependent who is enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond grade 12 within 365 days following the date of your spouse's or domestic partner's death. Benefit payments will stop if either of the following is true during the preceding annual period –

- the student's full-time school attendance is less than 6 months; or
- the student would no longer be considered your spouse's or domestic partner's eligible dependent under the definition of dependent in the policy.

Your dependent spouse or domestic partner must be insured for at least \$25,000 Dependent AD&D Insurance as shown on the Schedule of Benefits in order for the dependent student to be eligible for an Education benefit.

For:

The benefit is:

Education	An additional 5% of Full Amount of Dependent AD&D Insurance per year for up to 4 years to a maximum of \$3,000 per year
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Education benefits are paid to each eligible dependent student, or to the dependent's legal guardian.

LIFE INSURANCE

Transportation Benefit

ReliaStar Life pays a **Transportation** benefit in addition to the AD&D benefit if your insured dependent dies due to an accident that occurs at least 75 miles from his or her primary residence. Your dependent must be insured for at least \$25,000 Dependent AD&D Insurance as shown on the Schedule of Benefits in order to be eligible for a Transportation benefit.

For:

The benefit is:

Transportation An additional 2% of Full Amount
of Dependent AD&D Insurance
up to a maximum of \$2,000

Transportation benefits for your insured dependent are paid to you.

Common Carrier Benefit

ReliaStar Life pays a **Common Carrier** benefit in addition to the AD&D benefit if your insured dependent suffers a covered loss due to an accident, and the loss occurs while traveling:

- as a fare paying passenger,
- in or on or entering into or alighting from a public conveyance, and
- the public conveyance is operated by a licensed common carrier for passenger service.

For:

The benefit is:

Common Carrier An additional AD&D Amount equal to
50% of the Dependent AD&D amount
otherwise payable for this loss
up to a maximum of \$50,000

Common Carrier benefits for your insured dependent are paid to you.

Common Disaster Benefit

ReliaStar Life pays a **Common Disaster** benefit if, as a result of a common accident, you and your insured dependent spouse or domestic partner die within one year as a result of an accident.

In the event of:

The benefit is:

Common Disaster An increase in your insured
dependent spouse's or domestic partner's benefit
up to 100% of your AD&D amount, provided
the combined amounts do not exceed \$62,500.

Common Accident means the same accident or separate accidents that occur within the same 24-hour period.

Common disaster benefits are paid to your beneficiary.

Accidental Death and Dismemberment Exclusions

ReliaStar Life does not pay benefits for loss directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs when your insured dependent commits or attempts to commit a crime.
- Your insured dependent's intoxication. Intoxication means your insured dependent's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

ReliaStar Life does not pay benefits for loss sustained or contracted in consequence of your insured dependent being under the influence of any controlled substance unless administered on the advice of a doctor.

CONVERSION RIGHTS

Life Insurance

You or your insured dependent may convert this insurance to an individual life insurance policy if any part of your or your insured dependent's Life Insurance under the Group Policy stops. Proof of good health is not required.

Conditions for Conversion

You or your insured dependent may convert this Life Insurance if it stops for any of the following reasons:

- For coverage not continued under the portability option, you are no longer actively at work.
- For coverage not continued under the portability option, you are no longer eligible for Employee's Insurance under the Group Policy.
- For coverage continued under the portability option, you have reached the maximum age limit under the Group Policy.
- The Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 5 years in a row.
- For your Life Insurance –
 - the amount of Life Insurance is reduced.
 - the premium is no longer being waived under the Waiver of Life Insurance Premium Disability Benefit, and your group Life Insurance stops.
- For your dependent's Life Insurance –
 - your dependent's Life Insurance stops.
 - your dependent is no longer a dependent as defined.
 - your dependent's Life Insurance shown on the Schedule of Benefits is reduced.
 - your Life Insurance premiums are waived because of total disability.
 - if you divorce, your insured spouse may convert.
 - if you terminate your domestic partnership, your insured domestic partner may convert.
 - you die.

You or your insured dependent may convert this insurance by applying and paying the first premium for an individual policy within 31 days after any part of your or your insured dependent's insurance stops.

If you or your insured dependent are not given notice of this conversion right within 16 days after any part of this insurance stops, you or your insured dependent will have more time to apply and pay the first premium for the individual policy. This additional time period will end 25 days after you or your insured dependent is given notice of this conversion right. In no event will the additional time period extend for more than 91 days after any part of your Life Insurance or Dependent's Life Insurance stops.

ReliaStar Life or the Policyholder must be notified if you or your insured dependent wishes to convert. ReliaStar Life will supply you or your insured dependent with a conversion form to complete and return.

If your insured dependent is too young to contract for life insurance, the following people may apply in this order:

1. You, while living.
2. Your spouse or domestic partner, while living.
3. The court-appointed guardian of your insured dependent.

Type of Converted Policy

You or your insured dependent may purchase any individual nonparticipating policy offered by ReliaStar Life, except term insurance. The new policy must provide for a level amount of insurance and have premiums at least equal to those of ReliaStar Life's whole life plan with the lowest premium.

If your previous coverage included additional benefits such as disability, Accidental Death and Dismemberment Insurance or the Accelerated Death Benefit, the new insurance will not include these benefits.

CONVERSION RIGHTS

Amount of Conversion Coverage

If your or your insured dependent's Life Insurance is changed or cancelled because the Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 5 years in a row, the amount of the individual policy is limited to the lesser of –

- \$5,000 or
- the amount of your or your insured dependent's Life Insurance which stops, minus the amount of other group insurance for which you or your insured dependent becomes eligible, within 31 days of the date your or your insured dependent's insurance stops.

If your or your insured dependent's Life Insurance stops for any reason other than the above, the amount of your or your insured dependent's individual policy may be any amount up to the amount of your or your insured dependent's Life Insurance that stopped.

Effective Date

The new policy takes effect 31 days after the part of your or your insured dependent's Life Insurance being converted stops.

If you or your insured dependent dies within the 31-day period allowed for making application to convert, ReliaStar Life will pay a death benefit to your or your insured dependent's beneficiary in the amount you or your insured dependent were entitled to convert. ReliaStar Life will pay the amount whether or not application was made. ReliaStar Life will return any premium paid for the individual policy to your or your insured dependent's beneficiary named under the Group Policy.

Premiums

Premiums for the new policy are based on your or your insured dependent's age on the date of conversion.

CLAIM PROCEDURES

Submitting a Claim

You, your insured dependent or someone on your behalf must send ReliaStar Life written notice of the loss on which your claim will be based. The notice must –

- include information to identify you or your insured dependent, like your name, address and Group Policy number.
- be sent to ReliaStar Life or to the authorized administrator.
- be sent within 91 days after the loss for which claim is based has occurred or as soon as reasonably possible.

Claim Forms

ReliaStar Life or its authorized administrator will send proof of loss claim forms within 15 days after ReliaStar Life receives notice of claim.

Completed proof of loss claim forms or other written proof of loss detailing how the loss occurred must be sent to ReliaStar Life within 91 days after the loss or as soon as reasonably possible.

GENERAL PROVISIONS

Life Insurance Assignment

You can change the owner of your Life Insurance under the Group Policy by sending ReliaStar Life written notice. This change is an absolute assignment. You cannot make an absolute assignment to the Policyholder or the Employer. You transfer all your rights and duties as owner to the new owner. The new owner can then make any change the Group Policy allows. A request for an absolute assignment –

- does not change the insurance or the beneficiary.
- applies only if ReliaStar Life receives your notice.
- takes effect from the date signed.
- does not affect any payment ReliaStar Life makes or action ReliaStar Life takes before receiving your notice.

A collateral assignment is not allowed.

ReliaStar Life assumes no responsibility for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

Legal Action

Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the Group Policy. Legal action must be taken within 3 years after the date proof of loss must be submitted.

If the Policyholder's state requires longer time limits, ReliaStar Life will comply with the state's time limits.

Exam and Autopsy

For AD&D Insurance, when reasonably necessary, ReliaStar Life may have you or your insured dependent examined while a claim is pending under the Group Policy. ReliaStar Life pays for the initial exam. ReliaStar Life may have an autopsy made if you or your insured dependent dies, if not forbidden by state law.

Incontestability

Your and your dependent's insurance has a contestable period starting with the effective date of your insurance and continuing for 2 years while you are living. During that 2 years, ReliaStar Life can contest the validity of your and your dependent's insurance because of inaccurate or false information received relating to your and your insured dependent's insurability. Only statements that are in writing and signed by you or your insured dependent can be used to contest the insurance.

DEFINITIONS

Accident – an unexpected, external, violent and sudden event.

Active Work, Actively at Work – the employee is physically present at his or her customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of his or her job on that day.

Child –

- your natural or adopted child.
- a child for whom you have legal obligation for purposes of adoption.
- a child who is primarily dependent on you for support and lives with you in a permanent parent-child relationship, and who is your stepchild, your domestic partner's child, your foster child, or a child for whom you are a legal guardian.

Dependent –

- your lawful spouse.
- your domestic partner, as defined.
- your unmarried child until 26 years of age.

The term "dependent" does not include –

- a spouse, domestic partner, or child living outside the United States.
- a spouse, domestic partner, or child eligible for Employee's Insurance under the Group Policy.
- a spouse, domestic partner, or child on active military duty.
- a parent of you or your spouse or domestic partner.
- a spouse, domestic partner, or child who does not give proof of good health when asked, or whose proof is not accepted.

Domestic Partner – another adult with whom you have a Declaration of Domestic Partnership registered with the California Secretary of State. A copy of the certified registration may be required as proof.

Employee – an active employee residing in the United States who is employed by the County of Colusa (the Employer) and is regularly scheduled to work on at least a 20-hour-per-week basis. Such employees of the following affiliated employers of the Employer are included: Arbuckle College City Fire District, Sac River Westside Levee District, Arbuckle Cemetery, College City Cemetery, Colusa Cemetery, William Cemetery, Colusa Mosquito Abatement District, Colusa Basic Drainage District, and Colusa Resource Conservation District. Temporary and seasonal employees are excluded.

Group Policy – the written group insurance contract between ReliaStar Life and the Policyholder.

Nonworking Day – a day on which the employee is not regularly scheduled to work, including time off for the following:

- Vacations.
- Personal holidays.
- Weekends and holidays.
- Approved nonmedical leave of absence.
- Paid Time Off for nonmedical-related absences.

Nonworking day does not include time off for any of the following:

- Medical leave of absence. Time off for a medical leave of absence will be considered a scheduled working day.
- Temporary layoff.
- The Employer suspending its operations, in part or total.
- Strike.

Policyholder – CSAC Excess Insurance Authority. The Employer is defined as a unit of government who has subscribed to the agreement establishing the CSAC Excess Insurance Authority.

ReliaStar Life – ReliaStar Life Insurance Company, at its Home Office in Minneapolis, Minnesota.

Spouse – your lawful husband or wife.

Terminal Condition – an injury or sickness which is expected to result in your death within 6 months and from which there is no reasonable chance of recovery. ReliaStar Life, or a qualified party chosen by ReliaStar Life, will make this determination.

DEFINITIONS

Total Disability, Totally Disabled – your inability, due to sickness or accidental injury, to work at or perform the material and substantial duties of any job suited to your education, training or experience.

Written, In Writing – signed, dated and received at ReliaStar Life's Home Office in a form ReliaStar Life accepts.

You, Your – an employee insured for Employee's Insurance under the Group Policy.

COLUSA COUNTY

HUMAN RESOURCES DEPARTMENT



DAR RHODES
Human Resources Director

250 5th Street
Colusa, CA 95932
(530) 458-0420
(530) 458-0425 fax

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP) may be available to help pay your employer health plan premiums (see attached).

If you are eligible for CalPERS health coverage, but are not currently enrolled, you may qualify for a special enrollment opportunity under the following events:

- Employee or dependent becomes eligible for premium assistance under Medicaid or CHIP
- Employee or dependent, who is covered under Medicaid or CHIP, is terminated as a result of the loss of eligibility for such coverage

Please note the following:

- Employees who are eligible for these special enrollment opportunities may enroll within 60 days of the qualifying event
- Employees must notify employer of eligibility for premium assistance under Medicaid or CHIP within 60 days of eligibility
- Employees must notify employer of termination from premium assistance under Medicaid or CHIP as a result of loss of eligibility within 60 days of termination
- Employees must submit a completed Health Benefits Plan Enrollment Form and all required supporting documentation

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for 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 Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_co_nt.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/cohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”] Phone: 1-800-657-3739	NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

**ANTI-HARASSMENT AND
DISCRIMINATION POLICY**

**POLICY NUMBER: 301
DATE ADOPTED: 10/03/06
PAGE 1 OF 3**

It is the policy of Colusa County to provide fair and equal treatment to all county employees. We are committed to providing all employees a work environment free of discrimination and harassment based on membership in a protected group. In an effort to advance this policy and commitment, we have found it necessary to formulate a statement regarding discrimination and harassment. Discrimination and harassment creates a negative work environment and affects the work performance of all employees. This anti-harassment policy is applicable to the Colusa County workplace and prohibits unlawful harassment by anyone in the workplace, whether co-worker, manager, vendor, client, supplier-ANYONE.

Discrimination is being treated differently than others who are similarly situated and includes *harassment* which is being annoyed, disturbed, bothered, coerced, continually pestered or threatened on the job and/or in any work-related situation because of one's membership in a protected class: age, race, sex, color, national origin, national ancestry, physical disability, medical condition, religion, creed, marital status, sexual orientation, gender identification or any other classification deemed protected by law.

Any behavior or action may constitute harassment if:

1. Submission to the conduct is either an explicit or implicit term or condition of employment;
2. Submission to or rejection of the conduct is the basis for an employment decision (hiring, promotion or transfer) affecting the person rejecting or submitting to the conduct;
3. The conduct has the purpose or effect of substantially interfering with an affected person's work performance or creating an intimidating, hostile or offensive work environment.

Examples of harassment include, but are not limited to:

1. **Verbal harassment** may include, but is not limited to: vulgar remarks, implied or connotative meanings, ethnic jokes, slurs, epithets, threats of bodily harm or any other unwanted comment because of sex, race or other protected basis.
2. **Physical harassment** may include, but is not limited to: touching, hitting, shoving, pushing or any other form of physical contact because of sex, race or other protected basis.
3. **Sexual harassment** may include, but is not limited to: sexual conduct which is not freely entered into and mutually agreeable to both parties, continual or repeated abuse of a sexual nature including, but not limited to, graphic commentaries on the person's body, sexually degrading words used to describe the person, propositions of a sexual nature, the display of sexually offensive pictures and objects, uninvited sexual teasing, jokes, remarks or questions or threats or insinuation that the lack of sexual submission will adversely affect the person's employment, wages or other conditions of the person's

**ANTI-HARASSMENT AND
DISCRIMINATION POLICY**

**POLICY NUMBER: 301
DATE ADOPTED: 10/03/06
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livelihood or any derogatory, degrading behavior pattern which finds its genesis in one's sex [gender bias].

4. **Retaliation** for having reported or threatened to report harassment or discrimination.
5. **Any form of discrimination or harassment** is considered unacceptable whether it involves an employee and another employee, a supervisor, a manager, a client, a vendor or a supplier. We will take immediate and appropriate action when we receive a complaint of harassment. Our desire is to both alleviate any discrimination and/or harassment and ameliorate the effects of any discrimination and/or harassment.

ANY DISCRIMINATING OR HARASSING BEHAVIOR IS CONSIDERED MISCONDUCT AND MAY SUBJECT AN EMPLOYEE TO DISCIPLINARY ACTION AND/OR IMMEDIATE TERMINATION AS PROVIDED IN COLUSA COUNTY CODE SECTION 16-25.

If you believe you are experiencing discriminating or harassing behavior you should, when possible, confront the accused employee and persuade him/her to stop. When confronting the accused employee is not possible for you, provide a written or oral complaint to the Personnel Director. If you feel uncomfortable speaking to the Personnel Director for any reason, you may notify County Counsel.

Your complaint will be fully and effectively investigated. The investigation will be immediate, thorough, objective and complete. As part of the investigation, all persons with potential knowledge will be interviewed. Officials investigating such complaints shall have full authority to investigate all aspects of the complaint. The investigatory authority includes accessibility to records and cooperation of any involved employees. The investigation will be supervised and coordinated by the Personnel Department or County Counsel's Office as appropriate.

Special privacy safeguards will be applied in handling discrimination and/or harassment complaints. To the extent feasible, the identity of the charging party and the person accused of discrimination and/or harassment will be kept confidential. This, however, is not a guarantee of confidentiality; people can and do deduce from the investigative process who the parties involved are.

The results of the investigation and notice that corrective action has been taken, if it has, will be communicated to the complaining employee within ten (10) days of his/her registering the complaint. Steps will then be taken to avoid any further allegations of discrimination and harassment.

No action will be taken against you for complaining, whether a violation of this policy is proven or not. Colusa County will not retaliate against a complaining employee for filing a complaint and will not tolerate nor permit retaliation by management, employees or co-workers.

All employees are encouraged to report any incidents of discrimination/harassment forbidden by this policy immediately so that complaints can be quickly and fairly resolved.

**ANTI-HARASSMENT AND
DISCRIMINATION POLICY**

**POLICY NUMBER: 301
DATE ADOPTED: 10/03/06
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I hereby acknowledge that I have read and had the opportunity to ask questions about the policy Re: Discrimination and harassment. I understand the policy and that discriminating or harassing behavior is behavior not in the course and scope of my employment. I will abide by this policy personally and will report any incidence of such behavior I observe immediately to the Personnel Director or in the alternative to the County Counsel.

Date

Employee's Signature

Print Name

PURPOSE

It is the intention of this policy to eliminate substance abuse and its effect in the work place. While Colusa County has no intention of intruding into the private lives of its employees, involvement with drugs and alcohol can take its toll on job performance and employee safety, our concern is that employees are in a condition to perform their duties safely and effectively, in the interests of their fellow worker and the public, as well as themselves. The presence of drugs and alcohol on the job, and the influence of these substances on employees during working hours, are inconsistent with this objective.

Employees who think they may have an alcohol or drug usage problem are urged to seek confidential assistance, voluntarily from the Counseling Center or other competent professional help. While the County will be supportive of those who seek help voluntarily, the County will be equally firm in identifying and disciplining those who continue to be substance abusers and do not seek help.

Illegal drug use is conduct, in this state, which may subject the employee to criminal prosecution. Alcohol or drug abuse will not be tolerated, and disciplinary action, up to and including termination, will be used as necessary to achieve this goal.

This policy provides guidelines for the detection and deterrence of alcohol and drug abuse. It also outlines the responsibilities of county department heads, supervisors and employees. To that end the County will act to eliminate any substance abuse (alcohol, illegal drugs, prescription drugs, over the counter drugs, or any other substance which could impair an employee's ability to safely and effectively perform the functions of the particular job) which increases the potential for accidents, absenteeism, substandard performance, poor employee morale or damage to the County's reputation. All persons covered by this policy should be aware that violations of the policy may result in discipline up to and including termination or in not being hired.

In recognition of the public service responsibilities entrusted to the employees of Colusa County, and that drug and alcohol usage can hinder a person's ability to perform duties safely and effectively, the following policy against drug and alcohol abuse is hereby adopted by Colusa County.

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POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 10/1/91

Amended: 8/6/96

ALCOHOL AND DRUG ABUSE

POLICY NUMBER: 302

DATE ADOPTED: OCTOBER 1, 1991

PAGE 2 OF 5

I. It is County policy that employees:

- A. Shall not be under the influence of alcohol or drugs while on duty.
- B. Shall not possess alcohol or drugs while on County property or at work locations or in uniform;
- C. Shall not sell or provide drugs or alcohol to any other employee or to any person while such employee is on duty.
- D. Shall not have their ability to work impaired as a result of the use of alcohol or drugs when reporting for work.

Policy statements A through D in the preceding paragraph are intended to also apply to Sheriff's department personnel, except when necessary or required as part of a specific job assignment during the course of an investigation. Under these excepted circumstances, no Sheriff's employee will consume alcohol to the extent that mental or physical capabilities are impaired.

II. While use of medically prescribed medications and drugs is not per sé a violation of this policy, working when taking medications or drugs which could interfere with the safe and effective performance of duties or operation of County equipment may result in discipline, up to and including termination. In the event there is a question regarding an employee's ability to safely and effectively perform assigned duties while using such medications or drugs, clearance from a qualified physician may be required.

III. The County reserves the right to search all areas and property in which the County maintains control or joint control with the employee. No County employee shall have his/her locker, or other space for storage that may be assigned to him/her searched except in any of the following situations:

- A. In his or her presence; or
- B. With his or her consent; or
- C. When a valid search warrant has been obtained; or
- D. When she or he has been notified that a search will be conducted.

POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 10/1/91

Amended: 8/6/96

ALCOHOL AND DRUG ABUSE

POLICY NUMBER 302

DATE ADOPTED: OCTOBER 1, 1991

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This policy will be distributed to all current employees upon its adoption and will be provided to all newly hired employees with their "New Employee Packet".

When a supervisor reasonably determines an employee to be under the influence of alcohol or drugs, the supervisor will advise the employee that he/she is relieved from his/her duties for the remainder of the work shift. The employee shall be informed that he/she has the following options to be safely transported to his/her home or any other appropriate location:

1. The employee may call the person of his/her choice for transportation.
2. The employee may call a taxi-cab service.

The supervisor will further inform the employee that, in the event either of the above options are refused, law enforcement authorities will be notified in order to protect the employee and the safety of the public.

A detailed written report of any such incident shall be prepared by the supervisor, a copy of which shall be forwarded to the appropriate authority to be filed in the employee's personnel file.

The County is committed to providing reasonable accommodation to those employees whose drug or alcohol problem classifies them as handicapped under federal and/or state law or when the employee voluntarily recognizes that they have a drug/alcohol problem and is seeking professional counseling. Reasonable accommodation shall be determined by the County Risk Manager after consultation with the appropriate professionals.

When in the opinion of the Department Head and supported by complaint or observation it becomes obvious that an employee is suffering from drug or alcohol abuse, the following immediate corrective measures shall be taken:

1. The employee shall be advised of the suspected abuse and given the opportunity to present his/her views and urged to discuss the problem and the solution.
2. The employee shall be urged to seek professional help on his/her own initiative.

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POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 10/1/91

Amended: 8/6/96

3. As a last resort, the employee can be placed on administrative leave, pending enrollment and participation in a drug or alcohol abuse rehabilitation facility. Enrollment may be in-patient or out-patient depending upon recommendation of the appropriate professionals. Further, unless the alcohol or drug abuse problem is determined to be work related, the cost of the rehabilitation program shall be born by the employee or the employee's health insurance. If the employee refuses to participate in such a program he/she will be suspended pending a full investigation into the suspected abuse. If the investigation determines abuse does in fact exist the employee will be disciplined up to and including dismissal, after given another opportunity to engage in an abuse program.

The County has established a Substance Abuse Counseling Center, which has available confidential professional level counseling in both the drug and alcohol abuse area, to assist those employees who voluntarily seek help for their drug or alcohol related problems. Employees should contact their supervisors or the Counseling Center for additional information.

The County is committed to providing training of work place supervisors necessary for the recognition of drug and alcohol abuse by employees.

APPLICATION

This policy applies to all employees of and to all applicants for positions with the County. This policy applies to alcohol and to all substances, drugs, or medications, legal or illegal, which could impair an employee's ability to effectively and safely perform the functions of the job.

EMPLOYEE RESPONSIBILITIES

An employee shall not:

1. Report to work while his/her ability to perform job duties is impaired due to on or off duty alcohol or drug use;
2. Possess or use alcohol or impairing drugs (illegal drugs, and prescription drugs without a prescription) during his or her assigned work shift or while on standby duty, or at any time while on County property or while in uniform;

POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 10/1/91

Amended: 8/6/96

ALCOHOL AND DRUG ABUSE

POLICY NUMBER: 302
DATE ADOPTED: OCTOBER 1, 1991
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(Continued) An employee shall not:

3. Directly or through a third party sell or provide drugs or alcohol to any person, including any employee, while either employee or both employees are on duty. Employees who observe the purchase, sale or transfer of any controlled substance are encouraged to report the incident to the appropriate law enforcement agency.

An employee shall:

4. Provide, within 24 hours of request, bonafide verification of a current valid prescription for any potentially impairing drug or medication. The prescription must be in the employee's name.

5. Report alcohol or drug abuse by a manager or supervisor to the Department Head, the County Risk Manager or to the Board of Supervisors;

6. Immediately notify his/her supervisor of any conviction of alcohol or drug related offense.

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POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 10/1/91

Amended: 8/6/96

MEDICAL AND FAMILY LEAVE
POLICY

POLICY NUMBER: 308

DATE ADOPTED: 02/16/21

Page 1 of 9

1.0 Purpose

- 1.1 The purpose of this Medical and Family Leave Policy is to describe leaves potentially available to County employees under the Family Medical Leave Act, the California Family Rights Act, and California's Pregnancy Disability Leave Law. Additionally, this policy describes eligibility requirements, the administrative procedures for requesting leave, and the County's management of employee medical and family related leave.
- 1.2 This policy shall be administered in accordance with state and federal laws by the Human Resources Director ("Leave Administrator"), who may issue further procedural guidelines to accomplish its purpose.
- 1.3 This policy may be modified by the Board of Supervisors and shall replace any previous version of the policy.

2.0 Definitions

- 2.1 **Medical and Family Leave** means leave under the Family Medical Leave Act of 1993 and the California Family Rights Act of 1993, except as otherwise noted and not including Pregnancy Disability Leave.
- 2.2 **Rolling 12-Month Period** means a rolling twelve (12) month period measured backward from the date leave is taken and continuous with each additional leave day taken.
- 2.3 **Accrued Paid Leave** means an employee's accrued vacation, compensatory (comp) time, and sick leave.
- 2.4 **CFRA** means the California Family Rights Act of 1993 as amended; California Government Code section 12945.2.
- 2.5 **County** means the County of Colusa.
- 2.6 **Covered Active Duty** means:
 - 2.6.1 In the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country; and
 - 2.6.2 In the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty.

HISTORY

First Adopted: 6/30/15

Amended: 02/16/21

2.7 **Covered Servicemember** means:

2.7.1 A member of the Armed Forces who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a Serious Health Condition (as defined in Section 2.14.1); or

2.7.2 A veteran who is undergoing medical treatment, recuperation, or therapy, for a Serious Health Condition (as defined in Section 2.14.2) and who was a member of the Armed Forces at any time during the period of five (5) years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

2.8 **FMLA** means the Family Medical Leave Act of 1993; United States Code section 2612.

2.9 **Health Care Provider** means a doctor of medicine or osteopathy who is licensed to practice medicine or surgery by the State in which the doctor practices, or any other person determined by the United States Secretary of Labor to be capable of providing health care services under the FMLA.

2.10 **Key Employee** means a salaried employee who is among the highest paid ten (10) percent of the employer's employees.

2.11 **Next of Kin** means an individual's nearest blood relative.

2.12 **Pregnancy Disability Leave (PDL)** means leave provided to an employee who is disabled by pregnancy, childbirth, or a related medical condition.

2.13 **Qualifying Exigency** means an event as defined and declared by the United States Secretary of Labor, and applies only to members of the Armed Forces.

2.14 **Serious Health Condition** means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, residential medical care facility, or continuing treatment from a health care provider, or an illness, injury, impairment, or physical or mental condition that prohibits the employee from returning to work as ordered by a health care provider.

2.14.1 In the case of a member of the Armed Forces, an injury or illness that was incurred by the member in the line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating; and

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2.14.2 In the case of a veteran who was a member of the Armed Forces, and a covered servicemember, an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran.

2.14.3 **Inpatient Care** means a stay in a hospital, hospice, or residential health care facility, any subsequent treatment in connection with such inpatient care, or any period of incapacity. A person is considered an "inpatient" when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

2.15 **Spouse** means the employee's husband, wife, or registered domestic partner.

2.16 **Veteran** means a person who served in the active military and who was discharged or released therefrom under conditions other than dishonorable.

3.0 Eligibility for Leave

3.1 An employee is eligible for Medical and Family Leave if they were employed by the County for at least twelve (12) months immediately preceding the commencement of leave, and actually worked at least one thousand two hundred fifty (1,250) hours during the preceding twelve (12) month period. Under the CFRA an employee is eligible for leave based on the same criteria.

3.2 An employee is eligible for PDL upon employment with the County.

4.0 Reasons for Leave

4.1 Eligible Employees may be permitted to take Medical and Family Leave for the following reasons:

4.1.1 Following the birth of a child of the employee, the placement of a child with an employee in connection with the adoption or foster care of the child by the employee;

(a) When both parents, who are entitled to leave in connection with the birth, adoption, or foster care of a child under this policy, are both employed with the County, the employees are not cumulatively entitled to more than a combined 12 weeks of FMLA leave; however both employees are entitled to 12 weeks of CFRA leave for a combined 24 weeks of CFRA leave.

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First Adopted: 6/30/15

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- 4.1.2 To care for a parent, spouse, or child (including an adult child under CFRA) of the employee who has a serious health condition; or in the case of the CFRA, in addition to the foregoing, a grandparent, grandchild and siblings. Potentially, a parent-in-law is a qualifying relationship. Eligible spouses who work for the same employer are limited to a combined total of 12 workweeks of FMLA leave in a 12-month period to care for a parent with a serious health condition.
- 4.1.3 For an employee's own serious health condition that makes the employee unable to perform the essential functions of the employee's position;
- 4.1.4 Because of any qualifying exigency as defined in Section 2.13 out of the fact that the spouse, son, daughter, or parent of the employee is on covered active duty or call to active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces;
- 4.1.5 To care for a spouse, son, daughter, parent, or next of kin who is a covered service member of the United States Armed Forces who has a serious injury or illness incurred in the line of duty while on active military duty, or which existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces.
- 4.2 Eligible employees may be permitted to take PDL if they are disabled by pregnancy, childbirth, or a related medical condition.
- 5.0 Amount of Leave
 - 5.1 Medical and Family Leave. Eligible employees are entitled to a maximum twelve (12) workweeks of FMLA and CFRA leave during a twelve (12) month period.
 - 5.1.1 In the case where an employee is caring for a family member, or next of kin service member, who suffers from a serious health condition while on active duty, the employee may take up to a maximum twenty-six (26) weeks of leave during that period.
 - 5.1.2 Leave under the FMLA and CFRA, may run concurrently.
 - 5.2 Pregnancy Disability Leave. An employee is entitled to a maximum of four (4) months of PDL leave per pregnancy. PDL is separate and distinct from Medical and Family Leave.
 - 5.3 Intermittent Leave. Medical and Family Leave and PDL may be taken on an intermittent basis as authorized by the Leave Administrator, and when permitted under this policy.
 - 5.3.1 Leave taken on an intermittent basis shall be taken in increments of at least

HISTORY

First Adopted: 6/30/15

Amended: 02/16/21

one quarter (1/4, .25) of an hour.

- 5.3.2 Employees requesting intermittent leave must attempt to schedule their leave so as not to disrupt the County's operations. Intermittent leave is subject to the notification and certification requirements of this policy.

6.0 Notification and Procedure

- 6.1 Employees shall notify the Leave Administrator and their supervisor of their request to take leave under this policy, at least thirty (30) days prior to the commencement of the leave, or as soon as possible if circumstances do not permit notification within the required thirty (30) day period. If an employee knows that they will need leave in the future, but does not know the exact date(s) (e.g. for the birth of a child or to take care of a newborn), the employee shall inform the Leave Administrator and his/her supervisor as soon as possible that such leave will be needed.

- 6.1.1 Requests for leave pursuant to this policy shall be made in writing to the Leave Administrator on a *Leave Request Notification* form. The completed form shall be submitted to the Leave Administrator with all required accompanying documentation.

(a) Upon receipt of the *Leave Request Notification* form, the Leave Administrator shall notify and consult with the employee's department head to coordinate the leave and confirm that the employee notified the employee's supervisor of the leave request.

(b) An employee's failure to use the *Leave Request Notification* form is not sufficient grounds for denial of the leave.

- 6.1.2 The employee shall be notified, in writing, no later than five (5) business days after receiving the employee's request, by the Leave Administrator of the approval or denial of the leave, the reason(s) for the denial, or any conditions of the approval.

- 6.1.3 The employee's department head shall be notified of the Leave Administrator's decision, and the notification shall include the date the leave is to begin, and the date the leave is to be terminated.

7.0 Use of Accrued Paid Leave.

- 7.1 Except as provided for below, employees must exhaust their applicable Accrued Paid Leave balances concurrently with their use of Medical and Family Leave, or PDL. Use of their accrued leave balances will be concurrent with, and not in lieu of, Medical and Family Leave and PDL entitlements.

HISTORY

First Adopted: 6/30/15

Amended: 02/16/21

7.1.1 An employee, at their option, may choose not to use accrued vacation leave concurrently with PDL.

7.1.2 An employee may not use sick leave in conjunction with CFRA leave for the birth of an employee's child, or the placement of a child with an employee in connection with the adoption or foster care of the child by the employee.

8.0 Certification

8.1 Employees who request leave for their own serious health condition, or to care for a child, parent, or spouse who has a serious health condition, must provide written certification from the individual's health care provider.

8.1.1 If the leave is requested to care for a child, parent, or spouse who has a serious health condition the certification must include:

- (a) The date on which the serious health condition commenced;
- (b) The probable duration of the condition;
- (c) An estimate of the amount of time that the health care provider believes the employee needs to care for the individual requiring the care; and
- (d) A statement that the serious health condition warrants the participation of a family member to provide care during a period of the treatment or supervision of the individual requiring care.

8.1.2 Upon expiration of the time estimated by the health care provider in section 8.1.1(c) above, the employee must obtain a new certification for any further leave to the extent eligible.

8.2 If the leave is requested because of the employee's own serious health condition, the certification must include:

- (a) The date on which the serious health condition commenced;
- (b) The probable duration of the condition; and
- (c) A statement that, due to the serious health condition, the employee is unable to perform all the essential functions of their position.

8.2.1 If the employee is a Covered Servicemember, the written certification required by this section shall be done on the Department of Labor's (DOL) forms WH-385 or WH385-V. These forms can be obtained from the Colusa County Human Resources Office, local offices of the Wage and

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Hour Division of the Department of Labor, or the Internet at
www.dol.gov.whd.

- 8.3 The Leave Administrator, in his/her sole discretion, may periodically require recertification from the employee in accordance with this policy.
- 8.4 The Leave Administrator may require a medical opinion of a second health care provider chosen and paid for by County. If the second opinion is different from the first, the Leave Administrator may require the opinion of a third provider jointly approved by County and the employee, but paid for by County. The opinion of the third provider will be binding. An employee may request a copy of the health care providers' opinions when there is a second or third medical opinion sought.
- 8.4.1 When the leave is to care for a Covered Servicemember, second and third opinions shall not be required if the first certification was completed by:
- (a) A United States Department of Defense (DOD) health care provider;
 - (b) A United States Department of Veterans Affairs (VA) health care provider;
 - (c) A DOD TRICARE network authorized private health care provider; or
 - (d) A DOD non-network TRICARE authorized private health care provider.
- 8.4.2 However, second and third opinions may be required when the first certification was completed by a health care provider that is not one of the types identified in Section 8.4.1(a)-(d) of this Policy.
- 8.5 If the leave is requested to care for a covered service member who is a child, spouse, parent, or next of kin of the employee, the employee must provide written certification from the covered service member's health care provider regarding the service member's serious health condition.
- 8.5.1 The written certification required by this section shall be done on DOL forms WH-385 or WH385-V. These forms can be obtained from the Colusa County Human Resources Department, local offices of the Wage and Hour Division of the Department of Labor, or the Internet at www.dol.gov.whd.
- 8.5.2 In lieu of the DOL forms WH-385 or WH385-V, the employee may submit invitational travel orders or invitational travel authorizations issued to the employee to join a Covered Servicemember at their bedside.
- 8.6 Qualifying Exigency: The first time an employee requests leave because of a qualifying exigency, the employee shall provide a copy of the military member's

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active duty orders, or other documentation issued by the military, which indicates that the military member is on covered active duty or call to active duty status in a foreign country, and the dates of the military member's active duty service. A copy of new active duty orders or similar documentation shall be provided to the Leave Administrator if the need for leave because of a qualifying exigency arises out of a different active duty or call to active duty status of the same or a different military member.

- 8.7 If the leave is requested in cases of adoption or foster care placement, the employee must provide written verification, such as an adoptive home study, an adoption placement agreement, or a juvenile court order.

9.0 Benefits While on Leave

- 9.1 Leave under this policy is unpaid unless the employee is using his or her accrued paid leave concurrently with leave under this policy. While on unpaid leave, an employee will not accrue sick, vacation, or any other leave balances and will not be entitled to holiday or other similar compensation.
- 9.2 While on leave provided pursuant to this Policy, and if the employee was enrolled in the County's group health insurance at the time the leave commences, the employee will continue to be covered by County's group health insurance for the duration of the leave. The employee is required however, to continue paying the employee's share of premium payments, if, any. Additionally, the County may be entitled to reimbursement of its share of premium payments, from the employee, should the employee fail to return from leave.
- 9.3 Any obligation the County may have to maintain health insurance coverage ceases if an employee's premium share is more than thirty (30) days late.

10.0 Return from Leave

- 10.1 Upon expiration of leave, the employee shall be returned to the position of employment held when the leave commenced, or to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.
- 10.2 As a condition of return to employment for an employee whose leave was due to the employee's own serious health condition which made the employee unable to perform the essential functions of their job, the employee must obtain, and present to the Leave Administrator, a fitness-for-duty certification from the health care provider stating the employee is able to perform the essential functions of their job, without restriction.
- 10.2.1 If the employee provides the County with certification that accommodations are required as a condition of the employee's return to work, the County

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will engage in a process with the employee to determine if the employee can be reasonably accommodated.

10.2.2 If, at the end of the leave provided for pursuant to this Policy, the employee is unable to return to work with or without restrictions, the employee will be given an opportunity to engage the Leave Administrator regarding the employee's options, if any.

11.0 Key Employees. The County may deny a Key Employee's Medical and Family Leave if:

11.1 The employee is a Key Employee as defined by this Policy;

11.2 The denial is necessary to prevent substantial and grievous economic injury to the operations of the County; and

11.3 The County notifies the Key Employee of the intent to deny the Key Employee's request for leave at the time the County determines the denial is necessary under subsection 11.2.

11.4 In the case the leave pursuant to this Policy already commenced, the County shall give the Key Employee a reasonable opportunity to return to work following the notice prescribed in subsection 11.3.

11.5 The County may not deny leave under the CFRA based on Key employee status.

12.0 Extension of Probationary Period. An eligible probationary employee who requests and receives leave under this Policy shall have their probationary period extended for the full period of the leave taken.

HISTORY

First Adopted: 6/30/15

Amended: 02/16/21

MANDATORY PAID SICK HOURS POLICY

POLICY NUMBER: <u>308.1</u>
DATE ADOPTED: <u>6/30/15</u>
Page 1 of 3

I. Purpose

A. The purpose of this Policy is to comply with the Healthy Workplaces, Healthy Families Act of 2014 (Act).

B. This Policy shall be administered in accordance with applicable laws by the Human Resources Director who may issue further procedural guidelines to accomplish its purpose.

II. Applicability

A. This Policy applies to employees of the County of Colusa who are not covered by the sick leave provisions of Colusa County Code Chapter 45 and/or a negotiated Memorandum of Understanding between the County of Colusa and a bargaining representative. This Policy does not apply to county employees who are members of either a represented or unrepresented bargaining unit or elected officials. This Policy does not extend to in-home supportive services employees (IHSS).

III. Definitions

A. "Family member" means any of the following:

1. A child, which for purposes of this Policy means a biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis. This definition of a child is applicable regardless of age or dependency status.
2. A biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.
3. A spouse or a registered domestic partner.
4. A grandparent or a grandchild.
5. A sibling.

B. "Health care provider" is a physician, surgeon or osteopath as defined in paragraph (6) of subdivision (c) of Section 12945.2 of the California Government Code.

C. "Paid Sick Hours" means time that is compensated at the same wage as the employee normally earns during regular work hours and is provided by the County to an employee for the purposes described in Section V. "Reasons for Leave".

HISTORY

First Adopted: 6/30/15

Amended:

IV. Eligibility

A. An employee who, on or after July 1, 2015, works for Colusa County for thirty (30) or more days within a year from the commencement of employment is entitled to Paid Sick Hours as specified in this Policy.

B. An employee shall accrue Paid Sick Hours at the rate of one (1) hour per every thirty (30) hours worked, beginning at the commencement of employment or July 1, 2015, whichever is later.

C. An employee shall be entitled to use accrued Paid Sick Hours beginning on the ninetieth (90th) day of employment, after which day the employee may use Paid Sick Hours as they are accrued.

D. Accrued Paid Sick Hours shall carry over to the following year of employment. Use of Paid Sick Hours is limited to twenty-four (24) hours in each year of employment.

E. Total accrual of Paid Sick Hours is limited to forty-eight (48) hours.

F. The County will not provide compensation to an employee for accrued, unused Paid Sick Hours upon termination, resignation, retirement, or other separation from employment.

G. If an employee separates from County and is rehired by the County within one year from the date of separation, previously accrued and unused Paid Sick Hours shall be reinstated. The employee shall be entitled to use those previously accrued and unused Paid Sick Hours and to accrue additional Paid Sick Hours upon rehiring.

H. The County shall provide each eligible employee with written notice that sets forth the amount of Paid Sick Hours available, on the employee's itemized wage statement check receipt.

I. Paid Sick Hours under this Policy must be used in minimum allotment of two (2) hours per incident.

J. The rate of pay shall be the employee's hourly wage when Paid Sick Hours are used.

HISTORY

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MANDATORY PAID SICK HOURS POLICY

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K. If the need for Paid Sick Hours is foreseeable, the employee shall provide reasonable advance notification to the appointing authority or direct supervisor. If the need for Paid Sick Hours is unforeseeable, the employee shall provide notice of the need for the leave as soon as practicable.

L. The County shall provide payment for sick hours taken by an employee no later than the payday for which worked hours occurring during the same time frame would be paid.

V. Reasons for Leave

A. Upon the request of an employee, the County shall provide Paid Sick Hours on days the employee is scheduled to work, for the following purposes:

1. Diagnosis, care, or treatment of an existing health condition of, or preventive care for, an employee or an employee's family member.
2. For an employee who is a victim of domestic violence, sexual assault, or stalking, the purposes described in the subdivision (c) of Section 230 and subdivision (a) of Section 230.1 of the Labor Code.

HISTORY

First Adopted: 6/30/15

Amended:

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Equal Employment Opportunity (EEO) Policy

POLICY

The County of Colusa is committed to providing a professional work environment free from discrimination and harassment, including discrimination and harassment based on a protected category, and an environment free from retaliation for participating in any protected activity covered by this policy. The County of Colusa is committed to providing equal employment opportunities to all employees and applicants for employment. Accordingly, we have adopted and maintain this anti-discrimination policy designed to encourage professional and respectful behavior and prevent discriminatory and harassing conduct in our workplace. We will implement appropriate corrective action(s), up to and including formal discipline, in response to misconduct--including violations of The County of Colusa anti-discrimination policy--even if the violation does not rise to the level of unlawful conduct.

The County of Colusa prohibits discrimination or harassment based on the following categories: race, color, religion, religious creed (including religious dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability,¹ medical condition (including cancer and genetic characteristics), genetic information, marital status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), gender, gender identity, gender expression, age (40 years and over), sexual orientation, veteran and/or military status, protected medical leaves (requesting or approved for leave under the Family and Medical Leave Act or the California Family Rights Act), domestic violence victim status, political affiliation, and any other status protected by state or federal law. In addition, the County of Colusa prohibits retaliation against a person who engages in activities protected under this policy. Reporting, or assisting in reporting, suspected violations of this policy and cooperating in investigations or proceedings arising out of a violation of this policy are protected activities under this policy.

All employees are expected to assume responsibility for maintaining a work environment that is free from discrimination, harassment and retaliation.

Employees are encouraged to promptly report conduct that they believe violates this policy so that we have an opportunity to address and resolve any concerns. Managers and supervisors are required to promptly report conduct that they believe violates this policy. We are committed to responding to alleged violations

¹ The County of Colusa recognizes and supports the obligation to reasonably accommodate employees with disabilities or religious beliefs or practices in order to allow those employees to perform the essential functions of their jobs. If an employee believes they need a reasonable accommodation based on disability or a religious belief or practice, the employee should discuss the matter with their supervisor or the human resources unit.

of this policy in a timely and fair manner and to taking appropriate action aimed at ending the prohibited conduct.

Scope of Protection

This policy applies to the County of Colusa applicants and employees (co-workers, supervisors and managers). As used in this policy, the term “employee” includes contractors and volunteers in our workplace. In addition, this policy extends to conduct with a connection to an employee’s work, even when the conduct takes place away from the County of Colusa’s premises, such as a business trip or business-related social function.

Applicant/Employee Rights

- The right to a discrimination, harassment, and retaliation-free work environment.
- The right to file a complaint of discrimination, harassment, or retaliation. Employees are encouraged to report inappropriate conduct immediately and, whenever possible, to put the complaint or concern in writing.
- The right to a full, impartial and prompt investigation by a County of Colusa representative or designee into allegations of conduct that would violate this policy.
- The right to be timely informed of appropriate information related to the outcome of an investigation either as a complainant or a respondent in the investigation.
- The right to be represented by a person of the complainant’s choosing at each and all steps of the complaint process.
- The right to be free from retaliation or reprisal after filing a complaint or participating in the complaint process.
- The right to file a complaint directly with the California Department of Fair Employment and Housing, the federal Equal Employment Opportunity Commission or other appropriate state or federal agencies, or to file a civil action in the appropriate court.

CONDUCT PROHIBITED BY THIS POLICY / DEFINITIONS

Discrimination:

As used in this policy, discrimination is defined as the unequal treatment of an employee or applicant in any aspect of employment, including discrimination based solely or in part on the employee’s, or applicant’s, protected category. Protected categories include: race, color, religion, religious creed (including religious dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability, medical condition (including cancer and genetic characteristics), genetic information, marital status, sex (including pregnancy, childbirth,

breastfeeding, or related medical conditions), gender, gender identity, gender expression, age (40 years and over), sexual orientation, veteran and/or military status, protected medical leaves (requesting or approved for leave under the Family and Medical Leave Act or the California Family Rights Act), domestic violence victim status, political affiliation, and any other status protected by state or federal law. Discrimination includes unequal treatment based upon the employee or applicant's association with a member of these protected classes.

Discrimination may include, but is not necessarily limited to: hostile or demeaning behavior towards applicants or employees because of their protected category; allowing the applicant's or employee's protected category to be a factor in hiring, promotion, compensation or other employment related decisions unless otherwise permitted by applicable law², and providing unwarranted assistance or withholding work-related assistance, cooperation, and/or information to applicants or employees because of their protected category.

Harassment:

As used in this policy, harassment is defined as disrespectful or unprofessional conduct, including disrespectful or unprofessional conduct based on any of the protected categories listed above. Harassment can be verbal (such as slurs, jokes, insults, epithets, gestures, or teasing), visual (such as the posting or distribution of offensive posters, symbols, cartoons, drawings, computer displays, or emails), or physical conduct (such as physically threatening another person, blocking someone's way, making physical contact in an unwelcome manner, etc.).

² For example veterans preference as permitted under [Government Code 18973.1](#).

Sexual Harassment:

As used in this policy sexual harassment is defined as harassment based on sex or conduct of a sexual nature, and includes harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), gender, gender identity or gender expression. It may include all of the actions described above as harassment, as well as other unwelcome sex-based conduct, such as unwelcome or unsolicited sexual advances, requests for sexual favors, conversations regarding sexual activities, or other verbal or physical conduct of a sexual nature. Sexually harassing conduct need not be motivated by sexual desire and may include situations that began as reciprocal relationships, but that later cease to be reciprocal.

Sexual harassment is generally categorized into two types:

1. Quid Pro Quo Sexual Harassment ("this for that")
 - Submission to sexual conduct is made explicitly or implicitly a term or condition of an individual's employment.
 - Submission to or rejection of the conduct by an employee is used as the basis for employment decisions affecting the employee.

2. Hostile Work Environment Sexual Harassment

Conduct of a sexual nature or on the basis of sex by any person in the workplace that unreasonably interferes with an employee's work performance and/or creates an intimidating, hostile or otherwise offensive working environment. Examples include:

- Unwelcome sexual advances, flirtation, teasing, sexually suggestive or obscene letters, invitations, notes, emails, voicemails or gifts.
- Sex, gender or sexual orientation-related comments, slurs, jokes, remarks or epithets.
- Leering, obscene or vulgar gestures or making sexual gestures.
- Displaying or distributing sexually suggestive or derogatory objects, pictures, cartoons, or posters or any such items.
- Impeding or blocking movement, unwelcome touching or assaulting others.
- Any sexual advances that are unwelcome as well as reprisals or threats after a negative response to sexual advances.
- Conduct or comments consistently targeted at one gender, even if the content is not sexual.

Retaliation:

As used in this policy retaliation is defined as any adverse employment action taken against an employee because the employee engaged in activity protected under this policy. Protected activities may include, but are not limited to, reporting or assisting in reporting suspected violations of this policy and/or cooperating in investigations or proceedings arising out of a violation of this policy.

Adverse employment action is conduct or an action that materially affects the terms and conditions of the employee's employment status or is reasonably likely to deter the employee from engaging in protected activity. Even actions that do not result in a direct loss of compensation may be regarded as an adverse employment action when considered in the totality of the circumstances.

Examples of retaliation under this policy include but are not limited to: demotion; suspension; reduction in pay; denial of a merit salary increase; failure to hire or consider for hire; refusing to promote or consider for promotion because of reporting a violation of this policy; harassing another employee for filing a complaint; denying employment opportunities because of making a complaint or for cooperating in an investigation; changing someone's work assignments for identifying harassment or other forms of discrimination in the workplace; treating people differently such as denying an accommodation; or not talking to an employee when otherwise required by job duties, or otherwise excluding the employee from job-related activities because of engagement in activities protected under this policy.

TRAINING REQUIREMENTS

Every two years, all supervisory employees must attend Sexual Harassment Prevention and Workplace Civility training aimed at increasing their understanding of and preventing workplace sexual harassment (including harassment on the basis of sexual orientation, gender identity, and gender expression) and their role in creating an underlying culture of mutual respect in our workplace. Specific components of the training will include how to promptly and effectively respond to sexual harassment when it occurs, the effects of abusive conduct in the workplace, and ways to appropriately intervene if one witnesses behavior that is not in keeping with this policy. The training must be provided by trainers who, in addition to the other requirements set forth in [2 CCR 11024](#), have the ability through training or experience to train supervisors on how to identify, investigate, report, and respond to unlawful harassment, discrimination, and retaliation in the workplace.

ADDRESSING AND REPORTING VIOLATIONS OF THIS POLICY

Any employee or applicant who experiences or witnesses behavior that they believe violates this policy is encouraged to immediately tell the offending individual that the behavior is inappropriate and, if they feel comfortable doing so, to tell the offending individual to stop the behavior. The applicant or employee should also immediately report the alleged violation to his/her supervisor, manager or the EEO Officer aka Human Resources Director. There is no chain of command when contacting the EEO Officer; an individual does not need supervisor or manager approval to do this. If the alleged offender is the employee's supervisor or manager, the employee should report the conduct to any other supervisor, manager or the EEO Officer. A complaint may be brought forward verbally or in writing. Written complaints can be made using the EEO Complaint Form (attached to this policy).

Supervisors or managers who learn of any potential violation of this policy are required to immediately report the matter to the EEO Officer, and must follow that officer's instructions as to how best to proceed.

The County of Colusa will promptly look into the facts and circumstances of any alleged violation, as appropriate. Even in the absence of a formal complaint, the County of Colusa may initiate an investigation where it has reason to believe that conduct that violates this policy has occurred. Moreover, even where a complainant conveys a request to withdraw their initial formal complaint, the County of Colusa may continue the investigation to ensure that the workplace is free from discrimination, harassment and retaliation. Anonymous complaints will also be investigated. The method will depend on the details provided in the anonymous complaint. If the complaint is sufficiently detailed, the investigation may be able to proceed in the same manner as any other complaint. If the information is more general, the County of Colusa may need to do an environmental assessment or survey to try to determine if misconduct has occurred. All investigations will be fair, impartial, timely, and completed by qualified personnel.

To the extent possible, the County of Colusa will endeavor to keep the reporting of the applicant or employee's concerns confidential; however, complete confidentiality cannot be guaranteed when it interferes with the County of Colusa's ability to fulfill its obligations under this policy. All employees are required to cooperate fully with any investigation. This includes, but is not limited to, maintaining an appropriate level of discretion regarding the investigation and disclosing any and all information that may be pertinent to the investigation.

Upon completion of the investigation, if misconduct is substantiated, the County of Colusa will take appropriate corrective and preventive action calculated to end the conduct up to and including formal discipline where warranted.

The County of Colusa's EEO Officer is:

The Colusa County Human Resource Director

FILING OF COMPLAINTS OUTSIDE OUR COMPANY

Employees and applicants may file formal complaints of discrimination, harassment, or retaliation with the agencies listed below. Individuals who wish to pursue filing with these agencies should contact them directly to obtain further information about their processes and time limits.

California Department of Fair Employment and Housing

2218 Kausen Drive, Suite 100 Elk Grove,
CA 95758

800-884-1684 (voice), 800-700-2320 (TTY) or California's Relay Service at 711

contact.center@dfeh.ca.gov

<https://www.dfeh.ca.gov>

U.S. Equal Employment Opportunity Commission

450 Golden Gate Avenue 5 West,
P.O. Box 36025

San Francisco, CA 94102-3661

1-800-669-4000 or 510-735-8909 (Deaf/hard-of-hearing callers only)

<http://www.eeoc.gov/employees>

CORRECTIVE ACTION GUIDELINES

The County of Colusa will take appropriate corrective action(s) up to and including formal discipline against any employee(s) when an investigation has found that misconduct occurred. Such corrective action(s) may include, but are not limited to, letters of reprimand, suspension, demotion, or termination. Additionally, depending on the nature of the violation, civil liability could be imposed on the violator as well as the County of Colusa.

The County of Colusa
DISCRIMINATION, HARASSMENT, AND RETALIATION PREVENTION POLICY
COMPLAINT FORM

COMPLAINANT INFORMATION

NAME:

DIVISION / UNIT:

OFFICE LOCATION:

WORK PHONE:

IMMEDIATE SUPERVISOR:

Please describe the conduct that you believe violates the Discrimination, Harassment or Retaliation Prevention Policy. In your narrative, describe: (1) What happened to you; (2) Why you believe you are being discriminated, harassed, or retaliated against, including the reason or evidence you have to support your belief, and; (3) When the acts of discrimination, harassment, or retaliation occur (attach additional pages if needed). If you require assistance with completing this form as a reasonable accommodation, please contact the EEO officer.

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PERSON(S) ALLEGED TO HAVE VIOLATED THE POLICY

Person #1 - Name:	Position:	Work Location:
Person #2 - Name:	Position:	Work Location:
Person #3 - Name:	Position:	Work Location:

PERSON(S) WITH INFORMATION/KNOWLEDGE OF THE ALLEGED INCIDENTS

Witness Name:	Position:	Work Location:
Witness Name:	Position:	Work Location:
Witness Name:	Position:	Work Location:

HAVE YOU COMPLAINED TO ANYONE AT THE COUNTY OF COLUSA ABOUT THIS MATTER?

If yes, explain the situation. When did you complain, to whom, and what was the result?

Please submit to the Equal Employment Opportunity Officer:

**WORKPLACE VIOLENCE
PREVENTION POLICY**

POLICY NUMBER: 313 DATE ADOPTED: April 18, 2000 PAGE 1 of 13

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POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 4/18/00

Amended:

WORKPLACE VIOLENCE PREVENTION POLICY

POLICY NUMBER: 313
DATE ADOPTED: April 18, 2000
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I. GOAL STATEMENT

It is the goal of Colusa County to strive for an environment free from threats, intimidation, or actual workplace violence to its employees or the citizens they serve in the course of that employment.

II. POLICY STATEMENT.

A. As a part of our continuing commitment to workplace safety, the Board of Supervisors, Risk Manager, Department Heads, and all other employees of the County of Colusa, are determined to strive for an atmosphere free from actual or threatened workplace violence against any employee(s) or the citizen(s) we serve. The Workplace Violence Prevention Policy (WVPP) is implemented in accordance with Title 8, California Code of Regulations Section 3203.

B. Every employee has an obligation to assure that the work environment is free from workplace violence.

C. Any act of workplace violence or threatening conduct of any kind, whether directed against a co-worker, subordinate, manager or outside party will not be tolerated. This conduct includes but is not limited to:

1. Striking, punching, slapping, or assaulting another person.
2. Fighting or challenging another person to a fight.
3. Grabbing, pinching, or touching another person in an unwanted way (sexually or otherwise).
4. Bringing any firearm, knife or other weapon into/onto county-owned or leased property or while on county business unless specifically authorized by the employee's department head. A concealed weapon permit does not automatically authorize the holder to possess same and authorization must still be obtained from the department head.
5. Threatening or harming another person in any way, whether verbal, written or physical.

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POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 4/18/00

Amended:

WORKPLACE VIOLENCE PREVENTION POLICY

POLICY NUMBER: 313 DATE ADOPTED: April 18, 2000 PAGE 3 of 13
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6. Any intimidating behavior perceived as a threat.

D. Any employee(s) found to have engaged in such unacceptable behavior will be severely disciplined up to and including termination. In appropriate cases the County will inform and cooperate with law enforcement authorities.

E. No person shall have to tolerate workplace violence or the threat of workplace violence on the job. Any person who is the victim of any violent, threatening or harassing conduct, or who observes such conduct, shall report the conduct to her/his immediate supervisor or Department Head. That person shall initiate investigation procedures immediately.

F. Reasonable action will be taken to prevent any further violent conduct or threat of violent conduct from occurring or being repeated. No adverse action will be taken against anyone who brings a good-faith complaint under this policy.

G. Some employees, such as peace officers and custodial officers encounter threats and violence during the normal scope of their duties. Therefore, the procedures imposed by public safety agencies are deemed compliant with this policy.

III. DEFINITIONS

A. Threat. An expression of intention, coupled with a present ability, to inflict harm, injury or damage; to announce or forecast impending danger or harm.

B. Outside party: Any person not an employee of the county.

IV. RESPONSIBILITIES UNDER THE POLICY

A. Board of Supervisors

1. The Board of Supervisors have the ultimate authority and responsibility for the effective implementation of the provisions of the Colusa County Workplace Violence Prevention Policy.

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POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: 4/18/00

Amended:

WORKPLACE VIOLENCE PREVENTION POLICY

POLICY NUMBER: 313
DATE ADOPTED: April 18, 2000
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B. Risk Manager

1. Is responsible for implementing the Policy.
2. Ensure that all Department Heads implement and maintain this Workplace Violence Prevention Policy.
3. Assess the risk of the workplace violence and take action to mitigate any identified risk.
4. Inform the Board of Supervisors of any circumstance that creates a danger to a county employee.
5. Notify all departments of any trend or change in reported workplace violence incidents. The County will utilize mass mailings, departmental meetings and posting to ensure that employees are aware of workplace violence issues.
6. Immediately investigate all workplace violence reports.
7. Notify, in writing, the victim and the accused of the outcome of the investigation.

C. Department Head

1. Ensure that all employees are fully informed of all the elements of the Workplace Violence Prevention Policy.
2. Ensure that all managers and supervisors implement and maintain this Workplace Violence Prevention Policy.
3. Assure the Risk Manager is immediately notified of any threats or acts of workplace violence. Cooperate with and assist the Risk Manager in conducting any investigation.

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4. Ensure all appropriate employees are immediately made aware of the potential threat and provide a complete description (picture if possible) of the threatening employee(s), or citizen(s).
5. Provide a written report to the Risk Manager of any and all corrective action(s) taken to eliminate the problem.
6. Conduct ongoing workplace violence risk assessments. Supervise, evaluate, counsel, discipline, and document employee(s) behavior and performance in conformance with a safe work environment.
7. Department heads shall notify the Risk Manager and Sheriff's personnel whenever an employee has been authorized to be in possession of a concealed weapon on county property.

D. Supervisors, Mid-level and First-Line

1. Ensure implementation of the Workplace Violence Prevention Policy in all work areas under their authority.
2. Conduct ongoing workplace violence risk assessments. Supervise, evaluate, counsel, discipline, and document employee(s) behavior and performance in conformance with a safe work environment.
3. Report results of workplace violence risk assessments to department head.
4. Receive and assure immediate investigation of any reports of workplace violence or threat of workplace violence.
5. Immediately report all threats or violent acts to the department head.
6. Develop and implement a safe work environment for the control of potential workplace violence.
7. Train employee(s) in a safe work environment and ensure that they are fully informed of all the elements of the Workplace Violence Prevention Policy.

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8. Ensure employee(s) safety and security to the extent possible. Employees shall be notified of a potential threat, if deemed appropriate, under the circumstances.

E. Employees

1. Are to be fully informed of all the elements of the Workplace Violence Prevention Policy.

2. Immediately report all threats or incidents of violent behavior to your immediate supervisor or Department Head.

3. Immediately disengage and contact a supervisor upon any instance of direct workplace violence or threatening behavior.

4. Peace officers and correctional officers in the performance of their official duties shall follow the procedures established by their agency.

5. Employees in possession of a permit and wishing to carry a concealed weapon on county property must obtain authorization to do so from their department head.

F. County Safety Committee

1. Evaluate each incident, discuss the causes of the incident, and make recommendations on how to revise the program to prevent similar incidents from occurring. All revisions will be in writing and made available to all employees.

V. INCIDENT REPORTING

A. Prompt and accurate reporting of all incidents is required whether or not a physical injury has occurred. Victims of workplace violence will not be discriminated against.

B. Threats or incidents may be reported in person or anonymously to a departmental supervisor, Department Head, or Risk Manager. Reports may be done verbally or in written form. However, if done verbally, a written report must follow. An Incident Report Form may be obtained from the Department Head, a Supervisor, or the Risk Manager.

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C. A completed Incident Report Form will not be made available to the accused unless ordered by the court.

VI. INCIDENT INVESTIGATION

A. Incident investigation includes actual workplace violence as well as threats.

B. An investigation shall be initiated immediately upon knowledge of the incident and shall conclude as soon as possible. The reporting employee(s) (if known) shall be informed of the procedure to be followed.

C. The investigation shall take precedence over all other matters. The investigation will be conducted by the Risk Manager. The Department Head will cooperate and assist in the investigation as needed. The investigation may also include a representative from the personnel office and law enforcement and shall include a review of previous incidents.

D. All individuals necessary to conduct a thorough investigation will be interviewed. All employees shall cooperate with the investigation without fear of retaliation.

E. To the extent possible, proceedings under this policy, including the investigation, and all reports and records filed, shall be confidential. Review and release of any documents, including personnel records, shall be subject to any statutory requirements or restrictions.

F. To the extent possible, the department head or his/her designee will give the reporting employee(s) (if known) a verbal status report of the ongoing investigation.

G. When a department head, supervisor or the Risk Manager forms the opinion that the circumstances create a danger to the safety of staff members they shall:

1. Ensure security personnel, and other appropriate employees are immediately made aware of the potential threat and provide a complete, description (picture if possible) of the threatening employee(s), or citizen(s).

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2. Instruct personnel to immediately notify a designated person at the facility in the event the person who made the threat is seen at the facility.
 3. Contact the local law enforcement agency and request increased patrol/security checks are made at the facility. If appropriate, request a police report be taken on the incident.
 4. Make timely notification to the appropriate Department Heads, and Risk Manager.
 5. If other facilities are affected or are the object of the threats, ensure appropriate personnel at the facility are notified.
- H. Notify, in writing, the victim and the accused of the outcome of the investigation.
- I. Peace officers and correctional officers in the performance of their official duties shall follow the procedures established by their agency.

VII. COMPLIANCE

A. During the Investigation

1. When a complaint of the Workplace Violence Prevention Policy is received, the suspected employee(s) may be placed on administrative leave at the discretion of the department head during the investigation. The employer may also request a restraining order. The department head's decision will be based upon the following:
 - a. Type of complaint
 - b. Threat or actual workplace violence
 - c. Past behavior of employee
 - d. Potential for reoccurrence
2. The availability of professional counseling shall be communicated to the employee, victim and accused.
3. The victim will be protected to the extent possible. This may include a temporary departmental transfer or paid administrative leave.

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B. Conclusion of the Investigation

1. At the conclusion of the investigation the department head, with assistance from the Risk Manager, shall make one of the following findings:
 - a. Sustained - Findings found to be true with one or more of the following consequences:
 - (1) Training
 - (2) Written reprimand
 - (3) Documentation in personnel file
 - (4) Require professional counseling
 - (5) Suspension without pay
 - (6) Termination
 - (7) A restraining order
 - (8) Criminal charges
 - b. Not sustained - Findings were insufficient.
 - c. Unfounded - Allegations were found to be untrue.
 - d. Justified - Warranted self-defense, just cause.
2. The victim and the accused will be notified, in writing, of the outcome of the investigation by the Department Head and/or the Risk Manager.
3. Written documentation of the investigation and its conclusion will be prepared and stored in a confidential file with the Risk Manager.
4. All levels of management of appropriate departments shall be notified immediately upon the conclusion of the investigation.
5. The following measures may be implemented:
 - a. Professional counseling if recommended by medical doctor
 - b. Debriefing
 - c. Evaluation of the incident and possible risk factors
 - d. Evaluation of Office/building security measures
 - e. Implement corrective security measures and procedures.

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VIII. HAZARD ASSESSMENTS

A. The following inspections of the workplace will be conducted to identify potential workplace violence hazards that most likely will affect the workplace:

1. Semi-annual inspections conducted by the Risk Manager, the building safety inspector and/or the section safety representative as set forth in the Colusa County Injury and Illness Prevention Plan.

2. Periodic spot inspections as the need arises by appropriate personnel.

B. The inspection will identify three types of risk and evaluate areas of potential risk using the following criteria:

1. Type I - An act of workplace violence or the threat of workplace violence not associated with County business, committed by an individual who has no legitimate relationship to the workplace and usually enters the workplace to commit an illegal act such as robbery.

2. Type II - An act of workplace violence or threat of workplace violence committed by an individual who is either the recipient or the object of a service provided by the affected workplace or victim, such as an attack or threat by an irate or irrational citizen/client toward the employee(s).

3. Type III - An act of workplace violence or threat of workplace violence by an individual with an employment relationship with the affected workplace. This usually involves a current or ex-employee. This type also includes a person who may have a personal relationship with an employee outside of the workplace.

C. A potential hazard assessment checklist will include the following questions and others as necessary:

1. Is there a consistent response policy in place?

2. Are there substantial physical barriers between a potential attacker and the workplace?

3. Do employees work alone or in isolation?

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4. Do employees exchange money with the public?
 5. Can the worker see persons approaching the entrance?
 6. Is there control of the initial contact with persons entering the workplace?
 7. Are there remotely activated locks on entrance doors?
 8. What means of emergency communications are available to employees?
 9. Do employees have more than one escape route in the event of an incident?
 10. Have employees been trained in emergency response and have drills been held?
 11. Are local law enforcement authorities familiar with the physical layout of the workplace and response policy?
 12. Is the parking lot well lit and does it have unobstructed views?
 13. Who has keys to entrances and other locked spaces?
 14. Is the work area a high crime area?
 15. Are employees working late at night or early in the morning?
- D. Assessments will also include a review of previous reports and incidents.

IX. HAZARD CORRECTION

- A. Any hazard identified during scheduled inspections will be reported to the Department Head and the Risk Manager. The Risk Manager will prioritize first by severity and second by date of assessment or report, with appropriate action taken as soon as possible.

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X. TRAINING

A. Training will be ongoing for all County employees. The following training may be available:

1. Policy Training
2. Workplace Violence Awareness
3. Emergency Response Drills
4. Bomb Threats - prepared questions to ask when a threat is received
5. On-Site Customized Evacuation Plan
6. Diffusion Techniques
7. Forms of Hostility
8. Hostage Survival
9. Self Defense

XI. DOCUMENTATION

A. Record keeping is an important part of an effective Workplace Violence Prevention Policy. The following types of records will be kept:

1. Log-in sheet of training sessions
2. Inspection and assessment reports
3. Safety meetings and communication
4. Trindel Incident Hazard Reports
5. Incident investigation reports
6. Police reports

B. A record of all workplace violence incidents will be maintained in a confidential file in the Risk Manager's office.

C. Any employee injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness, is a Workers' Comp injury. In the event of such an injury, all Workers' Comp forms must be completed and the injury will be recorded on an OSHA 200 log available through the Risk Manager. If applicable, doctors' reports and supervisors' reports will be kept for each recorded incident.

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D. Incidents of abuse, verbal attack, or aggressive behavior, which may be threatening to the employee, but not resulting in injury, will be recorded. The County Safety Committee will evaluate these records on a regular basis.

E. Records of training program contents, and the sign-in sheets of all attendees will be maintained by the Safety Analyst.

XII. DISTRIBUTION

A. This policy, and any revision thereof, shall be distributed to all County Officers and employees.

(End)

HISTORY

First Adopted: 4/18/00

Amended:

WORKPLACE VIOLENCE INCIDENT REPORT FORM
Colusa County

1. Victims Name:

2. Job Title:

3. Victims Address:

4. Home Phone Number:

Work Phone Number:

5. Department:

6. Date of incident:

7. Time of incident:

8. Location of Incident:

9. Work Location (if different)

10. Type of Incident:

Assault

Robbery

Harassment

Disorderly Conduct

Sex Offense

Other (Please Specify): _____

(see attached – Definition of Incident)

11. Were You Injured:

Yes _____

No _____

If yes, specify your injuries and the location of treatment if applicable: _____

12. Did police respond to incident:

Yes _____

No _____

13. What police department: _____

14. Police report filed?

Yes _____

No _____

15. Was your supervisor notified?

Yes _____

No _____

If no, explain why they were not notified: _____

16. Supervisors Name: _____

17. Was your Employee Representative notified?

Yes _____

No _____

18. Was any action taken by employer:

Yes_____

No_____

Please specify: _____

19. Assailant/Perpetrator:

Department Head_____

Supervisor_____

Co-Worker_____

Other County Employee_____

Client_____

Former Employee_____

Intruder_____

Customer_____

Patient_____

Family Friend_____

Visitor_____

Student_____

Other, please specify: _____

20. Assailant/Perpetrator: (Complete information if known)

Name & Address: _____

21. Briefly describe the incident: _____

22. Did incident involve a weapon?

Yes_____

No_____

Please specify: _____

23. Did you lose any work days?

Yes_____

No_____

Please specify: _____

24. Were you singled out or was the violence directed at more than one individual? _____

25. Were you alone when the incident occurred: Yes _____ No _____

Please specify: _____

26. Did you have any reason to believe that an incident might occur? Yea _____ No _____

Please specify: _____

27. Has this type or similar incident(s) occurred to you or your co-workers in the past?

Yes _____ No _____ Please specify: _____

28. Have you had any counseling or support since the incident? Yes _____ No _____

Please specify: _____

29. What do you feel can be done in the future to avoid such an incident? _____

30. Has this assailant been involved in previous incidents? Yes _____ No _____

Specify: _____

31. Are there any measures in place to prevent similar incidents? Yes_____ No_____

Specify:_____

32. Has corrective action been taken? Yes_____ No_____

Specify:_____

33. Comments:_____

(Use back if more space is needed)

I CERTIFY THAT ALL STATEMENTS MADE IN THIS FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature

Today's Date

DEFINITION OF INCIDENTS

◆ **ASSAULT:** The intentional use of physical injury, (impairment of physical condition or substantial pain) to another person, with or without a weapon or dangerous instrument.

◆ **CRIMINAL MISCHIEF:** Intentional or reckless damaging of the property of another person without permission.

◆ **DISORDERLY CONDUCT:** Intentionally causing public inconvenience, annoyance or alarm or recklessly creating a risk thereof by fighting (without injury) or in violent numinous or threatening behavior of making unreasonable noise, shouting abuse, misbehaving, disturbing an assembly or meeting or persons or creating hazardous conditions by an act which serves no legitimate purpose.

◆ **HARASSMENT:** Intentionally striking, shoving or kicking another of subjecting another person to physical contact, or threatening to do the same (without physical injury). ALSO, using abusive or obscene language or following a person in about a public place, or engaging in a course of conduct which alarms or seriously annoys another person.

◆ **LARCENY:** Wrongful taking, depriving or withholding property from another (no force involved). Victim may or may not be present.

◆ **MENACING:** Intentionally places or attempts to pace another person in fear of imminent serious physical injury.

◆ **RECKLESS ENDANGERMENT:** Subjecting individual to danger by recklessly engaging in conduct which creates substantial risk of serious physical injury.

◆ **ROBBERY:** Forcible stealing of another's property by use of threat of immediate physical force. (Victim is present and aware of theft).

◆ **SEX OFFENSE:**

- ◆ Public Lewdness: Exposure of sexual organs to others.
- ◆ Sexual Abuse: Subjecting another to sexual conduct without consent.
- ◆ Sodomy: A deviant sexual act committed as in rape.
- ◆ Rape: Sexual intercourse without consent.

1.0 PURPOSE

- 1.1 Employees related by blood, marriage or adoption; i.e., spouse, mother, father, brother, sister, son, daughter, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law or daughter-in-law, or registered domestic partners, collectively referred to as “family,” are prohibited from working in the same office or department when doing so will cause one family member to directly or indirectly supervise, or monitor, the job performance of another family member, which can create an actual or potential conflict of interest. In the event two (2) employees in the same department marry, cohabitate, become registered domestic partners, or become related, reasonable efforts will be made to reassign one of the employees without job detriment.
- 1.2 This section shall not apply when the family member of an existing county employee is elected to head the same office in which the existing employee is assigned.
- 1.3 In such a case, the elected official will take all reasonable steps available to minimize his/her direct supervision of the employee and will report the steps taken, in writing, to the Board no later than thirty calendar days following his/her assumption of office.
- 1.4 The employee shall be prohibited from using his/her familial relationship with the elected official: to gain personal favor; to influence the decisions of others; to gain favor for others; or to the detriment of others. A violation of this provision shall be cause for discipline.
- 1.5 Nothing in the Colusa County Policy shall be interpreted or applied in such a manner as to allow an elected official to appoint a family member.
- 1.6 Complaints arising from the implementation or application of this policy will be referred to the human resources department for investigation.
- 1.7 If the investigation alleges misconduct on the part of the elected official, the findings of such investigation will be reported to the board of supervisors and the board shall take whatever action it deems appropriate.
- 1.8 If the investigation alleges misconduct on the part of the employee, the findings of such investigation will be reported to the county administrative officer (“CAO”) and he/she shall take whatever action deemed appropriate. Notwithstanding any other provision of the Colusa County Code, the CAO shall have exclusive authority to discipline the employee for a violation of this policy in the same manner as would normally be exercised by the elected official for discipline imposed under the County’s Discipline Policy No. 323.

1.0 PURPOSE

- 1.1 Military leave is governed by the provisions of the California Military and Veterans Code.

2.0 POLICY

- 2.1 The request of an employee who has permanent status for military leave of absence can be honored by the Director of Human Resources, only if the employee includes with their request a copy of their military orders.

3.0 PROCEDURE

- 3.1 This request is submitted not less than fifteen (15) days prior to the effective leave date unless an emergency arises preventing this.
- 3.2 A copy of the leave papers and the appropriate notification documents is submitted to the Director of Human Resources prior to the effective date of leave.
- 3.3 The granting of leave and payment therefore are not inseparable matters, but are mandatory under certain specific conditions specified by the Military and Veterans Code.
- 3.4 The Director of Human Resources will abide by the Military and Veterans Code in determining the appropriateness of leave and payment.
- 3.5 When the leave is to care for a covered military service member, second and third opinions shall not be required if the first certification was completed by:
 - 1) A United States Department of Defense (DOD) health care provider;
 - 2) A United States Department of Veterans Affairs (VA) health care provider;
 - 3) A DOD TRICARE network authorized private health care provider; or
 - 4) A DOD non-network TRICARE authorized private health care provider.
 - 5) However, second and third opinions may be required when the first certification was completed by a health care provider other than is provided herein.
 - 6) If the leave is requested to care for a covered service member who is a child, spouse, parent, or next of kin of the employee, the employee must provide written certification from the covered service member's health care provider regarding the service member's serious health condition.

7) The written certification required by this section shall be done on DOL forms WH-385 or WH385-V. These forms can be obtained from the Human Resources Department, local offices of the Wage and Hour Division of the Department of Labor, or the Internet at www.dol.gov.whd.

8) In lieu of the DOL forms WH-385 or WH385- V, the employee may submit invitational travel orders or invitational travel authorizations issued to the employee to join a covered military service member at their bedside.

9) Qualifying Exigency: The first time an employee requests leave because of a qualifying exigency, the employee shall provide a copy of the military member's active duty orders, or other documentation issued by the military, which indicates that the military member is on covered active duty or call to active duty status in a foreign country, and the dates of the military member's active duty service. A copy of new active duty orders or similar documentation shall be provided to the Human Resources Department if the need for leave because of a qualifying exigency arises out of a different active duty or call to active duty status of the same or a different military member.

10) If the leave is requested in cases of adoption or foster care placement, the employee must provide written verification, such as an adoptive home study, an adoption placement agreement, or a juvenile court order.

3.6 Benefits While on Leave: Leave under this rule is unpaid unless the employee is using their accrued paid leave concurrently with leave under this rule. While on unpaid leave, an employee will not accrue sick, vacation, or any other leave balances and will not be entitled to holiday or other similar compensation.

1) While on leave provided pursuant to this rule, and if the employee was enrolled in the County's group health insurance at the time the leave commences, the employee will continue to be covered by County's group health insurance for the duration of the leave. The employee is required however, to continue paying the employee's share of premium payments, if, any. Additionally, the County may be entitled to reimbursement of its share of premium payments, from the employee, should the employee fail to return from leave. Cash in-lieu will be paid only during paid status.

2) Any obligation the County may have to maintain health insurance coverage ceases if an employee's premium share is more than thirty (30) days late.

3.7 Return from Leave: Upon expiration of leave, the employee shall be returned to the position of employment held when the leave commenced, or to an equivalent position with equivalent employment benefits, pay, and other terms and conditions of employment.

1) As a condition of return to employment for an employee whose leave was due to the employee's own serious health condition which made the employee unable to perform the essential functions of their job, the employee must obtain, and present to the Human Resources Department, a fitness-for-duty certification from the health care provider stating the employee is able to perform the essential functions of their job, without restriction.

a) If the employee provides the County with certification that accommodations are required as a condition of the employee's return to work, the County will engage in a process with the employee to determine if the employee can be reasonably accommodated.

b) If, at the end of the leave provided for pursuant to these rules, the employee is unable to return to work with or without restrictions, the employee will be given an opportunity to engage in the interactive process with the Human Resources Department regarding the employee's options, if any.

3.8 Key Employees: The County may deny a Key Employee's Medical and Family Leave if:

1) The employee is a Key Employee; and

2) The denial is necessary to prevent substantial and grievous economic injury to the operations of the County; and

3) The County notifies the Key Employee of the intent to deny the Key Employee's request for leave at the time the County determines the denial is necessary; and

4) In the case the leave pursuant to these rules already commenced, the County shall give the Key Employee a reasonable opportunity to return to work following the notice.

3.9 Extension of Probationary Period: An eligible probationary employee who requests and receives leave under this rule shall have their probationary period extended for the full period of the leave taken.

1.0 PURPOSE

1.1 Like all organizations, the county requires order, discipline, and conscientious work performance to succeed and to promote efficiency, productivity, and cooperation among its employees. County employees are required to abide by certain rules and maintain appropriate performance levels and standards of conduct. These rules have been established to protect employees and the county from injury or other threats to its employees' well-being, as well as promote harmonious, efficient working practices. Failure to observe established rules and practices can lead to disciplinary action. The specific disciplinary action will normally be based on an assessment of the facts, the circumstances and the employee's previous record.

2.0 POLICY

2.1 For the purposes of this policy, discipline shall be defined as: (1) a temporary reduction in pay, not to exceed twelve pay periods; (2) a suspension not to exceed thirty days; (3) demotion; or (4) dismissal.

2.2 Causes for which an employee can be disciplined include:

- a) Inexcusable neglect of duty.
- b) Harassing an employee because of membership in a protected group, including but not limited to sexual harassment.
- c) Abusive, disrespectful, offensive, discourteous language or behavior directed at other county employees, which reasonably can be construed as intended to cause emotional distress, including nondiscriminatory "workplace bullying."
- d) Actual or threatened physical violence towards another person.
- e) Dishonesty.
- f) Working overtime repeatedly without a supervisor's approval.
- g) Driving a vehicle on county time without devoting full attention to driving, which can include but is not limited to eating, drinking, applying makeup, reading a map, or talking on the phone. Employees are expected to pull to the side of the road for such activities.
- h) Excessive unauthorized absenteeism, tardiness or other attendance problems.
- i) Unauthorized uses of county property.
- j) Intentional or repeated violations of safety rules.

- k) Possession or use of dangerous or unauthorized materials, such as explosives, firearms, or other similar items, while on county property, while on duty, or while operating a vehicle leased or owned by the county.
- l) Possession, distribution, sale, use, or being under the influence of alcoholic beverages or illegal drugs while on county property, while on duty, or while operating a vehicle leased or owned by the county.
- m) Smoking in restricted areas or where nonsmoking signs are posted.
- n) Conduct disrupting county activities.
- o) Excessive personal use of the telephone while on duty.
- p) Theft or unauthorized removal or possession of property from county, fellow employees, constituents, or anyone on county property.
- q) Insubordination or refusing to follow instructions.
- r) Unsatisfactory performance, including quantity and quality of work product.
- s) Violating a confidence placed with the employee in association with his/her job.
- t) Conviction of a felony bearing a reasonable relationship to the employee's position. A plea or verdict of guilty, or a conviction following a plea of nolo contendere, to a charge of felony is deemed to be a conviction within the meaning of this provision.
- u) Failure of an employee who is or has become a relative/spouse of another employee within the same department to disclose the relationship in writing to the appointing authority.
- v) Refusal to take and subscribe any oath or affirmation which is required by or in connection with his/her employment.
- w) Engaging in any outside employment, activity or enterprise for compensation which is inconsistent, incompatible, in conflict with or inimical to his/her duties as a county officer or employee or with the duties, functions, or responsibilities of the appointing authority.
- x) Using for private gain or advantage county time, facilities, equipment or supplies or his/her badge, uniform, prestige or influence as a county officer or employee.

y) Accepting any reward, favor, or other form of remuneration for the performance or nonperformance of his/her job duties or anticipation of such performance or nonperformance of his/her job duties from any vendor, contractor, individual, and/or private or public organization.

z) Acquiring a financial interest in any new or existing business venture or business property at a time when the employee believes or has reason to believe that the business or property will be directly affected by his/her official duties.

aa) Inappropriate or disrespectful treatment of the public which we serve.

2.3 This is a partial list and is not intended to reflect all behavior for which discipline may occur, nor is the placement of a cause on the list indicative of the seriousness of the cause.

3.0 Procedure

3.1 Prior to suspending, demoting or dismissing (collectively referred to herein as “discipline” or “disciplined”) an employee, the appointing authority shall contact and discuss such action with the Human Resources Director, except:

a) Any employee who reports to work and based on objectively reasonable suspicion is believed to be under the influence of alcohol or illegal drugs will be transported home as medically unfit for duty and may use any accumulated leave s/he has to cover the absence from work.

b) Before being transported home, an employee who challenges the determination s/he is unfit will be provided an opportunity that day, as soon as possible, to establish the suspicion is unfounded by having his/her blood or urine tested at the Colusa County department of public health or other approved laboratory meeting United States Department of Transportation (“DOT”) standards. The laboratory shall perform the least intrusive test needed to determine the presence of alcohol/drugs in accordance with the protocol established by the United States Department of Transportation for drug/alcohol tests.

3.2 In the event the test is positive for drugs or alcohol:

a) The employee will be immediately suspended without pay for five days by his/her supervisor.

b) The employee may request a retest in accordance with the DOT protocol.

c) In the event the retest is negative, the employee will be reimbursed for all lost wages arising from suspension and their initial removal from work.

d) In the event the retest is positive, the five-day suspension will stand and the employee will be subject to further disciplinary action as discussed in sections 3.5 through 3.8 of this policy.

e) An employee who elects not to submit to a test waives his/her right to challenge the determination s/he was medically unfit for duty due to drugs or alcohol and will be subject to further disciplinary action as discussed in sections 3.5 through 3.8 of this policy.

- 3.3 An employee in the possession of unauthorized firearms or explosives shall be immediately suspended without pay for five days by his/her supervisor subject to further disciplinary action as discussed in sections 3.5 through 3.8 of this policy.
- 3.4 After consultation between the appointing authority and the Human Resources Director, the Human Resources Director may direct that an employee be placed on administrative leave with pay status pending the results of an investigation into the alleged misconduct for no more than twenty work days. The Human Resources Director may extend the administrative leave for good cause.
- 3.5 If, following discussion and/or investigation, the appointing authority concludes that discipline, as defined in section 2.1 of this policy, is appropriate, the appointing authority or his/her designee shall immediately provide a notice of intent to discipline to the affected employee. At a minimum, the notice of intent to discipline shall include a statement of the proposed discipline, the facts and circumstances giving rise to the discipline, the specific cause(s) for the discipline as defined in section 2.2 of this policy, all the materials upon which the proposed discipline is based, notice of the employee's right to respond before the discipline is implemented, and instructions for filing a pre-disciplinary response.
- 3.6 The notice of intent to discipline will be personally served on the employee by the appointing authority or his/her designee. If personal service upon the employee is impossible, a copy of the notice of intent to discipline will be sent by first-class mail to the employee at his/her last known address.
- 3.7 Subject to the limitations of this policy, an employee who receives a notice of intent to discipline may respond to the notice either orally or in writing or by both methods. An employee who wishes to respond must initiate the pre-disciplinary review process by contacting the personnel director within seven days after service of the notice of intent to discipline to schedule a meeting. In the alternative, an employee who does not wish to attend a pre-disciplinary meeting may submit a written response to the Human Resources Director within seven days after service of the notice of intent to discipline. If the affected employee does not contact the Human Resources Director within seven days after service of the notice of intent to discipline, the appointing authority may implement the proposed discipline.

- 3.8 Upon being contacted by an employee who has received a notice of intent to discipline, the Human Resources Director shall initiate the pre-disciplinary hearing process as follows: (1) the Human Resources Director will either serve as the pre-disciplinary hearing officer or will designate another person who was not involved in the development of the disciplinary recommendation to so serve; (2) either the Human Resources Director or designee will contact the affected employee within seven days to schedule a meeting at which the employee will be afforded the opportunity to make oral presentations and to present written materials; (3) in the alternative, the employee may waive the pre-disciplinary meeting and respond only in writing. However, upon reviewing written materials submitted by the employee, the Human Resources Director or designee may request that a meeting be scheduled; and, (4) following the pre-disciplinary meeting and/or the submission of written materials by the affected employee, the Human Resources Director or designee will prepare a written report which will be submitted to the appointing authority. At a minimum, this report will include a summary of the employee's presentation and copies of any materials submitted by the employee. The report may include the recommendations of the Human Resources Director or designee.
- 3.9 Upon receipt of the Human Resources Director's or designee's report the appointing authority may take whatever action he/she deems appropriate. Such action may include but is not limited to the following: additional investigation/inquiry; reduction of the discipline; or implementation of the noticed discipline. If the appointing authority decides to move forward with discipline, as defined in section 2.1, he/she will issue a notice of discipline to the affected employee. At a minimum, the notice of discipline shall include a statement of the discipline to be imposed, the facts and circumstances giving rise to the discipline, the specific cause(s) for the discipline as defined in section 2.2, notice of the employee's right to appeal and instructions for filing a timely appeal.
- 3.10 If, following the pre-disciplinary hearing process described in sections 3.7 and 3.8 of this policy, the appointing authority authorizes additional investigation/inquiry pursuant to section 3.9 of this policy, and the appointing authority still intends to implement discipline pursuant to section 3.5 of this policy, an amended notice of intent to discipline will be issued. In addition to the content required by section 3.5 of this policy, the amended notice of intent to discipline will detail the results of the additional investigation/inquiry. An employee who receives an amended notice of intent to discipline may reinitiate the pre-disciplinary hearing process pursuant to section 3.7 of this policy.
- 3.11 At any time during the pre-disciplinary process, the parties may seek to identify a mutually acceptable alternative to the originally noticed disciplinary action. If mutual agreement is reached, the details of the agreement will be reduced to writing and will be signed by the appointing authority, the affected employee and, if the employee is represented, the employee's representative.

- 3.12 The employee's right to representation shall apply throughout pre-disciplinary proceedings. Except for the signing of an agreement reached pursuant to section 3.11 of this policy, any privileges extended to or obligations placed upon the employee during the pre-disciplinary process may be exercised on the employee's behalf by his/her designated representative.
- 3.13 An employee who receives a notice of discipline issued pursuant to section 3.9 of this policy may appeal the disciplinary action to the Board of supervisors by filing a written notice of appeal addressed to the Human Resources Director within seven days following service of the notice of discipline. The timely filing of an appeal does not stay the disciplinary action. In the absence of a timely filed appeal, the disciplinary action will be final.
- 3.14 Within five days following receipt of the appeal, the Human Resources Director will request a list of five hearing officers from the state agency providing such services.
- 3.15 Immediately upon receipt of the list of potential hearing officers, the Human Resources Director will coordinate the scheduling of a meeting of the parties, which may be held telephonically. The purpose of the meeting will be to select a hearing officer.
- 3.16 First, the parties will attempt to mutually agree to a hearing officer, whose name need not appear on the list provided.
- 3.17 If unable to mutually agree, the parties will select the hearing officer by alternately striking names from the list until only one name remains, with the first to strike to be determined by lot.
- 3.18 Upon selection, the hearing officer will coordinate the scheduling of the appeal hearing which will be conducted in accordance with California Government Code Policy [11513](#). Normally, the hearing officer will schedule the hearing to begin within thirty days of his/her selection. If the hearing officer is not available to begin the hearing within forty-five days of his/her selection, either party to the appeal may reinitiate the selection process described in section 3.15 of this policy.
- 3.19 The burden of proof shall be assigned to the county. The standard of proof shall be a preponderance of the evidence.
- 3.20 At the conclusion of the hearing, the hearing officer will take the matter under submission. Within thirty days following the close of the hearing, the hearing officer will submit a written report to the Board of supervisors which shall be advisory only. The hearing officer's report shall include findings of fact and recommendations.

- 3.21 The hearing officer will cause his written report and a complete record of the hearing to be delivered to the Clerk of the Board with copies delivered to the parties to the appeal, county counsel and the personnel director.
- 3.22 Upon receipt of the hearing officer's advisory report and the record of the hearing, the matter will be placed on the Board's agenda as a closed session item for discussion at its first regular meeting following receipt of the materials. The Board will take the matter under advisement.
- 3.23 Within forty-five days of the closed session, the Board will issue its decision, which shall be in writing and will be delivered to the parties to the appeal, county counsel, the personnel director and the appropriate appointing authority.
- 3.24 The Board's decision may be based on the hearing officer's findings and recommendations, or may be based on the Board's independent review of the record, including the transcript of the proceeding, or may be based on a combination of both.
- 3.25 In response to the appeal and consistent with its findings of fact, the Board may uphold, modify or overturn the discipline.
- 3.26 Copies of the Board's written decision will be provided to all interested parties, including but not limited to the parties to the appeal, county counsel, the personnel director, the appropriate appointing authority, and the employee's recognized exclusive employee organization.
- 3.27 If the Board's decision is to do anything other than adopt the hearing officer's findings of fact and recommendation, the decision will be issued as a tentative ruling. The parties to the appeal may, within ten days of receipt of the tentative ruling, file written comments which will be considered by the Board in closed session at its next regularly scheduled meeting. A copy of comments to be filed with the Board will be provided to the opposing party at least five days before the close of the ten-day filing period. In response to written comments received, the Board may:
- a) Issue a modified decision which shall be final upon distribution; or
 - b) Take no action, in which case the Board's tentative ruling shall become final upon redistribution as the Board's decision.
- 3.28 If no written comments are filed pursuant to section 3.27 of this policy, the Board's tentative ruling will be final with no need for further action by the Board.
- 3.29 At the conclusion of the appeal process, the matter will be referred back to the Human Resources Director, who shall certify that the Board's decision has been

finalized pursuant to the provisions of sections 3.27 through 3.25 of this policy and who shall coordinate implementation of the Board's decision.

- 3.30 All of the records in an appeal shall be remanded to the Clerk of the Board for filing.
- 3.31 Except as may otherwise be specified or mutually agreed upon, all costs of representation and participation in the proceedings shall be borne by the party incurring the cost.
- 3.32 The disciplinary procedures described in this policy shall be adhered to in all instances where discipline is contemplated and/or administered for all employees except:
- a) Appointed department heads, who are at-will employees and who serve at the pleasure of the Board, may be disciplined without cause and with no right to appeal. Appointed department heads will be provided a minimum of two weeks' notice before termination.
 - b) The Agricultural Commissioner, County Counsel and Sealer of Weights and Measures may be disciplined pursuant to the terms of their contracts and/or State Code.
 - c) A Deputy County Counsel is an at-will employee who serves at the pleasure of the County Counsel and may be disciplined without cause and with no right to appeal. A Deputy County Counsel shall be provided a minimum of two weeks' notice before termination.
 - d) First-time elected department heads within the first six months of office may remove incumbent assistant department heads and a chief deputy or Undersheriff, who will have no right of appeal. Any employee displaced by this provision may assume his/her former position with the county if the position continues to exist and s/he has seniority over the incumbent or such other open position within county service for which s/he is qualified and has seniority.
- 3.33 Nothing in this policy is intended to deprive any employee of any right s/he has at law.
- 3.34 For those employees who are covered by the Peace Officers' Procedural Bill of Rights Act, nothing in this policy will be interpreted, administered or applied inconsistent with the requirements of the Act.

1.0 PURPOSE

- 1.1 To describe reclassification and its effect on salary level, performance/merit review date, and employee status.
- 1.2 Reclassification is the reallocation of a position in one class to a different class as a result of a significant change in the duties, responsibilities, and/or qualification requirements of the position.

2.0 POLICY

- 2.1 It is the responsibility of department heads and immediate supervisors to ensure that employees perform work duties and responsibilities within the framework of the employee's assigned classification as described in the established classification specifications. Requests for review of the classification of a position may be initiated by a department or an employee, and shall proceed through the departmental chain of command for approval.
- 2.2 Requests will fall outside the budget cycle and will be due as follows:
 - June 1 of each year for midyear adjustment consideration
 - December 1 of each year for annual budget adjustment consideration

3.0 PROCEDURE

- 3.1 The department/employee shall complete a Position Classification Study Request Form. The department head can approve or deny the request and shall prepare a preliminary evaluation and/or justification. The request shall be forwarded to the Human Resources Department within ten (10) working days from date of receipt with comments and recommendations.
- 3.2 The Human Resources Department shall preliminarily review all requests and then forward to the County Administrative Officer (CAO) for review and approval. The CAO shall review each request and department evaluation. If approved, the Human Resources Department shall commence the study. If denied, the Human Resources Department notifies the requesting department head.
- 3.3 Upon receipt of the approved request from the County Administrator's Office, the Human Resources Department will prioritize, schedule, and conduct an appropriate classification study and advise the department head of the results.
- 3.4 The Human Resources Department shall determine the appropriate method(s) and/or evaluation tools to be utilized in making an effective analysis and recommendation.
- 3.5 The Human Resources Department presents the reclassification study results to the CAO who approves or denies the recommendations.

- 3.6 The CAO notifies the department head of the disposition of the reclassification study. Any approved recommendations for reclassification action will be included by the department in their annual budget proposal or midyear adjustments.
- 3.7 Following Board of Supervisors' approval, the Human Resources Department will prepare a Notice of Appointment and/or Personnel Action Form to enact the approved classification action. Reclassifications will be effective the beginning of the next fiscal year or at midyear (depending on the submission timeline or when agreed upon by the CAO, Board and any bargaining units).
- 3.8 Under special and/or time sensitive circumstances, the CAO may grant exceptions to the normal study cycle. This may occur when a request is made by a bargaining unit to study a position. In this event, the Human Resources Department shall make appropriate recommendations concerning the reclassification request, and with CAO approval, shall implement the recommended action as soon as practical with final adjustments to the budget made at mid-year or fiscal year budget, reflecting the reclassification.
- 3.9 A reclassification, if granted, may result in: a change of class title and class specification for a position by either moving the position to another existing class in the Classification Plan or to a new class specifically created for the position; or placement of the position in a salary range with a maximum salary rate that may be higher, lower or the same level as previously held.
- 3.9.1. Upward Reclassification - In any case where a position is reclassified to a class with a salary range having a higher maximum salary rate, and the incumbent meets the qualification requirement for the new class, and is in fact performing the full range of duties and responsibilities of that position, the effect of this action shall be as follows:
- 3.9.1.1 Effective Date - The effective date of a reclassification action shall normally coincide with the first working day of the first pay period following the date of Board meeting (except under special circumstances approved by the CAO).
- 3.9.1.2 Salary - The incumbent shall be entitled to the closest higher step within the new salary range that would provide a minimum of a 5% increase, not to exceed the maximum of the range.
- 3.9.1.3 Merit Increase Date - The incumbent's date for the next merit increase shall be set one year from the effective date of the reclassification.
- 3.9.1.4 Employee Status/Review Date - A new probationary period is not required. The incumbent's date for the next performance review shall be set one year from the effective date of the reclassification.

3.9.2. Downward Reclassification - In any case where a position is reclassified to a class with a salary range having a lower maximum salary rate, the effect of this action shall be as follows:

3.9.2.1 Effective Date - The effective date of a reclassification action shall normally coincide with the first working day of the first pay period following the date of Board approval (except under special circumstances approved by the CAO).

3.9.2.2 Salary- The incumbent shall either:

- a) Retain current salary if current salary is the same as a step within the salary range of the new class; or
- b) Be placed on the closest step within the salary range of the new class that approximates the current salary if the current salary is between steps within the new salary range; or
- c) Be reduced to the maximum step of the salary range of the new class if current salary is greater than the maximum of the new salary range; or
- d) Be assigned a "Y" rate designation that holds the incumbent at a current salary which is above the new range until such time as the salary rate of the new class is the same as or exceeds the amount of the "Y" rate. Establishment of a "Y" rate is an administrative determination and requires approval of the department head, Director of Human Resources, and CAO. This option may be considered in cases where there is a slight discrepancy in pay of 5% or less.

3.9.2.3 Merit Increase Date - There shall be no change in the incumbent's merit increase date as a result of downward reclassification. If applicable, merit increases shall occur according to regular County Compensation Plan or MOU agreement.

3.9.2.4 Employee Status/Review Date - A new probationary period is not required in a downward reclassification and/or if the demotion is the result of a convenience to the County (e.g. reorganization). The incumbent's date for the next performance review shall be set one year from the effective date of the reclassification (see Probation and Probationary Periods rules).

3.9.3. Lateral Reclassification - In any case where a position is reclassified to a class with a salary range having the same maximum salary rate, the effect of this action shall be as follows:

3.9.3.1 Effective Date - The effective date of a lateral reclassification action shall normally coincide with the first working day of the first pay period following the date of Board approval (except under special circumstances approved by the CAO).

3.9.3.2 Salary - There shall be no change in salary.

3.9.3.3 Merit Increase Date - If applicable, merit increases shall occur to the maximum of the salary range for the new class according to regular County Compensation or MOU agreement.

3.9.3.4 Employee Status/Review Date - When the lateral reclassification is intradepartmental, a new probationary period is not required.

**COLUSA COUNTY
DRIVING POLICY**

POLICY NUMBER: 501
DATE ADOPTED: 5 May 1998
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First Adopted: 5/5/1998

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Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

COLUSA COUNTY DRIVING POLICY

POLICY NUMBER: 501
DATE ADOPTED: 5 May 1998
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I. PURPOSE

The purpose of this policy is to define the responsibilities and rules for the use of County vehicles and equipment, and privately owned vehicles used for County business. This policy applies to County officers, employees, and other authorized individuals as specified in this policy. This policy supersedes all previous County vehicle policies and resolutions of the Colusa County Board of Supervisors related to these topics.

An exception to this policy shall be made for the Sheriff's Department as a result of its unique law enforcement function. The Sheriff's Department will develop and enforce its own written policy, a current copy of which shall be on file with the Risk Manager. This policy shall guide vehicle utilization of employees of the Sheriff's Department and other County employees engaged in law enforcement activities that are under the direction of the Sheriff.

II. DEFINITIONS

- A. **Authorized County Driver** - Employees whose job description and/or assigned duties require the operation of a motor vehicle
- B. **Code of Safe Practices** - List of safe workplace practices.
- C. **County Employees** - Persons who have completed all prerequisites to County employment. This includes all Elected Officials, Department Heads, Employees, and persons on volunteer status. This also includes the University of California Employees/COOP Extension.
- D. **County Vehicles** - Vehicles owned by the county and driven in the performance of, or necessary to, or in the course of, the duties of County employment.
- E. **Defensive Driving** - Driving to prevent an accident in spite of the incorrect action of others and adverse driving conditions.
- F. **DSR** - Department Safety Representative.
- G. **Privately Owned Vehicle (POV)** - Vehicles owned by the employee and driven in the performance of, or necessary to, or in the course of, the duties of County employment.
- H. **Safety Restraints** - Includes seat belts, shoulder harnesses, and child restraints.

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I. **Special Equipment** - Hi-lifts, high rangers, graders, mowers, cranes, or any unit which has special devices added for specific kinds of work.

J. **Vehicle Incident** – Any occurrence involving a motor vehicle occurring in a place of employment or in connection with any employment, resulting in, or having the potential for injury, illness, or property damage in excess of \$500.00.

III. RESPONSIBILITIES

A. **BOARD OF SUPERVISORS:**

The elected board of supervisors assigns the responsibility for the implementation of and compliance with this policy to the County Risk Manager.

B. **RISK MANAGER:**

1. Ensure that department heads, supervisors and employees fully implement and comply with this policy.

2. Ensure Department of Motor Vehicle license and medical certificate checks (for classes of licenses requiring such certification) be made regularly on safety sensitive employees who drive a vehicle on county business.

C. **SAFETY OFFICER:**

1. Provide support to county departments in the implementation of this policy.

2. Monitor all aspects of this policy and provide periodic status reports to the Risk Manager and/or County Board of Supervisors as requested.

3. Provide support to Department Safety Representatives in implementation of this policy.

4. Upon written request, may grant temporary driving privileges, to newly hired employees, prior to the Four Hour Defensive Driving Course being offered for the first time after the date of hire.

5. Will maintain records to assist the Department Heads in compliance with this policy and shall notify each department of their non-compliance employees before each Defensive Driving Course.

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D. DEPARTMENT HEADS:

1. Shall inform all employees of this policy standard and ensure employees acknowledge the reading of same by signing an "Acknowledgment of County Driving Policy" which shall be retained in the employee's personnel file.
2. Ensure that their supervisors and employees fully implement and comply with this policy.
3. Ensure the completion of the Incident/Hazard form resulting from a Vehicle Involved Incident.
4. Shall check with the Human Resources Director to ensure job descriptions for classifications requiring a drivers' license state that employees must continue to meet the established driving standards and that it is a condition of employment for that position.
5. Shall ensure driving standards are enforced consistently and fairly among all employees working in classifications where driving is required.
6. Are responsible for verifying that employees who drive on County business have a valid driver's license and that the license is the appropriate license for the vehicle(s) they are operating.
7. Are responsible for verifying that employees who drive their POV on County business have auto insurance. A copy of the insurance certificate will be filed with the County Clerk Recorder annually.
8. Shall ensure that all county vehicles have a county insurance card in the glove compartment. When departments procure a new vehicle, they will call Risk Management to get an insurance card for said vehicle.
9. Shall ensure that all new employees, including permanent and part time, who drive on County business, successfully complete the County sponsored Four Hour Defensive Driving Course within 30 days of hire.
10. Shall ensure that all employees, whether permanent or part time who drive on County business, successfully complete the County sponsored Two Hour Defensive Driving Refresher Course every two years following completion of the four hour course.

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11. Shall provide the County Safety Officer with a listing of all County Employees, both permanent and part-time, who will drive on County business, whether they use a County car or a POV.

E. SUPERVISORS:

1. Will ensure that before the initial use of any vehicle each day, the driver will walk around and inspect the vehicle. The inspection should include:

- a. Mirrors
- b. Steering
- c. Horn
- d. Overall cleanliness
- e. Brakes
- f. Fluid levels to include fuel.
- g. Lights and reflectors (if driving at night)
- h. Emergency equipment
- i. Tires

2. Ensure employees do not operate a County vehicle that appears unsafe. Supervisor will ensure that appropriate action is taken to correct any problems found while conducting the walk-around of the vehicle.

F. EMPLOYEES:

- 1. Employees shall comply with all provisions of this policy.
- 2. Employees shall operate all motor vehicles in accordance with state laws.
- 3. A valid driver's license, appropriate for the vehicle operated, must be in the possession of the operator any time a County vehicle is operated.

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4. If an employee's license is suspended for any reason, he or she must inform her/his supervisor immediately.

5. Employees will not engage in unsafe practices, including failure to use and to ensure that all passengers use all available safety restraints in the vehicle being operated. This requirement does not apply to motorcycles or to disabled individuals who cannot wear safety belts. Any defective safety belt shall be immediately reported to the employee's immediate supervisor.

6. Safety Restraints shall be worn by all occupants in the vehicle at all times when the vehicle is in motion. If children are being transported, they must be in the proper child restraint.

7. Vehicles are to be maintained in a safe operating condition. Unsafe vehicles are not to be driven. The employee is responsible for inspecting the vehicle prior to driving off the parking lot and for reporting any hazards to her/his supervisor immediately.

8. All employees who drive on county business shall be re-certified in the Defensive Driving Course offered by the Safety Officer every two years.

9. All new employees who require driving in the course of their employment are required to attend a Four Hour Defensive Driving Course offered by the Safety Officer within 30 days of hire.

10. Shall drive responsibly, anticipate emergency situations and make every effort to avoid accidents in the performance of their duties.

G. DEPARTMENT SAFETY REPRESENTATIVES (DSR):

1. Provide support within their department in the implementation of this policy.

2. Monitor all aspects of this policy within their department.

IV. DRIVING RULES AND REGULATIONS

A. Only county employees may drive county vehicles. Employees may not loan or lease a County vehicle to any non-county entity.

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- B. All drivers of county owned vehicles or those using their own vehicles pursuant to county business will comply with all applicable laws of the State of California.
- C. County vehicles are to be used for official business only.
- D. No employee, under any conditions, shall operate a vehicle or combination of vehicles if under the influence of illegal drugs and/or alcohol. If the employee is taking over the counter medication, said employee will ensure medication does not impact their ability to drive a vehicle in a safe manner.
- E. Smoking is prohibited in all county vehicles including special equipment vehicles.
- F. County vehicles will not be parked in "No Parking" zones except in an emergency situation.
- G. No county vehicle of any type will be left unattended with the ignition key left in the ignition.
- H. When leaving a vehicle, set the parking brake and lock the doors.
- I. No vehicle will be in motion day or night with only its parking lights on.
- J. If it is necessary to use your windshield wipers, you will also ensure that your head lights are on.
- K. During periods of limited visibility, headlights will be turned on.
- L. The driver will ensure that windows, headlights, tail lights and wipers are clean and in operating order at all times.
- M. If a vehicle does not have a tailgate but is loaded, the driver of the vehicle will ensure that the load is secure and that overhangs are properly flagged in accordance with state law.
- N. Backing of vehicles when the driver does not have a clear view of the entire area behind the vehicle will be done with the assistance of a spotter. If a second person is in the vehicle he will get out and guide the vehicle using appropriate hand and voice signals. If the driver is alone he will get out of the vehicle and inspect the area behind before backing and then back with extreme caution.

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- O. Riding on the sides, tool boxes, running boards, tailgates, on roof, and/or standing or riding in the back of any truck or pick-up is prohibited
- P. Posted speed limits will be obeyed.
- Q. Drivers will direct their full attention to driving while their vehicle is in motion. Necessary inspections, such as street, trees, signs, etc., will be made only when the vehicle is at a complete stop.
- R. Trailers are to be fastened securely to hitches according to prescribed safety standards for the equipment being towed.
- S. All items which might be transported either in a truck or trailer, which can move around during transport, will be secured.
- T. If your vehicle appears to have an unsafe operating condition, contact your supervisor or department head.
- U. Employees must expect reckless, illegal and clumsy behavior on the part of other drivers and be prepared to adjust their driving to prevent accidents.
- V. Be especially courteous to pedestrians regardless of whether or not they have the right-of-way. Watch carefully for erratic behavior by children.
- W. Learn to recognize the hazards rural roads present.
- X. Employees with three at-fault accidents and/or moving violations within the last two years may not be allowed to drive in the course of their employment. In addition, the county may implement disciplinary action up to and including termination of employment if an employee is unable to perform the responsibility of operating a motor vehicle, if the position requires it.
- Y. Employees having any of the following within the last three years shall be prohibited from driving in the course of their employment and may be subject to disciplinary action up to and including termination of employment:
 - 1. Driving while under the influence (DUI) offense; or
 - 2. Driving while license is suspended or revoked offense; or
 - 3. Two reckless driving or speed contest violations; or

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4. A combination of any two of the offenses named in 1, 2 and 3 above.
5. Hit and Run.
6. Homicide, assault or manslaughter arising out of the operation of a vehicle.

V. DRIVING COUNTY VEHICLES ON COUNTY PROPERTY

A. Employees who are required to drive any county vehicle (including forklift, cart, and other types of motor vehicles) within the perimeters of the county property shall also be subject to those minimum eligibility standards indicated above in addition to the following:

1. Employees with three vehicle accidents within three years that involve county vehicles shall be subject to disciplinary action up to and including termination of employment if it is determined by the county that the accidents or damage to the county property or vehicle was preventable.

VI. DRIVING PERSONAL VEHICLES ON COUNTY BUSINESS

A. The operation of a county owned vehicle or a personal vehicle on county business may be a requirement of an employee's work performance. All standards for obtaining and maintaining a California Drivers License, as set forth in the Vehicle Code, are adopted as the standard for operation of all county owned vehicles and for the operation of personal vehicles when operated in the course of county business.

VII. CELL PHONE USE WHILE DRIVING

- A. Talking on a cell phone or texting on a cell phone while driving a vehicle on County time is prohibited. Employees and volunteers are expected to pull to the side of the road for such activities.
- B. Employees and volunteers will not write, send, or read text-based communication on an electronic wireless communications device, such as a cell phone, while driving a motor vehicle while on county business.

HISTORY

First Adopted: 5/5/1998

Amended: 5/5/2009, 8/25/115

Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

**COLUSA COUNTY
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VIII. COMMON CAUSES OF VEHICLE ACCIDENTS

A. Most accidents are caused by the following operator errors:

1. Following too closely: This dangerous habit results in the most serious accidents. Injury to the back and neck, often irreparable, is common in this type of collision. Employees operating a vehicle must be aware of their situation at all times, anticipate potential problems, and provide adequate spacing for other vehicles.
2. Improper lane changes: The lane change is always a hazardous movement. It should only be done with extreme caution and alertness. Traffic laws generally give the vehicle in a traffic lane the right of way over other vehicles. Always use the mirror and look around to verify that the lane is clear.
3. Improper backing: Backing up is generally considered the most dangerous maneuver in vehicle operation. Thorough training is needed on all aspects of backing including backing from a parking space, proper use of mirrors, proper clearance, and general attentiveness.
4. Improper parking: All County vehicles shall be properly parked in legal spaces, except in an emergency situation or when necessary for service or repair work. Vehicles will not to be left running or keys left in the ignition when the vehicle is unattended.

IX. REPORTING OF ACCIDENTS/TICKETS INVOLVING COUNTY VEHICLES

- A. Should the operator of a county vehicle be involved in an accident, the appropriate law enforcement agency shall be called to the scene to make a report when the accident results in personal injury or when property damage exceeds \$500.00.
- B. Employees shall immediately report to her/his department head any vehicle accident or incident. Failure of the employee to report such an occurrence may result in disciplinary action up to and including termination of employment. All damage to county property shall be reported verbally, as soon as possible, to the department head or employee's immediate supervisor and shall be followed by a written report. All information, including witness information, damage incurred, etc., shall be included.

HISTORY

First Adopted: 5/5/1998

Amended: 5/5/2009, 8/25/115

Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

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C. Drivers of county-owned vehicles will give the driver's license information to the other party and state that all communications regarding losses, injuries, etc., are to be directed to the Colusa County Risk Manager, 546 Jay Street, Suite 202, Colusa, California.

X. VEHICLE ACCIDENT PROCEDURES

A. The following procedures are to be followed when an accident occurs, whether or not there is property damage or personal injuries:

1. Immediately **report the accident** to your supervisor and to Risk Management.
2. A Vehicle Incident Form (attachment 1) and an Incident Hazard Report Form (attachment 2) must be completed and sent to Risk Management as soon as possible.
3. Give the location, make, model, type and color of vehicle, extent of damage, and the license number of the vehicle struck.
4. Place warning triangles and/or traffic cones to protect the scene, if available and able to do so.
5. Make no comments or statement regarding the accident, or vehicle damage except to law enforcement personnel, the employee's supervisor, and to Risk Management.
6. If the employee hits an unoccupied vehicle while driving a County vehicle and the owner cannot be located, the employee should leave a note on the damaged vehicle stating the employee's name along with the County name, address and phone number.
7. The operator of the county vehicle, or the police officer, must obtain the following information from the driver(s), passenger(s), and witnesses:
 - a. Name(s), addresses and phone numbers.
 - b. Driver license numbers (from drivers)
 - c. Vehicle license numbers (if applicable)
 - d. Insurance carrier

HISTORY

First Adopted: 5/5/1998

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Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

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DATE ADOPTED: 5 May 1998
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8. If the accident occurs after hours or during the weekend,
 - a. Contact your supervisor immediately.
 - b. If your auto is damaged and needs to be towed, your supervisor will inform you of the following:
 - (1) Where to tow the vehicle
 - (2) What credit card to use
 - c. Attachments 1 and 2 must be submitted to the Supervisor and Risk Management the first workday following the event or when the injured party is able to give a statement of the occurrence.
 - d. If injuries are involved:
 - (1) Notify the local paramedics and law enforcement at 911.
 - (2) Inform the 911-dispatcher that there are injuries and to send an ambulance, if necessary.
 - (3) If able to do so, render first aid to all injured parties.
 - (4) Do not move vehicles until directed to do so by law enforcement unless it is necessary to prevent further accident or injuries.
 - (5) Except for the injured party, do not leave the scene until law enforcement arrives to make a report of the incident and injuries incurred.
 - (6) If you are injured, make sure you fill out the Workers' Compensation Forms and give them to your supervisor. Your supervisor will send them to Risk Management.

XI. DRIVING UNDER THE INFLUENCE OF ALCOHOL, DRUGS AND MEDICATION

- A. Employees shall not operate motor vehicles while under the influence of alcohol, drugs, or medication that may affect driving proficiency.

HISTORY

First Adopted: 5/5/1998

Amended: 5/5/2009, 8/25/115

Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

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B. Employees who are on call shall not consume intoxicating beverages or take medications which can affect driving while on call. If a call to return to work is received by an employee who is not on-call and he/she has partaken of alcohol, drugs, or is on medication which affects driving, the employee shall notify her/his supervisor who will contact another employee.

XII. SPECIAL EQUIPMENT

A. Special equipment such as hi-lifts, high rangers, graders, mowers, cranes, or any unit which has special devices added for specific kinds of work, will require formal training and instruction prior to use by a driver.

B. Passengers will ride only in seats designated for passengers. Employees riding in the back of crew trucks will remain seated when the vehicle is in motion.

C. Use of special equipment without training or authorization or the willful violation of any of these rules will result in disciplinary action up to and including termination of employment.

D. Employees are prohibited from using cell phones while operating special equipment.

E. Smoking is prohibited in all county vehicles including special equipment.

XIII. INCIDENT RESPONSE

A. Notify appropriate law enforcement agency.

B. Immediately notify the County Safety Officer.

C. Immediately notify their designated Department Safety Rep.

D. Immediately respond to the incident site.

E. Remain at the scene (unless injured) until the investigation is completed and/or has been released by Law Enforcement or the Vehicle Incident Investigation Team.

F. Do not disturb incident scene (except to prevent further injury or damage or if ordered to do so by law enforcement authorities) until all of the following have been completed:

HISTORY

First Adopted: 5/5/1998

Amended: 5/5/2009, 8/25/115

Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

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1. The arrival of the immediate supervisor.
2. In the event the incident takes place out of county and/or in a location not readily accessible by the immediate supervisor, the supervisor will direct the involved authorized county driver to follow direction of law enforcement and then await instructions in a safe and secure location.
3. The arrival of the County Safety Officer or designated person.
4. The arrival of the DSR or alternate.
5. The entire scene has been photographed.
6. Involved employees and witnesses have been interviewed

XIV. TRAINING

A. New Employees:

1. Including permanent and part time who drive on County business will successfully complete the County sponsored Four Hour Defensive Driving Course within 30 days of hire.

B. All Other Employees:

1. Including permanent and part time who drive on County business will successfully complete the County sponsored two hour Defensive Driving Refresher Course every two years after completing the four hour course.

XV. RECORDKEEPING

A. Records required by Colusa County will be maintained as follows:

1. The Safety Office will maintain:
 - a. A copy of all sign-in sheets
 - b. A training spreadsheet with dates of training for all county employees.

HISTORY

First Adopted: 5/5/1998

Amended: 5/5/2009, 8/25/115

Corrected numbering issue: 9/8/15, see Supervisors Minutes 9/8/15, Page 207.

POLITICAL ACTIVITIES OF COUNTY EMPLOYEES POLICY

<u>POLICY NUMBER:</u> 505
<u>DATE ADOPTED:</u> January 5, 1999
<u>PAGE 1 of 1</u>

I. GENERAL

The Board of Supervisors recognizes the right of employees to participate directly or indirectly in the establishment, policy, or administration of the affairs of government. In order to promote efficiency, integrity, and discipline of public service during working hours and on county premises the following policy is established.

II. POLICY

- A. Appointed officers and employees of the County are prohibited from engaging in political activities during working hours or on the premises of the county.

The term "working hours" does not include vacation, leave time, or standby time, but shall include rest periods and lunch periods while on county premises.

- B. The public, all elected and appointed County officials, and all employees of the County are prohibited from the use of County offices, work stations, and/or property for political activities except as permitted by law.

POLICY OF THE COLUSA COUNTY BOARD OF SUPERVISORS

HISTORY

First Adopted: January 5, 1999

Amended:

Political Activities of Public Employees - Government Code 3201 - 3209

The Legislature finds that political activities of public employees are of significant statewide concern. The provisions of this chapter shall supersede all provisions on this subject in the general law of this state or any city, county, or city and county charter except as provided in Section 3207.

(Repealed and added by Stats. 1976, Ch. 1422.) GC 3201

This chapter applies to all officers and employees of a state or local agency.

(a) "Local agency" means a county, city, city and county, political subdivision, district other than a school district, or municipal corporation. Officers and employees of a given local agency include officers and employees of any other local agency whose principal duties consist of providing services to the given local agency. (b) "State agency" means every state office, department, division, bureau, board, commission, superior court, court of appeal, the Supreme Court, the California State University, the University of California, and the Legislature. *(Amended by Stats. 1983, Ch. 143, Sec. 175.) GC 3202*

Except as otherwise provided in this chapter, or as necessary to meet requirements of federal law as it pertains to a particular employee or employees, no restriction shall be placed on the political activities of any officer or employee of a state or local agency. *(Repealed and added by Stats. 1976, Ch. 1422.) GC 3203*

No one who holds, or who is seeking election or appointment to, any office or employment in a state or local agency shall, directly or indirectly, use, promise, threaten or attempt to use, any office, authority, or influence, whether then possessed or merely anticipated, to confer upon or secure for any individual person, or to aid or obstruct any individual person in securing, or to prevent any individual person from securing, any position, nomination, confirmation, promotion, or change in compensation or position, within the state or local agency, upon consideration or condition that the vote or political influence or action of such person or another shall be given or used in behalf of, or withheld from, any candidate, officer, or party, or upon any other corrupt condition or consideration. This prohibition shall apply to urging or discouraging the individual employee's action.

(Repealed and added by Stats. 1976, Ch. 1422.) GC 3204

(a) An officer or employee of a local agency shall not, directly or indirectly, solicit a political contribution from an officer or employee of that agency, or from a person on an employment list of that agency, with knowledge that the person from whom the contribution is solicited is an officer or employee of that agency.

(b) A candidate for elective office of a local agency shall not, directly or indirectly, solicit a political contribution from an officer or employee of that agency, or from a person on an employment list of that agency, with knowledge that the person from whom the contribution is solicited is an officer or employee of that agency.

(c) This section shall not prohibit an officer or employee of a local agency, or a candidate for elective office in a local agency, from requesting political contributions from officers or employees of that agency if the solicitation is part of a solicitation made to a significant segment of the public which may include officers or employees of that local agency.

(d) Violation of this section is punishable as a misdemeanor. The district attorney shall have all authority to prosecute under this section.

(e) For purposes of this section, the term "contribution" shall have the same meaning as defined in Section 82015. *(Repealed and added by Stats. 1995, Ch. 653, Sec. 2. Effective January 1, 1996.) GC 3205*

No one who holds, or who is seeking election or appointment to, any office shall, directly or indirectly, offer or arrange for any increase in compensation or salary for an employee of a state or local agency in exchange for, or a promise of, a contribution or loan to any committee controlled directly or indirectly by the person who holds, or who is seeking election or appointment to, an office. A violation of this section is punishable by imprisonment in a county jail for a period not exceeding one year, a fine not exceeding five thousand dollars (\$5,000), or by both that imprisonment and fine.

(Added by Stats. 1997, Ch. 206, Sec. 1. Effective January 1, 1998.) GC 320505

No officer or employee of a local agency shall participate in political activities of any kind while in uniform. *(Repealed and added by Stats. 1976, Ch. 1422.) GC3206*

Any city, county, or city and county charter or, in the absence of a charter provision, the governing body of any local agency and any agency not subject to Section 19251 by establishing rules and regulations, may prohibit or otherwise restrict the following:

(a) Officers and employees engaging in political activity during working hours.

(b) Political activities on the premises of the local agency. *(Added by Stats. 1976, Ch. 1422.) GC 3207*

Except as provided in Section 19990, the limitations set forth in this chapter shall be the only restrictions on the political activities of state employees. *(Amended by Stats. 1983, Ch. 142, Sec. 25.) GC 3208*

Nothing in this chapter prevents an officer or employee of a state or local agency from soliciting or receiving political funds or contributions to promote the passage or defeat of a ballot measure which would affect the rate of pay, hours of work, retirement, civil service, or other working conditions of officers or employees of such state or local agency, except that a state or local agency may prohibit or limit such activities by its employees during their working hours and may prohibit or limit entry into governmental offices for such purposes during working hours. *(Added by Stats. 1976, Ch. 1422.) GC 3209*