SUPERIOR COURT OF CALIFORNIA
COUNTY OF KERN

The Benefits of Employment
Effective January 1, 2023

Smart Decisions

Getting the most value from your Superior Court benefits means making smart decisions, by knowing how the plans work and how they impact you and your family.

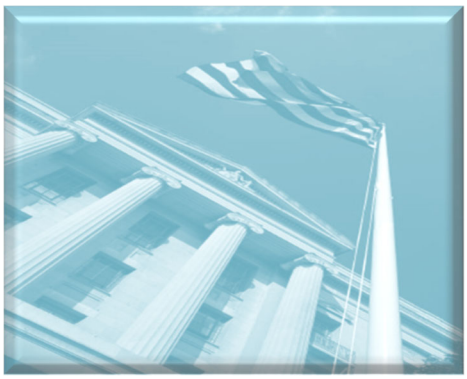
Introduction

We believe every employee at the Superior Court contributes his or her part to our commitment to service. We provide our employees with a comprehensive and competitive benefits package, including Medical, Dental, Vision, Prescription Drug, Life, AD&D and EAP coverage. In addition to these core benefits, the Court offers a variety of voluntary benefit programs, including Flexible Spending Accounts, Long-Term Disability Insurance, Supplemental Life Insurance, Critical Illness Insurance and Pet Insurance. This guide addresses all the Court's Core and Voluntary benefits. We encourage you to read this guide carefully, so you understand your benefits and how they affect you. If you have additional questions, please contact Human Resources.

Important Contact Information

For information about the Court's benefits, you may also contact the companies that help manage our plans. Below is a list of our vendors' phone numbers and websites. If you need further assistance, please contact the Human Resources Department.

Benefit	Company	Phone No.	Web Address
Medical, Vision, Dental & COBRA	HealthComp	(800) 442-7247	www.healthcomp.com
Prescription Drugs	Express Scripts	(800) 988-1913	www.express-scripts.com
Medical PPO Provider Networks	Anthem Blue Cross (Inquiries should be directed to Healthcomp)	(800) 442-7247	www.anthem.com/ca
Dental PPO Provider Networks	Connection Dental	(877) 277-6872	www.connectiondental.com
	First Dental Health	(800) 334-7244	www.firstdentalhealth.com
Vision Insurance	Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
Flexible Spending Accounts	HealthComp	(800) 442-7247	www.healthcomp.com
Life Insurance/LTD/ Critical Illness	United HealthCare	Contact your Human Resources Department	
Employee Assistance Plan	Optum Health	(866) 248-4098	www.liveandworkwell.com
Pet Insurance	Nationwide	(800) 540-2016	www.PetsNationwide.com
Human Resources	Superior Court of California, County of Kern	(661) 868-4957	CourtBenefits@kern.courts.ca.gov



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Eligibility and Enrollment

Active Employees

You are eligible for coverage if you work in a probationary, permanent, or extra help capacity and are assigned to work 30 or more scheduled hours per week. Your coverage will be effective on the first day of the pay period following 30 days of active, full-time employment, provided you are actively at work on the date your coverage would otherwise become effective. If you do not enroll for coverage within 31 days after you are first eligible to do so, you will be required to wait until the next Open Enrollment period, unless you experience an approved qualified status change.

Do You Both Work at The Superior Court?

If you and your spouse are both employees of the Court, there are unique rules that apply for coordination of dependent Medical, Rx, Dental and Vision coverage. Neither you nor your spouse are permitted to elect duplicate coverage for yourselves – and no two parents can elect to cover the same dependent children under any Court-sponsored Medical, Rx, Dental or Vision program.

Retired Employees

You are eligible for coverage if you have taken either a service retirement or a disability retirement on or after January 1, 2001.

Service retirement means:

1. You have 10 years of retirement service credit and are age 50 or older; or
2. You have 30 years of retirement service credit regardless of your current age; or
3. You are age 70, regardless of your years of service credit.

Disability retirement means you are disabled and permanently unable to perform your normal job duties and that your disability has been approved by, and meets the requirements of, the Board of Directors of KCERA.

Dependents

Dependent coverage will be effective on the same date as yours, if you enroll your eligible dependents at the same time that you enroll and you authorize any necessary payroll deduction(s). You can add newly acquired eligible dependents to your coverage within 31 days of any qualifying event.

Eligible dependents include your legally married spouse and your children under age 26. Dependent children over age 26 are also eligible if they are dependent on you because of a physical or mental disability and are incapable of sustaining employment at the time they reach the maximum age for coverage as a dependent.

The term "Spouse" shall also mean the person who is currently registered with the Court as the domestic partner of the Employee (this includes opposite sex and same sex couples). An individual is a domestic partner of an employee if that individual and the employee meet each of the following requirements:

(a) The employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The employee and the individual are not married to anyone.

(c) The employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The employee and the individual must have the intention that their relationship will be indefinite.

(e) The employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

The Court may require documentation proving a legal marital and/or domestic partner relationship. In California, registered domestic partners must meet certain requirements and both partners must sign and file a Declaration of Domestic Partnership with the state. If you and your partner are registered domestic partners, you may provide a copy of your Certificate of Registration of Domestic Partnership in lieu of the Plan's Affidavit of Domestic Partnership.

The term "children" shall include natural children of the employee or domestic partner or adopted children. Stepchildren who reside in the employee's household may also be included as long as a natural parent remains married to the employee and also resides in the employee's household. If a covered employee or domestic partner is the legal guardian of a child or children, these children may be enrolled as covered Dependents.

When Coverage Ends and COBRA Begins

Your coverage will end the date you are no longer an eligible employee or dependent. You and your covered family members may extend health coverage, at group rates, under the Consolidated Omnibus Budget Reconciliation Act (COBRA). The period of COBRA coverage is dependent on the qualifying event that resulted in the termination of coverage.

If your employment terminates or your hours are reduced, you will be sent an enrollment form and cost information regarding continuing your benefits. You will have 60 days from the loss of your coverage date to select coverage through COBRA.

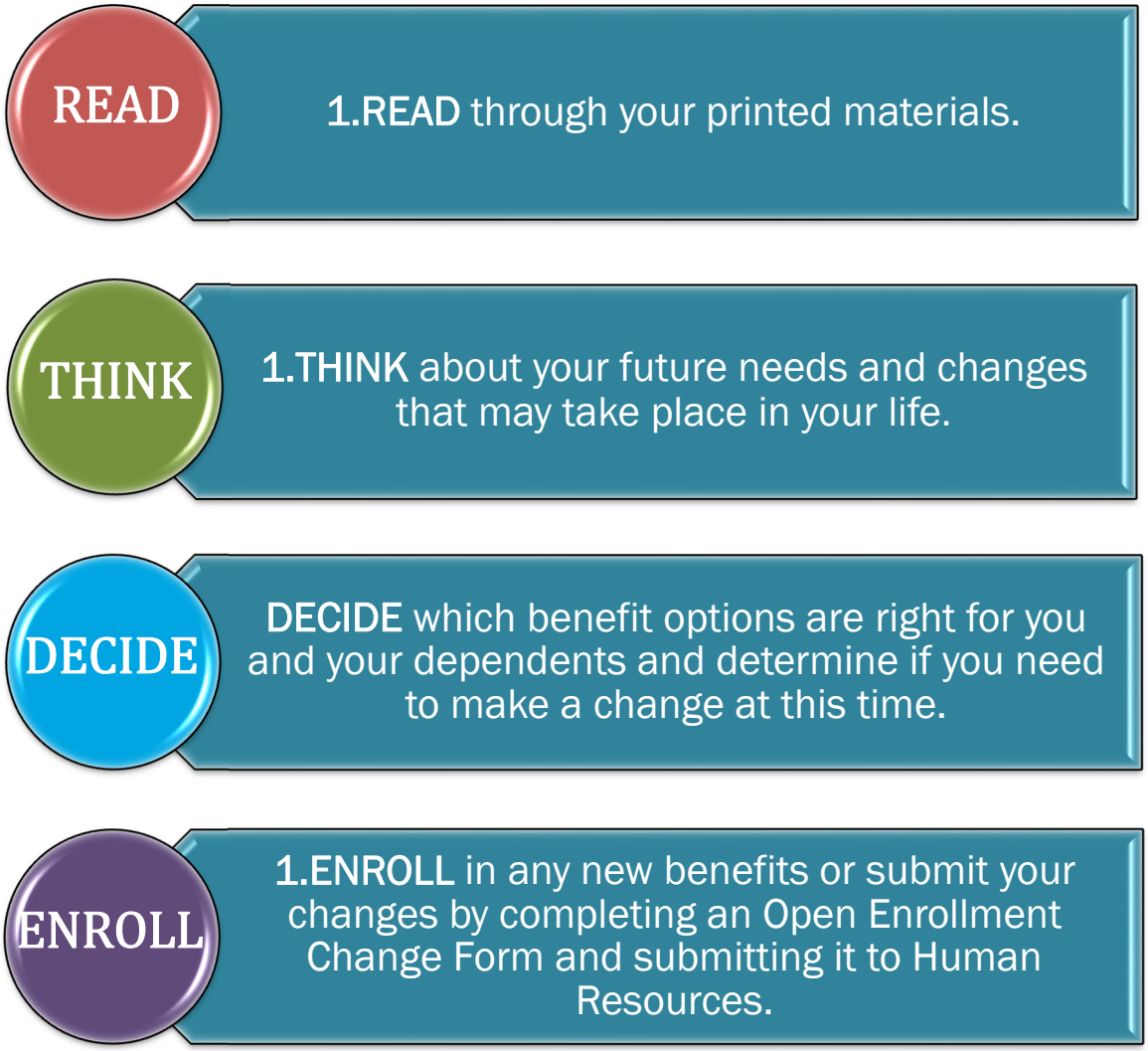
During the time you or your dependents have COBRA coverage, there may be changes to the Plan, such as new deductibles, copays, covered expenses, or changes to your premium. All changes to the Plan will also apply to your COBRA coverage.

Open Enrollment

Open enrollment is the time to evaluate your current benefits and plan for the future. Have you recently been married? Are you expecting a child? Do you want to change your life insurance beneficiary? These, and other life changes, should be considered when making your benefit selections for the new plan year.

Open Enrollment is typically held in October. Any benefit changes made during Open Enrollment will become effective January 1st. Change forms need to be completed only if you are making changes to your current benefit selections. If you do not turn in an Open Enrollment Change Form, your current benefits will continue for the next plan year.

OPEN ENROLLMENT STEPS



Qualified Status Changes

The one thing you can count on in life is change. Whatever the events in your life, certain changes can affect your Court benefits. Generally, you can only change your benefit elections during the open enrollment period, unless you have a qualified status change. Common qualified status changes include marriage, divorce, birth, death, and employment status change. Below is a detailed list of some of the more common Life Events and the associated benefit changes you can make as a result.

Qualified Status Changes for Medical / Dental / Vision

Life Event	Medical / Dental / Vision
Gain of Spouse • Marriage	May add new or existing dependents. May revoke only when spouse's benefit becomes effective or increased under spouse's plan.
Loss of Spouse • Divorce/Legal Separation • Annulment • Death	May revoke coverage only for spouse. May elect coverage for self or dependents that lose coverage under spouse's plan as a result of divorce, legal separation, annulment, or death.
Gain Dependent • Birth • Marriage • Adoption • Legal Guardianship	May elect coverage for new or existing dependents that were not previously covered.
Loss of Dependent • Death • Loss of Eligibility Due to Divorce	Employee may drop coverage only for the dependent who loses eligibility.
Spouse/Dependent Gain in Employment or Other Change in Employment that Affects Benefit Status	May cancel election for employee, spouse, or dependent coverage if added to dependent's coverage.
Rehiring a Terminated Employee	A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements
Termination of Employment	Coverage ends on the last day of the pay period in which the employee ceases to be in an eligible class. Employee and covered dependents become eligible for COBRA.
Termination of Employment for Spouse, Dependent or Loss of Benefit Eligibility Due to Change to Casual Status	May enroll any eligible dependent and all existing dependents who are not previously covered.
Dependent No Longer Meets Eligibility Requirements • Attains Specified Age	Employee must stop coverage only for the affected dependent. Eligible for COBRA continuation.

Things You Should Know

Out-of-Pocket (OOP) Maximum

What is an OOP Maximum?

An Out-of-Pocket (OOP) Maximum refers to the maximum amount that you will have to pay for expenses covered under the Medical and Prescription Drug plans (the Medical and Prescription Drug Plans have separate OOP Maximums). The maximum is the sum of all paid deductibles and coinsurance. The OOP maximum for in-network benefits also includes plan copays.

Deductible

What is a Deductible?

A Deductible is the amount of eligible plan expense that must be incurred by you before medical or dental benefits are payable. You are responsible for the deductible amount, unless the benefit specifically notes that the deductible is waived.

Recognized Charges

Recognized Charges (RC) Example

Sally's laboratory is an Out-of-Network provider. She recently had tests done which cost $400.00. Her insurance company said it would pay only 70% of $360.00, which was the amount considered as a recognized charge. Sally was responsible for:

$ 108.00 (30% of the $360.00 RC amount)
$ 40.00 (the amount over RC: $400.00 - $360.00)
$ 148.00

Sally paid a total of $148.00. Had she gone to an In-Network provider, Sally would have only been responsible for $36.00 (10% of the contract amount) since network providers will not bill the member any amount over RC.

Recognized Charges (RC) represent the maximum eligible amount the Plan will recognize when services are rendered by an Out-of-Network provider. RC is based on the usual rates charged by 80% of the providers in your geographic area, for a medical or dental service or supply. The Plan Administrator determines the appropriate RC levels for Out-of-Network claims using nationally recognized data.

Out-of-Network providers are not bound by network contracts and can bill you the balance over RC. You are responsible for paying any charges that exceed Recognized Charges if you are receiving services from an Out-of-Network provider.

Medical

The Court's Medical Plan utilizes Preferred Provider Organizations (PPOs). A PPO is a network of providers working in private practice, clinics, hospitals, or other health care facilities, who have agreed to charge lower network rates, so the cost savings is passed on to you in the form of a higher benefit. The plan gives you the choice of using preferred (PPO) providers or non-preferred (non-PPO) providers. Using the preferred providers keeps your costs down. Contact the PPO networks listed on your Identification Card by phone or via their websites for a current list of PPO providers.

PPO MEDICAL PLAN - BENEFITS-AT-A-GLANCE		
	In-Network (PPO)	Out-of-Network (Non-PPO)
Prior Authorization	**Some services require prior authorization. Refer to the Plan Document and your ID card.**	
PPO Network	Anthem Blue Cross	Not Applicable (where used below, "RC" refers to the "Reasonable and Customary" allowances as defined in the Plan Document.
Calendar Year Deductible	$0	$250 per individual / $500 per family (2 family members must meet $250)
Calendar Year Out-of-Pocket Maximum (Medical)	$1,500 per individual / $3,000 per family (2 family members must meet $1,500)	$2,500 per individual / $5,000 per family (2 family members must meet $2,500)
Lifetime Maximum	Unlimited	
Office Visit	Primary Care Physician - $20 copay Specialist Physician - $30 copay	70% coverage RC (after deductible)
Chiropractic Care (maximum of 30 visits per calendar year)	$20 maximum benefit per visit	$20 maximum benefit per visit
Diagnostic, X-ray, and Laboratory	90%	70% coverage RC (after deductible)
Durable Medical Equip. (amounts > $500 require pre-authorization)	$0 copay	70% coverage RC (after deductible)
Emergency Room	$100 copay (waived if admitted)	100% coverage RC after a $100 copay (copay waived if admitted)
Hearing Aids (Including exams and fittings) (Up to $3,000 per 3-year period)	90%	70% coverage RC (after deductible)
Hospital Services – Inpatient (Including Mental Health/Chemical Dependency)	$150 copay / day (maximum copays of $750 / calendar year)	70% coverage RC (after deductible)
Hospital Services – Outpatient	90%	70% coverage RC (after deductible)
Maternity Care	$200 copay	70% coverage RC (after deductible)
Outpatient Mental Health and Chemical Dependency	$20 copay	70% coverage RC (after deductible)
Outpatient Surgery	$100 copay	70% coverage RC (after deductible) (maximum of $1,000 per surgery)
Preventive Care (Refer to the SPD for a list of Preventive Care)	$0 copay	Not Covered
Urgent Care	$20 copay	70% coverage RC (after deductible)
Urgent Care - Physician	$0 copay	70% coverage RC (after deductible)
Prescription Drugs (Express Scripts) Generic Preferred Brand* Non-Preferred Brand*	In-Network Rx Calendar Year Out-of-Pocket Maximum: $7,600/individual, 15,200/family Retail: 30-day supply for 1 copay / Mail Order: 90-day supply for 2 copays $10 copay (waived for oral contraceptives) $20 copay $40 copay *If an FDA approved Generic equivalent is available, and you request the Brand, you will be responsible for the difference in cost between the Brand and Generic plus the Brand copay.	

This is a summary of benefits only. Actual Plan provisions and benefits are governed by the formal Plan Document.

Dental

Dental Coverage is an important part of your health care benefits. The Court's Dental Plan gives you the choice of using any dentist you like. However, employees are encouraged to access dental providers through the Connection Dental or First Dental Health (FDH) networks to take advantage of the additional discounts and the In-Network level of benefits. Using the Dental plan wisely will lower your out-of-pocket expenses.

PPO DENTAL PLAN - BENEFITS-AT-A-GLANCE

	In-Network (PPO)	Out-of-Network (Non-PPO)
PPO Network	First Dental Health (FDH) or Connection Dental	Not Applicable (where used below, "RC" refers to the "Recognized Charges" allowances as defined in the Plan Document.
Calendar Year Deductible	$50 per individual / $150 per family (3 family members must meet $50)	
Deductible is Waived For	Class A - Preventive Services, Class D - Orthodontia	Class A - Preventive Services, Class D - Orthodontia
Calendar Year Maximum	$1,750 per covered person	
Class A - Preventive Services		
Routine Oral Exams (maximum of 2 per year)	90% of contract amount	70% of RC amount
Cleaning & Scaling (maximum of 2 per year - once every 6 months)	90% of contract amount	70% of RC amount
Bitewing X-Rays (1 series per year)	90% of contract amount	70% of RC amount
Full Mouth (Panorex) X-Rays (1 every 36 months)	90% of contract amount	70% of RC amount
Fluoride Treatment for Children < 16 (maximum of 2 per year)	90% of contract amount	70% of RC amount
Sealants for Children < 16 (1 per 1st or 2nd permanent molar, every 5 years)	90% of contract amount	70% of RC amount
Class B- Basic Services		
Fillings - (per surface: once every 3 years)	90% of contract amount (Gold paid at 90% of resin composite contract amount)	70% of RC amount
Space Maintainers for Children < 16 (once lifetime to replace primary teeth)	90% of contract amount	70% of RC amount
Endodontics - Root Canal (once per site)	90% of contract amount	70% of RC amount
Oral Surgery	90% of contract amount	70% of RC amount
Extractions	90% of contract amount	70% of RC amount
Emergency Palliative Treatment	90% of contract amount	70% of RC amount
General Anesthesia (if required for children < age 6)	90% of contract amount	70% of RC amount
Class C- Major Services		
Inlays & Onlays (once every 5 years)	90% of contract amount	70% of RC amount
Installation of Crowns (once every 5 years)	90% of contract amount	70% of RC amount
Dentures - Full or Partial	90% of contract amount	70% of RC amount
Repair of Crowns, Bridges & Dentures	90% of contract amount	70% of RC amount
Dental Implants ($250 max per CY)	90% of contract amount	70% of RC amount
Class D- Orthodontia		
Initial Exam	$50 copay	$50 copay
Lifetime Maximum	The Plan will pay up to $3,000 per covered person (after any copays)	
Copays ● Per Adult ● Per Child	 $2,400 $2,600	 $2,400 $2,600

This is a summary of benefits only. Actual Plan provisions and benefits are governed by the formal Plan Document.

Vision

VISION PLAN - BENEFITS AT-A-GLANCE	
EYE EXAM ALLOWANCE	Once every 12 months
	Covered in full after a $20 copay
SPECTACLE LENS ALLOWANCE	Once every 24 Months
• Single Vision Lenses	Covered in full after a $20 copay
• Bifocal Lenses	Covered in full after a $20 copay
• Trifocal Lenses	Covered in full after a $20 copay
FRAME ALLOWANCE	Once every 24 months
	Covered in full up to $200
CONTACT LENS ALLOWANCE	Once every 24 months
• Cosmetic/Elective Contact Lenses	Covered in full up to $150
OUT-OF-NETWORK BENEFIT ALLOWANCES	
• Exam • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Frames • Contact/Elective Lenses	Up to $50 Up to $50 Up to $75 Up to $100 Up to $70 Up to $105
This Benefits At-A-Glance is intended to provide highlights of the benefit plan. Actual plan benefits and provisions are governed by the VSP Contract.	

Accessing your VSP Coverage is as simple as 1-2-3!

1. Find a VSP doctor at vsp.com or call 800-877-7195.
2. Make your appointment and tell them you have VSP.
3. Check out your coverage on vsp.com before you go.

The Court's Vision program is insured through VSP (Vision Service Plan). You can go to the vision provider of your choice; however, your benefits will be greater when you receive care from a VSP provider.

Are You Having Difficulty Reading This?

If reading your benefits information is a reminder that you need to visit your vision provider, now is the time to make the appointment!

Prescription Drug Program

Your pharmacy and mail order Prescription Drug Program is provided through Express Scripts. For short-term medications, fill your prescription at your local retail pharmacy. The amount of your copay for a 30-day supply will vary depending on whether you are requesting generic versus brand name drugs. If a Generic is available and the Brand is requested, you will be responsible for the difference in cost between the Brand and Generic in addition to the Brand copay.

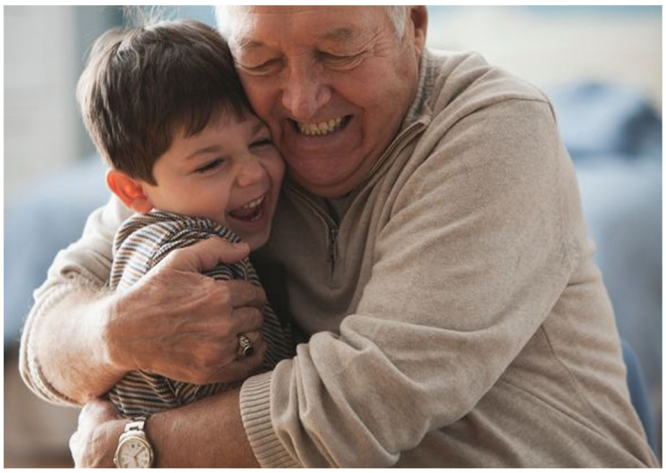
For long-term or maintenance medications, consider using Express Scripts Mail Order. Filling your long-term medications through mail order allows you to get a 90-day supply for only two copays. The medications are delivered to your home, and you may refill either by phone or online.

PRESCRIPTION DRUG PLAN - BENEFITS AT-A-GLANCE	
Pharmacy Calendar Year Out-of-Pocket Maximum: $7,600 per individual / $15,200 per family	
PRESCRIPTION DRUGS – RETAIL	30-day Supply
Generic	$10 copay per prescription
Brand Name*	$20 copay per prescription
Non-Formulary*	$40 copay per prescription
PRESCRIPTION DRUGS – MAIL ORDER	90-day Supply
Generic	$20 copay per prescription
Brand Name*	$40 copay per prescription
Non-Formulary*	$80 copay per prescription
*If an FDA approved Generic equivalent is available, and the Brand is still requested, you will be responsible for the difference in cost between the Brand and Generic in addition to the brand copay.	
This Benefits At-A-Glance is intended to provide highlights of the benefit plan. Actual plan benefits and provisions are governed by the formal Plan Document.	

Save Money with Generic Prescriptions

Save money on prescription medications by requesting generic drugs when filling a prescription. Generic drugs are comparable in strength, concentration, and dosage to their brand name counterparts.

Basic Life and AD&D



Life Insurance helps protect your family from a sudden loss of income resulting from your death. The Court recognizes the importance of life insurance for employees of all ages and stages in life. In the event of your death, the life insurance benefit provides financial protection for your beneficiary(ies) by paying the following death benefits:

Management	$100,000
Confidential	$50,000
Represented	$10,000

Accidental Death and Dismemberment (AD&D) insurance pays benefits for accidental death and certain serious bodily injuries. In the event of your death or if you suffer any other covered loss, the AD&D benefit provides financial protection for your beneficiary(ies) by paying double your death benefit.

Life and AD&D benefits reduce when you reach age 65 and terminate at retirement. Refer to the Life and AD&D Summary Plan Description for additional details.

The wording of beneficiary designations is critical, as an improperly named beneficiary can have drastic effects on how insurance proceeds are distributed. For example, you would not want to name your spouse simply by designating "husband" or "wife", as this could result in a former spouse receiving proceeds intended for others. It is also not generally advisable to name minor children as beneficiaries, but rather to name a guardian for minor children and a trustee for insurance proceeds and other assets to be managed, until they reach the age of majority. Choosing your beneficiary(ies) and keeping that choice up to date is important!

Employee Assistance Program (EAP)

Balancing life's challenges is not always easy. Fortunately, there's a place to turn for help when you need it – Optum EAP. This confidential comprehensive resource is available to you and your family members, 24 hours a day, 7 days a week, 365 days a year. The Optum EAP is designed to provide fast, convenient answers and advice on a wide range of topics such as managing stress, adjusting to change, child and elder care, legal and financial as well as emotional well-being.

Optum EAP also offers up to six personal counseling sessions per issue. As a Court employee, you have access to booklets and other tools as well as Web access to articles, self-assessment and interactive tools and newsletters designed to promote your good health.

24 hours a day, 7 Days a Week, 365 Days a Year

Voluntary Life Insurance

The Court recognizes the value of life insurance and, in addition to the Court-funded Basic Term Life Insurance, provides voluntary supplemental options, which you can purchase using the convenience of payroll deduction. All permanent employees (working at least 40 hours bi-weekly) are eligible to apply for additional Life insurance through United Healthcare (refer to Evidence of Insurability requirements below). To purchase Life coverage for dependents, the employee must have coverage. The chart below describes the types of coverage available.

EMPLOYEE COVERAGE	SPOUSE COVERAGE	CHILD COVERAGE
Increments of $10,000	Increments of $10,000	Flat $10,000 per child
Not to exceed $500,000	Not to exceed $500,000	Not to exceed $10,000
Can purchase up to $150,000 without evidence of insurability*	Can purchase up to $20,000 without evidence of insurability*	Not Applicable

*Amounts listed without the submission of evidence of insurability are available under the Guaranteed Issue period during the first 31 days of initial eligibility only. Evidence of Insurability Forms are available from your Human Resources Department.

AGE BAND	EMPLOYEE RATES bi-weekly per $1,000 of coverage	SPOUSE RATES bi-weekly per $1,000 of coverage	CHILD RATES bi-weekly
0-24	$0.028	$0.028	1.15
25-29	$0.032	$0.032	NOTE: The premium for child coverage is fixed, regardless of how many children you have covered.
30-34	$0.037	$0.037	
35-39	$0.042	$0.042	
40-44	$0.051	$0.051	
45-49	$0.092	$0.092	
50-54	$0.138	$0.138	
55-59	$0.277	$0.277	
60-64	$0.388	$0.388	
65-69	$0.660	$0.660	
70-74	$1.278	$1.278	
75+	$2.446	$2.446	

The Premiums for Voluntary Supplemental Employee and Spouse term life insurance are "age-rated" and are calculated based upon your (and your spouse's) age as of March 1st each year, as outlined in this table. Bi-weekly rates for employee and spouse coverage are expressed as rates "per $1,000 of coverage. It is important to note that coverage amounts will reduce to 65% of the original amount at age 65 and 50% of the original amount at age 70. Use the worksheet on page 12 to calculate your cost.

You will be required to submit an Evidence of Insurability Form for supplemental employee insurance greater than $150,000 and supplemental spouse insurance greater than $20,000. Amounts of insurance greater than the evidence of insurability limits will not be effective until approval has been received, in writing, from the insurance company. If you do not elect to enroll in supplemental life insurance within 31 days of when you are first eligible, all amounts of supplemental coverage will be subject to evidence of insurability.

Should you become totally disabled (as defined in the policy) and are no longer able to work, your premium payments will be waived during your period of disability. If you retire, reduce your hours, or leave employment, you can, in most cases, take the coverage with you according to the terms outlined in the policy.

	Coverage Amount				Bi-Weekly Rate		Bi-Weekly Cost
Employee	$	÷	$1,000	X	$	=	$
Spouse	$	÷	$1,000	X	$	=	$
Child(ren)	If electing the Voluntary Child Life option, enter $1.15					=	$

Total $ _____

Example: John Smith is age 31 and his spouse is age 29. John elected $80,000 of Supplemental Employee Insurance, $30,000 of Spouse Life Insurance and Child Life Insurance.

Supplemental Employee Premium: ($80,000 ÷ $1,000) X $.037 = $2.96 bi-weekly

Spouse Life Premium: ($30,000 ÷ $1,000) X $.032 = $0.96 bi-weekly

Child Life Premium: $1.15 bi-weekly

Total Premium: $5.07 bi-weekly

Voluntary LTD Insurance

Your ability to earn income is your biggest asset. Long-term Disability Insurance pays you a benefit while you are temporarily unable to work due to a covered accident or injury. It provides income protection so you can focus on your health rather than worrying about paying your bills and expenses.

All Active Full-Time Employees (excluding Firefighters, Police Officers and Security Officers) working at least 30 hours a week are eligible to apply for voluntary LTD insurance through United Healthcare.

The policy has a pre-existing condition provision which has a look-back period of 3 months and an exclusion period of 12 month. This means that any disease or physical condition you have received treatment for in the three months prior to the effective date of the policy will be excluded for 12 months into the policy.

EMPLOYEE COVERAGE:

- 60% of Monthly Earnings; not to exceed $5,000/month
- Minimum Monthly Benefit of $100
- Maximum benefit period: 5 year w/Reducing Benefit
- Benefits begin after an elimination period of 3 months
- Survivor Benefit: 3 months of the gross payment

PREMIUMS (bi-weekly per $100 of coverage)	
AGE BAND	EMPLOYEE RATE
0-24	$0.052
25-29	$0.063
30-34	$0.102
35-39	$0.137
40-44	$0.172
45-49	$0.296
50-54	$0.357
55-59	$0.444
60-64	$0.389
65+	$0.415

BENEFIT PERIOD	
AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD
60 or less	60 Months
61	48 months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and over	12 Months

Annual Salary						Bi-Weekly Rate		Bi-Weekly Cost
$	÷	12 months	÷	100	x	$	=	$

Example: Jane Smith is age 42 with an annual salary of $45,000.

LTD Premium: ($45,000 ÷ 12) ÷100 X $0.172 = $6.45 bi-weekly

Voluntary Critical Illness Insurance

Enrolling in a UnitedHealthcare Critical Illness Protection Plan helps give you and your family more financial security if you or a covered family member is diagnosed with a covered illness.

How the plan works

The Critical Illness Protection Plan sends a lump-sum payment directly to you after diagnosis of a covered condition.

The money is yours to use however you want, including paying for:

- Out-of-pocket health plan costs (deductibles, coinsurance, etc.)
- Mortgage or rent
- Groceries
- Prescriptions
- Treatment by a specialist
- Transportation to and from treatment

There is no pre-existing condition provision. Benefits reduce by 50% at age 70.

EMPLOYEE COVERAGE	SPOUSE COVERAGE*	CHILD COVERAGE*
$10,000, $20,000 or $30,000	$10,000, $20,000 or $30,000	$5,000, $10,000 or $15,000

* Employee can choose from lower coverage options for spouse and children.

CRITICAL ILLNESS INSURANCE - BENEFITS AT-A-GLANCE	
COVERED CONDITIONS	**COVERAGE PERCENTAGE**
Coronary Artery Bypass Surgery	25%
End Stage Renal (Kidney) Failure	100%
Heart Attack	100%
Major Organ Failure Requiring Transplant	100%
Stroke	100%
Cancer (invasive)	100%
Cancer (non-invasive)	25%
Coma	100%
Benign Brain Tumor	100%
Loss of Hearing	100%
Loss of Sight	100%
Permanent Paralysis	100%

AGE BAND	EMPLOYEE RATES bi-weekly per $1,000 of coverage		SPOUSE RATES bi-weekly per $1,000 of coverage		CHILD RATES bi-weekly
	NON-TOBACCO	TOBACCO	NON-TOBACCO	TOBACCO	
0-24	$0.055	$0.060	$0.051	$0.055	$0.060
25-29	$0.083	$0.092	$0.074	$0.088	NOTE: The premium for child coverage is fixed, regardless of how many children you have covered.
30-34	$0.115	$0.134	$0.102	$0.134	
35-39	$0.166	$0.208	$0.152	$0.212	
40-44	$0.258	$0.346	$0.249	$0.402	
45-49	$0.388	$0.572	$0.425	$0.762	
50-54	$0.522	$0.849	$0.637	$1.195	
55-59	$0.674	$1.182	$0.905	$1.749	
60-64	$1.015	$1.925	$1.320	$2.640	
65-69	$1.588	$3.226	$1.708	$3.531	
70-74	$2.128	$4.140	$2.442	$4.962	
75+	$2.852	$4.800	$3.198	$6.138	

	Coverage Amount				Bi-Weekly Rate		Bi-Weekly Cost
Employee	$	÷	$1,000	X	$	=	$
Spouse	$	÷	$1,000	X	$	=	$
Child(ren)	$	÷	$1,000	X	$	=	$

Total $ _____

Example: Wanda Smith is age 49 and her spouse is age 45, both non-smokers. Wanda elected $30,000 of Employee Critical Insurance, $20,000 of Spouse Critical Insurance and $10,000 Child Critical Insurance.

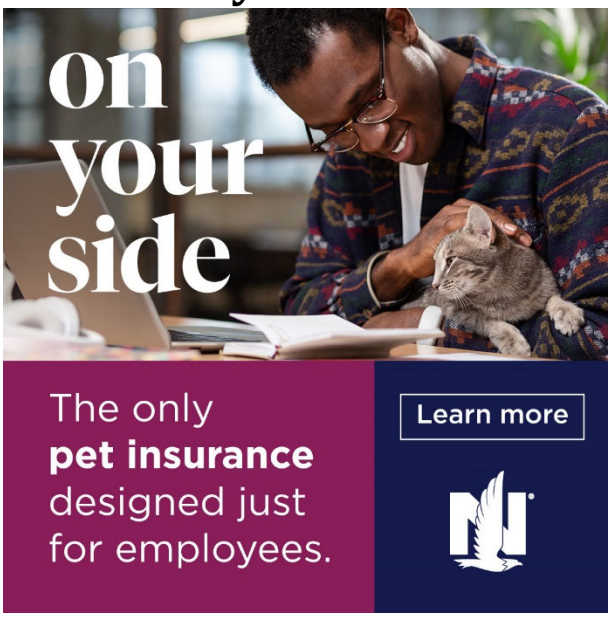
Employee Critical Illness Premium: ($30,000 ÷ $1,000) X $0.388 = $11.64 bi-weekly

Spouse Critical Illness Premium: ($20,000 ÷ $1,000) X $0.425 = $8.50 bi-weekly

Child Critical Illness Premium: ($10,000 ÷ $1,000) X $0.060 = $0.60 bi-weekly

Total Critical Illness Premium: $20.74 bi-weekly

Voluntary Pet Insurance



The Court has partnered with Nationwide® Insurance to make voluntary Pet Protection Insurance available through a convenient payroll deduction. With two budget-friendly options, there's never been a better time to protect your pet.

- **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%
- **Available exclusively for employees**: Plans with preferred pricing only offered through the Superior Court
- **Use any vet, anywhere:** No networks, no pre-approvals
- **Employees can enroll at any time throughout the year**

Choose your level of coverage

- Rates vary by location and pet
- Multi pet discounts available

50% reimbursement — **$20-$35/month**

70% reimbursement — **$27-$47/month**

PET INSURANCE - COVERAGE	
Annual Deductible	**$250**
Maximum Annual Benefit	**$7,500**
Covered Services	
• Accidents and Illnesses • Ear Infections, Vomiting and Diarrhea • Hereditary and Congenital • Cancer and Diabetes • Surgeries and Hospitalization • Dental Disease • Behavioral Treatments	• Prescription Medications • Therapeutic Diets • X-rays, MRIs and CT Scans • 24/7 VetHelpline™ • Advertising and Reward • Emergency Boarding • Loss due to theft • Mortality Benefit

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed for eligible expenses.

Flexible Spending Accounts

Flexible Spending Accounts let you set aside pre-tax dollars to pay for certain health care and dependent care expenses that you would typically pay out of your pocket with after-tax dollars. The tax savings can be significant.

Types of Accounts

There are two types of Flexible Spending Accounts – Health Care and Dependent Care. A Health Care Spending Account is used to pay for health care expenses not covered by the insurance plan (i.e., coinsurance, deductible, co-pays, corrective eye surgery, etc.). A Dependent Care Account is used to pay for the cost of dependent care for a child age 12 or under, for the care of a spouse or other dependent care, such as an invalid parent who is incapable of self-care.

Services provided to you, your spouse or any person who would qualify as your dependent under federal income tax rules (even if not covered by your insurance plan) are eligible.

Eligible Health Care Expenses

The following list provides examples of expenses eligible for reimbursement.

- Copayments, coinsurance, and deductibles (but not premiums)
- Acupuncture
- Orthodontia
- Laser eye Surgery
- Over the Counter Medications*
- Chiropractor
- Eyeglasses

* Requires a physician's written prescription.

Eligible Dependent Care Expenses

Qualifying Expenses include:

- Services for physical care of the child, not education, meals, etc.
- Services must be incurred to enable you (if married, you and your spouse) to be gainfully employed.
- The amount to be reimbursed must not be greater than your spouse's income or one-half your income, whichever is lower.

How the Accounts Work

During the Open Enrollment period, you will determine how much you want to contribute to either or both accounts. Each year, you may contribute up to the maximum allowable annual contribution amount. The 2022 maximum allowable annual contribution was $2,850 per year to the Health Care Account and/or up to $5,000 per year to the Dependent Care Account (or up to $2,500 if you are married and file separate tax returns). The 2023 maximum allowable amounts have not been announced yet, but you will have the option to automatically increase your election to the 2023 maximum once it is set. You cannot change your contribution amounts during the plan year unless you have a qualifying event so it is important you do not elect more than you would use during the plan year. Any remaining amounts not used during the plan year will be forfeited.

After you determine your election amount and submit the enrollment form to Human Resources, your contributions are deducted from your paycheck in equal amounts during the year. Because contributions are made **before** taxes are withheld, they are not subject to Social Security tax, federal income tax and, in most cases, state and local income taxes, so you save money.

All claims for reimbursement, under the Health Care or Dependent Care Flexible Spending Accounts, should be submitted directly to HealthComp.

Helpful Benefit Terms

Health Insurance terms can sometimes feel like a foreign language. To help you with these terms, below is a list of commonly used terms and their definitions.

A

Adjudication	The process used by health plans to determine the amount of payment for a claim.
Allowable Charge	The maximum fee that a health plan will reimburse a provider for a given service.
Appeals	The process used by a member to request that the health plan re-considers a previous authorization or denial decision.

B

Benefit	Payments provided for covered services under the terms of the policy. The benefits may be paid to the insured, or on his behalf, to the medical provider. Benefit design includes the types of benefits offered and any applicable limits to those benefits, e.g., number of visits, percentage paid, or dollar maximums applied, subscriber responsibility (cost sharing components), or subscriber incentives to use network providers.
Brand Name Drug	A prescription drug that has been patented and is only available through one manufacturer.

C

Case Management	A program that assists the member-patient in determining the most-appropriate and cost-effective treatment plan. Case management is usually provided to patients who have prolonged expensive or chronic conditions. The program helps determine the treatment location (hospital, other institution, or home) and may authorize payment for such care if it is not covered under the member's benefit agreement.
Chiropractic Care	An alternative medicine therapy administered by a licensed Chiropractor. The Chiropractor adjusts the spine and joints to treat pain and improve general health.
Claim	A request for payment for benefits received or services rendered.
Co-payment (or Co-pay)	A way in which the enrollee shares in the cost of health care. The benefit plan requires the enrollee to pay a flat dollar amount per unit of service. An example of a common co-pay is $10 per physician office visit.
COBRA	Consolidated Omnibus Budget Reconciliation Act: a federal law that requires most employers with 50 or more employees to provide continuation of coverage for members as prescribed by current federal law.
Coinsurance	An arrangement under which the insured person pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, a health plan might pay 80% of the allowable charge, with the enrollee responsible for the remaining 20%; the 20% amount is then referred to as the coinsurance amount.

Coordination of Benefits	The provision which applies when an enrollee is covered by two health plans at the same time. The provision is designed so that the payments of both plans do not exceed 100% of the covered charges. The provision also designates the order in which the multiple health plans are to pay benefits. Under a COB provision, one plan is determined to be primary, and its benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" between the two health plans.
Covered Services	Hospital, medical, and other health care services incurred by the enrollee that are entitled to a payment of benefits under a health benefit contract. The term defines the type and amount of expense, which will be considered in the calculation of benefits.
Custodial Care	Care that is provided primarily to meet the personal needs of the patient. Such care includes help in walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administering medicine, or any other care, that does not require continuing services of medical-trained personnel.

D

Deductible	An amount the insured person must pay for covered services during a calendar year, January 1 through December 31, before health benefit payments begin.
Dependent	Person (spouse or child) other than the subscribing member who is covered under the subscriber's benefit plan.
Diagnostic Tests	Tests and procedures ordered by a physician to determine if the patient has a certain condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory, pathology services or tests.
Durable Medical Equipment (DME)	Mechanical devices, equipment, and supplies, which enable a person to maintain functional ability. Also called Medical Equipment.

E

Effective Date	The date that you become covered or entitled to receive the benefits provided under the Plan.
Emergency Care	An injury or sudden, unexpected illness (including severe pain and active labor) of sufficient severity that if the member does not receive immediate treatment, it could present a serious threat to his or her health, could seriously impair physical functions, or could cause a serious dysfunction of any organ or body part if immediate medical treatment is not received.
Enrollee	An individual who is enrolled and eligible for coverage under a health plan contract. This term encompasses both the subscriber and any of his/her covered dependents, each of whom may also be referred to as a "Member".
Exclusions	Specific conditions or circumstances that are not covered under the health plan benefit agreement. It is very important to consult the health plan benefit agreement (may also be called the Evidence of Coverage, Certificate, or Subscriber Contract) to understand what services are not covered benefits.

Experimental Procedures	Procedures that are mainly limited to laboratory research.
Explanation of Benefits (EOB)	A form sent to the enrollee after a claim for payment has been processed by the health plan. The form explains the action taken on that claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment, and the claims appeal process.

G

Generic Drug	A drug, which is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand drug.

H

Health Benefits	The plan described and is defined in the health plan benefit booklet which describes the covered health care services and benefits offered, and the health care provider network available, to the member.
Home Health Care	Health services rendered in the home to an individual who is confined to the home. Such services are provided to aged, disabled, sick or convalescent individuals who do not need institutional care, but who do need nursing services or therapy, medical supplies, and special outpatient services.
Hospice	A facility or service that provides care for the terminally ill patient and who provides support to the family. The care, primarily for pain control and symptom relief, can be provided in the home or in an inpatient setting.
Hospital	An institution whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care.

I

Identification Card (ID Card)	A card issued to a subscriber and possibly his/her dependents, which allows the subscriber to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare the billing statement.
Immunizations	Immunizations and injections that are recommended by guidelines published by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service or the American Academy of Pediatrics (AAP).
In-Network	Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage enrollees to use participating (in-network) providers to reduce the enrollee's out-of-pocket expense.
Inpatient	Service provided after the patient is admitted to the hospital. Inpatient stays are those lasting 24 hours or more.

Investigational Procedures	Procedures that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community.
M	
Maternity Care	Health care provided during pregnancy, including care rendered during the pre- and post-natal phase of pregnancy, as well as care rendered throughout the entire course of pregnancy, continuing through to infant delivery and circumcision.
Medically Necessary	Services or supplies provided by a licensed health facility or health professional, which are determined by the health plan company and its contracting or employed Physician Group to be: 1. Not Experimental or Investigational, 2. Appropriate and necessary for the symptoms, diagnosis, or treatment of a condition, illness or injury, 3. Provided for the diagnosis or care and treatment of the condition, illness, or injury, 4. Not primarily for the convenience of the Member the Member's Physician, or anyone and the most appropriate supply or level of service that can safely be provided. For example, outpatient rather than inpatient surgery may be authorized when the setting is safe and adequate.
Member	An individual or dependent who is enrolled in and covered by a managed health care plan. Also called Enrollee or Beneficiary.
Mental Health / Behavioral Health	Conditions that affect thinking and the ability to figure things out and that affect perception, mood, and behavior. Such disorders are recognized primarily by symptoms or signs that appear as distortions of normal thinking or distortions of the way things are perceived (seeing or hearing things that are not there.) Disorders can also be recognized by moodiness, sudden or extreme changes in mood, depression, and highly agitated or unusual behavior.
N	
Network	The doctors, clinics, hospitals, and other medical providers that a health plan contracts with to provide health care to its members.
Network Provider	Physicians, Hospitals or other providers of health care who have a written agreement with the health plan to participate in the network. Providers are listed in the Preferred Provider Directory given to each Member upon enrollment and periodically updated.
Non-participating Provider	A medical provider who has not contracted with a health plan as a participating provider.
O	
Occupational Therapy	Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, and bathing.
Out-of-Network	The use of health care providers who have not contracted with the health plan to provide services. Members can go out-of-network but will pay some additional costs.

Out-of-Pocket Maximum	Refers to the maximum amount that an enrollee will have to pay for expenses covered under the health plan. The maximum is a sum of all paid deductible and co-payment or coinsurance amounts.
Outpatient	A patient who is receiving care at a hospital, physician office or other health facility without being admitted to the facility for an overnight stay. The term "ambulatory" is often used to describe outpatient care.
Outpatient Surgery	Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center, or physician office.

P

Participating Provider	A physician, hospital, pharmacy, laboratory, or other appropriately licensed facility or provider of health care services or supplies, that has entered into an agreement with a managed care entity, or HMO, to provide services or supplies to a patient enrolled in a health benefit plan.
Physical Therapy	Treatment involving physical movement to relieve pain, restore function and prevent disability following disease, injury, or loss of limb.
Pre-Authorization	A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.
Pre-Existing Condition	A health condition (other than a pregnancy) or medical problem that was diagnosed or treated before enrollment in a new health plan or insurance policy. Some pre-existing conditions may be excluded from coverage.
Preferred Provider Organization (PPO)	A type of health benefit plan designed to give enrollees incentives to use health care providers designated as "preferred providers", but that also give substantial coverage for services received from other health care providers.
Prescription	A written order or refill notice issued by a licensed medical professional for drugs which are only available through a pharmacy.
Preventive Care	Office visits for the evaluation and management of the member's physical development for prevention of future medical problems.
Prior Authorization	The process of obtaining advance approval before receiving certain health care services covered under a Certificate of Insurance or Evidence of Coverage.
Provider	A licensed health care facility, program, agency, physician, or other health professional that delivers health care services.
Provider Network	The set of providers contracted with a health plan to provide services to the enrollees.

R

Radiation Therapy	Treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

Recognized Charges	A charge that falls within the common range of services by a majority of providers for any procedure in a given geographic region, or which is justified based on the complexity or the severity of the treatment for a specific case.

S

Second Opinion	The voluntary option or mandatory requirement to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.
Skilled Nursing Facility (SNF)	A licensed institution (or a distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.
Speech Therapy	Treatment of the correction of a speech impairment which resulted from birth, or from disease, injury, or prior medical treatment.
Substance Abuse / Chemical Dependency	Alcoholism, drug addiction, or other chemical dependency problems.

U

Urgent Care	Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.
Usual, Customary And Reasonable (UCR)	The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient after medical review of the case. Also referred to as the Recognized Charge (RC).
Utilization Management	The entire program of systems designed to ensure that members receive quality, medically necessary health care services at the appropriate level of care in a timely, effective, and cost-efficient manner. It includes precertification, concurrent review, discharge planning, care management and retrospective review.

W

Well Baby / Well Child Care	Routine care, testing, checkups, and immunizations for a generally healthy child.