Full-Time Benefits Information

100 Civic Center Drive
Newport Beach, CA 92660

p. 949-644-3256
f. 949-644-3305

hrbenefit@newportbeachca.gov
jortiz@newportbeachca.gov
www.newportbeachca.gov

Section 1

Health Plan Information

CITY OF NEWPORT BEACH

MOUs and Benefits Summary

Access and review the M.O.U.s (Memoranda of Understanding) and Benefit Summaries for your business unit from the City website:

City of Newport Beach MOUs and Benefits Summary

The Human Resources Department administers ten employment contracts (Memorandums of Understanding) and the Key and Management Compensation Plan, which represent the interests of the employees of the City of Newport Beach. The Memoranda of Understanding (MOUs) detail the agreement between the City and the labor associations on matters concerning wages, benefits, and other terms and conditions of employment for the employees represented by the association. The Key and Management Compensation Plan represent the salary and benefit program established by the City Council for Key and Management employees (Executive Management, Administrative Management, Divisional Management and Confidential). The Benefit Summaries provide a highlight of the primary benefits offered to employees.

- Association of Newport Beach Ocean Lifeguards
- Key and Management Employees
- Newport Beach City Employees Association
- Newport Beach Employees League
- Newport Beach Firefighters Association
- Newport Beach Fire Management Association
- Newport Beach Lifeguard Management Association
- Newport Beach Police Association
- Newport Beach Police Management Association
- Newport Beach Professional and Technical Employees Association
- Part Time Employees Association of Newport Beach

CITY OF NEWPORT BEACH
HUMAN RESOURCES DEPARTMENT
MEMORANDUM

DATE: March 2, 2018

TO: All Employees & Retirees

FROM: Human Resources

SUBJ.: Health Insurance Portability & Accountability Act (HIPAA)/Privacy Law

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This memo is to inform you about the Privacy Rules under HIPAA that went into effect April 17, 2004. On August 14, 2002, the U.S. Department of Health and Human Services (HHS) published final regulations for Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) enacted on April 14, 2001.

The Privacy Rule has federal requirements where in most cases health insurance carriers, doctors, hospitals and other health care providers must obtain a patient's written authorization before using or disclosing a patient's protected health information (PHI).

The following are examples of protected health information:

Explanation of benefits (EOB)
Physician or hospital bill for services rendered to a member
Verbal or written information on an individual's claim or treatment
Medical, dental, vision, or mental health medical files/records.

If you or your dependents need assistance with claims issues, (i.e. disputes, billing, complaints, etc.), an authorization form will need to be completed and signed by you before Human Resources can get involved. An insurance carrier or provider will not talk to us about your protected health information without a signed authorization.

If you have any questions regarding HIPAA, or would like to request an authorization form please contact Human Resources at (949) 644-3256.

CITY OF NEWPORT BEACH
GENERAL NOTICE
REGARDING HEALTH BENEFITS UNDER COBRA
FOR THE RETIREMENT HEALTH SAVINGS (RHS) PLAN

PLEASE READ AND SAVE

1. COBRA. You are a participant in the **Retirement Health Savings Plan** (hereafter the "Plan") of the City of Newport Beach (hereafter the "RHS" or the "Plan"), which provides reimbursement towards health insurance premiums and/or medical expenses after retirement or upon separation from service with the City. Contributions are made into a "Health Reserve Account" (HR Account) in your name, to be used for medical expenses after retirement.

Continued participation in any health plan is a right governed by federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as "COBRA".[1] If you are covered by this Plan, you have the right to continue contributions to this Plan in certain instances described below, after you terminate employment with the City.

THIS COBRA INFORMATION WILL INFORM YOU OF YOUR RIGHTS AND OBLIGATIONS UNDER COBRA. YOU AND YOUR SPOUSE SHOULD TAKE THE TIME TO READ THIS CAREFULLY.

COBRA Coverage Means the Right to Continue Contributions to Plan. The type of continuation coverage in this Plan is unusual. As with normal COBRA coverage, this Plan gives the Employee (or family member) the right to elect to self-pay contributions into the Plan. (When you were working, these amounts were paid automatically, e.g., pursuant to a collective bargaining agreement.) In most plans, COBRA coverage provides you a continuation of an employer's comprehensive health coverage after you leave employment. However, in this Plan, the benefit is not comprehensive health coverage, but instead access to your HR Account,[2] to reimburse you on a tax-favored basis for medical expenses and insurance premiums paid after retirement or upon separation from service with the City.

The Trustees are obligated by federal law to give you this COBRA notice. However, as your Trustees and fellow employees, it is important that we inform

[1] Public Law 99-272, Title X.

[2] In a typical health plan, the COBRA right entitles the employee to self-pay contributions to continue to receive health coverage. In contrast, this Plan does not provide health coverage, but instead accepts contributions during active employment into , which are being held and invested on a tax-favored basis by the Plan, and will be used by employees to cover health care expenses after retirement. In the event of the employee's death, the surviving spouse can access the account for medical expenses.

you that, depending on your particular situation, COBRA coverage in *this* Plan may not be as valuable as is COBRA coverage for a health plan that provides a comprehensive health coverage plan. Please consider the following.

First, if you make COBRA contributions into this Plan, you can withdraw them after retirement tax-free, but *only* for medical expenses or health insurance premiums, as defined in the Plan. If you put the same money into a Roth IRA, you could withdraw it after retirement tax-free, for any purpose.

Second, unlike the contributions into the Plan while you were an active employee, your COBRA self-paid contributions will be made with after-tax money[3]. I.e., you will be making your COBRA self paid contributions with *income that has already been taxed.* So, COBRA contributions will allow you to augment your account in the Plan, and the Plan will give you tax-free earnings on the money. However, if you were to put the same money in a Roth IRA, you would have the same tax-free buildup, without the restriction on how to use the money after retirement.

Third, any balance left in your HC Account in this Plan when you die can be used *only* by surviving dependents (spouse or family member that is legally dependent). If any amount remains after the death of your dependents, it must forfeit into the Plan, for use by other Plan beneficiaries. In contrast, when you die, you can bequeath your savings in a Roth IRA to any named beneficiary (not only dependent family members).

In making your decision on whether to make COBRA contributions, please note the foregoing distinctions between COBRA coverage for a regular health plan that provides insurance coverage, and for this Plan, which provides *post-retirement* reimbursement of medical expenses.

Widowed spouses and dependent children may also have the right to continue self-payment under certain circumstances. Contact the Plan Office at the address in part **4** below, for details.

2. Qualifying Events. If you are an Employee and you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part), these are called "Qualifying Events," which generally give you the right to continue contributions to this Plan. If you are the spouse of an Employee covered by this Plan, you have the right to choose continued participation for yourself if you lose coverage under this Plan for any of the following reasons, which also are Qualifying Events:

[3] To explain, for every $100 that was contributed on your behalf (employer and employee contributions), the entire $100 went into the Plan, no payroll taxes or income taxes were due. It was so-called "pre-tax money". This is one reason the Plan is so valuable; it's funded with tax sheltered money. But COBRA contributions are paid with "after-tax money".

a) The death of your spouse, or

b) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment, provided that your spouse does not elect COBRA coverage.

Dependent children of an Employee covered by this Plan may also have rights to continue contribution to this Plan if coverage under this Plan is lost for any of the following Qualifying Events:

a) The death of a parent,

b) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment, where neither the employee parent nor spouse elect COBRA coverage.

3. Notice Requirements of Employee and/or Family Member. Under COBRA, the Employee or a family member has the responsibility to provide written notice, within the time limits described in part **5** below, to the Plan Office of the occurrence of any of the following qualifying events:

a) The divorce or legal separation of a covered employee from his or her spouse;

b) The child of a covered employee losing dependent status under this Plan;

c) The occurrence of a second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 months (or 29 months in the case of a disability, as described in part **6** below);

d) A qualified beneficiary being determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of continuation coverage; or

e) A qualified beneficiary, with respect to whom a notice described in part **3(d)** above has been provided, is subsequently determined by the Social Security Administration to no longer be disabled.

4. Procedures for Notifying Plan of Qualifying Event. Subject to the time limits in part **5** below, a qualified beneficiary must provide written notice of the qualifying events, described in part **3** above, to the Plan Office by either first class mail or facsimile (fax). The contact information for the Plan Office is as follows:

City of Newport Beach
Human Resources
100 Civic Center Drive
Newport Beach, CA 92660
Phone (949) 644-3256
Fax (949) 644-3305

The notice of the qualifying event should include:

a) The name and social security number of the employee and of the qualified beneficiary;

b) The nature of the qualifying event and the date of the qualifying event; and

c) The current address and phone number of the qualified beneficiary who is filing the notice.

When the Plan is notified that one of these qualifying events has happened, it will, in turn, notify you about details concerning your election to continue your contributions to the Plan, for the right to receive future benefits.

5. Time Limits for Notifying Plan of Qualifying Events.

a) The period of time for providing notice to the Plan Office of the qualifying events listed in part **3(a), (b)** or **(c)** above, is sixty (60) days after the latest of:

(i) The date on which the qualifying event occurs;

(ii) The date on which you lose (or would lose) coverage under the Plan as a result of the qualifying event; or

(iii) The date on which you are informed through this summary plan description of the responsibility to provide notice and the Plan's procedures for providing notice (see part **4** above).

b) The period of time for providing notice to the Plan Office of a disability determination pursuant to part **3(d)** above, is before the end of the first eighteen (18) months of continuation coverage and sixty (60) days after the latest of:

(i) The date of the disability determination by the Social Security Administration;

(ii) The date on which a qualifying event occurs;

(iii) The date on which you lose (or would lose) coverage under the Plan as a result of the qualifying event; or

(iv) The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice (see part **4** above).

c) The period of time for providing notice to the Plan Office of a change in disability status pursuant to part **3(e)** above, is thirty (30) days after the latest of:

(i) The date the Social Security Administration determines that you are no longer disabled; or

(ii) The date on which you are informed through this Notice of the responsibility to provide notice and the Plan's procedures for providing notice (see part **4** above).

6. Length of COBRA Payments. The COBRA law requires that you be afforded the opportunity to continue to make contributions to the Plan for thirty-six (36) months (three years) unless you lost coverage because of a termination of employment or reduction in hours. In that case, the required self-payment period is eighteen (18) months. The eighteen (18) month period may be extended to thirty-six (36) months if a second qualifying event (divorce, legal separation, or death, but not termination of employment) occurs during that eighteen (18) month period.

The eighteen (18) month period may be extended for an additional eleven (11) months (for a total of twenty-nine (29) months) if an individual becomes disabled (as determined under the rules for Social Security disability benefits) within the first sixty (60) days of continuation coverage and the Plan Office is notified of the Social Security determination within sixty (60) days of the determination and before the end of the eighteen (18) month period. The affected individual also must notify the Plan Office within thirty (30) days of a determination (for purposes of Social Security disability benefits) that the individual is no longer disabled. The eleven (11) month extension applies to all disabled and non-disabled individuals entitled to continuation coverage as a result of the same event. Please note the cost you pay for the additional eleven (11) months will be approximately 50% higher than the cost for the first eighteen (18) months if the continuation coverage includes the disabled individual and the continuation coverage would not be available in the absence of a disability.

7. Termination of COBRA Payments. The COBRA law provides that your right to continue COBRA payments may be cut short of the full coverage period – eighteen (18), twenty-nine (29), or thirty-six (36) months – for any of the following reasons:

a) The Plan no longer maintains the Plan;

b) Your employer no longer contributes to the Plan on behalf of employees;

c) The premium for your continuation coverage is not timely paid; or

d) There has been a final determination that you are no longer disabled if you qualified for an extra eleven (11) months' continuation coverage based on disability.

You do not have to show that you are insurable to choose continued participation.

8. Refund of Contributions Erroneously Paid. Any self-paid contributions to the Plan made and accepted in error, shall be refunded to you by the Plan Administrator and shall not confer upon you any rights under the Plan if it is determined that you are ineligible for continuation coverage.

If you have any questions about COBRA, you should contact the Plan Administrator at the address and/or phone number appearing below. Also, if you have changed marital status or you or your spouse have changed address, please notify the Plan Office at the address in part **4**, above.

City of Newport Beach
Human Resources
100 Civic Center Drive
Newport Beach, CA 92660
Phone (949) 644-3256
Fax (949) 644-3305

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
City of Newport Beach, California

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under one or more of the City of Newport Beach's health plans ("the Plan"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is the City of Newport Beach, 100 Civic Center Drive, Newport Beach, CA 92660. However, the Plan Administrator has delegated the day-to-day administration of COBRA to its agent: Workterra P.O. Box 11657, Pleasanton, CA 94588 (Tel. *800*-229-7683). Accordingly, Workterra has ongoing responsibility for the City of Newport Beach's COBRA continuation coverage plan.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced below the number needed to qualify for participation, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced below the number needed to qualify for participation;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced below the number needed to qualify for participation;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Newport Beach, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events. For these qualifying events (only), the City of Newport Beach will notify its agent, Workterra, that an event has occurred.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator’s agent, Workterra. The Plan requires you to notify the Plan Administrator’s agent within 60 days after the qualifying event

occurs. You must send this notice to: Workterra, P.O. Box 11657, Pleasanton, CA 94588. If you fail to timely notify Workterra when one of these qualifying events occurs, your spouse or dependent child may lose their rights to COBRA continuation coverage.

Once the Plan Administrator's agent receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. However, there are ways in which this 18-month period of COBRA continuation coverage can be extended in certain cases.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator's agent in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator's agent is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to: Workterra, P.O. Box 11657, Pleasanton, CA 94588.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and, dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator's agent is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to Workterra at the address listed above.**

CALIFORNIA CONTINUATION RIGHTS

California has enacted a law that can extend health care continuation coverage for all individuals to 36 months, rather than the 18 or 29 months that may be provided under COBRA for loss of coverage due to termination of employment or a reduction in hours worked. The law is effective for individuals who begin receiving continuation coverage after 2002. The premium charged for this additional coverage (after the maximum COBRA period has expired) will generally be 110% of the current premium rate. However, the rate for disabled individuals will be 150%.

In addition, if you are age 60 or over at the time of your termination of employment and you have worked for the City of Newport Beach for at least the past five years, then the normal continuation period for you and your spouse can be extended for an additional period of time.

The extension lasts until the earliest of (a) the date the individual attains age 65, (b) the date the employer ceases to offer any group health plan, (c) the date the individual becomes covered under another group health plan, regardless of whether the coverage is less valuable than the extended coverage, (d) the date the individual becomes entitled to Medicare, or (e) for a spouse, five years from the date the former employee's employment ended. Of course, the extension is also contingent upon the timely submission of premium payments. Coverage of children is not allowed.

To qualify for this special extension, you and your spouse must both be covered at the end of the normal 36-month COBRA continuation coverage period. However, there is no requirement that you take the extension for your spouse to continue coverage under the extension.

In general, the premium charge for this special extension period is 213% of the current premium rate.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Workterra or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and its agent, Workterra, informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or to Workterra.

Basic Term Life / AD&D

Metropolitan Life Insurance Company

Plan Design for: City of Newport Beach
Original Plan Effective Date: January 1, 2021
For All Active Full Time Employees working at least 40 hours per week

Basic Life	An amount equal to 1 times Your Basic Annual Earnings, rounded to the next higher $1,000.
Accidental Death & Dismemberment	An amount equal to Your Basic Life Insurance.
Plan Maximum	$50,000
Non-Medical Maximum	$50,000
Age Reduction Formula (reduces by)	50% at Age 70
Employee Contribution • **Basic Life** • **AD&D**	 0% 0%

Term Life Features (1):

- Continuation of Life insurance while totally disabled as defined by the Group Policy (2)
- Accelerated Benefits Option (3)
- Life Settlement Account (4)
- Grief Counseling (5)
- Funeral Discounts and Planning Services (6)

Additional Features:

- WillsCenter.com (7)

AD&D Features (1):

- Seat Belt Benefit (8)
- Child Care Benefit
- Life Settlement Account (4)
- Air Bag Benefit
- Common Carrier Benefit

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What Is Not Covered?

Like most insurance plans, this plan has exclusions. In addition, a reduction schedule may apply. Please see your benefits administrator or certificate for specific details.

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99 or G2130-S) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases when your Life and AD&D contributions cease, or upon termination of the group insurance policy. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer. Specific details regarding these provisions can be found in the certificate. If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

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(1) Features may vary depending on jurisdiction.

(2) Total disability or totally disabled means your inability to do your job and any other job for which you may be fit by education, training or experience, due to injury or sickness. Please note that this benefit is only available after you have participated in the Basic/Supplemental Term Life Plan for 1 year and it is only available to the employee.

(3) When life expectancy is certified by a physician to be 12 months or less. The Accelerated Benefits Option (ABO) is subject to state availability and regulation. The ABO benefits are intended to qualify for favorable federal tax treatment in which case the benefits will not be subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of ABO benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of ABO benefits will have on public assistance eligibility for you, your spouse or your family.
This is a life insurance benefit that also gives you the option to accelerate some or all of the death benefit in the event you meet the criteria for a qualifying event described in the policy. This policy or certificate does not provide long-term care insurance subject to California long-term care insurance law. This policy or certificate is not a California Partnership for Long-Term Care program policy. This policy or certificate is not a Medicare supplement (policy or certificate).

(4) Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of $5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims paying ability of MetLife.

(5) Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have masters or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.

(6) Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is

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not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.

(7) WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. is not affiliated with MetLife and the WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters.

(8) The Seat Belt Benefit is payable if an insured person dies as a result of injuries sustained in an accident while driving or riding in a private passenger car and wearing a properly fastened seat belt _or a child restraint if the insured is a child_. In such case, his or her benefit can be increased by 10 percent of the Full Amount — but not less than $1,000 or more than $25,000.

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WORKTERRA
a CAREERBUILDER® company

Flexible Spending Accounts —
REAL SAVINGS. REAL SIMPLE.

Using a Flexible Spending Account (FSA) is great way to stretch your benefit dollars. You use before-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings and increased take-home pay—all with the convenience of a prepaid benefits card. And that makes **real sense**.

WHAT IS AN FSA?

With an FSA, you elect to have your annual contribution (up to the $2,750.00 limit set by the IRS) deducted from your paycheck each pay period, in equal installments throughout the year, until you reach the yearly maximum you have specified. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services.

A Healthcare FSA allows reimbursement of qualifying out-of-pocket medical expenses.

A Limited Purpose Medical FSA works with a qualified high deductible health plan (HDHP) and Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses.

A Dependent Care FSA allows reimbursement of dependent care expenses, such as daycare) incurred by eligible dependents.

Please check with your employer to see what plans are offered.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.



In addition, you'll receive a convenient prepaid benefits card to make it easy to pay for eligible services and products not covered by your health insurance. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and most of the time you won't have to submit receipts to verify the purchase. Just swipe the card and go. It's that easy!



WITH AN FSA YOU CAN:

Enjoy significant tax savings with pre-tax deductible contributions and tax-free distributions used for qualified plan expenses

Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app

Reduce filing hassles and paperwork by using your prepaid benefits card

Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365

Manage your FSA "on the go" with an easy-to-use mobile app

File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds

Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages

Get one-click answers to benefits questions

IS AN FSA RIGHT FOR ME?

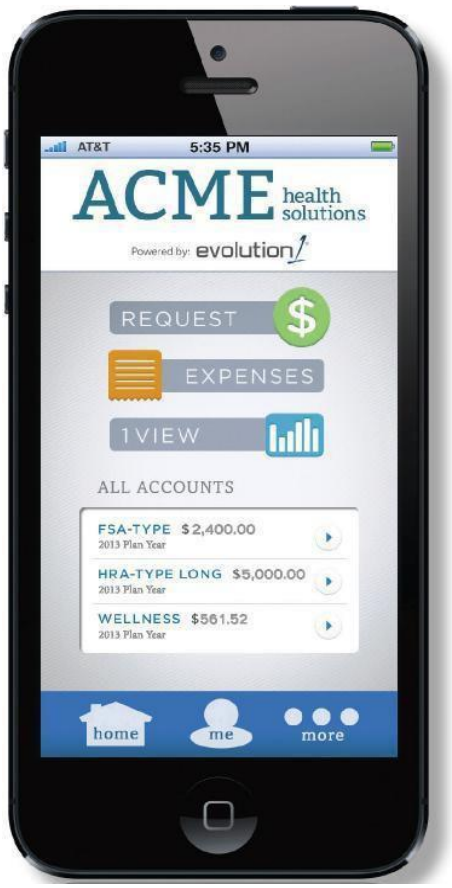
An FSA is a great way to pay for expenses with pre-tax dollars.

A **Healthcare FSA** could save you money if you or your dependents:

- Have out-of-pocket expenses like co-pays, coinsurance, or deductibles for health, prescription, dental or vision plans
- Have a health condition that requires the purchase of prescription medications on an ongoing basis
- Wear glasses or contact lenses or are planning LASIK surgery
- Need orthodontia care, such as braces, or have dental expenses not covered by your insurance

A **Dependent Care FSA** provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

- Your dependent children under age 13 attend daycare, after-school care or summer day camp
- You provide care for a person of any age whom you claim as a dependent on your federal income tax return and who is mentally or physically incapable of caring for himself or herself



Left: With the convenience of a mobile device, you can see your available balance anywhere, anytime as well as file claims and upload receipts.

PLAN AHEAD

Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the upcoming plan year, as Federal tax regulations require that unused amount at the end of the plan year (or grace period) be forfeited.

Throughout the year, you'll likely find yourself with expenses for yourself and your family that insurance won't cover. By taking advantage of an FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for the things you'd purchase anyway.

WORKTERRA
a CAREERBUILDER® company

*The amount you save in taxes with a Flexible Spending Account will vary depending on the amount you set aside in the account; your annual earnings; whether or not you pay Social Security taxes; the number of exemptions and deductions you claim on your tax return; your tax bracket and your state and local tax regulations. Check with your tax advisor for information on how participation will affect your tax savings. This brochure highlights some of the benefits of a Prepaid Benefits Card. If there is a discrepancy between this material and your official plan document, the plan document will govern. Evolution1 reserves the right to amend or modify the services at any time. This document is confidential to Evolution1®, Inc., and may not be used, copied or disclosed except with express prior written consent of Evolution1, Inc. Evolution1 makes no warranties, expressed or implied in connection with its content. Copyright © 2013 Evolution1, Inc., all rights reserved. Evolution1 FSA Flyer Employee EC-080 062413

WORKTERRA
a CAREERBUILDER® company

FLEXIBLE SPENDING ACCOUNTS ~ MOST FREQUENTLY ASKED QUESTIONS

How do I get reimbursed from this plan? - You may file a claim online via the consumer portal, via the mobile app, via fax, via email, or regular mail. If you are not filing via the consumer portal or mobile app you need to send in a claim form (instructions are on page three) and receipts for eligible expenses.

How do I know if my expenses are eligible for reimbursement? - A partial list of eligible expenses is included in this packet.

What information needs to be included on receipts for reimbursement? - Attach all receipts to the claim form before sending to WORKTERRA. Receipts MUST include the following information:

- Name of the patient (you, your spouse or dependent) unless expense is an OTC purchase;
- The date the service was provided or the date the item was purchased;
- The name of the service provider or the merchant;
- Description of the service or item purchased;
- A prescription or letter of medical necessity from your health provider if it is an OTC drug or medicine purchase; and
- The amount/cost of the item or service provided.

– All over-the-counter (OTC) expenses must be accompanied by proper documentation from your health provider. The receipt for OTC expenses must include a description of the product, the date of the purchase, the name of the service provider (drugstore, doctor, etc.) and the amount of the item. Effective January 1, 2011, all OTC drug and medicine expenses must be accompanied by a prescription or letter of medical necessity from your provider to be eligible under your FSA plan.

Why is a description of service required on my receipts? - The IRS determines eligible expenses and the documentation required to claim a reimbursement from this plan. A documented description of services or products is required to prove that your incurred expense is eligible for reimbursement under the guidelines set by the IRS for this plan.

Why would WORKTERRA deny my claim? - The most commons reasons claims are denied are:

- Missing or illegible information;
- Submission of ineligible expenses;
- Receipts are lacking a description of service / items purchased;
- Expenses have been incurred outside the plan year; and
- Expenses have already been submitted (duplicate claims).

How long does it take WORKTERRA to process claims?

– All claims are processed within three to five business days after receipt of complete information. Reimbursements could be timed differently depending on your employer. If you have questions on the timing of your claim, please call our Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770.

May I fax my claim to WORKTERRA? - Yes – claims should be faxed to 925.460.3929.

If I fax a claim, do you need originals in the mail? - No, please keep the original receipts for your records.

What is the deadline for submitting claims? - Please contact Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770 for submission deadlines for your specific plan.

Why would the reimbursement I received be less than the claim I sent? - You may have exceeded the amount available to you. Medical FSA reimbursements are limited to your annual election (the amount you elected to set aside at the beginning of the plan year). Reimbursements are paid up to the annual election amount at any time during the plan year but cannot exceed this amount. Dependent Care reimbursements are limited to the amount in your account

at the time of your claim.

For example, if you have made three contributions of $50 each, you would have an account balance of $150. If you sent in a claim for $200, you will receive only the $150 until further contributions are made. As soon as we receive further contributions to the plan, the balance of the claim (in this case $50) will be paid up to the amount in the account, not to exceed your annual election amount for that plan.

- A portion of your claim may have been denied. If so, you will receive a letter in the mail explaining why that portion of your claim was denied. If you have questions on the rejection of your claim, please call our Customer Service from 8AM to 5PM PST, Monday through Friday at 888.327.2770.

What if I need to change my annual elections? - You may only change your annual elections during the plan year if you qualify for a "change in family status". To qualify, you must experience a life-changing event such as marriage, divorce, birth or adoption of a child, death of a spouse or dependent, or change in spouse's employment, etc. These changes are defined by the IRS and outlined in your plan communication materials. If you have a question about your status, you should consult your employer.

Are my spouse and I both able to elect $5,000 as our Dependent Care annual election? - If you are married and file a joint tax return, the maximum amount you may elect is $5,000. The maximum amount available if you are married but filing separate returns is $2,500. If you file separately, you cannot claim the same expense in each of your dependent care accounts.

What happens if I don't claim all the money in my account? - According to the IRS guidelines, funds that are not claimed during the plan year are forfeited to the plan. This is called the "use it or lose it" clause. Funds are not transferable from one plan year to another and they are not available for other benefits. The unused funds are retained by your plan sponsor and are often used to offset administrative costs of the plan.

What information does WORKTERRA report to the IRS? - WORKTERRA does not supply information to the IRS related to your FSA. Your plan sponsor may be required to file an IRS form 5500 which includes participation and total disbursement information (does not include individual FSA account information) and your participation in the Dependent Care Assistance program will be reported on your W2 at the end of the year by your employer.

Tips for a successful claim submission

- Verify all expenses were incurred during the plan year before submitting;
- Verify the expenses were not previously submitted;
- Make sure that all of the information provided on the claim form is clearly legible – claim forms that cannot be read will not be processed;
- Make sure each receipt and each expense / purchase is itemized; and
- Make sure all expenses / purchases have a description on the receipt or Explanation of Benefits.

How can I find out what my account balance is or when WORKTERRA sent me a claim reimbursement?

- You are able to logon through the Member Center at www.WORKTERRA.com for online account balance information and information on claims paid.
- WORKTERRA representatives are available from 8AM to 5PM PST, Monday through Friday at 888.327.2770 or you can e-mail WORKTERRA Customer Service at custserv@WORKTERRA.com. Please do not include any confidential information, such as your Social Security number, in your email for security reasons.

FLEX Department

WORKTERRA
P.O. Box 11657
Pleasanton, CA 94588
P 888.327.2770 F 925.460.3929

Dear Flexible Benefit Plan Participant:

Welcome to your **WORK**TERRA Flexible Spending Accounts! Enclosed you will find important information to help you manage your accounts:

HOW TO LEARN MORE ABOUT YOUR ACCOUNTS:

WORKTERRA **CONSUMER PORTAL:** You can access all of your applicable account information on the EBS Benefit Accounts Consumer Portal. This one-stop portal gives you 24/7 access to view information and manage your accounts. It enables you to:



- File claims online, upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims history and payment (reimbursement) history
- Report a lost/stolen Card and request a new one
- Apply for/Update your direct deposit information to receive reimbursements faster
- Change your login ID and/or password
- Download plan information, forms and notifications

More information on how to use the Consumer Portal is provided in the Consumer Portal Quick Start guide available on our website at **www.workterra.com -> member center -> WORKTERRA System User Guide** http://workterra.com/pdf/workterra_participant_guide_13.pdf

WORKTERRA MEMBER CENTER: Provides additional resources for your applicable Flexible Spending Accounts:

- Claim Forms with instructions (for submission via mail or fax)
- Direct Deposit Form (to initiate, change or cancel your direct deposit via mail or fax).
- Eligible Expenses (generic list). *please note: your Employer's plan may restrict reimbursement of one or more of the expenses listed on this page. Please refer to your applicable Summary Plan Description and information provided in your consumer portal for eligible expenses)
- Frequently Asked Questions
- FSA Savings Calculator
- VISA Flex Debit Card – Frequently Asked Questions
- Information Release Document
- Creating and Viewing your Account Online

To access the tools and resources above, please visit **www.workterra.com ->member center**

HOW TO USE THE FUNDS IN YOUR ACCOUNTS:

DEBIT CARD: You may access funds in your Flexible Spending Accounts by using your VISA Stored Value Benefits Card. You will receive this card in the mail separately from this letter in a standard size 10 envelope.

* All Flexible Spending Accounts on One Card! Your VISA Card is loaded with all of your flexible spending account balances managed by EBS. You do not need to direct payments to specific plans – it is done automatically at the point of sale based on merchant type and your benefit plan rules.

* Using your Card helps you keep cash in your wallet and makes accessing your FSA funds easy. The Card can be used, instead of cash, to conveniently and securely pay for qualified expenses. When you use the card, payments are automatically withdrawn from your account(s); and most of the time you won't have to submit receipts for reimbursement.

* VISA Card uses its auto-substantiation technology to electronically verify the transaction's eligibility according to the IRS rules. Over 85% of swipes will not require follow up. Just swipe the card and go. It's that easy! *Please note: IRS requires 100% of card transactions be substantiated; some transactions do not qualify to be auto substantiated according to the IRS rules and you may be required to provide documentation to adjudicate some of the transactions made with the VISA Card.*

MOBILE: Conveniently manage your Flexible Spending Account information when you want, from wherever you want. Whether on your couch or at the store, the WORKTERRA Online FSA System App for iPhone® or Android™ smartphones makes it easy to manage your benefit accounts on the go. Using the app allows you to:

- Check current Flexible Spending account balances;
- View account activity and receive text message alerts
- View VISA Card transaction details
- File new claims with receipt images
- Enter and review expenses
- Submit Flexible Spending claims and upload receipts using the mobile device's camera



Get started with WORKTERRA Online FSA System App in minutes! Simply download the WORKTERRA Online FSA System App for your Android or iPhone (also compatible with iPad® and iPod touch®) and log in using the same password you use to access your consumer portal.

CLAIMS via CONSUMER PORTAL: You may submit your claims for reimbursement online by logging in to your consumer portal and clicking "File a Claim"

CLAIMS via MAIL or FAX: You may also mail or fax us your completed claim forms accompanied by the required receipts/EOBs to the address/fax number below. Claim forms with instructions are available for download on our website at www.WORKTERRA.com -> member center

We are committed to providing you with superior service. Should you have any questions or concerns about your FSA benefits, please call WORKTERRA Customer Service at 888.327.2770 and a representative will assist you. You may also e-mail your questions to customerservice@WORKTERRA.com.

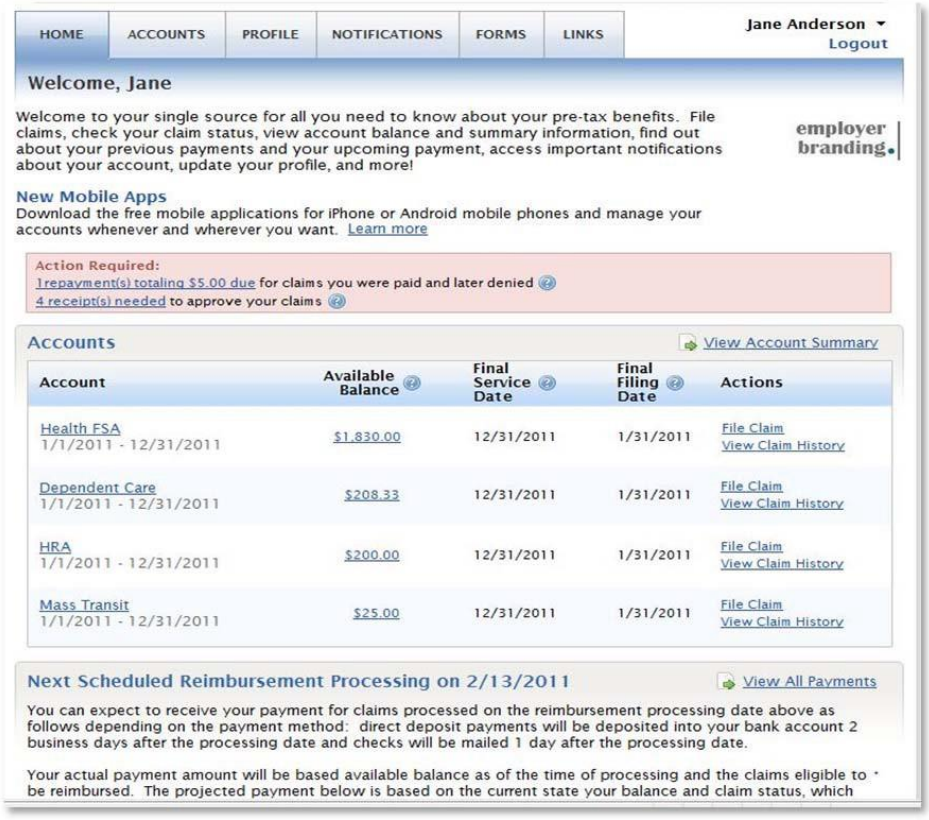
Sincerely,
WORKTERRA Customer Service
WORKTERRA PO Box 11657, Pleasanton, CA 94588
PH: 888.327.2770 | FAX: 925.460.3929

Participant Quick Start Guide – Online System

Welcome to your WORKTERRA Benefit Accounts Consumer Portal. This one-stop portal gives you 24/7 access to view information and manage your Accounts. It enables you to:

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims history and payment (reimbursement) history
- Report a lost/stolen Card and request a new one
- Update your personal profile information
- Change your login ID and/or password
- Download plan information, forms and notifications

The portal is designed to be easy to use and convenient. You have your choice of three ways to navigate this site: 1) work from sections within the Home Page, 2) hover over the six tabs at top of Home Page to see drop-down menus, or 3) follow links at the bottom of each page.



HOW DO I LOG ON TO HOME PAGE?

- Go to https://workterra.lh1ondemand.com.
- Enter your login ID and password. Your login ID is the first initial of your first name, your full last name and the last four of your Social Security number. Your password is your full social.
- Click Login.
- You will be prompted to change your password upon your initial login; please follow the instructions on the screen.

The **Home Page** is easy to navigate:

- The top section shows messages from your employer and links to employee information.
- The Action Required section displays alerts and relevant links that enable you to keep current on your accounts.
- The Accounts section has links to account balances and activity details. On the far right, View Account Summary links to the Account Summary page, where you can see and manage your accounts.
- The Next Scheduled Reimbursement section details when and how much you are projected to receive from any/all plans in which you are enrolled. (optional)

You can also hover over the tabs at top or use links at the bottom of the page.

HOW DO I FILE A CLAIM AND UPLOAD A RECEIPT?

1. On the **Home Page**, under the **Accounts** tab, click **File Claim** on the drop-down menu. .
2. **OR** on the Home **Page**, in the **Accounts** section, click **File Claim** link.
3. Enter your claim information, and upload the receipt, on the form that appears and click **Add Claim**. The claim is then added to the **Claims Basket**.
4. For submitting more than one claim, click **Add Another Claim**, select the Account Type and complete the form and click **Add Claim**.
5. When all claims are entered in the **Claims Basket**, click **Submit** to send the claims for processing.
6. The **Claim Confirmation** page displays. Print the **Claim Confirmation Form** as a record of your submission. If you did not upload a receipt, print another **Claim Confirmation Form** to submit to the administrator, attaching the required receipts. **OR** if a receipt is required, you will see the **Upload Receipt** link. Click on it and the **Receipts Needed** screen displays.
7. For each claim that requires a receipt, click **Upload Receipt** on the far right and follow instructions. (Your receipt must be in .doc, pdf, bmp, or gif format.)
8. The Receipt Uploaded confirmation appears: “Your receipt has been uploaded. You may upload additional receipts if needed until the claim is approved.”
9. After uploading, you may also click **View Confirmation** and print the form for your records.

NOTE: If you see a **Receipts Needed** link in the Action Required section of your Home Page, click on it. A listing of any **Claims Requiring Receipts** will appear.

HOW DO I VIEW CURRENT ACCOUNT BALANCES AND ACTIVITY?

1. For current Account Balance only, on the **Home Page**, in the **Accounts** section, see the **Available Balance** column next to the applicable account.
2. For an Account Summary of your account(s) that includes your current Account Balance(s), on the **Home Page**, on the top right hand in the **Accounts** section, click on the **View Account Summary** link.

   OR under the **Accounts** tab, click **Account Summary** on the drop-down menu.
3. For all Account Activity, on the **Home Page**, click on the **Available Balance Amount** link for the plan [if enabled by your employer]. The Account Activity screen will appear. Click **View** for each account listed in the drop-down menu.

HOW DO I VIEW MY CLAIMS HISTORY?

1. On the **Home Page**, in the **Accounts** section, click **View Claim History** next to the applicable account.
2. **OR** on the **Home Page**, under the **Accounts** tab, click **File Claim** on the drop-down menu. Then click

   View History on the far right on the File Claim screen.
3. **OR** on the **Home Page**, in the **Accounts** section, click **View Account Summary** on the far right.

   Then click on the dollar amount in the **Submitted Claims** column next to the applicable amount.

HOW DO I VIEW MY PAYMENT (REIMBURSEMENT) HISTORY?

1. On the **Home Page**, under the **Accounts** tab, click **Payment History** on the drop-down menu.
2. You will see reimbursement payments made to date, including debit card transactions.
3. Click **View Detail** on the far right to see claim details.

HOW DO I UPDATE MY PERSONAL PROFILE?

1. On the **Home Page**, under the **Profile** tab, click your choice on the drop-down menu: **Profile Summary** or **Bank Accounts**.
2. Click any link on the Profile screen: **Update Profile** or **Add/Update Dependent** or **Update Bank Account.** Some profile changes will require you to answer an additional security question.
3. Complete your changes in the form.
4. Click **Submit**.

HOW DO I GET MY REIMBURSEMENT MONEY FASTER?

The fastest way to get your money is to sign up online for direct deposit to your personal checking account. Before you begin, make sure that your employer is offering direct deposit setup online.

1. On the **Home Page**, under the **Accounts** tab, click **Change Payment Method** on the drop-down menu.
2. Select **Direct Deposit** and click **Change Payment Method**. The **Add Bank Account: Direct Deposit Setup** page displays.
3. Enter your bank account information, and click **Submit**.
4. The **Payment Method Changed** confirmation displays.

HOW DO I CHANGE MY LOGIN AND/OR PASSWORD?

1. On the **Home Page**, under the **Profile** tab, click **Login Information** on the drop-down menu.
2. Follow instructions on the screen. (For a new account, the first time you log in, you will be prompted to change the password that was assigned by your plan administrator. Follow the instructions.)
3. Click **Save**.

HOW DO I VIEW OR ACCESS…

…FORMS?

1. On the **Home Page**, use the **Forms** tab.
2. Click any form of your choice.

…NOTIFICATIONS?

1. On the **Home Page**, under the **Notifications** tab, click **Notification History** on the drop-down menu.
2. Click any link of your choice. **Receipt Reminders**, **Account Statements**, **Advice of Deposits**, **Denial Letters**, or **Denial Letters with Repayments** are a few options.

…PLAN INFORMATION?

1. On the **Home Page**, under the **Accounts** tab, click **Account Summary** on the drop-down menu.
2. Click the applicable account in the first column on the left and the **Plan Rules** open in another browser

   OR on the **Home Page**, under the **Accounts** tab, click **Plan Descriptions** on the drop-down menu for basic information. Then click each applicable plan to see the Plan Detail screen.



Andre Hamil
We help our MHN members get the support they need.

MHN
A Health Net Company℠

Your Employee Assistance Program

How can we help?

Life can be complicated. With MHN, getting help is easy.

Your EAP is here to help with life's many challenges. MHN provides the following services, paid for by your employer.

Problem-solving support

Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about your use of alcohol or drugs.

When you call, you can make an appointment that works for you:

- **Face-to-face sessions** – Meet with a provider from our network (for example, a counselor, marriage and family therapist, or psychologist) in his or her office. We can provide a referral when you call us. You can also search for a provider on our member website.
- **Phone or web-video consultations** – Easily accessed support provided by a network provider or MHN consultant.

Remember that EAP services are not medical care or mental health treatment of any kind. If, in the course of a consultation, clinical problems are suspected, including drug or alcohol problems, we will offer a referral to appropriate medical or mental health services.

Work and life services

Our experts can help you balance your work with your life![1] Call us for:

- **Childcare and eldercare assistance** – We'll find out what kind of help you need caring for children or elders in your life. Then we'll give you names and numbers of providers in your area with confirmed openings.
- **Financial services** – Talk to an advisor over the phone about:
  - Budgeting
  - Credit and financial questions (investment advice, loans and bill payments not included)
  - Retirement planning



- **Legal services** – Talk to a lawyer over the phone or face to face about:
  - Civil, consumer and criminal law
  - Personal and family law, including adoption, divorce and custody issues

(continued)

[1]Please contact us for details, including limitations and exclusions.

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FLY003406EH00 MCF-01 (8/15)

  - Financial or tax matters. (Business matters are excluded. Also excluded are any disputes or actions between members and their employer, business partners, MHN, Health Net, or their affiliates.)
  - Real estate
  - Estate planning

- **Identity theft recovery services** – Speak with a certified consumer credit counselor who can learn more about your situation and help you create a plan. If there is a potential of ID theft, we'll connect you to an identity recovery specialist.
- **Daily living services** – Need help with errands? Planning an event or a vacation? We'll track down businesses and consultants for you. (MHN does not cover the cost nor guarantee delivery of vendors' services.)



Our member website can help with:

- Childcare and eldercare directories.
- Tips, tools and calculators to help you with finances, legal issues and retirement planning.

Health and wellness resources



Take charge of your well-being! MHN can help. Just register on our member website to:

- Assess your health and get tips for living better.
- Track progress toward your wellness goals.
- Take advantage of interactive e-learning programs.
- Find articles and videos about health topics.

Call your EAP number to learn more about our wellness coaching services – personalized support to help you set and reach your wellness goals.

This is just a summary. For details about services and eligibility, please contact MHN or your employer, or check your plan documents (such as an *Evidence of Coverage* booklet or *Summary Plan Description*).

Your privacy

EAP services are confidential. Your privacy is important to us, and it is protected by state and federal laws.

Need help?

Call toll-free, 24 hours a day, seven days a week: 1-800-242-6220
TTY users call 711.
Or visit us at: members.mhn.com
and register with the company code: newport

You are entitled to 3 face-to-face sessions or telephonic or web-video consultations for problem-solving support per incident, per calendar year.

Separate limits apply for work-life consultations.

We speak your language!

When you call MHN, free interpretation services are available in over 170 languages. We also contract with a vendor who can physically attend appointments with you, at no cost, if you need help communicating with doctors or other providers.

¡Hablamos su mismo idioma!

Cuando llame a MHN, podrá usar nuestros servicios de interpretación gratuitos en más de 170 idiomas. Además, contamos con proveedores contratados que pueden asistir en persona a las citas con usted, sin cargo alguno, en caso de que necesite ayuda para comunicarse con los médicos u otros proveedores.

我們說您的語言!
您致電 MHN 時，我們可提供 170 多種語言的免費傳譯服務。我們還聘用了翻譯人員，如果您需要翻譯人員幫助您與醫生或其他醫療服務提供者進行交流，該翻譯人員可以與您一道參加約診，該服務爲免費提供。

Section 2

Retirement

City of Newport Beach Employee Orientation

Retirement Benefits

We are proud to offer employees a generous retirement benefits package. Below is a brief summary of the types of plans offered you may be eligible for. We encourage you to become familiar with these benefits; please don't hesitate to ask questions by contacting Human Resources at X3256, or refer to the benefits provider websites for more information.

PERS Pension Benefit

The City offers full-time employees a pension retirement benefit through the California Public Employees Retirement System (PERS). This is deemed a "defined benefit". This means the employee receives a "defined" amount of income (a pension benefit) at retirement. With PERS there are 3 factors that determine your benefit upon retirement:

- Your Years of Service
- Your Age at Retirement
- Your Retirement Formula

The City offers Tiered retirement benefits. The Tier to which you are assigned is based on your prior employment history (whether you've worked for a PERS or reciprocal agency and when) and your date of hire with the City. Refer to your MOU for information about Tiered benefits.

Information about specific PERS benefits can be found on the PERS website. We encourage you to set-up an online account/profile so that you can access your personal data, as well as take advantage of the training and resources available. Please go to:

www.calpers.ca.gov

Empower Retirement: 457 Deferred Compensation Plan

The City's 457 Deferred Compensation is a "defined contribution" plan, as the amount contributed is a defined or specified amount. The plan offers employees an additional option for saving for retirement through a tax-deferred contribution. The City does not contribute on behalf of the employee for this benefit. See the following flyer from Empower Retirement on how to enroll in this plan.

Other Plans

Depending on the Employee Association you are represented by, you may be eligible for additional retirement-related benefits, which may include:

- LIUNA supplemental retirement plan (CEA, Prof Tech, and Key & Management employees)
- PORAC medical retirement supplement (NBPA employees)
- 401(a) Defined Contribution (NBFA/FMA employees in PERS Tiers II or III)

Refer to your Employee Association MOU, or speak with your Association representatives for more information about plan eligibility.

California Public Employees' Retirement System
P.O. Box 942715 | Sacramento, CA 94229-2715
(888) CalPERS (or **888**-225-7377) | TTY: (877) 249-7442
www.calpers.ca.gov

Payroll

Circular Letter

January 6, 2021
Circular Letter: 200-001-21
Distribution: IV, V, VI, X, XII, XVI

To: **All CalPERS Employers**
Subject: **2021 Compensation Limits for Classic and PEPRA Members**

Purpose

The purpose of this Circular Letter is to inform all employers of the 2021 compensation limits for classic and Public Employees' Pension Reform Act (PEPRA) members and provide guidelines for how to report payroll when Internal Revenue Code (IRC) or PEPRA limits have been reached in a calendar year. Section 401(a)(17) of the IRC provides earnings limits on annual compensation that can be considered under qualified retirement plans for some classic members. Government (Gov.) Code section 7522.10 of the PEPRA law provides the authority for the earnings limit for all PEPRA members.

Employers should notify all classic or PEPRA members who are subject to the compensation limit requirements.

Compensation Limits

Classic Members

The compensation limit for classic members for the **2021 calendar year is $290,000**. Employees with membership dates prior to July 1, 1996, are not impacted by these limits.

The compensation limits for classic members during calendar years 2017 through 2020 are:

2020	**2019**	**2018**	**2017**
$285,000	$280,000	$275,000	$270,000

PEPRA Members

The compensation limit for PEPRA members for the 2021 calendar year is:

Year	Social Security Participants	Non-Social Security Participants
2021	$128,059	$153,671

The compensation limits for PEPRA members during calendar years 2017 through 2020 are:

Year	Social Security Participants	Non-Social Security Participants
2020	$126,291	$151,549
2019	$124,180	$149,016
2018	$121,388	$145,666
2017	$118,775	$142,530

Reporting Guidelines

Compensation limits for both classic and PEPRA members do not limit the salary an employer can pay; they limit the amount of compensation considered under the defined benefit plan.

For classic members, report compensation earnable to CalPERS; for PEPRA members, report pensionable compensation to CalPERS. For classic and PEPRA members, contributions should not be made on compensation that exceeds the limit for each calendar year. In addition, exclude items such as overtime, automobile allowances, and lump-sum payouts for all compensation reported.

Employers are responsible for monitoring when an employee meets or exceeds the limit. Once a participant reaches the compensation limit, the employer must continue reporting compensation as earned; however, employer and employee contributions should no longer be reported for the rest of the calendar year. myCalPERS will track classic and PEPRA member earnings over multiple CalPERS contracting agencies. Therefore, if a member is hired in the middle of the year from another CalPERS agency, myCalPERS will notify the current employer when the member reaches or exceeds the compensation limit. Monitoring and contribution reporting begin on January 1 of each calendar year. The end date of the payroll earned period determines which calendar year the period falls in.

Federal law does not permit CalPERS to refund over-reported contributions to an active CalPERS member. Employers must report these adjustments and refund the money to the employee(s) once these adjustments have posted.

Impact on Final Compensation

For classic members, final compensation is the highest average annual compensation earnable for a 12- or 36-consecutive month period of employment, depending on the employer contract.

Classic members' retirement allowances are subject to final compensation limits under IRC section 401(a)(17). The calculation of each 12-month period will be subject to the annual compensation limit in effect for the calendar year in which the 12-month period begins. If final compensation exceeds 12 months, each 12-month period is calculated based on the applicable annual compensation limit for that 12-month period.

For PEPRA members, final compensation is the average annual pensionable compensation for a 36-consecutive month period of employment.

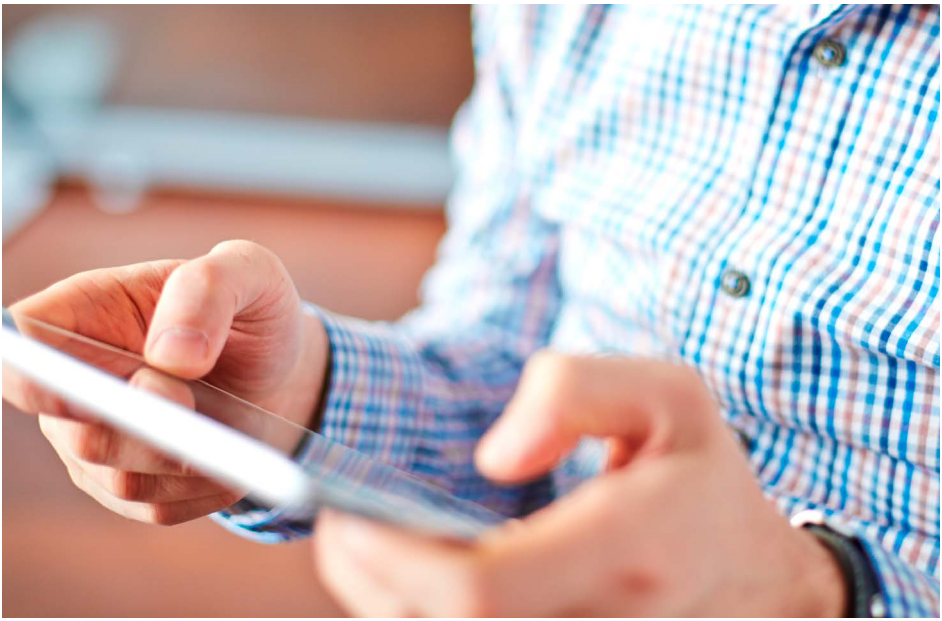
PEPRA members' retirement allowances are subject to pensionable compensation limits under Gov. Code section 7522.10. The pensionable compensation limit — used to calculate final compensation — is calculated based on the limit in effect for each calendar year and the number of days per year included in the final compensation period.

Online Training

The **myCalPERS Payroll: Reporting Earnings Over the Compensation Limit** online class is available for employers. This class provides instruction on how to report payroll information when the compensation limit has been reached. To enroll in the class, log in to your myCalPERS account and select the **Education** tab.

If you have any questions, call our CalPERS Customer Contact Center at **888 CalPERS** (or **888**-225-7377).

Renee Ostrander, Chief
Employer Account Management Division



Guide to Web Resources

CalPERS Website

my|CalPERS

Social Media

Email Subscriptions

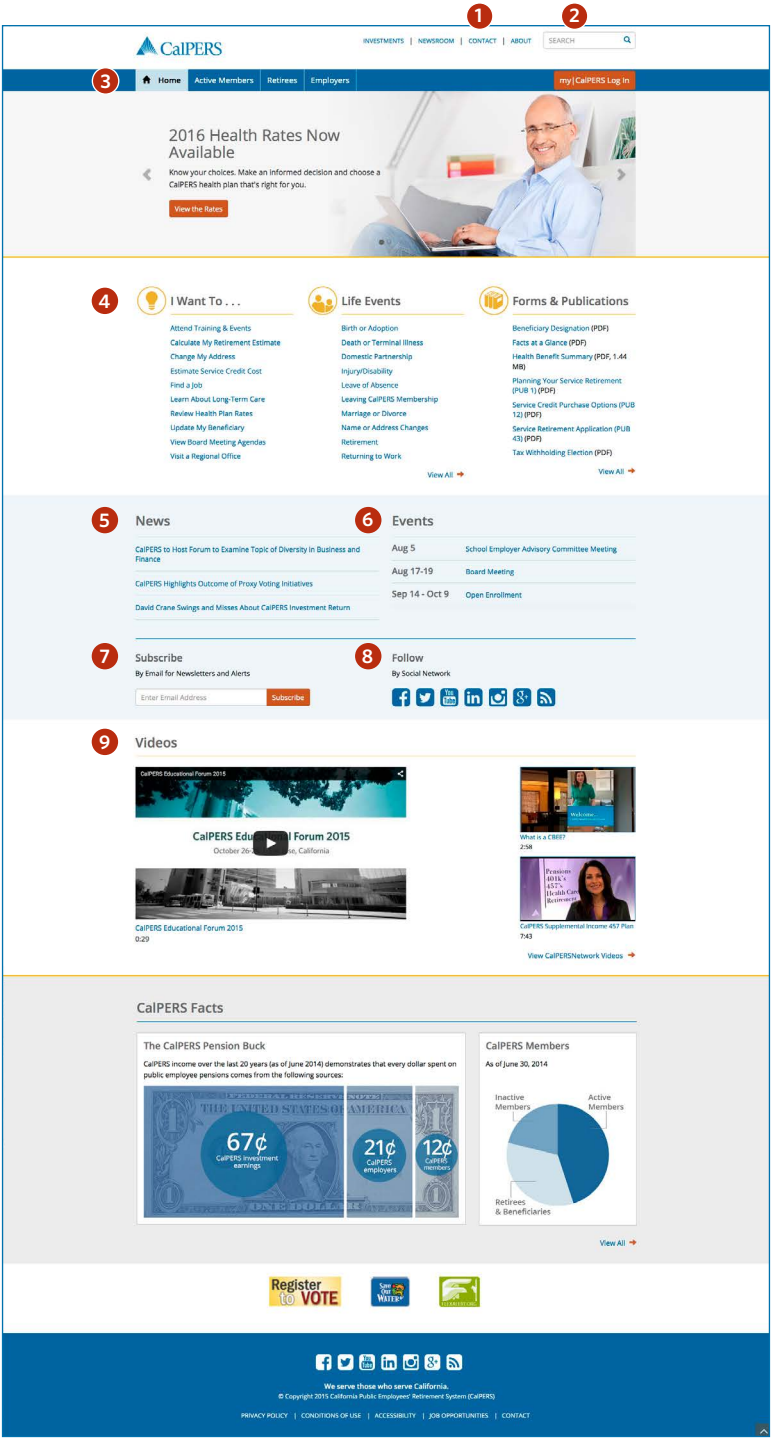
CalPERS

CalPERS Website

CalPERS' improved website makes it easier for you to access the information you need quickly and easily. Whether you're still working, retired, or an employer, our website has the information you're looking for. Visit calpers.ca.gov and discover for yourself what our site has to offer.

Use these tips to get the most out of our CalPERS website:

1. Find out how to reach us, get directions to our headquarters or Regional Offices, or make a public records request. You can also submit your questions and comments online.
2. Get accurate and relevant results with the Search function powered by Google.
3. Choose a category from **Home**, **Active Members**, **Retirees**, **Employers** that is tailored to your specific needs.
4. Select a quick link for direct access to the top tasks and frequently requested areas of our website. Attend training or learn about long-term care, report a life event such as a birth, adoption, marriage or a domestic partnership, or download a form or publication such as the Service Retirement application.
5. View the latest CalPERS news.
6. Find out the dates for important events such as Open Enrollment or upcoming Board meetings.
7. Sign up to receive emails for newsletters and alerts.
8. Follow us on the various social media channels to engage with us and receive current information.
9. View our videos about current issues and CalPERS benefits. Learn general facts about CalPERS.


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SEARCH
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Home
Active Members
Retirees
Employers
my|CalPERS Log In
2016 Health Rates Now Available
Know your choices. Make an informed decision and choose a CalPERS health plan that's right for you.
View the Rates
4
I Want To . . .
Attend Training & Events
Calculate My Retirement Estimate
Change My Address
Estimate Service Credit Cost
Find a Job
Learn About Long-Term Care
Review Health Plan Rates
Update My Beneficiary
View Board Meeting Agendas
Visit a Regional Office
Life Events
Birth or Adoption
Death or Terminal Illness
Domestic Partnership
Injury/Disability
Leave of Absence
Leaving CalPERS Membership
Marriage or Divorce
Name or Address Changes
Retirement
Returning to Work
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Forms & Publications
Beneficiary Designation (PDF)
Facts at a Glance (PDF)
Health Benefit Summary (PDF, 1.44 MB)
Planning Your Service Retirement (PUB 1) (PDF)
Service Credit Purchase Options (PUB 12) (PDF)
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CalPERS to Host Forum to Examine Topic of Diversity in Business and Finance
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The CalPERS Pension Buck
CalPERS income over the last 20 years (as of June 2014) demonstrates that every dollar spent on public employee pensions comes from the following sources:
67¢
CalPERS investment earnings
21¢
CalPERS employers
12¢
CalPERS members
CalPERS Members
As of June 30, 2014
Inactive Members
Active Members
Retirees & Beneficiaries
View All
Register to VOTE
We serve those who serve California.
© Copyright 2015 California Public Employees' Retirement System (CalPERS)
PRIVACY POLICY | CONDITIONS OF USE | ACCESSIBILITY | JOB OPPORTUNITIES | CONTACT

my|CalPERS

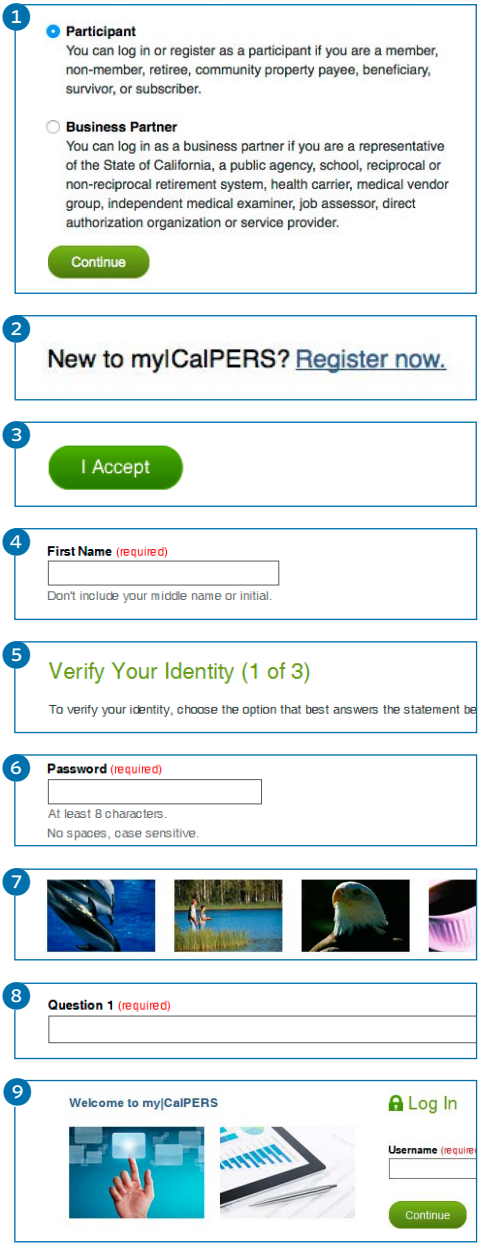
Your resource for your personal account information

my|CalPERS is a personalized, centralized, and secure website that allows you to access your personal information quickly, easily, and reliably. You can use it to plan for your retirement, manage your health plans, and conduct your business with CalPERS. Access my|CalPERS at my.calpers.ca.gov.

How to Register for my|CalPERS

Not registered yet? Follow these steps:

1. On the Pre-Log In page, select **Participant** and **Continue**.
2. Select **Register now**.
3. **Accept** the terms and conditions under the security agreement.
4. Identify yourself by providing your name, date of birth, last four digits of your Social Security number, or your CalPERS Identification number.
5. Answer a set of questions about your CalPERS account to verify your identity.
6. Create a username and password, and enter your email address.
7. Choose a personal security image and message.
8. Choose your security questions and answers. It's important to choose questions and answers you will remember.
9. Log in to my|CalPERS.


1
Participant
You can log in or register as a participant if you are a member, non-member, retiree, community property payee, beneficiary, survivor, or subscriber.
Business Partner
You can log in as a business partner if you are a representative of the State of California, a public agency, school, reciprocal or non-reciprocal retirement system, health carrier, medical vendor group, independent medical examiner, job assessor, direct authorization organization or service provider.
Continue
2
New to myICalPERS? Register now.
3
I Accept
4
First Name (required)
Don't include your middle name or initial.
5
Verify Your Identity (1 of 3)
To verify your identity, choose the option that best answers the statement be
6
Password (required)
At least 8 characters.
No spaces, case sensitive.
7
8
Question 1 (required)
9
Welcome to my|CalPERS
Log In
Username (require
Continue

How to Access my|CalPERS

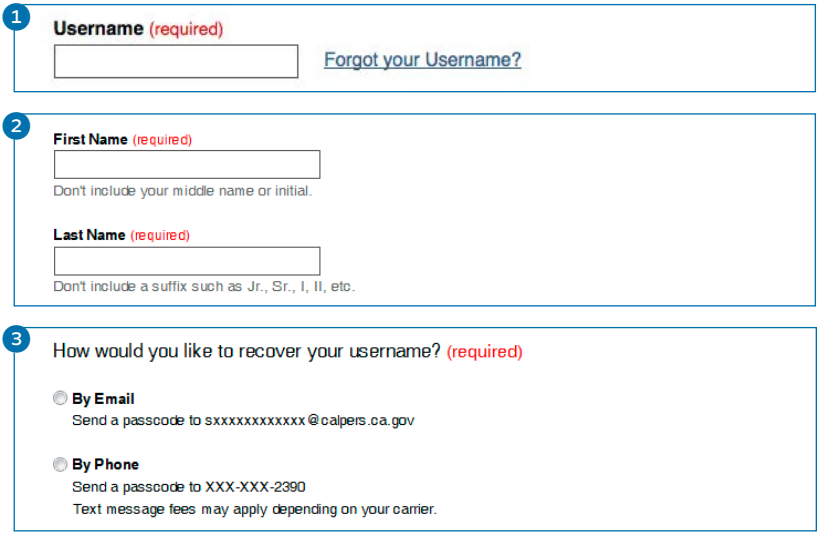
Can't remember your username?

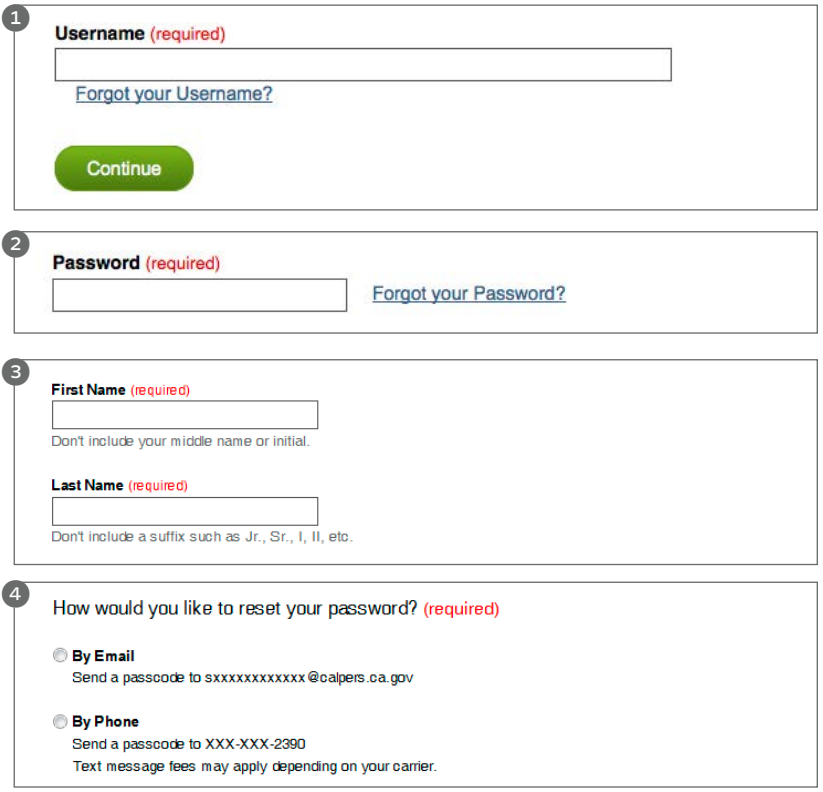
1. Select **Forgot your Username?**
2. Identify yourself by providing your name, date of birth, last four digits of your Social Security number, or your CalPERS Identification number.
3. Select how you want to recover your username. You can choose to answer your security questions or have a temporary passcode sent to your email address or mobile number on record. Once you enter your temporary passcode, your username will appear.

Can't remember your password?

1. Enter your **Username** and select **Continue**.
2. Select **Forgot your Password?**
3. Identify yourself by providing your name, date of birth, last four digits of your Social Security number, or your CalPERS Identification number.
4. Select how you want to reset your password. You can choose to reset your password by answering your security questions or by having a temporary passcode sent to your email address or mobile number on record. Once you enter the temporary passcode, you can create a new password.

If you exceed the allowed number of attempts to validate your identity, your account will be locked to protect your security. To unlock your account, contact us at **888 CalPERS** (or **888**-225-7377).


1
Username (required)
Forgot your Username?
2
First Name (required)
Don't include your middle name or initial.
Last Name (required)
Don't include a suffix such as Jr., Sr., I, II, etc.
3
How would you like to recover your username? (required)
By Email
Send a passcode to sxxxxxxxxxxx@calpers.ca.gov
By Phone
Send a passcode to XXX-XXX-2390
Text message fees may apply depending on your carrier.


1
Username (required)
Forgot your Username?
Continue
2
Password (required)
Forgot your Password?
3
First Name (required)
Don't include your middle name or initial.
Last Name (required)
Don't include a suffix such as Jr., Sr., I, II, etc.
4
How would you like to reset your password? (required)
By Email
Send a passcode to sxxxxxxxxxxx@calpers.ca.gov
By Phone
Send a passcode to XXX-XXX-2390
Text message fees may apply depending on your carrier.

my|CalPERS (Continued)

Your resource for your personal account information

Use these tips to get the most out of my|CalPERS:

- Review your personalized information on the home page, which offers a quick snapshot of your member benefits and easy access to further details.
- Choose whether you want statements and publications mailed to you or only be available online.
- Access Annual Member Statements or Tax and Benefit Statements from a centralized **Statements** page.
- Download or order publications.
- Learn about upcoming classes, events, and other educational opportunities.
- Visit the **Education Resources** area for access to available learning resources.
  - » Sign up for instructor-led or online classes.
  - » Schedule a one-on-one appointment with a retirement counselor at a CalPERS Regional Office.
- Have a specific question about your personal account? Use the **Message Center** to ask your confidential questions.

To learn more about what you can do in my|CalPERS, visit Using my|CalPERS at calpers.ca.gov/usingmycalpers.

Social Media

Stay informed and engage with us

Join our social media communities to receive relevant up-to-date information. We welcome your comments, but please don't post confidential or sensitive information.



Facebook

facebook.com/myCalPERS – "Like" us on Facebook to engage with us and stay informed of news and information about our programs, benefits, and events.



Twitter

twitter.com/CalPERS – Follow us on Twitter to see brief updates. We tweet news and information about CalPERS benefits and programs.



Instagram

instagram.com/CalPERS – Follow us on Instagram for photos and videos that show our commitment, dedication, and passion for the work we do in serving those who serve California. Have you taken photos you think would be of interest to our community? Tag them with #CalPERS so others searching for photos of CalPERS can easily find them.



YouTube

youtube.com/CalPERSNetwork – Watch webinars and tutorials on topics such as planning your retirement, health benefits, and retirement calculation factors. Subscribe to our videos, share them, and embed them in your own sites.



LinkedIn

linkedin.com/company/CalPERS – Connect with us on LinkedIn to view CalPERS job postings and more.



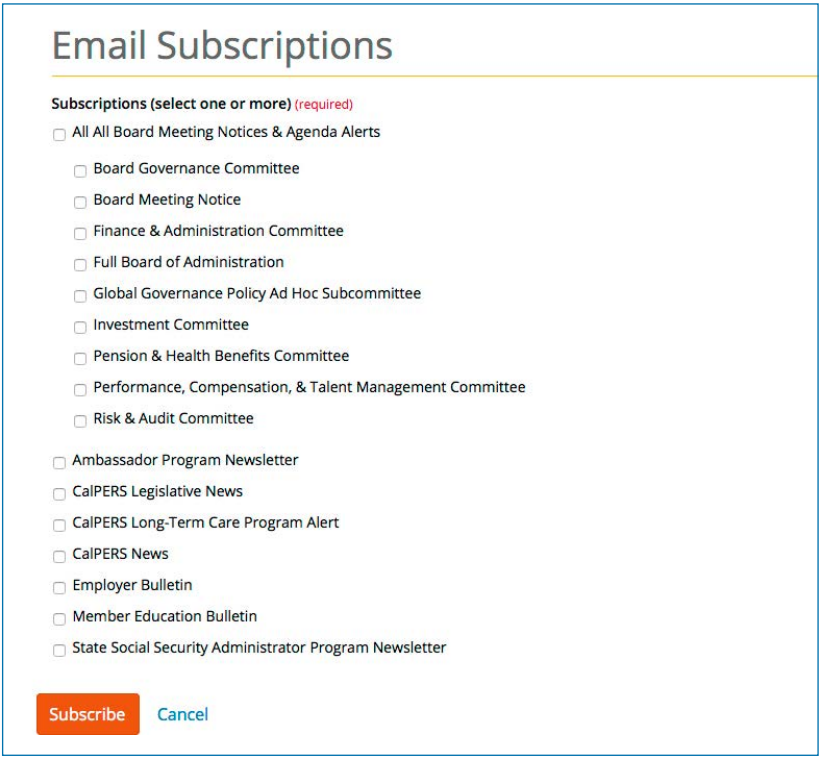
News Feeds (RSS)

Subscribe to our RSS feeds through the CalPERS website to have updates come to you as soon as we post them. We offer RSS feeds for CalPERS News, Circular Letters, Facts at a Glance, and more.

Email Subscriptions

Receive the latest news and information by email

Sign up on the CalPERS website for email subscriptions, including CalPERS News, Board Meeting Notices, and Member Education Bulletins.





California Public Employees' Retirement System
400 Q Street
P.O. Box 942701
Sacramento, CA 94229–2701
www.calpers.ca.gov

888 CalPERS (or 888-225-7377)

Printed at CalPERS – PUB 71 | 2016.6

*Employee to send this form to CalPERS once completed.

CalPERS

P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | Fax: (800) 959-6545
www.calpers.ca.gov

California Public Employees' Retirement System

Pre-Retirement Lump Sum Beneficiary Designation

Section 1 Member Information

Please include your first name, middle initial and last name.

Member's Full Name _____ Social Security Number or CalPERS ID _____

Telephone Number _____ Birth Date _____

Section 2 Beneficiary Designation

Provide on the form the full name of your beneficiaries, relationship, Social Security number or CalPERS ID and the complete address.

If a percentage (%) is entered make sure the total equals 100%.

If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date and write your Social Security number or CalPERS ID at the top of each additional sheet.

I understand that if I am married or in a registered domestic partnership but do not name my spouse or registered domestic partner as beneficiary, she/he may still be entitled to a community property share of my "Lump Sum Contributions" or a share of any monthly allowance that may be payable. My "Non-Spouse" or "Non-Registered Domestic Partner" designated beneficiaries will receive the portion of my lump sum benefits, which are not payable to my spouse or registered domestic partner as his/her community property share. I further understand that if my death is determined to be "Industrial," special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, the applicable benefits will be paid **share and share alike**.

Primary Beneficiaries

Name of Primary Beneficiary _____ Birth Date _____

Relationship to the Member _____ Percentage of the Benefit _____ Social Security Number or CalPERS ID _____

Address (Number, Street, City, State and Zip Code) _____

Name of Primary Beneficiary _____ Birth Date _____

Relationship to the Member _____ Percentage of the Benefit _____ Social Security Number or CalPERS ID _____

Address (Number, Street, City, State and Zip Code) _____

Name of Primary Beneficiary _____ Birth Date _____

Relationship to the Member _____ Percentage of the Benefit _____ Social Security Number or CalPERS ID _____

Address (Number, Street, City, State and Zip Code) _____

Put your name and Social Security number or CalPERS ID at the top of every page.

Member's Name | Social Security Number or CalPERS ID

Section 2

Beneficiary Designation - Continued

If a percentage (%) is entered make sure the total equals 100%.

In the event that I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) is given, benefits will be paid **share and share alike**.

Secondary Beneficiaries

If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date and write your Social Security number or CalPERS ID at the top of each additional sheet.

Name of Secondary Beneficiary | Birth Date

Relationship to the Member | Percentage of the Benefit | Social Security Number or CalPERS ID

Address (Number, Street, City, State and Zip Code)

Name of Secondary Beneficiary | Birth Date

Relationship to the Member | Percentage of the Benefit | Social Security Number or CalPERS ID

Address (Number, Street, City, State and Zip Code)

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

Section 3

Required Signature(s)

Provide the date you signed the form and your current mailing address.

Member's Acknowledgement:

By this Beneficiary Designation, I hereby revoke any previous designation I have filed. I understand that my marriage or registered domestic partnership, dissolution or annulment of my marriage or registered domestic partnership, or the birth or adoption of a child or termination of membership subsequent to the date I file this form with CalPERS, will automatically void this designation. However, a designation filed after the initiation of a dissolution/annulment of marriage or registered domestic partnership is not revoked when the dissolution/annulment is finalized.

Are you legally married or have a registered domestic partner? ☐ Yes ☐ No

If yes, your spouse or registered domestic partner must sign this form. If no, please indicate:

☐ Never Married/Never in Registered Domestic Partnership ☐ Divorced/Annulled ☐ Widowed

If you are married or in a registered domestic partnership and your spouse or registered domestic partner **does not** sign this form, you must complete and submit the **Justification for Absence of Spouse's or Registered Domestic Partner's Signature** (my|CalPERS 0775) form with your designation form.

IMPORTANT - You must complete the Justification for Absence of Spouse's or Registered Domestic Partner's Signature (my|CalPERS 0775) if you are married or have a registered domestic partnership but your spouse or registered domestic partner is unable to sign below.

Member's Signature | Date (mm/dd/yyyy)

Member's Address | City | State | Zip Code

Spouse's/Registered Domestic Partner's Acknowledgement:

By signing this beneficiary designation form, I acknowledge the information entered by my spouse/ registered domestic partner.

Spouse's/Registered Domestic Partner's Signature | Date (mm/dd/yyyy)

Mail to: CalPERS Benefit Services Division · P.O. Box 942711, Sacramento, CA 94229-2711

Section 4 Information and Instructions

Information

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please order or download your Member Benefit Publication from our website www.calpers.ca.gov or see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

A. If you are a safety member and your death is job-related, or if you are not a safety member but you are fatally attacked while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step-children under age 22, whether or not you have filed a beneficiary designation.

B. If you are eligible for retirement or you are a State member with at least 20 years of State service credit, a monthly death benefit allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner to whom you have been married to or in a partnership with for either one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

   If you do have a valid beneficiary designation on file, your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions or monthly death benefit allowance. However, your non-spouse/non-registered domestic partner designated beneficiaries will receive the portion of your lump sum benefits that are not payable to your spouse/ registered domestic partner as his/her community property share.

C. If A and B do not apply and there is no valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

   1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death); or if none
   2. Natural and adopted children, including (in limited situations) a natural child adopted by another, share and share alike; or if none,
   3. Parents, share and share alike; or if none,
   4. Brothers and sisters, share and share alike, or if none,
   5. Your estate (if probated, or subject to probate), or if not,
   6. Your trust (if one exists), or if not,
   7. Stepchildren, share and share alike or if none,
   8. Grandchildren, including step-grandchildren, share and share alike, or if none,
   9. Nieces and nephews, share and share alike, or if none,
   10. Great-grandchildren, share and share alike, or if none,
   11. Cousins, share and share alike.

   If A and B do not apply and there is a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are married or have a registered domestic partner at the time of death, your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions.**

D. You may designate or change your beneficiaries at any time by completing another Beneficiary Designation form. You may name as beneficiary any person or persons, a corporation or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. Reminder: **If you are married or in a registered domestic partnership at the time of your death and you do not name your spouse/registered domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump sum contributions or a share of any monthly allowance that may be payable.**

E. Your Beneficiary Designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CalPERS:
   1. Marriage/Registration of domestic partnership; or
   2. Dissolution or annulment of your marriage/registered domestic partnership. However, a designation filed after the initiation of a dissolution/annulment of marriage or registered domestic partnership is NOT revoked when the dissolution/annulment is finalized; or
   3. Birth or adoption of a child; or
   4. Termination of membership that results in a refund of your contributions.

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).

*Employee to send this form to CalPERS once completed.

Special Power of Attorney

888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442

Section 1 — Creation of Durable Power of Attorney for Retirement-Related Business

When completing this form, please be sure to print the requested information.

For the purpose of this form, a "principal" is defined as a person who empowers another to act as a representative on his or her behalf.

The "agent" is the attorney-in-fact.

Name of Principal (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Address | County

City | State | ZIP | Daytime Phone

By this document I intend to create a power of attorney by appointing the person(s) named below to make retirement-related decisions for me as allowed by the California Probate Code. The authority granted pursuant to this power of attorney is expressly limited to decisions relating to my financial and health benefits under the California Public Employees' Retirement System, the Judges' Retirement System I or the Judges' Retirement System II, and the Legislators' Retirement System, hereinafter CalPERS, JRS I, JRS II, and LRS, respectively. I give my agent, also called an attorney-in-fact, the powers specified herein with the understanding that these powers will be used for my benefit and will be exercised only in a fiduciary capacity. This power does not authorize the appointed agent to make any medical decisions for me.

Section 2 — Designation of Attorney-in-Fact (Agent)

If you appoint more than one attorney-in-fact and do not check a box, all of your attorneys-in-fact must act or sign together (jointly).

You have the option to designate one attorney-in-fact.

If you appoint more than one attorney-in-fact, choose the jointly, separately, or alternately check box below:

☐ **Jointly** – All designated attorneys-in-fact must sign for any action. Granting joint authority to two or more attorneys-in-fact means that the agents' authority is exercisable only by their unanimous action. If one is unavailable because of absence, illness, or other temporary incapacity, the other attorneys-in-fact may exercise their authority under the power of attorney.

☐ **Separately** – Any one designated attorney-in-fact may act without the other(s).

*If you choose "Alternately," identify the order of your attorneys-in-fact in the boxes below.

☐ **Alternately** – Your attorney-in-fact will act in the numerical order you assign in the boxes below.* The successor attorney-in-fact will act if the person you originally appointed is unavailable because of absence, illness, or other temporary incapacity. Delegation of powers to any third party who is not named as an alternate attorney-in-fact is not permitted under this document.

☐ Name of Attorney-in-Fact (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy) | Relationship

Address | Social Security Number or CalPERS ID

City | State | ZIP | Daytime Phone

☐ Name of Attorney-in-Fact (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy) | Relationship

Address | Social Security Number or CalPERS ID

City | State | ZIP | Daytime Phone

☐ Name of Attorney-in-Fact (First Name, Middle Initial, Last Name) | Birth Date (mm/dd/yyyy) | Relationship

Address | Social Security Number or CalPERS ID

City | State | ZIP | Daytime Phone

Put your name and Social Security number or CalPERS ID at the top of every page

Name of Member | Social Security Number or CalPERS ID

Section 3

General Statement of Authority Granted

You must check a box to indicate whether you are granting the specific authority to your attorney(s)-in-fact. If you do not check a box, your attorney(s)-in-fact will not be granted this specific authority.

See ***A Guide to the CalPERS Special Power of Attorney*** (PUB 30) for a detailed explanation of the authority you are granting.

I hereby grant to my attorney-in-fact full power and authority to transact matters on my behalf relating to CalPERS, JRS I, JRS II, or LRS. I understand that I am granting authority to the attorney-in-fact regardless of whether that person is related to me by blood, marriage, or legal domestic partnership. By signing this ***Special Power of Attorney*** form I intend that:

- My attorney-in-fact (☐ is; ☐ is not) authorized to select any retirement payment option available under the retirement plan other than the Unmodified Allowance.
  Note: Allowing your attorney-in-fact to choose any retirement payment option available under the retirement plan other than the Unmodified Allowance may reduce the monthly allowance that would otherwise be paid to you during your lifetime.
- My attorney-in-fact (☐ is; ☐ is not) authorized to designate or change my beneficiary.
  - My attorney-in-fact (☐ is; ☐ is not) authorized to designate him or herself as my beneficiary.

On the following lines you may give special instructions limiting the powers granted to your attorney(s)-in-fact.

Section 4

Duration of Power of Attorney

Please be careful in choosing when you want your power of attorney to commence and/or terminate.

Check **one** box to indicate your choice. Checking multiple boxes may invalidate this form.

The person that you authorize to make the determination of incapacity must be at least 18 years old at the time of designation. This person may be, but is not required to be, a licensed physician or attorney.

Unless I indicate otherwise, this power of attorney shall be considered effective immediately and will continue for the duration specified below or, if no duration is specified, until my death. My attorney-in-fact is hereby instructed to notify CalPERS in writing of my disability, incapacity, or death immediately upon its occurrence. I understand that I may revoke this power of attorney at any time by providing CalPERS with a written statement of my intent to do so.

☐ This **durable** power of attorney is to commence immediately and to remain in effect for my lifetime, even if I become incapacitated, or until I specifically revoke it.

☐ This **limited** power of attorney is to commence on _____ and terminate on
Date (mm/dd/yyyy) or Event

_____.
Date (mm/dd/yyyy) or Event

☐ This **contingent/springing** power of attorney is to commence only upon a determination that I am incapacitated and/or unable to handle my own affairs. The determination of whether I am incapacitated and/or unable to handle my own affairs for the purpose of this instrument shall be made in a written statement signed by

_____.
Name and Relationship or Title of Person Authorized to Make the Determination

☐ This **general (non-durable)** power of attorney is to terminate in its entirety if I become incapacitated. The determination that I am incapacitated and/or unable to handle my own affairs for the purpose of this instrument shall be made in a written statement signed by

_____.
Name and Relationship or Title of Person Authorized to Make the Determination

Section 5

Warning Statements

Attorney(s)-in-fact may not conduct business by accessing your online mylCalPERS account. All contact with CalPERS on your behalf must be made by telephone, by written correspondence, or by visiting a Regional Office.

The "agent" is the attorney-in-fact.

The authority granted by the CalPERS ***Special Power of Attorney*** form is limited to matters relating to CalPERS, JRS I, JRS II, and LRS. The person designated as your attorney-in-fact does not have any authority over your other real and/or personal property. If you wish that your attorney-in-fact have authority over your real and/or personal property, it is recommended that you seek legal counsel.

You may notice that the language contained in the following Warning Statements refers to more extensive authority than granted by the CalPERS *Special Power of Attorney* form. These Warning Statements are required by Probate Code section 4128 and must be included in all preprinted durable power of attorney forms even though the CalPERS *Special Power of Attorney* form does not authorize your attorney-in-fact to do many of the things mentioned in the Warning Statements. If you are concerned with the Warning Statements or the extent of the authority being granted by the CalPERS *Special Power of Attorney* form, we again recommend that you seek legal counsel.

(Warning): Notice to Person Executing Durable Power of Attorney

A durable power of attorney is an important legal document. By signing a durable power of attorney, you are authorizing another person to act for you, the principal. Before you sign this durable power of attorney, you should know these important facts:

- Your agent (attorney-in-fact) has no duty to act unless you and your agent agree otherwise in writing.
- This document gives your agent the powers to manage, dispose of, sell, and convey your real and personal property, and to use your property as security if your agent borrows money on your behalf. This document does not give your agent the power to accept or receive any of your property, in trust or otherwise, as a gift, unless you specifically authorize the agent to accept or receive a gift.
- Your agent will have the right to receive reasonable payment for services provided under this durable power of attorney unless you state otherwise in this power of attorney.
- The powers you give your agent will continue to exist for your entire lifetime, unless you state that the durable power of attorney will last for a shorter period of time or unless you otherwise terminate the durable power of attorney. The powers you give your agent in this durable power of attorney will continue to exist even if you can no longer make your own decisions regarding the management of your property.
- You can amend or change this durable power of attorney only by executing a new durable power of attorney or by executing an amendment through the same formalities as an original. You have the right to revoke or terminate this power of attorney at any time as long as you are competent.
- This durable power of attorney must be dated and must be acknowledged before a notary public or signed by two witnesses. If it is signed by two witnesses, they must witness either (1) the principal's signing of the power of attorney or (2) the principal's acknowledgement of his or her signature. A durable power of attorney that may affect real property should be acknowledged before a notary public so that it can easily be recorded.
- You should read this durable power of attorney carefully. When effective, this durable power of attorney will give your agent the right to deal with property that you now have or might acquire in the future. This durable power of attorney is important to you. If you do not understand the durable power of attorney or any provision of it, you should obtain the assistance of an attorney or other qualified person.

Put your name and Social Security number or CalPERS ID at the top of every page

Name of Member | Social Security Number or CalPERS ID

Section 5, continued

Warning Statements, Continued

(Warning): Notice to Person Accepting the Appointment as Attorney-in-Fact

By acting or agreeing to act as the agent (attorney-in-fact) under this power of attorney you assume the fiduciary and other legal responsibilities of an agent. These responsibilities include:

- The legal duty to act solely in the interest of the principal and to avoid conflicts of interest.
- The legal duty to keep the principal's property separate and distinct from any other property owned or controlled by you.

You may not transfer the principal's property to yourself without full and adequate consideration or accept a gift of the principal's property unless this power of attorney specifically authorized you to transfer property to yourself or accept a gift of the principal's property. If you transfer the principal's property to yourself without specific authorization in the power of attorney, you may be prosecuted for fraud and/or embezzlement. If the principal is 65 years of age or older at the time the property is transferred to you without authority, you may also be prosecuted for elder abuse under Penal Code section 368. In addition to criminal prosecution, you may also be sued in civil court.

I have read the foregoing notice and I understand the legal and fiduciary duties that I assume by acting or agreeing to act as the agent (attorney-in-fact) under the terms of this power of attorney. Lastly, the principal's benefit shall not be subject to execution, process, or assignment under California Public Employees' Retirement Law section 21255.

Signature of the agent (attorney-in-fact) is optional.

Print Name of Agent (First Name, Middle Initial, Last Name)

Signature of Agent | Date (mm/dd/yyyy)

Print Name of Agent (First Name, Middle Initial, Last Name)

Signature of Agent | Date (mm/dd/yyyy)

Print Name of Agent (First Name, Middle Initial, Last Name)

Signature of Agent | Date (mm/dd/yyyy)

Section 6

Principal's Acknowledgement and Execution

To be completed and signed by the principal.

I am of sound mind and have consulted with an attorney or otherwise understand my elections. I am executing this legal document under my own free will. I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party has actual knowledge of the revocation.

Date Executed (mm/dd/yyyy) | City | State

Signature of Principal | County

Print Name of Principal (First Name, Middle Initial, Last Name) | Social Security Number or CalPERS ID

Put your name and Social Security number or CalPERS ID at the top of every page

Name of Member | Social Security Number or CalPERS ID

Section 7

Witness Information

Must be completed by two individuals who are at least 18 years of age and are not named as attorney-in-fact or successor attorney-in-fact.

Alternately, Section 8 below must be completed by a notary public.

I have witnessed the principal's signature or the principal's acknowledgment of his or her signature designating power of attorney. I am of sound mind, I am an adult at least 18 years old, and I am not the attorney-in-fact or successor attorney-in-fact. My signature certifies that the principal is known to me and is the same person who signed and dated this Special Power of Attorney form.

Signature of Witness 1 | Print Name of Witness 1 (First Name, Middle Initial, Last Name)

Address | Date (mm/dd/yyyy)

City | State | ZIP

Signature of Witness 2 | Print Name of Witness 2 (First Name, Middle Initial, Last Name)

Address | Date (mm/dd/yyyy)

City | State | ZIP

Section 8

Notary Public Acknowledgement

Must be completed by a notary public if Section 7 is not completed.

CalPERS images these documents. Please be advised embossed seals may not appear when this document is reviewed. An inked stamp is preferred.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

Notary

State | County

On _____ (Date (mm/dd/yyyy)) before me _____ (Printed Name of Notary Public), personally appeared

_____ (Name of Principal), who proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under Penalty of Perjury under the laws of the State of California that the foregoing paragraph is true and correct.

Witness my hand and official seal.

Signature of Notary Public | Notary Seal

Print Name

Mail to: **CalPERS Benefit Services Division • P.O. Box 942716, Sacramento, California 94229-2716**

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).



City of Newport Beach
Deffered Compensation Plan

"Life should be as colorful as the rainbow. Remember, you are your own painter, always..." ~ Kazeronnoe Mak

CITY OF NEWPORT BEACH PLAN SERVICES

Your City of Newport Beach 457 Deferred Compensation Plan has a number of services to make it easier for you to prepare for retirement.

Change Your Contribution

No more paper! You can change your contribution directly with Empower Retirement anytime, anyplace, 24/7.

Here's how to do it:

1. Log in to your account at **www.empower-retirement.com/participant**.[1]
2. Click on Change Paycheck Contribution under the Transactions menu.
3. Select the type of contribution change you would like to make, including Ongoing, Single Payroll, Scheduled Increase, Cancel Request, and Stop All Paycheck Contributions.
4. Enter the paycheck contribution to be deducted from each paycheck. The effective date is automatically filled.
5. Confirm the change and click Submit.

You can also go on auto-pilot with your contributions by setting up an automatic increase at a set interval.

If you're away from a computer, you may also call KeyTalk® at **(800) 701-8255** to change your paycheck contribution through the automated voice response system or by speaking to a customer service representative, available Monday through Friday, 9:00 a.m. to 8:00 p.m. ET.[1]

Are You on Track for Your Retirement Goals?

Check out the Retirement Income Control Panel, brought to you by Advised Assets Group, LLC (AAG), a registered investment adviser, after logging in to the website at **www.empower-retirement.com/participant**.[2] You can see what your balance, when projected out to age 67, may equate to in terms of monthly retirement income, and you can see how you can improve your strategy.

Not Enrolled? You Can Enroll Online

Once you have learned about your Plan and are ready to enroll, visit **www.empower-retirement.com/participant** and click on Let's Get Started. You should have received a Personal Identification Number (PIN) by mail at your home address.[3] If you have not yet received your PIN but are ready to enroll, please call KeyTalk® to request a new one.

On the next page, enter Plan ID 98310-01 and click Continue. On the following page, enter your Social Security number (SSN) and PIN, then click Continue. From there, you can follow the onscreen prompts to select your paycheck contribution amount and investment options and complete the enrollment process.

If you need help at any point during the enrollment process, call KeyTalk for guidance from a Empower Retirement representative.

Retired and Need Money? Access Distribution Features Online

To request a distribution from your account, log in to your account at **www.empower-retirement.com/participant** and click on the Loans and Withdrawal tile, then Withdrawal Request, and follow the instructions.

Financial Planning

Are you all set on your retirement income goals? Then start thinking about other financial aspects, such as having sufficient life and disability insurance, college planning, and more. Contact us for more details.

Plan Representative

Your local rep is Jessica Bigueur. She is at City Hall every Wednesday, except the last Wednesday of the month when she is at the Police Department instead.

For more information, contact Jessica[4]:

email: jessica.bigueur@empower-retirement.com | phone: 909-353-5483

1 Access to KeyTalk and the website may be limited or unavailable during periods of peak demand, market volatility, systems upgrades/maintenance or other reasons.

2 The Retirement Income Control Panel is provided as an educational tool for the participant's private use to assist in analyzing the various impacts of his or her savings and investment decisions. It is not intended to provide financial planning or investment advice. All information provided by the Retirement Income Control Panel is hypothetical and for illustrative purposes only. The accuracy of these results or their applicability to the participant's individual circumstances cannot be and is not guaranteed. The Retirement Income Control Panel is brought to you by Advised Assets Group, LLC (AAG), a registered investment adviser and wholly owned subsidiary of Great-West Life & Annuity Insurance Company, under a licensing agreement with your retirement plan service provider. All rights reserved.

3 The account owner is responsible for keeping the assigned PIN confidential. Please contact Empower Retirement immediately if you suspect any unauthorized use.

4 Representatives of GWFS Equities, Inc. are not registered investment advisors and cannot offer financial, legal or tax advice. Please consult with your financial planner, attorney and/or tax advisor as needed.

Core securities, when offered, are offered through GWFS Equities, Inc. and/or other broker dealers.

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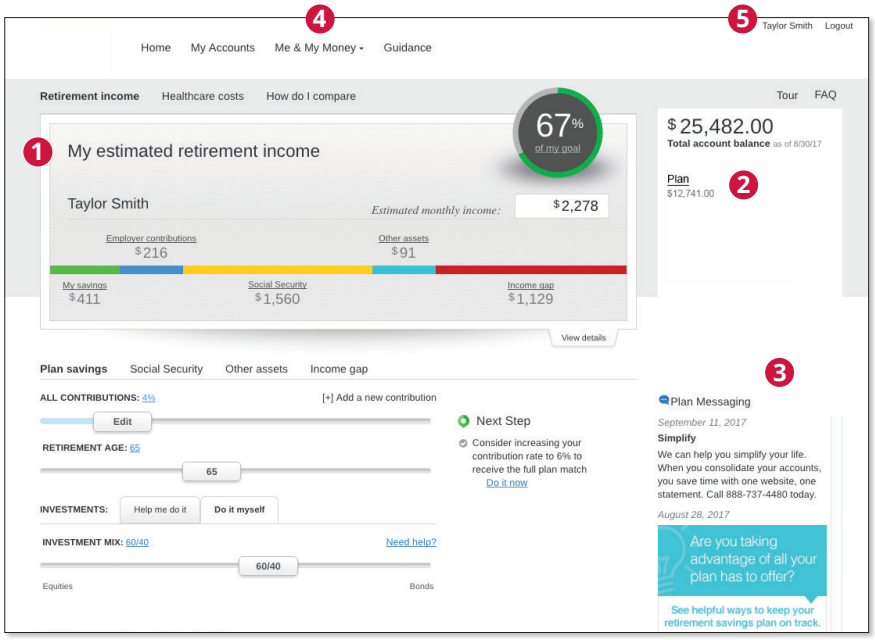
Stay on track by going online

Get your score, see how you compare and view next steps

Visit your plan website to quickly and easily see how much you've saved and more. Simply log in to your account to:

- View your estimated monthly retirement income and see if your future savings are on track.
- Model different savings scenarios and view the possible outcomes.
- Make changes to your account with just one click.

Your home page at a glance



FOR ILLUSTRATION PURPOSES ONLY

To experience all these features and more, visit empowermyretirement.com

OR

For more help, call 800-701-8255. Live representatives available Monday through Friday 6am– 8pm Mountain time and Saturdays 7am–3:30pm Mountain time.

1. Know your estimated monthly income in retirement

Your retirement plan can help you work toward an estimated monthly income in retirement to:

- Find out how much income you may have in retirement.
- See the effects of any changes you make in real time if you made adjustments.
- Put your savings in context.
- Request changes immediately.

2. Get your account details

Click on your plan name to:

- See your balance.
- Get fund information.
- View your statements.
- And more.

3. Receive plan messaging

Bulletins posted to your home page help you stay up to date on plan events and changes.

4. Quickly link to *Me & My Money*

Here you will find the Empower Wellness and Financial Center with information, videos and calculators to help you address important financial needs. Me & My Money is organized into four key areas — Spending, Saving, Investing and Protecting — and suggests next steps.

5. Access your personal profile

Click your name to:

- Choose electronic communications.
- Make or update a beneficiary designation, if applicable to your plan.
- Update your contact information.
- Make sure your communication preferences and email are up to date.

CITY OF NEWPORT BEACH CALIFORNIA

EMPOWER RETIREMENT®

Stay on track by going online

Start by registering your account

- Log on and select *Register.*
- Choose the *I do not have a PIN* tab.
- Follow the prompts to create your username and password.

If we don't have your email or phone number on file from your employer, or if you have another account with Empower (with a former employer, for example), you will need to call to access your new plan account.

For more help, call 800-701-8255. Live representatives available Monday through Friday 6am– 8pm Mountain time and Saturdays 7am–3:30pm Mountain time.

Contact:
Jessica Bigueur (909)353-5483, or
jessica.bigueur@empower-retirement.com

Get the mobile app and connect to your plan whenever, wherever

View and manage your plan anywhere, anytime with the Empower Retirement app for your mobile device or Apple Watch®. Available in the App Store® from Apple® for iOS or on Google Play for Android™.

See the other side for helpful features on the site, including:

- Your retirement income score — see how you're tracking
- Account management
- How to make changes with one click

empowermyretirement.com

NOW IS A GOOD TIME

Securities distributed through GWFS Equities, Inc., Member FINRA/SIPC and a subsidiary of Great-West Life & Annuity Insurance Company.

This material has been prepared for informational and educational purposes only and is not intended to provide investment, legal or tax advice.

IMPORTANT: The projections, or other information generated on the website by the investment analysis tool regarding the likelihood of various investment outcomes, are hypothetical in nature, do not reflect actual investment results and are not guarantees of future results. The results may vary with each use and over time. Healthcare costs and projections, if applicable, are provided by HealthView Services. HealthView Services is not affiliated with GWFS Equities, Inc. Empower Retirement does not provide healthcare advice. A top peer is defined as an individual who is at the 90th percentile of the selected age band, salary range and gender.

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ICMA-RC
Building Retirement Security

Plan 803377
CITY OF NEWPORT BEACH

Welcome to ICMA-RC!

We have set up your new VantageCare Retirement Health Savings (RHS) account and would like to welcome you. Your RHS Plan allows you, when benefit eligible, to pay for qualified medical expenses on a tax-free basis.

We make it our business to provide you with quality service. Please take advantage of our services and let us know how we may improve them. Here is a sample of our services:

- ***The VantageLine*** is toll-free and gives you fast, private access to your daily account balance and allows you to make investment changes using your touch-tone telephone 24 hours a day. You may assign your own Personal Identification Number (PIN) and gain private access by calling the VantageLine at 1-800-669-7400.

- ***Our Internet site*** provides you with private access to your account balance and the ability to make investment changes. Find us online at www.icmarc.org.

- ***Account statements*** are mailed quarterly, and year-to-date statements are available at any time by calling the VantageLine. ***Confirmations*** are mailed within one business day of any investment or address change, so that you may verify quickly that the change you requested has been properly recorded. Statements and confirmations are also available online.

We extend our warmest welcome to you and look forward to serving you. Please call us with any questions you may have at 800-669-7400.



www.icmarc.org

Login Process Instructions

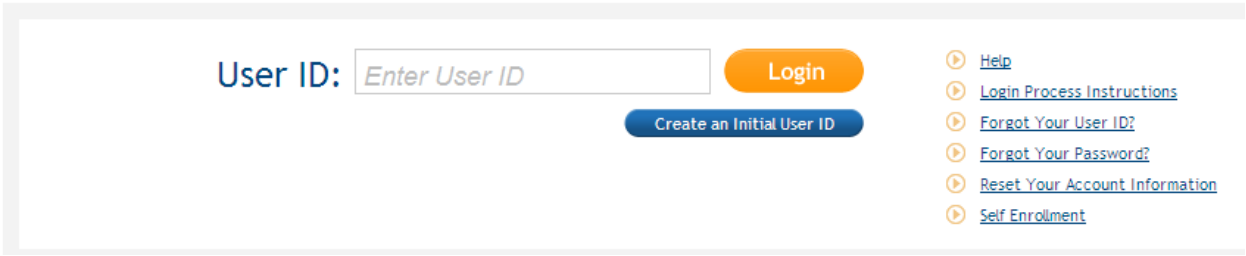
ICMA-RC has streamlined the process for logging into your ICMA-RC account. In addition, you are now required to provide an email address in order to use Account Access. Here are simple instructions for logging in:

1. **New Account Access users** who have not yet established a user ID and password should go to the Login page, and click on the blue "Create Your Own Account" button and follow the instructions provided.
2. **Current Account Access users** should go to the Login page, enter your user ID in the User ID box, and click on the orange "Login" button.
3. You will then see the security image you have previously chosen and a password box. If you are logging in from a different computer or browser than the last time you logged in, you will also see one of your security questions.
4. Enter your password in the box under "Your Password," and enter the answer to your security question in the box under the question, if requested.
5. Click on the "Login" button.
6. If you have not already provided an email address to ICMA-RC, you will be prompted to enter an email address on the next screen. Enter your email address and click on the "Login" button. You will be required to enter an email address in order to proceed from this screen.

Once you have entered all required information and clicked on the "Login" button, you will have successfully completed the Account Access login process. You can now review your account information and securely conduct transactions at your convenience!

Login

(For Account Access and EZLink)



**Only Applies to Employees in CEA, K&M and ProfTech

LiUNA NATIONAL (INDUSTRIAL) PENSION FUND

Summary of Supplemental Retirement Plan

STRUCTURE

The LIUNA National (Industrial) Pension Fund was founded in 1967 as a joint labor-management trust fund. It is a defined benefit pension plan that offers multiple levels of benefits based on a contribution rate and length of covered employment. It covers workers in many different industries in a wide variety of occupational areas outside of the construction industry. For over 50 years, the Board of Trustees has monitored and continues to monitor the Pension Fund to ensure its actuarial and financial soundness.

WHAT THE PLAN OFFERS

A Participant will receive a monthly retirement benefit for their lifetime and there is a monthly lifetime benefit available for a surviving spouse. Participants earn two kinds of credits under the Fund; Vesting Credits determine eligibility for a benefit, and Pension Credits determine the amount of the lifetime monthly benefit. Such lifetime benefits are available to Participants who earn at least five (5) years of Vesting Service Credits. Earning Vesting Credits for employment during the contribution period is as follows:

Hours of Employment in Calendar Year for which Contributions are Made to Pension Fund	Months of Vesting Credit for Future Service for Calendar Year
1 – 166	1 month
167 – 332	2 months
333 – 499	3 months
500 – 666	4 months
667 – 832	5 months
833 – 999	6 months
1,000 or more	12 months (one year)

Earning Pension Credits during the contribution period is as follows:

Hours of Employment in Calendar Year for which Contributions Are Made to Pension Fund	Months of Future Pension Credit for Calendar Year
1 – 166	1 month
167 – 332	2 months
333 – 499	3 months
500 – 666	4 months
667 – 832	5 months
833 – 999	6 months
1,000 – 1,166	7 months
1,167 – 1,332	8 months
1,333 – 1,499	9 months
1,500 – 1,666	10 months
1,667 – 1,799	11 months
1,800 or more	12 months

FUNDING RELIEF PROGRAM

The Pension Protection Act of 2006 (PPA) amended federal pension law to impose stricter funding standards on multiemployer pension plans, including the Laborers' National (Industrial) Pension Fund. The PPA requires a plan's actuary to annually certify to the plan trustees and federal government the plan's funding zone status based on the standards passed into law.

Under the Funding Improvement Plan adopted by the Board of Trustees in 2008, the Pension Fund was on track for long-term financial security until the triple disasters of 2008-2009: the investment market crash, the deep economic recession, and the continuing unemployment crisis. One consequence is that the Pension Fund's funding status slipped from the "yellow zone" to the "red zone" under the PPA's stricter funding rules.

The Board of Trustees adopted the Funding Rehabilitation Plan (FRP) on July 26, 2010 as required by the PPA. The FRP is designed to encourage continued participation in the Pension Fund by, among other ways, enabling participating groups to maintain the current benefit program (with minor changes) and continue to provide a lifetime annuity. The FRP is designed with two different schedules, the Preferred Schedule and the Default Schedule. The FRP period is the period of 10 plan (calendar) years commencing on January 1, 2013. The Fund is expected to emerge from the red zone, based on reasonable assumptions, by the plan year beginning January 1, 2023. The actuaries have indicated that the FRP is ahead of schedule.

TYPES OF BENEFIT PAYMENTS – PREFERRED SCHEDULE

Regular Pension

- Retire at age 62 under a full Regular Pension for those individuals who were Participants as of December 31, 2007
- Individuals for whom the Pension Fund first receives contributions on or after January 1, 2008, can receive the full Regular Pension retirement at age 65.
- Determination of Regular Pension Amount is as follows under percentage of pay:

  Step 1: Annual salary x % rate ÷ 1,800 hours = hourly rate for the period:

  Step 2: Hourly rate for the period = benefit level x number of months for period ÷ 360 = monthly benefit amount at normal retirement age.

  The hourly rate for the period ties back to the appropriate Benefit Levels schedule in effect as of January 1, 1994 and/or January 1, 2008 and up to the adoption date of the Preferred Schedule under the Funding Rehabilitation Plan (FRP) which was January 1, 2013 for the City of Newport Beach. The salary earned in 2012 and the percentage rate of 1.5% in effect as of December 31, 2012 will determine the monthly benefit amount for the portion of pension credits earned after December 31, 2012. For new hires on or after January 1, 2013, year one salary will be used with a rate of 1.5% to determine all future credits earned. Fund Office contacts employer to get new hires annual salary to determine benefit accrual rate for that employee.

Early Pension

- Participants for whom the Pension Fund first receives contributions on or before December 31, 2007 can retire as early as age 55 with a reduction of 3% per year for each year under full retirement age.
- Participants for whom the Pension Fund first receives contributions on or after January 1, 2008 can retiree as early as age 55 with a reduction of 6% per year for each year under full retirement age.

Deferred Pension

- This applies to Participants whose covered employment ends before they attain retirement age.
- Employee must be at leas age 55, have at least five (5) years of Vesting Credits before covered employment has ended and not in disqualifying employment under the suspension rules.
- Benefit is determined based on formula above and the number of Pension Credits earned.

Disability Pension

- ●No age limit;
- ●Lifetime benefit with no age reduction;
- ●10 years of Pension Credits;
- ●Must have 3 months of Pension Credits in the calendar year in which you became disabled or 3 months of Pension Credits in the previous calendar year;
- ●Must be found totally and permanently disabled. Total and permanent disability means that the employee is totally unable, as a result of a bodily injury or disease, to engage in or perform the duties of any occupation for remuneration or profit and such disability is expected to be permanent and continuous for the remainder of the employee's life.
- ●Employee must submit medical records and other information required for a determination to be made by the Pension Fund Board of Trustees.
- ●There is a five-month waiting period for a Disability Pension.

Reciprocal Pension

- ●Laborers' National Reciprocal Agreement provides LIUNA Members the ability to bridge Vesting Credits earned under different LIUNA Pension Funds if they lack enough Vesting Credits to qualify for a pension benefit. This prevents the member from incurring a break-in-service and helps them meet the five (5) year vesting requirement needed for a retirement benefit.

Optional Forms of Pension Benefits

- ●50% Joint and Survivor Pension is the normal form of pension payable to a married participant at the time if their retirement.
- ● Regular and Pop-up Joint and Survivor Options – 50%, 75% and 100% are available for married Participants who properly reject the 50% Joint and Survivor Pension;
- ●Single Life Annuity with 60-month guarantee;
- ●120 Certain Payment Option.

Widow's/Widower's Pension (Pre-Retirement)

- ●Lifetime monthly benefit payment for those married vested Participants who pass away before retirement. Must be lawfully married at time of death.

Death Benefit

- ●$5,000 to unmarried vested Participants' beneficiaries who pass away before retirement.
- ●Payable in equal shares to any surviving children. No surviving children, then payable in equal shares to the surviving parents. No surviving parents, then payable in equal shares to any surviving siblings. No such survivors, then paid to the Participant's estate.

Collecting Your Benefits

You must contact the Pension Fund Office at least 2 to 3 months prior to your intended retirement by calling or writing to the Fund Office. You can ask the Fund Office any questions about the application package and process, options available and your rights under the Plan Rules.

To collect your benefits or for any questions or assistance needed regarding this Pension Fund, please contact us as follows:

LIUNA National (Industrial) Pension Fund
905 16th St, NW
Washington, DC 20006-1765
Phone 202-737-1664 or 800-544-7422
Fax 202-347-0721
Website www.lnipf.com
Hours of Operation: 8:30AM EST to 4:15PM EST, Monday – Friday, except Holidays

LIUNA NATIONAL (INDUSTRIAL) PENSION FUND
&
Q & A FOR CITY OF NEWPORT BEACH EMPLOYEES

LIUNA Questions from Key & Management

1) What age is retirement for LIUNA?

Normal Retirement Age under the LIUNA National (Industrial) Pension Fund ("LNIPF") is age 62 for individuals who participated in the Fund prior to December 31, 2007. Individuals who first had contributions remitted after January 1, 2008 have a Normal Retirement age of 65.

Any vested participant may retire as early as age 55 under the Plan, but the monthly benefit payable is reduced actuarily for each month below normal retirement age that the individual retires and commences their pension benefit.

2) What age must I be to collect 100% of the LIUNA value?

You must be of Normal Retirement Age to collect your maximum benefit amount based on your reported salary under the percentage of pay that ties back to the benefit accrual schedule and the number of pension credits earned under the Plan Rules.

3) What is the vesting criteria?

Once a participant is vested then he or she has a right to receive a pension upon retirement that cannot be taken away even if the individual leaves covered employment. A participant is vested once the individual earns 60 vesting credits under the Plan without a permanent break in service (normally 5 years). Credits are applied monthly based the following chart:

Hours of Contribution	Vesting Credits
1-166	1 month
167-332	2 months
333-499	3 months
500-666	4 months
667-832	5 months
833-999	6 months
1000 or more	12 months

The following schedule relates to pension credits which are used to determine the participant's monthly retirement benefit:

Hours of Contributions	Months of Future Pension Credits
1-166	1 month
167-332	2 months
333-499	3 months
500-666	4 months
667-832	5 months
833-999	6 months
1,000-1,166	7 months
1,167-1,332	8 months
1,333-1,499	9 months
1,500-1,666	10 months
1,667-1,799	11 months
1,800 or more	12 months

4) How are benefits calculated? What is the formula to calculate?

The formula is:

Step 1: Annual salary x % rate ÷ 1,800 hours = hourly rate for the period:

Step 2: Hourly rate for the period = benefit level x number of months for period ÷ 360 = monthly benefit amount at normal retirement age.

The hourly rate for the period ties back to the appropriate Benefit Levels schedule in effect as of January 1, 1994 and/or January 1, 2008 and up to the adoption date of the Preferred Schedule under the Funding Rehabilitation Plan (FRP) which was January 1, 2013 for the City of Newport Beach. The salary earned in 2012 and the percentage rate of 1.5% in effect as of December 31, 2012 will determine the monthly benefit amount for the portion of pension credits earned after December 31, 2012. For new hires on or after January 1, 2013, year one salary will be used with a rate of 1.5% to determine all future credits earned. Fund Office contacts employer to get new hires annual salary to determine benefit accrual rate for that employee.

The 1,800 hours is used since under the Plan Rules a participant is granted 1 year of pension credit once the employer reports at least 1,800 hours within a calendar year. The 360 months is used since the maximum amount of years a participant can earn under the Plan Rules is 30 years.

5) Is there a tiered benefit calculation based on employment date? And if so, what is it?

All credits earned prior to January 1, 2008 are calculated under the January 1, 1994 Benefits Level schedule based on the highest contribution rate earned with at least 160 hours at the highest contribution rate. Then beginning with credits earned on or after January 1, 2008, each year is calculated at the contribution rate earned that year and ties back to the Benefit Levels schedule in effect as of January 1, 2008 until the adoption date of the Preferred Schedule (January 1, 2013) under the FRP.

Example: Participant earned 20 years 7 month of pension credits through December 31, 2018. Participant's 2007 salary was $79,817.77. In 2008 the Participant earned a salary of $79,222.39 and 1 year of pension credit. In 2009, 2010 and 2011 the Participant earned salaries of $88,802.01 in each calendar year. In 2012 the Participant earned a salary of $99,626.86. Calculations are as follows:

2007 – $79,817.77 x 1.5% = $1,188.34 ÷ 1800 hours = 0.66. The 0.66 cent contribution rate under the January 1, 1994 Benefit Level schedule produces a benefit level of 834.24 x 115 months ÷ 360 = **266.49**.

2008 – 79,222.39 x 1.5% = $1,188.34 ÷ 1800 hours = 0.66. The 0.66 cent contribution rate under the January 1, 2008 Benefit Level schedule under the Funding Improvement Plan produces a benefit level of $435.60 x 12 months ÷ 360 = **14.52**.

2009-2011 – 88,802.01 x 1.5% = $1,332.03 ÷ 1800 hours = 0.74. The 0.74 cent contribution rate under the January 1, 2008 Benefit Level schedule under the Funding Improvement Plan produces a benefit level of $488.40 x 36 months ÷ 360 = **48.84**.

2012-2018 – $99,626.86 x 1.5% = $1,494.40 ÷ 1800 hours = 0.83. The 0.83 cent contribution rate under the January 1, 2008 Benefit Level schedule produces a benefit level of 547.80 x 84 months ÷ 360 = **127.82**.

The total Normal Retirement Age amount is **457.67 (266.49 + 14.52 + 48.84 + 127.82)**.

6) What is the reduction per year if someone retires before the age (of collecting 100%)?

Under the Preferred Schedule, a participant hired before December 31, 2007, the early retirement reduction is 3% per year below age 62. A participant hired January 1, 2008 or later would be reduced 6% per year below age 65 for early retirement.

7) Are benefits capped based on a maximum salary? If so, what is the maximum salary used to calculate benefits?

The Pension Fund complies with Section 401(a)(17) of the Internal Revenue Code which limits the amount of annual compensation that can be taken into account in calculating benefits. For 2019, the indexed limit is $280,000.

8) What is the maximum pension I can receive?

The maximum pension under the Plan Rules is $2271 per month for life.

9) How can a person find out exactly how much they will receive?

The Fund annually sends a pension statement to each participant which contains an estimate of the single life annuity payable at normal retirement age. A participant can call the Fund Office and discuss their benefit and options with a pension specialist.

10) Can we get examples of scenarios of what the payout is upon retirement for 5, 10, 15 years in LIUNA?

Based on participant earning $84k per annum, an estimated benefit at the various years of service is below. Please be reminded that this makes assumptions of full-time work going back up to 30 years from 2018. Every participant's actual benefit may be different based on their particular circumstances. See following examples:

5 years = 77.00 per month
10 years = 154.00 per month
20 years = 433.00 per month
30 years = 726.00 per month

11) Can I defer receiving my benefit until the ideal age to collect 100%, even if I retire from the City prior to that age?

Yes, but you must commence pension payments at age 65 if you are not working or can delay to age 70 ½ if still working. If delayed, the benefit will be calculated and paid back to age 65. By law all participants must start collecting at age 70 ½. Under this Plan it is by April 1st of the following calendar year in which the participant turns age 70 ½.

12) Are taxes withheld from LIUNA benefits when paid out, or is the retiree responsible for paying taxes? Do they receive a 1099?

The pension application process includes a W-4P for the participant to indicate what taxes they would like withheld from their monthly benefit. Also, 1099R's are mailed annually to all pensioners.

13) How is the benefit distributed upon retirement?

All pensioners are set up on direct deposit and deposits are made to the pensioners bank account on the 1st of each month.

14) What is the lag time between notification and collecting benefits?

The pension application process can take up to 90 days. We recommend participants contact us to start the paperwork at least 90 days prior to their intended retirement date.

15) Can individuals terminate their portion of the plan and receive the cash value?

No, the Plan rules do not allow for it. This Plan is a defined benefit plan and no participant has an individual account balance. When contributions are received from participating employers those contributions are immediately pooled together and invested together under the Plan as a whole so the Plan can payout the promised lifetime monthly retirement benefits to those participants who meet the vesting requirements.

16) How can we get a plan document or summary plan description and any amendments?

The Plan documents, Summary Plan Description, amendments, and other documents about the Pension Fund are available via written request or on our website at www.LNIPF.com.

17) How can we get a copy of the funding schedule?

The Annual Funding Notice is mailed to all participants at their home address on file with the Fund Office each spring. The Notices are also published on the website.

18) What is, or how can we see the fund's plan performance?

Preliminary plan investment performance as of December 31, 2018 is -4.51% for the one year, 7.16% for three years, 5.27% for five years, 8.35% for seven years and 8.61% for ten years.

19) Where can we go to get detailed information regarding our benefits specific to Newport Beach?

Annual benefit statements are mailed to each participant at their home address of record each March. The statement includes the contributions reported by their employer for the prior year, pension and vesting credits earned in each calendar year, and an estimate of the single life annuity payment earned at normal retirement age as of the date of the statement. Each individual employee can also login to the secure website at www.lnipf.com to view their information under the Plan, excluding the single life annuity amount at normal retirement age.

20) Is there a designated representative who City employees can talk to about their specific account?

All participants may call the Fund Office to discuss their pension benefit with a pension specialist. Our pension team handles accounts based on the participants last name. They can call toll free 800-544-7422, Monday through Friday, 8:30 AM to 4:15 PM EST.

Last name	Specialist	Direct Dial
A -D	Darlene McCalip-Thaxton	202-737-1278
E – K	Carmen Hacker	202-737-1599
L – Q	Karen King	202-737-2948
R- Z	Dana Foor	202-737-2947

21) Who is our point of contact with LIUNA? Is this the same contact for basic matters, such as updating a mailing address, to even more complex matters? Or are there different people to contact based on the category of question?

As addressed above, you can call your pension specialist for assistance. If they are unable to assist or if you wish to speak with a Manager, you may call the Pension Dept Manager Jennifer Dodohara or the Contributions Manager Paul MacKinnon at 800-544-7422.

22) Please explain the current contribution rate for K&M members. Are there any future projected / contemplated contribution rates?

The Funding Rehabilitation Plan Preferred Schedule Contribution Rates for the City of Newport Beach is:

Effective Date	Rate
1/1/2013	1.65%
1/1/2014	1.82%
1/1/2015	2%
1/1/2016	2.2%
1/1/2017	2.42%
1/1/2018	2.66%
1/1/2019	2.92%
1/1/2020	3.22%
1/1/2021	3.54% - Final ends 12/31/2021

There are no other future contribution rate increases after 12/31/2021 at this time.

23) Is there any sort of web-based portal K&M members can access for our membership?

Individual participants can access their information by logging into a secure website at www.lnipf.com.

a. What about for confirming earned hours / membership is correct / accurate?

Participants are sent a pension credit history statement annually in the spring which shows the hours and contributions reported by your employer or participants can access this information at www.lnipf.com. If a participant sees an error, please contact the Fund Office.

b. What about for making calculations of projected retirement funds at different dates/ages?

This feature is not available at this time.

24) Are the LIUNA benefits subject to an offset of our retirement benefits, such as Social Security is to PERS benefits?

No. The participant receives the benefit earned under the Plan Rules.

25) Besides the annual report members receive each March, showing the hours earned with LIUNA, is there any other documentation or information we should expect to receive?

Annual Funding Notice is mailed each April to all participants

All notices are available on our website: www.LNIPF.com

26) Do members receive a confirmation or proof of vesting or informational material when they become eligible?

The information is contained on the annual pension benefit statement that is mailed to all participants each March. Vesting in the Plan is 60 vesting credits.

27) Several years ago, LIUNA changed the benefit allocation due to a fund "rehabilitation" plan. Is there a time frame when the rehabilitation will end? Is it a ten (10) year period? Once it does end, will we go back to the benefit calculation we had originally when we joined LIUNA?

The Fund is scheduled to emerge from the "Red Zone" by January 1, 2023. According to the Fund's actuary the Funding Rehabilitation Plan is ahead of schedule and could emerge out of the Funding Rehabilitation Plan sooner than January 1, 2023. The contribution rate and benefit accrual rate will remain at the final Preferred Schedule rate at the end of year 9 (3.54% for City of Newport Beach).

28) How does is the benefit computed given: *25 years of service, 100,000 annual compensation and normal retirement age of 62?

See formula and sample above under #4 and #5 about how to calculate.

29) With respect to IRS Section 415 limits for 2019, How is the benefit level capped for highly compensated employees, if at all. Are benefits accrued and distributed in any fashion beyond the cap?

The Pension Fund complies with Section 415 to the extent applicable. The Fund is a collectively bargained, multiemployer pension plan for purposes of the Internal Revenue Code and the Employee Retirement Income Security Act (ERISA). As such, the compensation limit of Section 415(b)(1)(B) does not apply. Only the annual dollar limit of Section 415(b)(1)(A) applies. That limit for 2019 benefits is $225,000 for a pensioner at age 62. There is no participant in the Newport Beach group who comes near the Section 415(b)(1)(A) limit.

Note that pensions under the Pension Fund are not based entirely on compensation, but rather are based on the collectively bargained contribution level and the number of pension credits earned by a participant.

30) If benefits are capped at any level, is the Employer or employee contribution formula capped at any level too?

As noted in answer #29, the Section 415 limit is not meaningful in the context of Newport Beach's participation in this Pension Fund. Contributions to the Pension Fund are required for all covered employment by each employee covered by the collective bargaining agreement in order to properly fund all benefits. By the way, there are no "employee contributions" to the Fund; all contributions are collectively bargained employer contributions.

31) Are benefits coordinated or otherwise reduced relative to benefits received from another pension plan (e.g. CalPERS)?

No. The Pension Fund does not offset or reduce benefits earned by participants based on benefits they may have earned under another pension plan. The Pension Fund is not generally aware of benefits that a participant might be earning under another pension plan.

32) If I die before I retire, what would my beneficiary receive?

For married vested participants there will be a Widow's Pension payable for the lifetime of the surviving spouse. The widow is eligible to start receiving the Widow's Pension as early as the Participant turning age 55 or at the Participant's normal retirement age (either age 62 or age 65). The amount will be 50% of the monthly benefit amount that a participant would be eligible to receive as early as age 55 under an Early Retirement Benefit minus the reduction factor for the 50% Joint and Survivor Pension, or at normal retirement age minus the reduction for the 50% Joint and Survivor Pension.

For unmarried vested participants under the Preferred Schedule who pass away before retiring there will be a Death Benefit payable in the amount of $5,000. The Plan Rules require that the Death Benefit is payable to any surviving children divided equally. If there are no surviving children, the amount will be payable to surviving parents divided equally. If there are no surviving parents, the amount will be payable to surviving siblings divided equally. If there are no such survivors, the amount will be paid to the deceased Participant's estate.

33) If I am retired and receiving pension benefits, would those benefits continue on to my beneficiary after my death?

If no survivor election is made at retirement, under the Preferred Schedule, a beneficiary is only eligible to receive the remaining payments under the 60 month-guarantee which means that if the retiree dies prior to receiving 60 monthly payments, the remaining payments up to the 60th payment will be paid to the beneficiary. The retiree will elect the beneficiary or beneficiaries at the time of their retirement.

A Participant can elect a survivor option at the time of their retirement. The following options are available to Participants covered under the Preferred Schedule:

120 Certain Payment Option – allows for at least 120 retirement benefit payments. If a retiree dies before receiving 120 retirement benefit payments, then the remaining benefit payments up to the 120th payment will be payable to the retiree's beneficiary. The beneficiary or beneficiaries are chosen at the time the Participant retires.

50%, 75%, 100% Regular Joint and Survivor Options – a married participant can elect a Joint and Survivor Option that will provide a lifetime benefit to the spouse of a retiree upon the death of the retiree. The percentage amounts of 50%, 75% or 100% are the amounts available for the spouse upon the death of the retiree. The retiree and spouse will make the election of the percentage at the time of retirement. The age difference between the participant and the spouse will determine the reduction for electing such an option.

50%, 75%, 100% Pop-up Joint and Survivor Options – a married participant can elect a Joint and Survivor Option that will provide a lifetime benefit to the spouse of a retiree upon the death of the retiree with added insurance that if the spouse pre-deceases the retiree, the retirees monthly benefit will Pop-up to the Single Life Annuity amount. The Pop-up percentage amounts of 50%, 75% or 100% are the amounts available for the spouse upon the death of the retiree. The retiree and spouse will make the election of the percentage at the time of retirement. The age difference between the participant and the spouse will determine the reduction for electing such an option.

34) Who can be designated as a beneficiary?

As explained in question #32, if a Participant passes away before retirement the Plan Rules determine who will receive either a Widow Benefit if married at time of death or a Death Benefit of $5,000 to specific surviving family members.

When a Participant retires and if they are not married at the time of their retirement they may elect whomever they want as their beneficiary or beneficiaries. When a married Participant retires, the spouse must sign off and agree that he/she is waiving all rights to the Regular Joint and Survivor Options and the Pop-up Joint and Survivor Options to allow the retiree to elect either the Single Life Annuity with 60 month-guarantee or the 120 Certain Payment Option. The retiree can elect whomever they want as their beneficiary to receive any final payments under the Single Life Annuity or the 120 Certain Payment Option as long as the spouse agrees to it.

35) How can I add a beneficiary to my account through the online portal?

This feature is not available for Participants through the online portal. If a retiree wants to change a beneficiary, and if eligible to do so, they must notify us in writing if they are not married.

36) Currently, the contributions are percentage based on gross salary. Can this be changed to base salary by one or all of the Newport groups?

No group can change from gross salary to base salary while the Plan is under the Funding Rehabilitation Plan. If in the future, Newport Beach does vote to change it, it will have to be the same for each unit. It is important to note that the Special Class groups rate cannot exceed the collective bargaining units' rate.

LABORERS' NATIONAL (INDUSTRIAL) PENSION FUND
905 16th Street, NW, 3rd Floor
Washington, DC 20006
Hours: Monday through Friday, 8:30 AM to 4:15 PM E.S.T.
Phone: 800-544-7422
Website: www.lnipf.com

Revised March 27, 2019

Section 3

Other Information

LOGIN TO ESS

PLEASE TAKE A MOMENT TO LOGIN TO ESS

Direct link:
https://selfservice.newportbeachca.gov/MSS/login.aspx

User ID: Employee number

Password: The last four digits of your social security number

Review your personal information for accuracy and make any nessessary changes. Please ensure your email address stays updated as this will be your bridge for communication.

THROUGH ESS

Review Pay Stub History
Review Time Off Information
Select Benefits during Open Enrollment
Update W-4 Information
Review your Deductions and Benefits

If you need assistance with ESS, please ask your Administrative Assistant or contact HR (949) 644-3256.

CITY OF NEWPORT BEACH
2021 EMPLOYEE CALENDAR

PAY DAY | OBSERVED HOLIDAY | PAY PERIOD ENDS | COUNCIL MEETING

JANUARY

Su	M	Tu	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

FEBRUARY

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28						

MARCH

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APRIL

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30	31					

JUNE

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JULY

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AUGUST

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29	30	31				

SEPTEMBER

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26	27	28	29	30		

OCTOBER

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24	25	26	27	28	29	30
31						

NOVEMBER

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21	22	23	24	25	26	27
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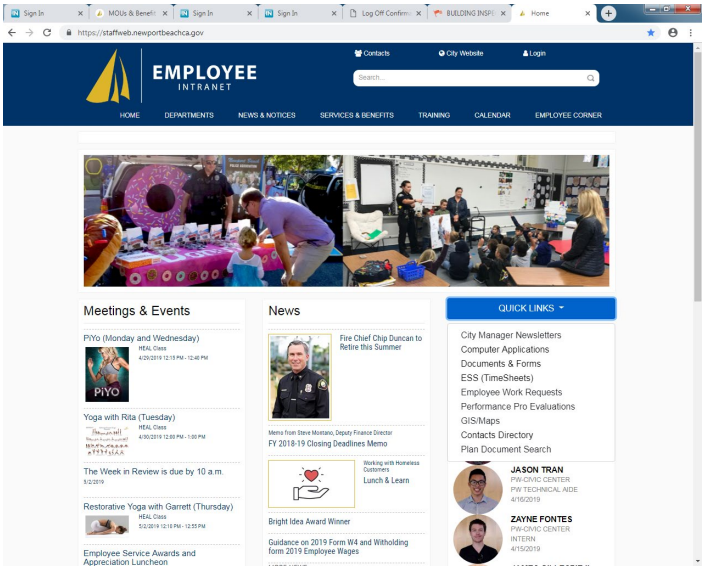
DECEMBER

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Performance Pro Training

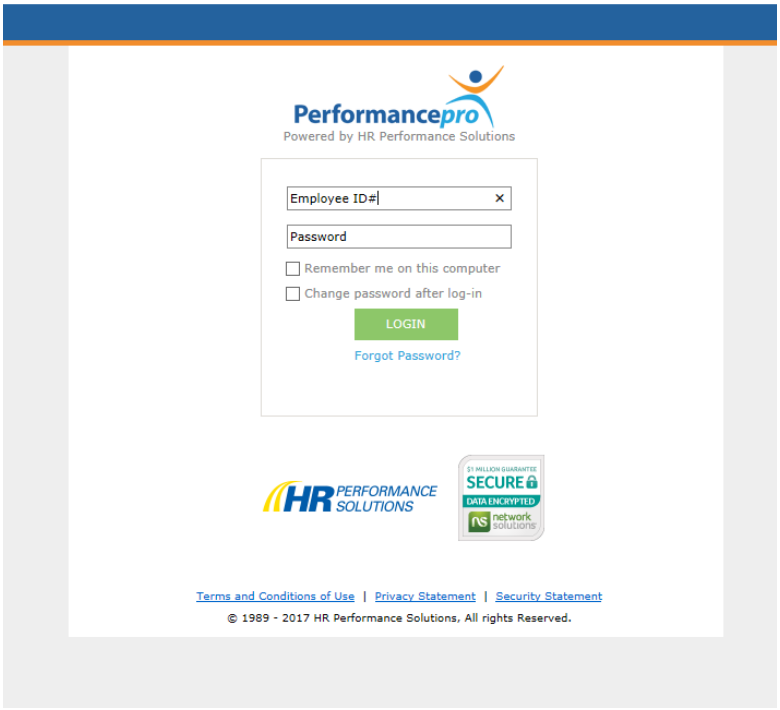
Logging In

a. The link to Performance Pro can be found on the City's Intranet page under Quick Links. https://newportbeachca.perfpro-hrnonline.com



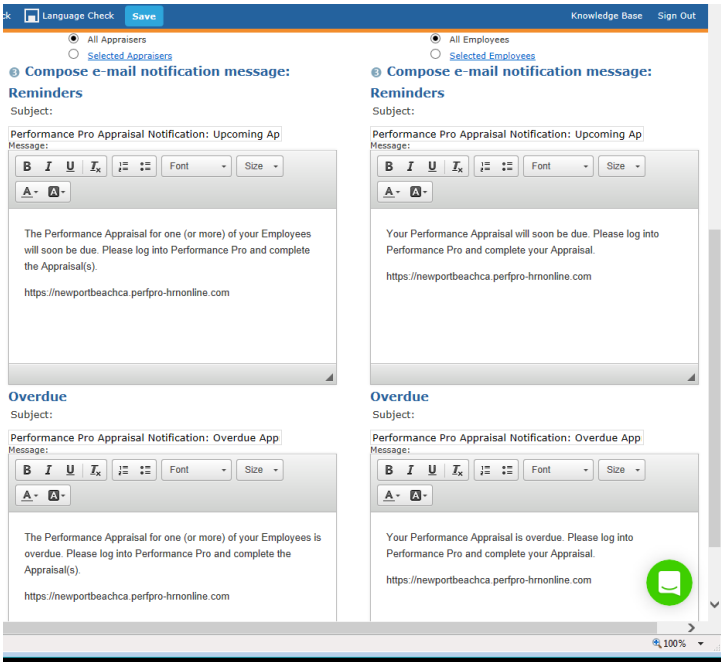
b. To login the employee uses their 5-digit employee ID#. The first time logging in the password is: Welcome123

c. Once logged in, the employee is prompted to reset their password to something they determine themselves.



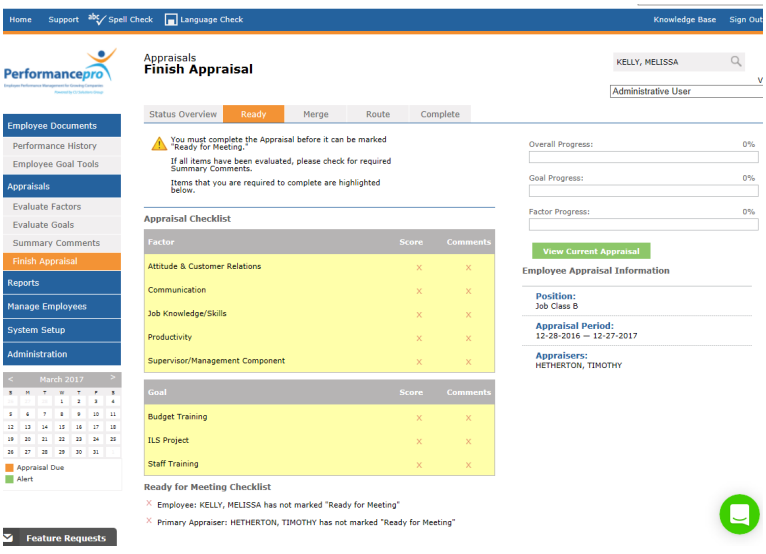
Notifications

a. Appraisers will receive a notification of an upcoming appraisal at 30 days, 2 weeks and 1 week before the appraisal due date/appraisal period end date.
   Notification of overdue evaluations are sent weekly until completed.
b. Employees will receive a notification of an upcoming appraisal at 30 days, and two weeks before the due date/appraisal period end date.
   Notifications of overdue evaluations are sent weekly until completed.

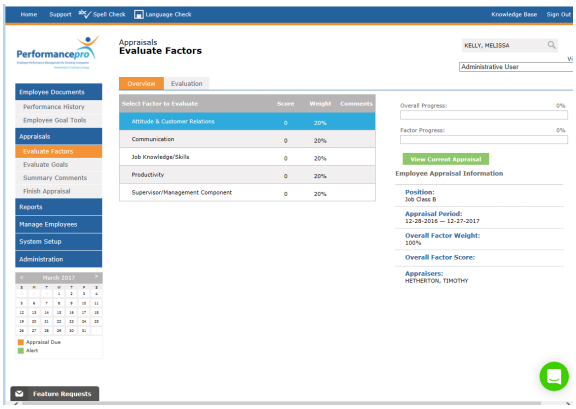


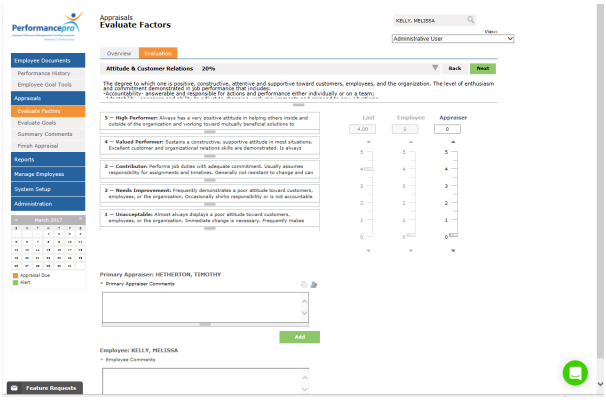
Beginning an Evaluation

a. An appraiser should always check with the employee to see if they will be completing a self-evaluation. The self-evaluation is encouraged and appreciated, however it is not required to be completed by the employee. If the employee does not want to complete a self-evaluation, then the supervisor can complete their rating, comments, goals, and summary comments then route to an up-line supervisor.
b. *DO NOT Mark ready for meeting and merge the evaluation until you know if the employee is going to complete their self-evaluation.
c. If the employee plans to complete an evaluation, they can complete their rating, their comments, goals and summary comments and then Mark Ready for Meeting. This will alert the supervisor that the employee has completed their portion of the process.

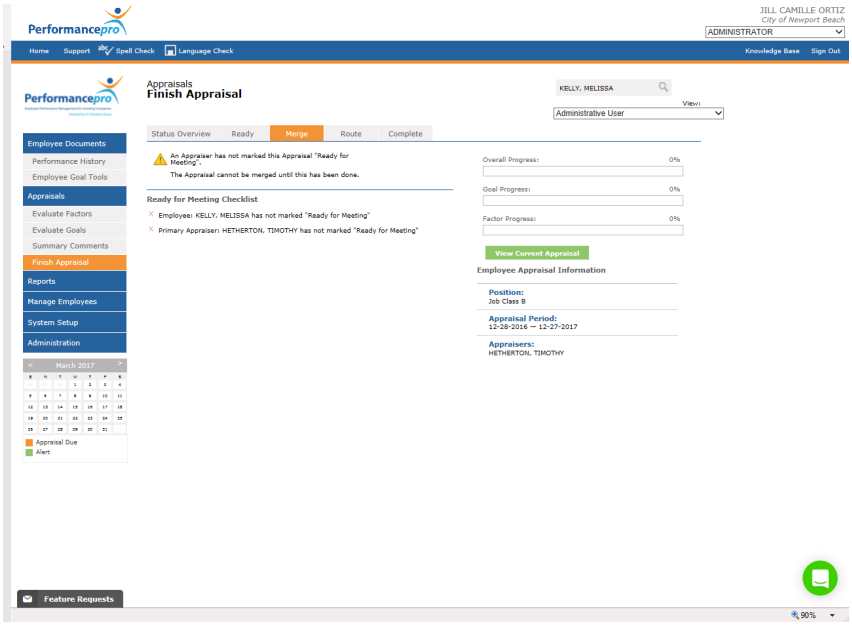


d. The quickest way to start an evaluation is to go to the Appraisals tab located in the blue menu on the left side of the screen.
e. Click on the Appraisals tab to expand the section, and then click on Evaluate Factors.





f. An employee will only see their comments field and be able to rate themselves.
g. An appraiser will only see their comments field and be able to rate the employee.
h. Once the employee and appraiser have marked ready for meeting, the evaluation can be Merged.



Merging

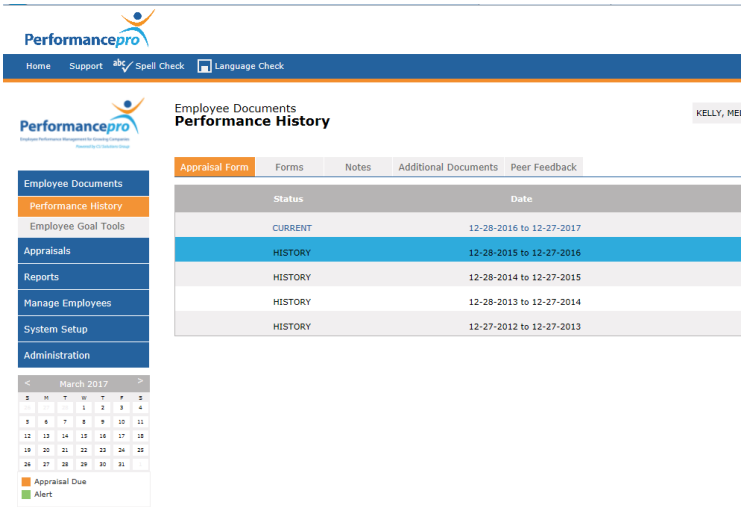
a. Merging the evaluation brings the employee's comments and the appraiser's comments together as one document. Once this happens, the employee cannot view it any longer. The employee will have a "read only" view, and will not be able to see the appraiser's comments until it is ready to be completed.
b. Now the evaluation is ready to route to an up-line supervisor for review and approval.

Routing

a. The Appraiser will move the evaluation by clicking on the route tab and selecting an up-line supervisor.
b. The up-line supervisor will receive notification that an evaluation is in their in-box on their performance pro home page.
c. **Please Note that routing will expire at 15 days. So if you are an appraiser, please make sure you continue to push it forward and re-route if necessary. Many evaluations are stalled at this point and result in being past due.
d. Supervisors can approve, approve with edits, or not approve.
e. Once the Supervisor has completed the review and any necessary changes are complete, then the Appraiser can move forward with scheduling a meeting with the employee to give them their review.
***DO NOT COMPLETE the evaluation until you have met with the employee and there are no other changes or comments.

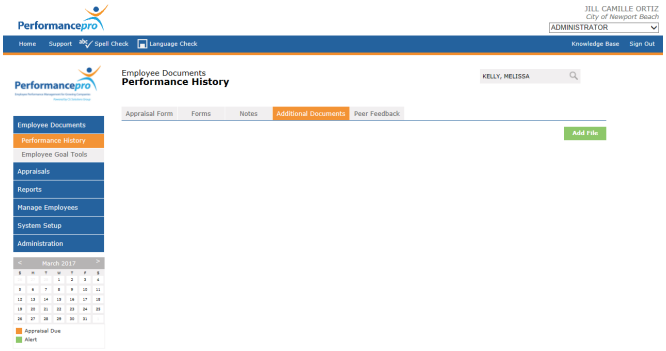
Complete

a. Once the Appraiser has met with the employee and there are no subsequent changes, then the evaluation is ready to be completed.
b. Clicking on the complete tab will prompt the employee, the Appraiser and the up-line Supervisor to go back in and sign the evaluation.
c. This evaluation has now become historical and the new evaluation for the next evaluation period is generated.



TIPS

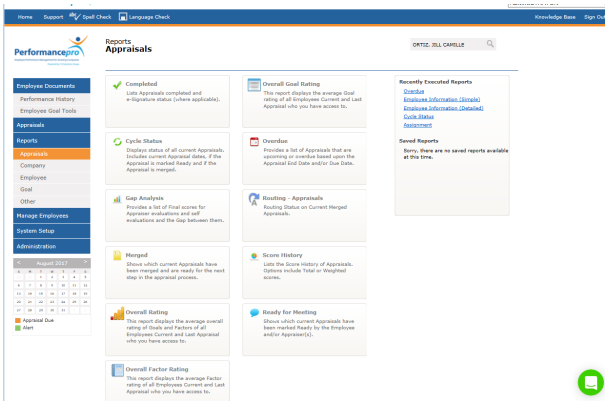
1. Make sure that you are using the correct “role”. This affects what you can see and what permissions you have in the system.
2. Talk to your employee and communicate.
3. Use the “Finish Appraisal” tab as a road map.
4. Appraisal comments and ratings save automatically, but Goals do not!
5. Always review your tool bar at the top to see if there is a save button.
6. An evaluation cannot be marked “ready for meeting” unless there are summary comments.
7. Did you know you could upload documents?



8. Updates to the system are done on a bi-weekly bases based on processed PAF changes, or changes made to Tyler Munis.

9. What can an Administrator do for you?
    1. Reset passwords & unlock and employee
    2. Uncomplete an evaluation
    3. Assign access levels
    4. Terminate a record, or re-activate a record
    5. Adjust the evaluation dates
    6. Change Supervisors
    7. Help walk you through the process or troubleshoot issues

10. Reports



11. Help!

2021 Disaster Service Worker Training for New Employees

- Tuesday, January 19, from 9:00 a.m.-12:00 p.m.
- Tuesday, March 16, from 9:00 a.m.-12:00 p.m.
- Tuesday, May 19, from 9:00 a.m.-12:00 p.m.
- Tuesday, July 20, from 9:00 a.m.-12:00 p.m.
- Tuesday, September 21, from 9:00 a.m.-12:00 p.m.
- Tuesday, November 16, from 9:00 a.m.-12:00 p.m.

The class includes: information for full-time employees on their role as a Disaster Service Worker, the City's Emergency Operations Center and the completion of the required National Incident Management System (NIMS) classes.

You must RSVP to Katie Eing at keing@nbpd.org to attend. All trainings will be in the City's Emergency Operations Center (EOC), which is located in the Lower Level of City Hall.

WHAT IS MY ROLE AS A DISASTER SERVICE WORKER?

Rules & Regulations

New Employee Orientation Overview

TITLE 19. PUBLIC SAFETY
DIVISION 2. OFFICE OF EMERGENCY SERVICES
CHAPTER 2. EMERGENCIES AND MAJOR DISASTERS
SUBCHAPTER 3. DISASTER SERVICE WORKER VOLUNTEER PROGRAM

§ 2570. Short Title.
This subchapter shall be known and may be cited as the Disaster Service Worker Volunteer Program (DSWVP) Regulations.

§ 2570.1. Purpose.
The Legislature has long provided a state-funded program of workers' compensation benefits for disaster service worker volunteers who contribute their services to protect the health and safety and preserve the lives and property of the people of the state. This program was established to protect such volunteers from financial loss as a result of injuries sustained while engaged in disaster service activities and to provide immunity from liability for such disaster service worker volunteers while providing disaster service.

NOTE
Authority cited: Sections 8587 and 8580, Government Code. Reference: Section 8657, Government code, Sections 3211.9 through 3211.93a, Labor Code.

§ 2570.2. Definitions.
(a) Disaster Service Worker.

(1) A disaster service worker is any person registered with a disaster council or the Governor's Office of Emergency Services, or a state agency granted authority to register disaster service workers, for the purpose of engaging in disaster service pursuant to the California Emergency Services Act without pay or other consideration.

(2) Disaster service worker includes public employees, and also includes any unregistered person impressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.

(3) Exclusion: Disaster service worker does not include any member registered as an active fire fighting member of any regularly organized volunteer fire department, having official recognition, and full or partial support of the county, city, town or district in which such fire department is located.

(b) Disaster Service.

(1) Disaster service means all activities authorized by and carried on pursuant to the California Emergency Services Act, including approved and documented training necessary or proper to engage in such activities.

(2) Exclusion. Disaster service does not include any activities or functions performed by a person if the disaster council with which the person is registered receives a fee or other compensation for the performance of that person's activities or functions.

(c) Training. For purposes of these regulations, training is a planned activity sponsored by a disaster council (or designated agency or authority) and may include classroom instruction, disaster drills or exercises, or related activities that are designed to enhance the disaster response skills (including safety) of the disaster service worker.

(d) Disaster Council. A disaster council is a public agency established by ordinance which is empowered to register and direct the activities of disaster service workers within the area of the county, city, city and county, or any part thereof. In this respect, the disaster council is acting as an instrument of the state in aid of carrying out general state government functions and policy with regard to disaster services.

(e) Accredited Disaster Council. A disaster council may become accredited through certification by the California Emergency Council, or the Governor when the Emergency Council is not meeting, when the disaster council agrees to follow and comply with the rules and regulations established by the Emergency Council pursuant to the provisions of the Emergency Services Act. Upon certification, and not before, the disaster council becomes an accredited disaster council. A disaster council remains accredited only while the certification of the California Emergency Council is in effect and is not revoked.

(f) Auxiliary Fire Fighter. An auxiliary fire fighter is a person recruited, registered and trained as a supplement or reserve for unusual fire emergencies or disaster

situations. Workers' compensation benefits for auxiliary fire fighters may be provided by the state. An auxiliary fire fighter is not a "volunteer fire fighter," who is a person recruited and trained to meet the day-to-day operational requirements of a fire department. Workers' compensation insurance premiums for the volunteer fire fighter are the responsibility of the local government or fire entity.

(g) Public Employee. All persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed, are considered to be public employees.

(h) Convergent Volunteers. Convergent volunteers are individuals that come forward to offer disaster response and recovery volunteer services, during a disaster event. Convergent volunteers are not persons impressed into service at the scene of an incident.

NOTE
Authority cited: Sections 8567 and 8580, Government Code. Reference: Sections 8581, 8610 and 8612, Government Code; Sections 3100, 3211.9, 3211.91, 3211.92, 3211.93 and 3211.93a, Labor Code.

§ 2571. Accredited Disaster Council.
(a) Disaster councils shall be accredited in accordance with Sections 8581 (b) or 8612, Government Code.

(b) When applying for accreditation, disaster councils shall furnish the Governor's Office of Emergency Services with a certified copy of the ordinance which has provided for the following:

(1) a disaster council;

(2) a Chairperson or director of the disaster council;

(3) an Emergency organization; and,

(4) compliance with the Emergency Services Act.

NOTE
Authority cited: Sections 8567 and 8580, Government Code. Reference: Sections 8579 (g), 8581 (b), and 8612, Government Code.

§ 2572.1. Classifications and General Duties.
The various classifications of disaster service workers and the general duties of the members of each classification shall be limited to those described below.

(a) Animal Rescue, Care and Shelter. Veterinarians, veterinary support staff and animal handlers providing skills in the rescue, clinical treatment, and transportation of all animals, including but not limited to companion animals, livestock, poultry, fish, exhibition animals, zoo animals, laboratory and research animals, and wildlife; assisting in the procurement of shelters, equipment, and supplies; documenting arrival, sheltering, treatment, and discharge or placement of animals.

(b) Communications. Install, operate and maintain various communications systems and perform related service, to assist officials and individuals in the protection of life and property.

(c) Community Emergency Response Team Member. Under the direction of emergency personnel or a designated team leader, assist emergency units within their block, neighborhood, or other area assignment; survey area conditions; disseminate information; secure data desirable for emergency preparedness planning; report incidents; and generally assist officials and individuals in the protection of life and property.

(d) Finance and Administrative Staff. Perform executive, administrative, technical, financial and clerical functions for the emergency organization.

(e) Human Services. Assist in providing food, clothing, bedding, shelter, and rehabilitation aid; register evacuees to promote reuniting families and to support the needs of special populations; compile authoritative lists of deceased and missing persons; and other phases of emergency human services, such as maintaining morale and administering to the mental health, religious or spiritual needs of persons suffering from the effects of the disaster.

(f) Fire. As auxiliary fire fighters or auxiliary wildland fire fighters, assist regular fire fighting forces or fire protection agencies to fight fire, rescue persons, and save property; control forest or wildland fires or fire hazards; instruct residents in fire prevention and property defense methods, methods of detecting fire, and precautions to be observed in reducing fire hazards.

(1) For purposes of these regulations only, the ratios between auxiliary fire fighters, volunteer fire fighters, and paid fire fighters shall be one auxiliary for one volunteer and three volunteers for one paid fire fighter. The basis for applying these ratios is that the staffing of an engine company, truck company, or a squad shall not exceed six paid fire fighters, and a salvage and rescue company shall not exceed two paid fire fighters. A fire department that has no volunteer fire fighters is limited to three auxiliary fire fighters for each paid fire fighter in the companies and squads, staffed as above. These staffing standards are based on the number of first line (not reserve) apparatus operated by the fire department.

(2) When auxiliary fire fighters are registered with other than an established fire service organization; for example, auxiliary fire fighters in a county or city emergency management services organization, a total number of eligible auxiliary fire fighters shall be computed for that city or unincorporated area. The emergency management services organization is entitled to register auxiliary fire fighters not otherwise registered with other established fire service organizations, and to a number not to exceed the allowable total as indicated in Section 2572.1 (f) (1), above.

(g) Laborer. Under the direction and supervision of the responding agency, performs general labor services and supports emergency operations.

(h) Law Enforcement. As Auxiliaries, assist law enforcement officers and agencies to protect life and property; maintain law and order; perform traffic control duties; guard buildings, bridges, factories, and other facilities; isolate and report unexploded ordnance.

(i) Logistics. Under the direction of the emergency organization, assist in procurement, warehousing, and release of supplies, equipment materials, or other resources. Assist in mobilization and utilization of public and private transportation resources required for the movement of persons, materials, and equipment.

(j) Medical and Environmental Health. Staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public health installations; maintain or restore environmental sanitation; assist in preserving the safety of food, milk, and water and preventing the spread of disease; perform laboratory analysis to detect the presence and minimize the effects of nuclear, chemical, biological, radiological or other hazardous agents.

(k) Safety Assessment Inspector. Survey, evaluate and assess damaged facilities for continued occupancy or use; assist in emergency restoration of facilities for utilities, transportation, and other vital community services; and provide recommendations regarding shoring or stabilization of damaged or unsafe buildings or structures.

(l) Search and Rescue. Under the direction of the appropriate authority, perform search and rescue operations in one or more of several areas including: search and rescue; urban search and rescue; or mine and confined space rescue.

(m) Utilities. Assist utility personnel in the repair and restoration of public utilities damaged by disaster.

NOTE
Authority cited: Sections 8587 and 8580, Government Code. Reference: Section 8580, Government Code.

§ 2572.2. Scope Of Disaster Service Duties.
Each disaster service worker in any classification shall, without regard to a formal designation or assignment, be considered to be acting within the scope of disaster service duties while assisting any unit of the emergency organization or performing any act contributing to the protection of life or property, or mitigating the effects of an emergency or potential emergency either:

(a) under the authorization of a duly constituted superior in the emergency organization; or,

(b) under the supervision and direction of the American Red Cross while carrying out its programs in consonance with state and local statements of understanding, or in carrying out a mission assigned to that agency by a responsible state or local authority.

NOTE
Authority: Sections 8567 and 8580, Government Code. Reference: Section 8580, Government Code.

§ 2573.1 Registration and Training.
(a) Registration. A person shall be deemed to be registered if the following information is on file with the Governor's Office of Emergency Services or with the appropriate authority as indicated in Section 2573.2:

(1) name of registrant;

(2) address of registrant;

(3) date enrolled (established as the date the loyalty oath is administered);

(4) classification of disaster service to which the volunteer is assigned; and,

(5) a signed statement that the loyalty oath or affirmation was taken or subscribed before an officer authorized to administer oaths.

(b) Training.

(1) Disaster councils may require each person registered as a disaster service worker to satisfactorily complete a course of training or instruction, including periodic refresher training. If warranted by the classification, disaster councils may require documented proof of professional certification or licensing.

(2) The disaster council (or designated agency or authority) shall ensure disaster training is approved, documented and supervised, and shall ensure disaster training is commensurate with the duties of the disaster service worker.

(3) Exclusions: Unless the volunteer is directly providing disaster services, activities that are not covered include parades, public exhibitions, physical fitness training or other training activities not related to disaster service.

NOTE Authority cited: Sections 8567 and 8580, Government Code. Reference: Section 8580, Government Code.

§ 2573.2 File Retention and Recordkeeping.
(a) Documented proof of the oath or affirmation of any disaster service worker is an integral part of an injury claim for workers' compensation. File retention should follow the same rules as other public personnel records. The oath or affirmation shall be filed as follows:

(1) State. File as prescribed by the State Department of Personnel Administration within 30 days of the date it was taken or subscribed.

(2) County. File in the office of the county clerk. The oath may also be filed in either the office of the county auditor or in the office of the clerk of the board of supervisors.

(3) City. File in the office of the city clerk.

(4) Other Agencies or Districts. File with an agency or district designated officer or employee,

(b) All registration records shall be available for inspection by any officer or employee of the State Compensation Insurance Fund or of the Governor's Office of Emergency Services.

(c) The personnel officer or other individual designated by the disaster council shall be responsible for keeping the registration current, and for the accuracy and safekeeping of the official registration records.

(d) The California Emergency Council may prescribe additional registration requirements as it may deem necessary.

NOTE Authority cited: Sections 8567 and 8580, Government Code. Reference: Section 3105, Government Code.

§ 2573.3 Workers' Compensation Claims.
(a) Claim Packages. Workers' compensation claims for injuries sustained by disaster service workers while performing disaster service, shall be filed under the same authorities and guidelines as claims filed by paid employees. The claim shall include:

(1) the appropriate claim and employer's report of injury forms as prescribed by the State Compensation Insurance Fund;
(2) a written narrative account of the incident that may include witness statements; and,

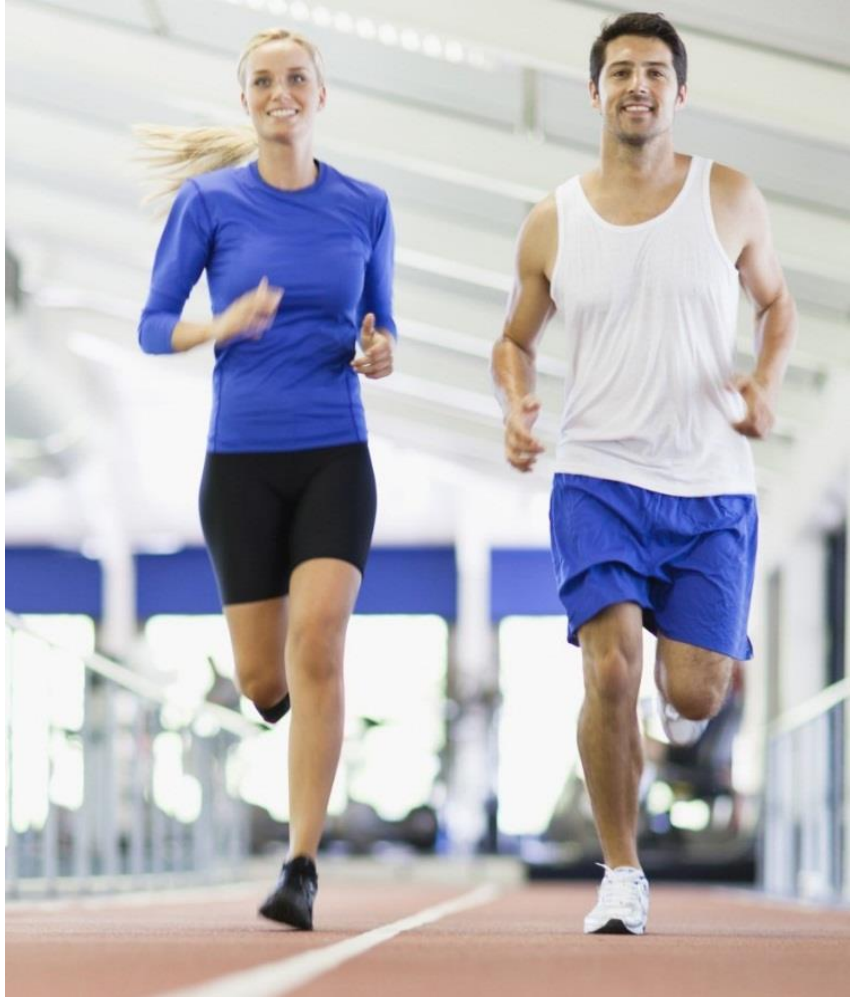
(3) a copy of the claimant's current disaster service worker registration form indicating the loyalty oath or affirmation was administered.

(b) Convergent Volunteers. For purposes of obtaining workers' compensation benefits through the disaster service worker program, convergent volunteers will be eligible when the requirements of disaster service worker are met in accordance with these regulations.

NOTE
Authority cited: Sections 8567 and 8580, Government Code. Reference: Section 3211.92, Labor Code; Sections 5400 et seq., Labor Code and Section 3102, Government Code.







HEALTHY EATING ACTIVE LIVING CITY™

HEALTHY EATING ACTIVE LIVING (HEAL) PROGRAM

SUBSCRIBE TO THE HEAL PROGRAM AND RECEIVE INFORMATION ON FITNESS CLASSES, HEALTHY EATING, AND OVERALL WELLNESS

VISIT THE HR WEBPAGE ON THE INTRANET TO SUBSCRIBE
HTTP://CITYNET.NEWPORTBEACHCA.GOV/INDEX.ASPX?PAGE=7540

We're here for you!



Life can be complicated. With MHN, getting help is easy. Remember, the best time to seek help is before a problem turns critical.

Call toll-free 24 hours a day, seven days a week:
1-800-242-6220

TTY users call 711.

Or visit us at:
members.mhn.com

Register with the company code:
newport

You are entitled to: 3 face-to-face sessions or telephonic or web-video consultations for problem-solving support per incident, per calendar year.

Separate limits apply for work-life consultations.

MHN can help you and your family with personal and work-related issues, including:

- Concerns about alcohol or drug use
- Stress, anxiety, changes in mood, and sadness
- Grief and loss
- Problems at work or home
- Health and wellness
- Daily living
- Financial and legal issues
- Identity theft

MHN
A Health Net Company℠

Your privacy

EAP services are confidential. Your privacy is important to us, and it is protected by state and federal laws.

We speak your language!

When you call MHN, free interpretation services are available in over 170 languages. We also contract with a vendor who can physically attend appointments with you, at no cost, if you need help communicating with doctors or other providers.

¡Hablamos su idioma!

Cuando llame a MHN, podrá usar nuestros servicios de interpretación gratuitos en más de 170 idiomas. Además, contamos con proveedores contratados que pueden asistir en persona a las citas con usted, sin cargo alguno, en caso de que necesite ayuda para comunicarse con los médicos u otros proveedores.

我們說您的語言！

您致電 MHN 時，我們可提供 170 多種語言的免費傳譯服務。我們還聘用了翻譯人員，如果您需要翻譯人員幫助您與醫生或其他醫療服務提供者進行交流，該翻譯人員可以與您一道參加約診，該服務爲免費提供。

Appeals and grievances

If you have a complaint or dispute about MHN's services or counselors, you may call the same toll-free number you use to access your EAP services, submit a complaint online at www.mhn.com, or submit a complaint in writing to:

MHN Appeals and Grievances
PO Box 10697
San Rafael, CA 94912

Within five business days of receiving your complaint, we will let you know (in writing) that we have received your complaint, and we will submit it for resolution to the appropriate department.

Evidence of Coverage and Disclosure

To see a detailed description of your EAP benefits, please review your *Employee Assistance Program Combined Evidence of Coverage and Disclosure Form* (EOC), available through your benefits department. You may also contact MHN at the number in this brochure for a copy of the EOC (California members only). Please note that, in the event of discrepancies between member materials and EOC documents, the terms of the EOC will prevail.

MHN is a licensed California specialized health care service plan. The California Department of Managed Health Care (the "Department") is responsible for regulating health care service plans in California. If you have a grievance against MHN, you should first call MHN at the number in this brochure, and use MHN's grievance process, as described above, before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

You may call the Department if you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by MHN, or a grievance that has remained unresolved for more than 30 days, (unless the member is notified within those 30 days that additional time is required and the reason for the delay is documented). You may also be eligible for an Independent Medical Review (IMR). If so, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The Department has a toll-free telephone number (1-888-466-2219) to receive complaints and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's website (www.hmohelp.ca.gov) has grievance forms, IMR application forms and instructions.

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Your Employee Assistance Program



MHN
A Health Net Company℠



Welcome to MHN

Your Employee Assistance Program – or EAP – is here to help you with emotional, family and other personal problems; offer guidance on financial and legal issues; support healthy choices; and much more. There is no charge to you for covered services.

Your EAP services

This is just a summary. For details about services and eligibility, please contact MHN or your employer, or check your plan documents (such as an Evidence of Coverage booklet or Summary Plan Description). See *My Benefits* on our website for a list of your rights and responsibilities as a member.

Getting help

Just call the number in this brochure. We are available 24 hours a day, seven days a week. A customer service representative will ask a few questions and connect you with the right EAP solution for you.

Problem-solving support

Call us for help with life's ups and downs. We'll connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety, changes in mood, and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about use of alcohol or drugs.

When you call, you can make an appointment that works for you:

- **Face to face** – Meet with a provider from our network (for example, a counselor, marriage and family therapist, or psychologist) in his or her office. We can provide a referral when you call us. You can also search for a provider on our member website.
- **Phone or web-video** – Easily accessed support provided by a network provider or MHN consultant.

See the inside flap of this brochure for the number of appointments your plan includes. Remember that EAP services are not medical care or mental health treatment of any kind. If, in the course of a consultation, clinical problems are suspected, including drug or alcohol problems, we will offer a referral to appropriate medical or mental health services.

Work and life services

Our experts can help you balance your work with your life![1] Call us for:

- **Childcare and eldercare assistance** – We'll find out what kind of help you need, and we'll give you names and numbers of providers in your area with confirmed openings.
- **Financial services** – Talk to an advisor over the phone about:
  - Budgeting.
  - Credit and financial questions (investment advice, loans and bill payments not included).
  - Retirement planning.
- **Legal services** – Talk to a lawyer over the phone or face to face about:
  - Civil, consumer and criminal law.
  - Personal and family law, including adoption, divorce and custody issues.
  - Financial or tax matters. (Business matters are excluded. Also excluded are any disputes or actions between members and their employer, business partners, MHN, Health Net, or their affiliates.)
  - Real estate.
  - Estate planning.
- **Identity theft recovery services** – Speak with a certified consumer credit counselor. If there is a potential of ID theft, we'll connect you to an identity recovery specialist.

[1]Please contact us for details, including limitations and exclusions.

- **Daily living services** – Need help with errands? Planning an event or a vacation? We'll track down businesses and consultants for you. (MHN does not cover the cost or guarantee delivery of vendors' services.)

Our member website can also help with:

- Tips, tools and calculators to help you with finances, legal issues and retirement planning.
- Childcare and eldercare directories.

Health and wellness resources

Take charge of your well-being! MHN can help. Just register on our member website to:

- Assess your health and get tips for living better.
- Track progress toward your wellness goals.
- Take advantage of interactive e-learning programs.
- Find articles and videos about health topics.

Call your EAP number to learn more about our wellness coaching services – personalized support to help you set and reach your wellness goals.

MHN A Health Net Company℠ For more information about your EAP or to schedule an appointment, please call:

1-800-242-6220
TTY users call 711.

Or visit: members.mhn.com
Company code: newport

In an emergency, please call 911.

When a work injury or illness occurs...

1. If emergency medical care is needed, call 911 or go to the nearest emergency room.
2. Report injuries immediately to your supervisor or employer representative at _____(telephone). For non-emergency medical care go to the clinic or doctor's office that is listed below or on the workers' compensation poster at your worksite, or your employer may advise you on where to go for treatment. Your employer also is required to provide you with a claim form within one working day of learning of your injury, so ensure your rights to benefits by reporting every injury, no matter how slight, and request a claim form if it's more than a simple first-aid injury.
   Your employer must notify the claims administrator and authorize medical treatment within one working day of receiving your claim form. Any delay in reporting an injury may delay workers' compensation benefits and you could lose your right to benefits if your employer does not learn of your injury within 30 days of the injury date. If your injury or illness develops over time, report it as soon as you learn it was caused by your job. If a requested medical service is determined not medically necessary, you will receive information on how to appeal that decision, but if you choose to appeal you must do so within 30 days of receiving the decision. If your claim or other benefits are denied, you have a right to challenge the decision at the Workers' Compensation Appeals Board (WCAB), but there are deadlines for filing the necessary papers, so don't delay.
3. Call your claims administrator or employer representative if you have questions or problems. It is illegal for an employer to fire or discriminate against you just because you file, intend to file, or settle a workers' compensation claim, or because you testify for a co-worker who was injured. If you prove this kind of discrimination, you will be entitled to job reinstatement, lost wages and increased benefits, plus costs and expenses up to a maximum set by the state legislature.

Emergency Telephone Number: Call 911. For nonemergency medical care, contact your employer and go to the following doctor/clinic:

_____

Workers' Compensation Insurer:

_____

❑ Check if company is self-insured

Claims Administrator:

Name_____

Telephone _____

If your employer has an MPN, you can use the information below to get more details:

MPN website: _____

MPN effective date: _____

MPN identification number: _____

For help locating an MPN physician, call your MPN access assistant at:

_____

For questions or other MPN issues, call the MPN contact person at:

_____

Free help and information are available by contacting a Division of Workers' Compensation Information and Assistance Officer at the local office listed below. You can hear recorded information and get a list of local offices by calling (800-736-7401), or you can get additional written information about workers' compensation by going to the Division of Workers' Compensation web site at www.dwc.ca.gov.

DWC Information & Assistance Office

Street Address _____

City _____

Telephone_____

WORKERS' COMPENSATION FRAUD IS A FELONY

Anyone who makes or causes to be made any knowingly false or fraudulent material statement for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

This pamphlet is available in Spanish. For a free copy, please write: CWCI, 1333 Broadway, Suite 510, Oakland, CA 94612.
Este información esta traducido al español. Para conseguir una copia, favor de escribir a: CWCI, 1333 Broadway, Suite 510, Oakland, CA 94612.

The information in this pamphlet has been approved by the Administrative Director of the Division of Workers' Compensation.

To reorder: This pamphlet, as well as state-approved workers' compensation posting notices, DWC-1 claim forms, and other information for injured workers and employers may be ordered from the online store at www.cwci.org, or you may request an order form by calling 510-251-9470.

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Rev. 9/15

Facts About Workers' Compensation

The Way It Was

In the early 20th century, workers injured on the job had to sue their employer to recover medical expenses and lost wages. Lawsuits took months and sometimes years. Juries had to decide who was at fault and how much, if anything, would be paid. In most instances, the worker got nothing. It was costly, time consuming, and often unfair.

The Way It Is

Today, the California workers' compensation law provides a faster, fairer way to take care of injured workers… where fault doesn't have to be proved to recover medical expenses and lost wages. This job-injury insurance is paid for by your employer and supervised by the state. It pays your medical bills, and if you can't work due to a job-related injury or illness, it provides money to help replace lost wages until you can return to work.

Who's Covered?

Almost every employee in California is protected by workers' compensation, but there are a few exceptions. People in business for themselves and unpaid volunteers may not be covered. Maritime workers and federal employees are covered by similar laws. If you have a question about coverage, ask your employer.

What's Covered?

Any injury or illness is covered if it's due to your job. It can be caused by one event like a fall, or repeated exposures, such as repetitive motion over time. Everything from first-aid type injuries to serious accidents is covered. Workers' compensation even covers injuries – including physical or psychiatric injuries – resulting from a workplace crime. (Some injuries from voluntary, off-duty recreational, social or athletic activity – for example, the company bowling team – may not be covered. Check with your supervisor or the claims administrator listed at the end of this document if you have questions.)

Coverage is automatic and immediate. There is no qualifying period, no need to earn a certain amount in wages before you're covered… protection begins the first minute you're on the job.

What You Have To Do

If you have a work injury or illness, immediately notify your supervisor or call the phone number for the employer representative listed on the back of this pamphlet so you can get medical help right away. If it's more than a simple first-aid injury, your employer will give you a claim form so you can describe the injury and how, when and where it happened. To file a claim, complete the "Employee" section of the claim form, keep one copy and return the rest to your employer. Your employer will then complete the "Employer" section, give you a signed and dated copy of the form, keep one copy and send one to the claims administrator, the company that is responsible for handling your claim and notifying you about your eligibility for benefits.

Benefits can't start until the claims administrator knows of the injury, so report the injury and file the claim form with your employer as soon as possible. State law requires that within one working day of receiving a claim form employers authorize medical care consistent with applicable treatment guidelines for the injury. Employers may be liable for as much as $10,000 in treatment until a claim is accepted or rejected. Delays in reporting may delay workers' compensation benefits, and you could lose your right to benefits if your employer does not learn of your injury within 30 days of the date of injury. If your injury or illness develops over time, report it as soon as you learn it was caused by your job. To ensure your right to benefits, report every injury, no matter how slight, and request a claim form if it's more than a minor injury requiring only first aid.

Benefits

The California workers' compensation law guarantees you three kinds of benefits:

- All reasonable and necessary medical care for your injury or illness... with no deductibles. Medical benefits may include treatment by a doctor, hospital services, lab tests, x-rays, physical therapy, medicines, medical equipment and transportation costs to and from appointments. Workers' compensation medical services are subject to authorization for medical necessity and there are limits on the number of chiropractic, physical therapy and occupational therapy visits.
- Tax-free payments to help replace lost wages while you are temporarily disabled. Additional payments are made if the injury causes a permanent disability or death.
- If your injury or illness causes permanent disability that prevents you from returning to work and your employer doesn't offer appropriate modified or alternative work, you may be eligible for a supplemental job displacement benefit. This is a nontransferable voucher of up to $6,000 for education-related retraining and/or skill enhancement at state-approved schools, and other services and resources to help you get back to work.

Benefit Payments

- **Medical Care:** All medical bills for reasonable and necessary treatment will be paid directly by the claims administrator, so you should never receive a bill. The name and phone number of the claims administrator are at the end of this pamphlet and are posted at your workplace.
- **Temporary Disability:** If you are unable to work for more than three days, including weekends, you are entitled to temporary disability (TD) payments to help replace your lost wages. About two weeks after reporting the injury, you'll get a check from the claims administrator. You will continue to receive TD checks every two weeks after that until the doctor says you can return to work, or that your medical condition is "permanent and stationary." (Payments won't be made for the first three days, however, unless you're hospitalized as an inpatient or unable to work more than 14 days.) The amount of these checks will be two-thirds of your average wage, subject to minimums and maximums set by the state legislature. It probably won't be the full amount of your regular paycheck, but there are no deductions and the payments are tax free. Under state law, TD payments for a single injury may not extend for more than 104 compensable weeks within five years from the date of injury, or for more than 240 weeks within five years from the date of injury for a few long-term injuries such as severe burns or chronic lung disease. If you reach the maximum TD payment period before you can return to work or before your medical condition becomes permanent and stationary, you may be able to obtain State Disability benefits through the California Employment Development Department (EDD). You also may be able to get these benefits if your TD is delayed or denied. There are time restrictions, however, so contact EDD at (800) 480-3287 or www.edd.ca.gov for information on when and how to apply.
- **Permanent Disability:** If your injury or illness results in a permanent loss of physical or mental function that a doctor can measure, you may receive permanent disability payments. The amount depends on the doctor's report, how much of the permanent disability was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. The minimum and maximum amounts are set by state law, and vary by injury date, but if you have a permanent disability, your claims administrator will send you a letter explaining how the benefit was calculated. In general, the total amount is set at a weekly rate spread over a fixed number of weeks. The first payment is due within 14 days after the final temporary disability payment, or if you were not receiving temporary disability, 14 days after your doctor says your condition is permanent and stationary. After that, the benefit will be paid every 14 days until you reach the maximum or until you settle your case and receive a lump sum.
- **Death Benefits:** If the injury or illness causes death, payments may be made to individuals who were financially dependent on you. These benefits are set by state law and the amount depends on the number of dependents and the date of injury. Generally, the payments are made at the same rate as temporary disability payments; however, no payments will be less than $224 per week. Workers' compensation also provides a burial allowance.
- **Supplemental Job Displacement Benefit:** If the claims administrator receives a doctor's report that you have recovered as much as possible from your job injury, and that you have a permanent disability, within 60 days you may receive a form with an offer of regular, modified or alternative work from your employer. If 60 days after receiving the doctor's report your employer has not offered you regular, modified or alternative work, your claims administrator has 20 days to provide you a Supplemental Job Displacement Benefit. This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at a state accredited school, books, required tools, license or certification fees, or other resources that can help you find a new job. There are limits on how much you can spend for some items, but if you qualify, you'll receive a letter explaining what types of expenses are covered, the limits, documentation requirements, and deadlines for using this benefit.

Other Resources

Workers' compensation is sometimes confused with State Disability Insurance (SDI). They seem similar, but there are important differences. Workers' compensation insurance covers on-the-job injuries and illnesses and is paid for entirely by your employer. On the other hand, SDI covers off-the-job injuries or sickness, and is paid for by deductions from your paycheck. If you are not receiving workers' compensation benefits, you may be able to get State Disability benefits. For information, call the local office of the state Employment Development Department listed in the government pages of your phone book, or learn more at www.edd.ca.gov/disability/.

If you receive a Supplemental Job Displacement Benefit voucher, you may qualify for additional money from the Return to Work Supplement Program. This program is administered by the California Department of Industrial Relations, so if you qualify, a check will be issued by the state, not the workers' compensation claims administrator, as this is not a workers' compensation benefit. For details on eligibility and how to apply, visit the Return to Work Supplement Program section of the Department of Industrial Relations web site at www.dir.ca.gov/RTWSP/RTWSP.html or contact the local DWC Information and Assistance office listed in the back of this pamphlet.

If You Have Questions

… ask your supervisor or employer representative. Or contact the workers' compensation claims administrator (the name and phone number are listed at the end of this pamphlet and are posted at your workplace).

Information prepared by the state for injured workers also is posted on the DWC web site at www.dwc.ca.gov. In addition, you can contact an information and assistance officer at the State Division of Workers' Compensation (DWC). Information and assistance officers are available at no charge to answer questions, review problems and provide additional written information about workers' compensation. The local office is listed at the end of this pamphlet, posted at your workplace, and in the white pages of the phone book under State Government Offices/Industrial Relations/Workers' Compensation. For a list of all information and assistance offices throughout the state, or to hear recorded information, call (800) 736-7401.

More About Medical Care

Good medical care is important – to you, your family and your employer. Quality medical treatment is the quickest way to recovery.

- If emergency medical care is needed, immediately call 911 or go to the nearest hospital emergency room.
- For nonemergency medical care, notify your supervisor and go to the clinic/doctor's office listed on the back of this pamphlet or on the workers' compensation poster at your worksite. If only first-aid is needed and it is available at your workplace, seek it immediately. If it's more than a simple first-aid injury, ask your employer for a claim form.
- To make sure your medical bills get paid and you get all of your benefits, complete the "Employee" section of the claim form and return it to your employer as soon as possible. Employers must notify the claims administrator and authorize medical care within one working day of receiving a claim form, so get a signed and dated copy back from your employer and keep it with the other paperwork related to your claim.
- Your claims administrator will arrange medical care that meets the applicable treatment guidelines for the injury. The doctor, who may be a specialist for your type of injury, will be familiar with workers' compensation requirements and will report promptly so your benefits can be paid.
- Your employer may have a Medical Provider Network (MPN), which is a network of health care providers who treat workers injured on the job. If so, MPN contact information can be found on the back of this pamphlet and on the workers' compensation poster at your worksite. You also can request information on how to use the MPN by asking your employer, or by visiting the MPN website or calling the MPN phone number listed in this pamphlet and on the workers' compensation poster.
- The doctor responsible for developing your treatment plan and managing your care is your "primary treating physician" (PTP). Your PTP also will coordinate any care you receive from other medical providers. Workers' compensation medical services are subject to authorization, and must meet the state's treatment guidelines for the type of injury. If a medical service requested by your PTP or another provider is determined not medically necessary, you will receive information on how to appeal that decision, but if you choose to appeal you must do so within 30 days of receiving the decision.
- The PTP also will decide when you can return to work and may review your job description with you and your employer to define any limitations or restrictions that you may have when you go back to work. For a serious injury, the PTP will write reports about any permanent disability or need for future medical care.
- You can be treated by your personal doctor immediately if you have health care coverage for nonwork injuries and illnesses; the doctor has treated you before, has your medical records, and has agreed in advance to treat you for work injuries or illnesses; and you gave your employer the doctor's name and address in writing before the injury. This is called "predesignating a personal physician." If you decide to predesignate, the doctor must be someone who has limited his or her practice of medicine to general practice or be a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner; or you can predesignate a multispecialty group of licensed doctors of medicine or osteopathy (M.D.s or D.O.s) that provides comprehensive medical services primarily for nonoccupational injuries and illnesses.You can use the Predesignation of Personal Physician form (Optional DWC Form 9783) included in this pamphlet to give your employer the necessary information. You can use the optional DWC Form 9783.1 to name a personal chiropractor or acupuncturist, but different rules apply, and you need to see an employer-selected doctor first.
- If your employer has an MPN, but you predesignated a personal physician prior to the injury, you may receive treatment immediately from that doctor. If your employer has an MPN but you did not predesignate a personal physician, a network doctor will generally be your PTP for the duration of treatment. For treatment other than emergency care, your claims administrator should direct you to an MPN doctor for your first medical visit, though you may choose to be treated by another doctor in the network anytime after your first visit. If you want to switch to a chiropractor or acupuncturist, including a personal chiropractor or personal acupuncturist named prior to the injury, he or she must be in the network. Different rules apply if you are in a workers' compensation Health Care Organization (HCO). If your employer offers an MPN or if you are in an HCO, your employer will provide additional information about the network and your rights under your plan.
- Generally, if you are not covered by an MPN and did not predesignate a personal physician, you can switch to your own doctor 30 days after the injury is reported. If you want to switch doctors before that, your claims administrator will give you a list of doctors to choose from. (Different rules apply if you are in a HCO, so check with your claims administrator if that's the case.) If you want to change doctors for any reason, choose carefully, and if you want advice on specialists, talk to the claims adjuster who works for your claims administrator. They're as interested as you are in your prompt recovery and return to work and will help you get a different doctor.
- In any event, report your choice to the claims adjuster as soon as you make it so the bills will be paid for you. Even minor injuries may need expert care. Prompt, quality medical care is the best investment you and your employer can make.

If you receive a supplemental job displacement voucher for an injury that occurred on or after January 1, 2013, you may qualify for additional money from the Return to Work Supplement Program (RTWSP) administered by the California Department of Industrial Relations (DIR). For details on eligibility and how to apply, visit the Return to Work Supplement Program section of the DIR website at www.dir.ca.gov/RTWSP/RTWSP.html, or contact the local DWC Information and Assistance office which you can find by calling (800) 736-7401, by going to www.dwc.ca.gov, or by checking the workers' compensation posting notice at your work site. If you qualify, a check will be sent by the state, not the workers' compensation claims administrator, as this is not a workers' compensation benefit.

Where Can I Get More Information?

Start by asking the workers' compensation claims administrator (the name and phone number are on the workers' compensation poster at your workplace). Many times problems can be solved and questions answered with a simple phone call. In addition, you can get recorded information or order free written materials about workers' compensation by calling the State Division of Workers' Compensation (DWC) at (800) 736-7401, or by visiting the DWC web site at www.dwc.ca.gov.

If you are not represented by an attorney and would like a State Information & Assistance Officer to explain your rights, solve problems, or provide other information, you can call and leave a message at the nearest local office of the DWC. The address and phone number are on the DWC web site, are posted at your workplace, and are listed in the State Government section of the phone book under "Industrial Relations Department." The state's information and assistance services are free.

More About Medical Care

Good medical care is important -- to you, your family and your employer. Quality medical treatment is the quickest way to recovery, so report all work injuries and illnesses to your employer as soon as possible so appropriate medical care can be arranged.

- If it's more than a first-aid injury, your employer will give you a claim form. To make sure you get all your benefits, complete the "Employee" section of the form and return it to your employer as soon as possible. Within one working day, your employer should give you a signed and dated copy, send a copy to the claims administrator, and your medical treatment will be authorized. If additional treatment is necessary, your claims adjuster will arrange for medical care that meets applicable treatment guidelines for your injury.
- The doctor who will develop your treatment plan and manage the care of your injury or illness is your "primary treating physician" (PTP). The PTP also decides when you can return to work, and he or she may review your job description with you and your employer to determine your capabilities for returning to work. This doctor also will coordinate the care you receive from other medical providers, and will write reports about your medical condition and treatment, temporary disability, permanent disability, and other issues that will affect your benefits.
- If on the date of injury you have health care coverage for non-work injuries and illnesses, you can be treated right away by your own doctor if you gave your employer the doctor's name and business address in writing prior to the injury, and the doctor has treated you before, has your medical records, and agreed to treat you for work injuries or illnesses prior to the injury. This is called predesignating a personal physician. The state requires that a predesignated physician must have limited his or her practice of medicine to general practice, or that they be a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, or a multispecialty group of licensed doctors of medicine or osteopathy (M.D.s or D.O.s) that provides comprehensive medical services primarily for nonoccupational injuries and illnesses. Different rules apply if you gave your employer the name of your personal chiropractor or acupuncturist before the injury, and you may need to see a doctor selected by the claims adjuster first, so check with your claims adjuster.
- If, prior to the injury, you did not predesignate a personal doctor who meets the state requirements, you may be sent to a doctor you don't know, but that doesn't mean it's a "company doctor." The doctor may be a specialist for the specific injury. In addition, the doctor will be familiar with workers' compensation requirements and will report promptly so your benefits will be paid.
- Your employer may have a Medical Provider Network (MPN), which is a network of health care providers who treat workers injured on the job. If so, MPN contact information, including a phone number to help you find an MPN physician should be on the workers' compensation poster at your worksite. You also can request information on how to use the MPN by asking your employer, or by calling the MPN number or visiting the MPN website listed on the posting notice.
- Generally, if you did not predesignate a personal physician prior to the injury and you are not covered by an MPN or a workers' compensation Health Care Organization (HCO), your employer will select the PTP you will see for the first 30 days. If you want to switch doctors within the first 30 days, your claims adjuster will give you a list of doctors to choose from.
- If you are covered by an MPN or an HCO, different rules apply. For example, if you are in an MPN, your claims administrator should direct you to an MPN doctor for your first medical visit for treatment, and a network doctor will generally be your PTP for the duration of treatment. You may switch to another doctor in the MPN any time after your first visit; but if you want to switch to a chiropractor or acupuncturist, including one named prior to the injury, he or she must be in the MPN. State law allows a chiropractor to be a treating physician for up to 24 visits, but beyond that you may need to switch to another doctor, so check with your claims administrator.
- If your employer has an MPN, but you have a predesignated personal physician, you may receive treatment immediately from that doctor.
- Workers' compensation medical services are subject to authorization for medical necessity and must be consistent with treatment guidelines for the type of injury. If a medical service requested by your PTP or another provider is determined not medically necessary, you will receive information on how to appeal that decision. If you do decide to appeal, there are time limits, so don't delay.
- If you are in an MPN or HCO and you have questions, ask your employer or claims adjuster for more information about the network and about your rights under your plan. In any event, if you're thinking of changing doctors, consider this decision carefully. If you want advice about specialists, or want to change doctors for some other reason, talk to your claims administrator and always report your choice as soon as you make it so your bills will be paid for you.

Above all, report promptly. Even minor injuries need expert care, and prompt, quality medical treatment is the best investment for you and your employer.

WORKERS' COMPENSATION FRAUD IS A FELONY

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be punished by imprisonment in county jail for one year, or in state prison for up to five years, and/or fined up to $150,000 or double the value of the fraud (whichever is greater), and ordered to pay restitution for any medical evaluation or treatment. (IC §1871.4).

If you are being provided a temporary disability check, please note the following:

WARNING: You are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty may be jail or prison, a fine, and loss of benefits.

Si se le está proporcionando un cheque por incapacidad temporal, por favor note lo siguente:

ADVERTENCIA: Es necesario que usted le avise a su patron o a su compañía de seguro todo dinero que usted ha ganado por trabajar, durante el tiempo cubierto por este cheque, y antes de cambiar este cheque. Si usted no sigue estos reglamentos, usted puede estar en violación de la ley y el castigo podria ser carcel o prisión, una multa, y perdida de beneficios.

This pamphlet is available in Spanish. For a free copy, please write to the California Workers' Compensation Institute.
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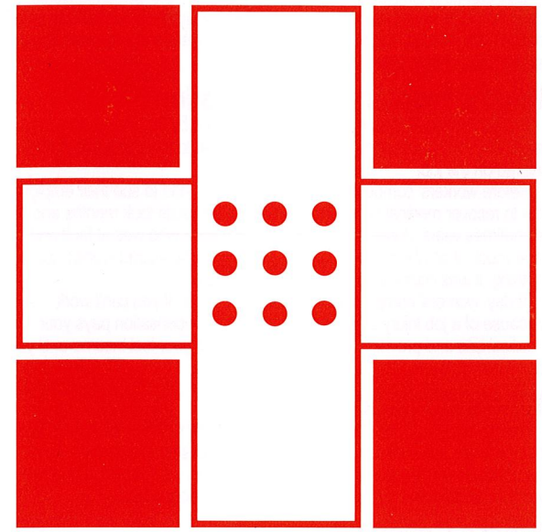
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www.cwci.org

This pamphlet provides an overview of California workers' compensation for workers who are injured on the job and describes the workers' compensation system as of the revision date noted below. It is not intended to provide legal advice. Workers may check for updates in the Communications section of our website under FAQs for Employees, or on the Division of Workers' Compensation (DWC) website.

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FACTS FOR INJURED WORKERS

Hurt On The Job?

That can be a terrible experience. But fortunately, the California workers' compensation system takes away a lot of the worry about job injuries and illnesses. It's no-fault insurance, paid for by employers and supervised by the state. This guide explains this valuable benefit.

What's Workers' Compensation?

California's workers' compensation law, passed by the state Legislature more than 100 years ago, guarantees prompt, automatic benefits to workers injured on the job.

Before workers' compensation, injured workers had to sue their employers to recover medical costs and lost wages. Lawsuits took months and sometimes years. Juries and judges had to decide who was at fault and how much, if anything, would be paid. Too often, the injured worker got nothing. It was costly, time consuming and unfair.

Today, workers' compensation is faster and fairer. If you can't work because of a job injury or job illness, workers' compensation pays your medical bills and provides money to help replace your lost income until you can return to work.

Who's Covered?

Nearly every working Californian is protected by workers' compensation, but there are a few exceptions. People in business for themselves, some domestic workers, and unpaid volunteers may not be covered. Maritime workers and federal employees are covered by federal laws.

What's Covered?

Any injury caused by the job is covered -- everything from minor injuries to serious accidents. It can be caused by one event, such as a fall, or repeated exposures, such as doing a repetitive motion over time. Job-related illnesses are covered too. (For example, common colds and flu aren't covered, but if you catch tuberculosis while working at a TB hospital, that's covered.) Workers' compensation even covers physical or psychiatric injuries resulting from a workplace crime. The key is whether the injury or illness is caused by your job.

When Am I Covered?

Coverage begins the first minute you're on the job and continues anytime you're working. With the exception of certain psychiatric injuries and residential workers, you don't have to work a certain amount of time or earn a certain amount before you're protected. Coverage is automatic and immediate.

How Do I Get Benefits?

Report the injury to your employer or supervisor immediately and complete a claim form if it is more than a simple first-aid injury. The claim form will ask what, where, when and how it happened.

Prompt reporting is the key because your medical bills and any other workers' compensation benefits can't be paid until your workers' compensation claims administrator knows about the injury. The claims administrator is the company responsible for handling your claim and notifying you about your eligibility for benefits. Under state law, medical treatment must be authorized within one working day of the employer's receipt of the claim form. After you return the claim form, your employer will notify the claims administrator, you will be directed to a doctor, clinic or hospital if necessary, and a claims adjuster will be assigned to handle your claim. Until a claim is accepted or rejected, up to $10,000 in medical treatment may be covered. State law requires pre-authorization of non-emergency medical care, and there are limits on some types of treatment, so stay in touch with your claims adjuster to make sure you get appropriate care and your bills will be paid.

Ensure your right to benefits by reporting every injury, no matter how slight, and request a claim form if it's more than a minor injury requiring only first aid. You may not be able to get benefits if your employer doesn't learn of the injury within 30 days of the date of injury. If your injury or illness developed over time, report it as soon as you learn it was caused by your job. If your claim or benefits are denied you have a right to challenge the decision, but there are deadlines for filing the necessary paperwork, so don't delay.

What Are The Benefits?

California law guarantees three kinds of worker's compensation benefits:

- **Reasonable and necessary medical care to cure or relieve the effects of the injury or illness.** Not just doctor bills, but medicines, hospital costs, fees for lab tests, x-rays, crutches -- even travel expenses for required medical treatment. The state has set limits on some medical services – for example the number of visits for chiropractic care, occupational therapy, and physical therapy are subject to caps set by state law, and medical services may be subject to authorization for medical necessity, but all costs for reasonable and necessary treatment are paid directly by the claims administrator without deductibles, so you should never see a bill.
- **Cash payments to help replace lost wages.** Some injuries only keep you from working temporarily, and you may receive "temporary disability" (TD) payments until the doctor says you're able to return to work or that your medical condition is "permanent and stationary." Under state law, TD for a single injury may be paid for no more than 104 weeks within five years from the date of injury, or for a few very serious types of injuries such as amputations, severe burns, or chronic lung disease, TD may be paid for a maximum of 240 weeks within five years from the date of injury.

  Additional cash payments will be made after you're able to work if the work injury or illness caused a permanent disability (PD) -- for example, the loss of a finger or an eye – that your doctor says will always leave you somewhat limited in your ability to work -- or if you can't return to work at all. If the injury results in death, benefits and a burial allowance will be paid to your surviving dependents.
- **Supplemental Job Displacement Benefits.** If you have recovered as much as possible and your doctor says your injury caused a permanent disability, the doctor should send your claims administrator a "Physician's Return to Work and Voucher Report" with information on your capacity to work and any work restrictions. After the claims administrator receives this report, your employer has 60 days during which they may send you an offer of regular, modified or alternative work. If after 60 days your employer has not offered you regular, modified or alternative work, your claims administrator has 20 days to provide you a Supplemental Job Displacement Benefit. This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at a state-accredited school, books, tools, license and certification fees, or other resources that can help you find a new job. There are limits on how much you can receive for some items, but if you qualify, you will receive information on the types of expenses that are covered, the limits, documentation requirements, and deadlines for using the benefit.

How Much Are The Cash Payments?

Temporary disability payments generally are two-thirds of your wages – subject to minimums and maximums set by the state. At the beginning of each year, the minimum and the maximum weekly TD rates that will apply for injuries that occur during that year are subject to adjustments based on increases in the state average weekly wage, so the amount of your payments depends on your date of injury. For example, for injuries occurring in 2018, the minimum weekly TD payment is $182.29 and the maximum is $1,215.27. Your claims adjuster will send you a letter explaining how much your TD payments will be based on your earnings and the rate in effect at the time of injury. If you are still eligible for temporary disability payments two years after the injury, any TD payments made after that will be adjusted to the current rates if justified by earnings.

- TD isn't paid for the first three days you're unable to work -- unless you're hospitalized as an in-patient or unable to work for more than 14 days. In these instances, even the "waiting period" will be paid.
- If you report the injury promptly, your claims administrator should mail your first TD check within 14 days. After that, you'll receive a check every two weeks until the doctor says you can go back to work or that your medical condition is "permanent and stationary," or the time limit set by the state is reached.
- After you recover to the fullest extent possible, the doctor who treated you will evaluate the permanent effects of your injury. You and your employer may agree to rely on the treating doctor's report to establish your permanent disability (PD) payment. If you have questions about the report, or disagree with the treating doctor's opinions, you may contact the claims adjuster, an information and assistance officer at the Division of Workers' Compensation, or your attorney if you are represented. They can explain your rights and the process for resolving disputes, which varies depending on a number of factors.

  Your level of permanent disability will be based on the doctor's opinion about how much of the PD was directly caused by your work, as well as other factors including your age, pre-injury occupation, type of injury, and the date of injury. The weekly benefit amount is subject to minimums and maximums set by the state, which vary according to the date of injury and your level of permanent disability. If you have a permanent disability, the calculation of the benefit will be fully explained in a letter from the claims administrator.
- Death benefit payments to survivors who were financially dependent on a deceased worker are set by state law according to the number of dependents and the date of injury. Generally, payments are made at the same rate as TD benefits, however, no payments will be less than $224 per week. Workers' compensation also pays a burial allowance of up to $10,000.

  Workers' compensation payments are tax free. There are no deductions for state or federal taxes, Social Security, union or retirement fund contributions, etc. For some workers the compensation check will be close to regular take-home pay.

What If There's A Problem?

Fortunately most claims are handled routinely. After all, workers' compensation benefits are automatic and the amounts are set by the Legislature.

But, mistakes and misunderstandings do happen. If you think you haven't received all your benefits, start by calling workers' compensation claims adjuster. Many questions can be cleared up with a phone call.

- If you still have questions, contact the nearest office of the State Division of Workers' Compensation (DWC). Information & Assistance Officers are employed by the state to protect your rights, review your claim, and let you know what steps you can take. For example, they can tell you about the procedures for resolving medical disputes and direct you on how to proceed. Information and Assistance Officers also can provide you with free written materials about workers' compensation. Information and Assistance services are free. For the nearest office check the State Government Offices section of the phone book under "Industrial Relations Department," call (800) 736-7401 for recorded information and the location of a local office, or visit the Division of Workers' Compensation website at www.dwc.ca.gov.
- Some problems may need to be resolved by the Workers' Compensation Appeals Board, the state agency responsible for handling many disputes. The Appeals Board is a court of law. You can represent yourself or you can hire an attorney, but you should be aware that attorneys are paid out of the injured worker's permanent disability benefits awarded by the Appeals Board. Attorney fees generally are 12 to 15 percent of your award, and must be approved by a judge. For example, if the Appeals Board awards you $10,000 for permanent disability, less 15 percent for attorney fees, your attorney will get $1,500 and you will get $8,500.
- You also need to be aware that if you hire an attorney, other people involved in your case -- including your claims adjuster -- may no longer be allowed to speak directly to you about important matters, and the Division of Workers' Compensation Information & Assistance Officers may be unable to advise or assist you with certain issues. If you choose to stop having an attorney represent you, or you want to change lawyers, your original lawyer can still claim a portion of your benefits as attorney fees.
- Delays in reporting may delay workers' compensation benefits, and you may not be able to get benefits if your employer doesn't learn of your injury within 30 days of the date of injury, or if you don't file a claim within one year of the date of injury, the date you knew the injury was work related, or the date benefits were last provided. To ensure your right to benefits, report every injury, no matter how slight, and request a claim form if it's more than a simple first aid injury. You also have the right to challenge the decision if your claim or benefits are denied, but there are deadlines for filing the necessary papers, so don't delay.
- Keep in mind, it is illegal for an employer to fire or discriminate against employees just because they file, intend to file, or settle a workers' compensation claim -- or because they testify for a coworker who was injured. A worker who proves this kind of discrimination will be entitled to job reinstatement, lost wages and increased benefits, plus costs and expenses up to a maximum set by the state Legislature.

Other Resources

If the injury is very serious -- one where you won't be able to work for a year or more -- you may be eligible for additional benefits from Social Security. For information, contact the nearest office of the Social Security Administration (listed in the white pages of the phone book under "United States Government"), go to the website at www.ssa.gov, or discuss it with your employer or claims adjuster.

Workers' compensation sometimes is confused with another state program, State Disability Insurance (SDI). They seem similar, but there are important differences. Workers' compensation takes care of on-the-job injuries and illnesses, and is paid for by your employer. On the other hand, SDI covers off-the-job injuries or sickness and is paid for by deductions from your paycheck. If you are not receiving workers' compensation benefits – for example, if TD has been delayed or denied, or the maximum TD payment period expires before you can return to work, you may be able to get State Disability benefits. There are time restrictions, however, and you need to apply in advance, so for forms and information, call the local office of the state Employment Development Department (EDD) listed in the government pages of your phone book, or (800)480-3287, or go to the EDD website at www.edd.ca.gov.

Employment Development Department
State of California

NOTICE TO EMPLOYEES
UNEMPLOYMENT INSURANCE BENEFITS

This employer is registered under the California Unemployment Insurance Code and is reporting wage credits to the Employment Development Department (EDD) that are being accumulated for you to be used as a basis for Unemployment Insurance benefits.

You may be eligible to receive Unemployment Insurance benefits if you are:

- Unemployed or working less than full-time.
  and
- Out of work due to no fault of your own and physically able to work, ready to accept work, and looking for work.

Employees of Educational Institutions:

Unemployment Insurance benefits based on wages earned while employed by a public or nonprofit educational institution may not be paid during a school recess period if the employee has reasonable assurance of returning to work at the end of the recess period (California Unemployment Insurance Code section 1253.3). Benefits based on other covered employment may be payable during recess periods if the unemployed individual is in all other respects eligible, and the wages earned in other covered employment are sufficient to establish an Unemployment Insurance claim after excluding wages earned from a public or nonprofit educational institution(s).

Note: Some employees may be exempt from Unemployment and Disability Insurance coverage.

The fastest way to file for Unemployment Insurance (UI) is with UI Online at www.edd.ca.gov/UI_Online.

You may also file for Unemployment Insurance by calling toll-free from anywhere in the U.S. at:

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

Note: Waiting to file a claim could delay benefits.
EDD representatives are available Monday through Friday between 8 a.m. and 12 noon (Pacific Time).

EMPLOYERS MUST PROVIDE THIS INFORMATION TO NEW WORKERS WHEN HIRED AND TO OTHER WORKERS WHO ASK FOR IT

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING

Your Right to Take Time Off:

- You have the right to take time off from work to get help to protect you and your children's health, safety or welfare. You can take time off to get a restraining order or other court order.
- If your company has 25 or more workers, you can take time off from work to get medical attention or services from a domestic violence shelter, program or rape crisis center, psychological counseling, or receive safety planning related to domestic violence, sexual assault, or stalking.
- You may use available vacation, personal leave, accrued paid sick leave or compensatory time off for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer before, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, court order or doctor's or counselor's note or similar document.

Your Right to Reasonable Accommodation:

- You have the right to ask your employer for help or changes in your workplace to make sure you are safe at work. Your employer must work with you to see what changes can be made. Changes in the workplace may include putting in locks, changing your shift or phone number, transferring or reassigning you, or help with keeping a record of what happened to you. Your employer can ask you for a signed statement certifying that your request is for a proper purpose, and may also request proof showing your need for an accommodation. Your employer cannot tell your coworkers or anyone else about your request.

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, or stalking.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

You can file a complaint with the Labor Commissioner's Office against your employer if he/she retaliates or discriminates against you.

For more information, contact the California Labor Commissioner's Office. We can help you by phone at 213-897-6595, or you can find a local office on our website: www.dir.ca.gov/dlse/DistrictOffices.htm. If you do not speak English, we will provide an interpreter in your language at no cost to you. This Notice explains rights contained in California Labor Code sections 230 and 230.1. Employers may use this Notice or one substantially similar in content and clarity.

EMPLOYEE RIGHTS

UNDER THE FAIR LABOR STANDARDS ACT

FEDERAL MINIMUM WAGE

$7.25 PER HOUR

BEGINNING JULY 24, 2009

The law requires employers to display this poster where employees can readily see it.

OVERTIME PAY

At least 1½ times the regular rate of pay for all hours worked over 40 in a workweek.

CHILD LABOR

An employee must be at least 16 years old to work in most non-farm jobs and at least 18 to work in non-farm jobs declared hazardous by the Secretary of Labor. Youths 14 and 15 years old may work outside school hours in various non-manufacturing, non-mining, non-hazardous jobs with certain work hours restrictions. Different rules apply in agricultural employment.

TIP CREDIT

Employers of "tipped employees" who meet certain conditions may claim a partial wage credit based on tips received by their employees. Employers must pay tipped employees a cash wage of at least $2.13 per hour if they claim a tip credit against their minimum wage obligation. If an employee's tips combined with the employer's cash wage of at least $2.13 per hour do not equal the minimum hourly wage, the employer must make up the difference.

NURSING MOTHERS

The FLSA requires employers to provide reasonable break time for a nursing mother employee who is subject to the FLSA's overtime requirements in order for the employee to express breast milk for her nursing child for one year after the child's birth each time such employee has a need to express breast milk. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by the employee to express breast milk.

ENFORCEMENT

The Department has authority to recover back wages and an equal amount in liquidated damages in instances of minimum wage, overtime, and other violations. The Department may litigate and/or recommend criminal prosecution. Employers may be assessed civil money penalties for each willful or repeated violation of the minimum wage or overtime pay provisions of the law. Civil money penalties may also be assessed for violations of the FLSA's child labor provisions. Heightened civil money penalties may be assessed for each child labor violation that results in the death or serious injury of any minor employee, and such assessments may be doubled when the violations are determined to be willful or repeated. The law also prohibits retaliating against or discharging workers who file a complaint or participate in any proceeding under the FLSA.

ADDITIONAL INFORMATION

- Certain occupations and establishments are exempt from the minimum wage, and/or overtime pay provisions.
- Special provisions apply to workers in American Samoa, the Commonwealth of the Northern Mariana Islands, and the Commonwealth of Puerto Rico.
- Some state laws provide greater employee protections; employers must comply with both.
- Some employers incorrectly classify workers as "independent contractors" when they are actually employees under the FLSA. It is important to know the difference between the two because employees (unless exempt) are entitled to the FLSA's minimum wage and overtime pay protections and correctly classified independent contractors are not.
- Certain full-time students, student learners, apprentices, and workers with disabilities may be paid less than the minimum wage under special certificates issued by the Department of Labor.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
TTY: 1-877-889-5627
www.dol.gov/whd

WH1088 REV 07/16

EMPLOYEE RIGHTS

UNDER THE FAIR LABOR STANDARDS ACT

FEDERAL MINIMUM WAGE

$7.25 PER HOUR

BEGINNING JULY 24, 2009

STATE AND LOCAL GOVERNMENT EMPLOYEES

OVERTIME PAY

At least 1½ times the regular rate of pay for all hours worked over 40 in a workweek.

Law enforcement and fire protection personnel: You may be paid overtime on the basis of a "work period" of between 7 and 28 consecutive days in length, rather than on a 40-hour workweek basis.

COMPENSATORY TIME

Employees may receive compensatory time off instead of cash overtime pay, at a rate of not less than 1½ hours for each overtime hour worked, where provided pursuant to an agreement or understanding that meets the requirements of the Act.

EXEMPTIONS

The Act does not apply to persons who are not subject to the civil service laws of State or local governments and who are: elected public officials, certain immediate advisors to such officials, certain individuals appointed or selected by such officials to serve in various capacities, or employees of legislative branches of State and local governments. Employees of legislative libraries do not come within this exclusion and are thus covered by the Act.

Certain types of workers are exempt from the minimum wage and overtime pay provisions, including bona fide executive, administrative, and professional employees who meet regulatory requirements.

Any law enforcement or fire protection employee who in any workweek is employed by a public agency employing less than 5 employees in law enforcement or fire protection activities is exempt from the overtime pay provisions.

YOUTH EMPLOYMENT

16 years old is the minimum age for most occupations. An 18-year old minimum applies to hazardous occupations. Minors 14 and 15 years old may work outside school hours under certain conditions. For more information, visit the YouthRules! Web site at www.youthrules.dol.gov.

ENFORCEMENT

The Department has authority to recover back wages and an equal amount in liquidated damages in instances of minimum wage, overtime, and other violations. The Department may litigate and/or recommend criminal prosecution. Employers may be assessed civil money penalties for each willful or repeated violation of the minimum wage or overtime pay provisions of the law. Civil money penalties may also be assessed for violations of the FLSA's child labor provisions. Heightened civil money penalties may be assessed for each child labor violation that results in the death or serious injury of any minor employee, and such assessments may be doubled when the violations are determined to be willful or repeated. The law also prohibits retaliating against or discharging workers who file a complaint or participate in any proceeding under the FLSA.

ADDITIONAL INFORMATION

- Some state laws provide greater employee protections; employers must comply with both.
- Employees under 20 years of age may be paid a youth minimum wage of not less than $4.25 an hour during their first 90 consecutive calendar days after initial employment by an employer.
- Employers are required to display this poster where employees can readily see it.

The law requires employers to display this poster where employees can readily see it.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

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WH1385 REV 07/16

EMPLOYEE RIGHTS

FOR WORKERS WITH DISABILITIES PAID AT SUBMINIMUM WAGES

This establishment has a certificate authorizing the payment of subminimum wages to workers who are disabled for the work they are performing. Authority to pay subminimum wages to workers with disabilities generally applies to work covered by the **Fair Labor Standards Act (FLSA)**, **McNamara-O'Hara Service Contract Act (SCA)**, and/or **Walsh-Healey Public Contracts Act (PCA)**. Such subminimum wages are referred to as "commensurate wage rates" and are less than the basic hourly rates stated in an SCA wage determination and/or less than the FLSA minimum wage of **$7.25 per hour**. A "commensurate wage rate" is based on the worker's individual productivity, no matter how limited, in proportion to the wage and productivity of experienced workers who do not have disabilities that impact their productivity when performing essentially the same type, quality, and quantity of work in the geographic area from which the labor force of the community is drawn.

Employers shall make this poster available and display it where employees and the parents and guardians of workers with disabilities can readily see it.

WORKERS WITH DISABILITIES

Subminimum wages under section 14(c) are not applicable unless a worker's disability actually impairs the worker's earning or productive capacity for the work being performed. The fact that a worker may have a disability is not in and of itself sufficient to warrant the payment of a subminimum wage.

For purposes of payment of commensurate wage rates under a certificate, a worker with a disability is defined as: An individual whose earnings or productive capacity is impaired by a physical or mental disability, including those related to age or injury, for the work to be performed.

Disabilities which may affect productive capacity include an intellectual or developmental disability, psychiatric disability, a hearing or visual impairment, and certain other impairments. The following do not ordinarily affect productive capacity for purposes of paying commensurate wage rates: educational disabilities; chronic unemployment; receipt of welfare benefits; nonattendance at school; juvenile delinquency; and correctional parole or probation.

WORKER NOTIFICATION

Each worker with a disability and, where appropriate, the parent or guardian of such worker, shall be informed orally and in writing by the employer of the terms of the certificate under which such worker is employed.

KEY ELEMENTS OF COMMENSURATE WAGE RATES

- **Nondisabled worker standard**—The objective gauge (usually a time study of the production of workers who do not have disabilities that impair their productivity for the job) against which the productivity of a worker with a disability is measured.
- **Prevailing wage rate**—The wage paid to experienced workers who do not have disabilities that impair their productivity for the same or similar work and who are performing such work in the area. Most SCA contracts include a wage determination specifying the prevailing wage rates to be paid for SCA-covered work.
- **Evaluation of the productivity of the worker with a disability**—Documented measurement of the production of the worker with a disability (in terms of quantity and quality).

The wages of all workers paid commensurate wages must be reviewed, and adjusted if appropriate, at periodic intervals. At a minimum, the productivity of hourly-paid workers must be reevaluated at least every six months and a new prevailing wage survey must be conducted at least once every twelve months. In addition, prevailing wages must be reviewed, and adjusted as appropriate, whenever there is a change in the job or a change in the prevailing wage rate, such as when the applicable state or federal minimum wage is increased.

WIOA

The Workforce Innovation and Opportunity Act of 2014 (WIOA) amended the Rehabilitation Act by adding section 511, which places limitations on the payment of subminimum wages to individuals with disabilities by mandating the completion of certain requirements prior to and during the payment of a subminimum wage.

EXECUTIVE ORDER 13658

Executive Order 13658, Establishing a Minimum Wage for Contractors, established a minimum wage that generally must be paid to workers performing on or in connection with a covered contract with the Federal Government. Workers covered by this Executive Order and due the full Executive Order minimum wage include workers with disabilities whose wages are calculated pursuant to certificates issued under section 14(c) of the FLSA.

FRINGE BENEFITS

Neither the FLSA nor the PCA have provisions requiring vacation, holiday, or sick pay nor other fringe benefits such as health insurance or pension plans. SCA wage determinations may require such fringe benefit payments (or a cash equivalent). Workers paid under a certificate authorizing commensurate wage rates must receive the full fringe benefits listed on the SCA wage determination.

OVERTIME

Generally, if a worker is performing work subject to the FLSA, SCA, and/or PCA, that worker must be paid at least 1 1/2 times their regular rate of pay for all hours worked over 40 in a workweek.

CHILD LABOR

Minors younger than 18 years of age must be employed in accordance with the child labor provisions of the FLSA. No persons under 16 years of age may be employed in manufacturing or on a PCA contract.

PETITION PROCESS

Workers with disabilities paid at subminimum wages may petition the Administrator of the Wage and Hour Division of the Department of Labor for a review of their wage rates by an Administrative Law Judge. No particular form of petition is required, except that it must be signed by the worker with a disability or his or her parent or guardian and should contain the name and address of the employer. Petitions should be mailed to: Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue NW, Washington, D.C. 20210.

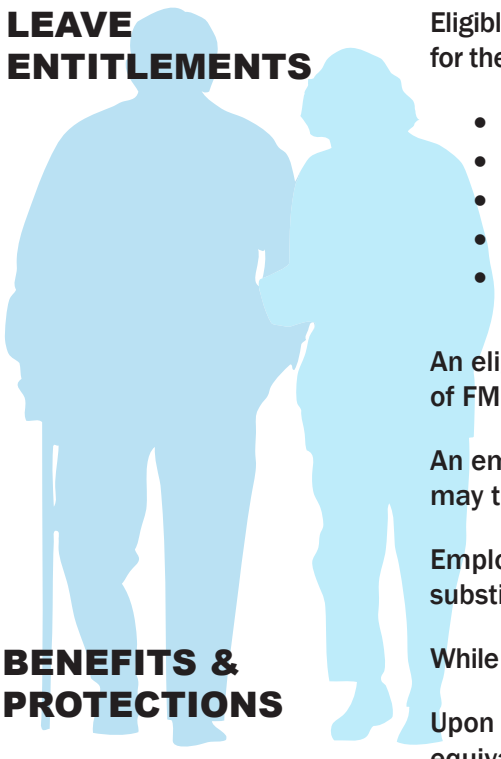
WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

1-866-487-9243
TTY: 1-877-889-5627
www.dol.gov/whd

WH1284 REV 01/18

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

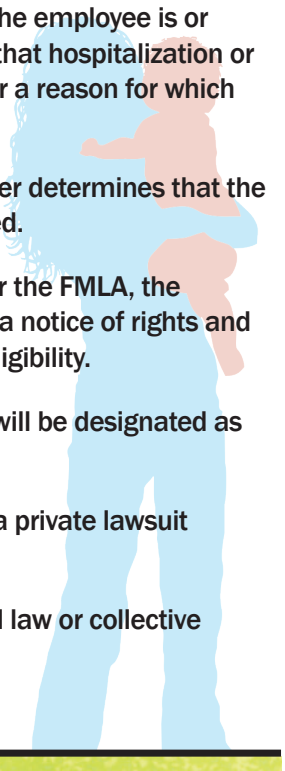
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

WH1420 REV 04/16

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

WH1422 REV 03/20

Break Time for Nursing Mothers

under the Fair Labor Standards Act (FLSA)



WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

The Fair Labor Standards Act (FLSA) requires employers to provide **break time and space** for a covered nonexempt nursing mother to express breast milk for her nursing child for one year after her child's birth.

- Employers must allow reasonable **break time** whenever a covered employee needs to express breast milk.
- Employers must provide covered employees with space that is:
  - functional for expressing milk
  - shielded from view
  - free from intrusion
  - available as needed, AND
  - **NOT a bathroom**.

If an employer has fewer than 50 employees **AND** can demonstrate that compliance with this law would impose an undue hardship on the employer, that employer does not have to provide nursing breaks.

Note: The FLSA requirement of break time for nursing mothers to express breast milk does not preempt state laws that provide greater protections to employees (for example, providing compensated break time, providing break time for exempt employees, or providing break time beyond one year after the child's birth).

UNLAWFUL ACTS

Any employee who is "discharged or in any other manner discriminated against" because he or she has filed a complaint or cooperated in an investigation may file a retaliation complaint with the Wage and Hour Division or directly in court seeking appropriate remedies.

1-866-4US-WAGE
www.dol.gov/whd

WH1527 1218

SEXUAL HARASSMENT

FACT SHEET

DFEH

Sexual harassment is a form of discrimination based on sex/gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, or sexual orientation. Individuals of any gender can be the target of sexual harassment. Unlawful sexual harassment does not have to be motivated by sexual desire. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity.

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

1. "Quid pro quo" (Latin for "this for that") sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.

2. "Hostile work environment" sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you.

The harassment must be severe or pervasive to be unlawful. A single act of harassment may be sufficiently severe to be unlawful.

SEXUAL HARASSMENT INCLUDES MANY FORMS OF OFFENSIVE BEHAVIORS

BEHAVIORS THAT MAY BE SEXUAL HARASSMENT:

1. Unwanted sexual advances
2. Offering employment benefits in exchange for sexual favors
3. Leering; gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters
4. Derogatory comments, epithets, slurs, or jokes
5. Graphic comments, sexually degrading words, or suggestive or obscene messages or invitations
6. Physical touching or assault, as well as impeding or blocking movements

Actual or threatened retaliation for rejecting advances or complaining about harassment is also unlawful.

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with DFEH within three years of the last act of harassment or retaliation.

DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court to address the causes of the discrimination and on behalf of the complaining party. DFEH may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

EMPLOYER RESPONSIBILITY & LIABILITY

All employers, regardless of the number of employees, are covered by the harassment provisions of California law. Employers are liable for harassment by their supervisors or agents. All harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassment or for aiding and abetting harassment. The law requires employers to take reasonable steps to prevent harassment. If an employer fails to take such steps, that employer can be held liable for the harassment. In addition, an employer may be liable for the harassment by a non-employee (for example, a client or customer) of an employee, applicant, or person providing services for the employer. An employer will only be liable for this form of harassment if it knew or should have known of the harassment, and failed to take immediate and appropriate corrective action.

Employers have an affirmative duty to take reasonable steps to prevent and promptly correct discriminatory and harassing conduct, and to create a workplace free of harassment.

A program to eliminate sexual harassment from the workplace is not only required by law, but it is the most practical way for an employer to avoid or limit liability if harassment occurs.

SEXUAL HARASSMENT

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CIVIL REMEDIES

- **Damages for emotional distress from each employer or person in violation of the law**
- **Hiring or reinstatement**
- **Back pay or promotion**
- **Changes in the policies or practices of the employer**

ALL EMPLOYERS MUST TAKE THE FOLLOWING ACTIONS TO PREVENT HARASSMENT AND CORRECT IT WHEN IT OCCURS:

1. Distribute copies of this brochure or an alternative writing that complies with Government Code 12950. This pamphlet may be duplicated in any quantity.

2. Post a copy of the Department's employment poster entitled "California Law Prohibits Workplace Discrimination and Harassment."

3. Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023. The policy must:

- Be in writing.
- List all protected groups under the FEHA.
- Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
- Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reason able progress; appropriate options for remedial actions and resolutions; and timely closures.
- Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor. That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a designated company representative; and/or a complaint hotline; and/or access to an ombudsperson; and/or identification of DFEH and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.
- Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).
- Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
- Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.

4. Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:

- Printing the policy and providing a copy to employees with an acknowledgement form for employees to sign and return.
- Sending the policy via email with an acknowledgment return form.
- Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
- Discussing policies upon hire and/or during a new hire orientation session.
- Using any other method that ensures employees received and understand the policy.

5. If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.

6. In addition, employers who do business in California and employ 5 or more part-time or full-time employees must provide at least one hour of training regarding the prevention of sexual harassment, including harassment based on gender identity, gender expression, and sexual orientation, to each non-supervisory employee; and two hours of such training to each supervisory employee. Training must be provided within six months of assumption of employment. Employees must be trained during calendar year 2020, and, after January 1, 2021, training must be provided again every two years. Please see Gov. Code 12950.1 and 2 CCR 11024 for further information.

TO FILE A COMPLAINT

Department of Fair Employment and Housing
dfeh.ca.gov
Toll Free: 800.884.1684
TTY: 800.700.2320

DFEH-185-ENG / April 2020



WHAT DOES "TRANSGENDER" MEAN?

Transgender is a term used to describe people whose gender identity differs from the sex they were assigned at birth. Gender expression is defined by the law to mean a "person's gender-related appearance and behavior whether or not stereotypically associated with the person's assigned sex at birth." Gender identity and gender expression are protected characteristics under the Fair Employment and Housing Act. That means that employers may not discriminate against someone because they identify as transgender or gender non-conforming. This includes the perception that someone is transgender or gender non-conforming.

WHAT IS A GENDER TRANSITION?

1. "Social transition" involves a process of socially aligning one's gender with the internal sense of self (e.g., changes in name and pronoun, bathroom facility usage, participation in activities like sports teams).

2. "Physical transition" refers to medical treatments an individual may undergo to physically align their body with internal sense of self (e.g., hormone therapies or surgical procedures).

A person does not need to complete any particular step in a gender transition in order to be protected by the law. An employer may not condition its treatment or accommodation of a transitioning employee upon completion of a particular step in a gender transition.

FAQ FOR EMPLOYERS

▪ What is an employer allowed to ask?

Employers may ask about an employee's employment history, and may ask for personal references, in addition to other non-discriminatory questions. An interviewer should not ask questions designed to detect a person's gender identity, including asking about their marital status, spouse's name, or relation of household members to one another. Employers should not ask questions about a person's body or whether they plan to have surgery.

▪ How do employers implement dress codes and grooming standards?

An employer who requires a dress code must enforce it in a non-discriminatory manner. This means that, unless an employer can demonstrate business necessity, each employee must be allowed to dress in accordance with their gender identity and gender expression. Transgender or gender non-conforming employees may not be held to any different standard of dress or grooming than any other employee.

▪ What are the obligations of employers when it comes to bathrooms, showers, and locker rooms?

All employees have a right to safe and appropriate restroom and locker room facilities. This includes the right to use a restroom or locker room that corresponds to the employee's gender identity, regardless of the employee's assigned sex at birth. In addition, where possible, an employer should provide an easily accessible unisex single stall bathroom for use by any employee who desires increased privacy, regardless of the underlying reason. Use of a unisex single stall restroom should always be a matter of choice. No employee should be forced to use one either as a matter of policy or due to harassment in a gender-appropriate facility. Unless exempted by other provisions of state law, all single-user toilet facilities in any business establishment, place of public accommodation, or state or local government agency must be identified as all-gender toilet facilities.

FILING A COMPLAINT

If you believe you are a victim of discrimination you may, within three years* of the discrimination, file a complaint of discrimination by contacting DFEH.

To schedule an appointment, contact the Communication Center below.

If you have a disability that requires a reasonable accommodation, the DFEH can assist you by scribing your intake by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

CONTACT US

Toll Free: (800) 884-1684
TTY: (800) 700-2320
contact.center@dfeh.ca.gov
www.dfeh.ca.gov

* Effective 1/1/2020.