



FELTON/FAMILY SERVICE AGENCY OF SAN  
FRANCISCO AND SERVICE EMPLOYEES  
INTERNATIONAL UNION LOCAL 1021-AFL-CIO

Family Development Center (FDC)  
and  
Teenage Pregnancy & Parenting Program  
(TAPP)

UNION CONTRACT  
JULY 1, 2019 – June 30, 2022

## TABLE OF CONTENTS

| <u>Section</u> |   | <u>Page</u> |
|----------------|---|-------------|
|                | Agreement   | 3           |
| 1              | Management Rights   | 3           |
| 2              | Union Membership  | 3 - 4       |
| 3              | Union Business  | 4 - 5       |
| 4              | Card Check Neutrality                                       | 5 - 6       |
| 5              | Discrimination and Affirmative Action                       | 6           |
| 6              | Sexual Harassment   | 6-7         |
| 7              | Employee Classifications/Probationary Period                | 7 - 8       |
| 8              | Discipline and Discharge                                    | 8-10        |
| 9              | Personnel File  | 10          |
| 10             | Grievance Procedure   | 10 -11      |
| 11             | Job Posting and Promotion                                   | 12          |
| 12             | Seniority and Layoffs                                       | 12-13       |
| 13             | Hours of Work, Overtime, and Pay Period                     | 13-14       |
| 14             | Reimbursement of Expenses                                   | 14          |
| 15             | Annual Leave, Sick Leave and Holidays                       | 14 - 17     |
| 16             | Insurance Benefits  | 17 - 18     |
| 17             | Leave of Absence  | 18          |
| 18             | Family Care Leave   | 18-19       |
| 19             | Leave – Organ Donation                                      | 19          |
| 20             | Military Leave  | 19          |
| 21             | Jury Duty   | 19          |
| 22             | Bereavement Leave   | 19          |
| 23             | Return to Work after Medical Leave                          | 20          |
| 24             | Education and Literacy Assistance Leave                     | 20 - 21     |
| 25             | Leave Pursuant to the Domestic<br>Violence Employment Leave | 21          |
| 26             | Wages and Classifications                                   | 21 - 22     |
| 27             | Beneficial Practices  | 22          |
| 28             | Personnel Policies  | 23          |
| 29             | Separability  | 23          |
| 30             | Labor-Management Committee                                  | 23          |
| 31             | Written Communications                                      | 23          |

32 Term of Agreement  
& Signatures

23 - 24

Appendix A – Benefits Guide 2019 - 2020

## **Felton Institute/FSA and Service Employees International Union, Local 1021**

### **AGREEMENT**

This Agreement is entered into between Felton Institute/FSA (hereinafter referred to as the “Employer” and/ or FSA) and Service Employees International Union, Local 1021, AFL-CIO (hereinafter referred to as the “Union”)

This Agreement defines the relationship between SEIU1021 and the following FSA bargaining units, which shall be considered individual bargaining units, included in this master agreement:

Family Developmental Center (FDC)  
and  
Teenage Pregnancy and Parenting Program (TAPP)

### **Section 1: Management Rights**

It is mutually agreed that, except as modified or limited by this agreement, it is the Employer’s exclusive duty and right to manage the operations of the Employer and to direct the working forces. This right includes, but is not limited to, the right to determine the number and location of facilities; determine the size of the work force; set personnel policies; hire, transfer, promote, demote, schedule, determine the job content of, reclassify, discipline or discharge employees; and to contract out for services, subject to the conditions provided herein.

### **Section 2: Union Membership**

A. All employees who are subject to this Agreement and who are employed on the effective date of this Agreement, shall, not later than the thirty-first (31st) calendar day following the effective date of this Agreement, either (1) become members of the Union in good standing and remain members in good standing during the course of their employment, or (2) pay an amount equal to Union fees and dues to the Union as a service fee for Union representation.

B. All employees who are subject to this Agreement and who are hired on or after the effective date of this Agreement shall, not later than the thirty-first (31) calendar day following their date of hire, either (1) become members of the Union in good standing and remain members in good standing during the course of their employment, or (2) pay an amount equal to Union fees and dues to the Union as a service fee for Union representation.

C. Upon receipt of written notice to the Employer and upon examination of documented proof that an employee has not complied with the above requirement, the Employer shall terminate the employment of such employee within thirty (30) calendar days after receipt of such written notice unless thereafter the employee complies with the above requirements within said time period.

D. The Union shall indemnify and hold the Employer harmless from any and all claims, suits or other actions arising from this Section or complying with any request for termination of employment under this section.

E. The Employer will distribute and collect membership cards at the orientation meeting when other necessary pre-employment documents are completed. The original copy of the form shall be sent to the Union Headquarters.

F. The Employer agrees to collect dues, assessments, initiation charges and any other contribution from each unit member's wages as specified by the Union. The Employer agrees to transfer all funds collected to the Union as soon as possible, but not later than ten days from the final pay period of each month.

G. Not less frequently than once each month, the Employer shall supply the Union with a list of bargaining unit employees with their name, work email and work phone number (if available), classification, mailing address and date of hire of any newly hired employee(s) that fall within the FDC or TAPP classified roles and the names of any bargaining unit employees terminated or lay laid off during the previous month.

### **Section 3: Union Business**

A. A duly authorized representative of the Union shall be permitted to talk with bargaining unit employees away from clients with a minimum disturbance of work for the purpose of seeing that the terms of this contract are being observed, provided admission to the site on each occasion is effected through a usual entrance. Discussions will not entail withdrawal of any employee from the classroom at any time when children are present.

B. For the purpose of representation, the Union shall be entitled to five (5) Stewards and one (1) Chief Steward on the job at FDC and TAPP who shall restrict work time Union activities to the handling of grievances. The Union will notify the Employer in writing when a Steward is designated. A Steward may assist an employee in the presentation of a grievance if an employee requests such assistance. In no case will the Steward leave the place of work during work time without requesting approval from the site Manager or Supervisor. The Steward's activities shall not interfere with the work of any employee or the Steward's work.

C. Shop Stewards shall receive 10-day notice of and shall be permitted to make appearances at New Employee Orientation sessions, held at Bryant Street, in order to distribute Union materials, to make presentation about the Union, and to discuss Employee rights and obligations under the CBA. The Employer shall allow the Shop Steward up to thirty (30) minutes paid release time to do the presentation. During such time, the Employer personnel present and other non-represented Employee(s) shall leave the orientation room. The Union Field Representative shall notify Human Resources at least seven (7) business days in advance as to which Union representative/and or steward will be conducting the Union orientation at a particular new hire session.

D. FSA agrees to provide space on an existing bulletin board at each work location covered by this Agreement or if not available, wall space which the Union may use to post notices of official Union business as it pertains to the employees of FSA. The Union bulletin board or space shall be located in a staff-oriented area. The space provided will be maintained by the Union. The Union assumes all responsibility for the material contained in its notices and the postings shall be official correspondence from the Union. The Union recognizes the nature of the clinical setting and the need to avoid material that is potentially disturbing to clients. FSA may remove any material that is not an official notice of the Union.

E. All designated Shop Stewards shall be allowed 7.5 hours paid release time annually to attend Union Shop Steward training and Union contract seminars conducted by SEIU. The 7.5 hours paid release time may be taken in part or in full, however, should a Shop Steward attend a whole day training for 7.5 hours, the Employer will only pay that Steward what they were scheduled to work on the date of the training. The Parties understand and agree that Steward Training time does not count as an hour worked for purposes of computing overtime. The Employer must be notified at least five (5) business days in advance of any release time. Shop Stewards must get prior approval to be released for

training, which shall not be unreasonably withheld. In the event of a staffing hardship or unforeseen crises, Felton Institute/Family Service Agency administration reserves the right to cancel the training and ask staff to remain performing their classroom duties in order to meet the needs of the program and be in compliance with title 22 CCL teacher to child ratios. The Union Field Representative will provide training calendar listing all training days, 15 days in advance if possible and not later than five (5) business days in advance.

#### **Section 4: Card Check Neutrality**

The Service Employees International Union Local 1021 (“The Union”) and Family Services Agency or Felton Institute (“The Employer or The Agency”) hereby agree to the following recognition procedure for all full-time and part-time staff, employed at the Agency not already covered by the existing Memorandum of Understanding.

The value of a respectful, cooperative and constructive relationship between the Employer and the Union is recognized as essential and mutually beneficial for the Employer’s continued success. The Union is considered a valuable partner in achieving this success.

The Employer agrees to adopt a position of neutrality with regard to any organizing campaign or effort that could affect the Union’s representation of the acknowledged appropriate bargaining unit.

Neutrality means that, except as explicitly provided herein, the Employer will not in any way, directly or indirectly involve itself in or help or hinder Union efforts to campaign or influence bargaining unit members to sign authorization cards or otherwise aid, assist or support the Union.

The Employer (and its supervisors) will not take any action or make any statement that will directly or indirectly state or imply any opposition by the Employer to the selection of a collective bargaining agent, or preference or opposition to SEIU Local 1021 as a bargaining agent. The Employer shall advise their employees that the Employer is not opposed to the selection of SEIU Local 1021 as their collective bargaining representative. The Employer shall refrain from lending any support or assistance of any kind to any individual or group opposed to SEIU Local 1021.

The Employer agrees not to discriminate, discharge, lay-off, or discipline any employees because that employee joined the Union, signed an authorization card or engaged in any type of union activity.

The Union and its representatives will not coerce or threaten any employees of the Employer in an effort to obtain authorization cards.

Upon the Union’s request, the Employer will provide within five (5) days a list of the names, addresses, phone numbers and work locations of all unrepresented employees. The Employer agrees to update the lists upon request from the Union.

In addition, the Employer and the Union shall meet to determine an appropriate method for the Union to communicate with the unrepresented employees during working hours. Such communication can be in one or both of the following ways as agreed to by the parties: The Employer will grant the Union access to employees at the job site for the purpose of distributing literature and meeting with bargaining unit employees, provided there is no interference with the conduct of the Employer’s

business or with the performance of work by the employees during their work time. Access shall include the right to post notices on designated company bulletin boards and the right to speak with employees during non-work time.

The Union will arrange a series of meetings for employees and will post notices for employees at the work location.

Once the Union claims majority status of the Employer, the Employer and the Union will meet within 10 days of the union's notification of its claim of majority status. The Parties will mutually agree on a date and time to meet. The Union will notify the Employer of the collective bargaining unit it seeks to represent. The Union will select a neutral third party who will verify the Union's majority status.

The Union will present a neutral third party with signed authorization cards and with the list of bargaining unit employees. The neutral third party shall examine the signatures on the authorization cards against any documents kept by the Employer in its regular course of business that contain the employees' signature. Once the neutral third party has examined the signatures on the authorization cards and verified that the Union has a majority, said neutral third party will certify in writing that the Union represents the employees in the bargaining unit.

Once it is certified that the Union has majority support among the existing, unrepresented employees, the Agency shall recognize the Union as the exclusive representative for said employees and proceed to negotiate either 1) a new collective bargaining agreement (CBA) covering all employees and governing wages, benefits and working conditions or 2) to accrete all employees to an existing CBA or Memorandum of Understanding (MOU) currently in effect with the Agency.

### **Section 5: Discrimination and Affirmative Action**

There shall be no discrimination by the Employer, the Union or employees covered under this agreement against an employee or applicant for employment because of race, creed, religion, color, national origin, age, sex, sexual orientation, marital status, parenthood, disability, veteran status, political affiliation or because of membership in the Union or activities on behalf of the Union.

### **Section 6: Sexual Harassment**

A. The Employer, the Union and the employees agree that an employee or applicant for employment shall not be the subject of sexual harassment. The Fair Employment and Housing regulations define sexual harassment as unwanted sexual advances, or visual, verbal or physical contact of a sexual nature when such conduct is made explicitly or implicitly a term or condition of employment, is used as a basis of employment decisions, or has the effect of interfering with work performance or creating an otherwise offensive working environment.

B. Employees who feel they have been discriminated against on the basis of sex, sexuality, and sexual orientation or in any other manner harassed should immediately report such incidents following the procedure described below without fear of reprisal. Confidentiality will be maintained to the extent permitted by the circumstances.

C. Complaints of sexual harassment of any type should be reported to the employee's immediate supervisor and/or the Human Resources Director. In the event the complaint is against the supervisor, the employee should contact the Human Resources Director.

## **Section 7: Employee Classification and Probationary Period**

Upon hire, employees shall be in a "probationary period" for a period of 4 months. If the employee has experienced any performance issues during this time, the probation period could be extended with a "performance plan of correction" submitted for an additional 2 months (total of 6 months maximum). If the employee has successfully completed the probation period, they will be moved to "regular" employment status. If the employee fails to successfully complete the extended probation period, they could be subject to further disciplinary action, up to and including termination.

A. Job descriptions for all employees covered by this agreement shall be included in Appendix A and shall state whether the position is "exempt" or "non-exempt."

1. An exempt employee is one who is paid at least the minimum specified by applicable law for an exempt employee and is employed in Executive, management or professional capacities. Exempt employees do not receive overtime compensation.
2. Non-exempt employees are those not employed in Executive, managerial or professional capacities. They are entitled to be paid overtime at the rate of time and one-half after 37.5 hours in one week or after seven and one-half (7.5) hours in one day for employees subject to this Agreement. Where permitted by law the Employer and the Union will, at the request of either party, negotiate the implementation of alternative work schedules.

B. A regular employee is either fulltime or part time and works for an indefinite period of time. A regular full-time employee is one who works 37.5 hours or more per week. A regular part-time employee is one who works less than 37.5 hours per week.

C. A Temporary employee is hired for the sole purpose to work in place of a regular employee (a) during periods of prolonged absence of up to thirteen (13) consecutive weeks; (b) where excessive workloads exist in a work unit for a limited duration of less than four (4) months; or (c) when the completion of a specific job is desired which shall take one week or less. If any of these time limits are violated by one employee or more than one employee successively performing the same basic job functions, any and all negatively impacted employees shall be awarded regular status and their loss shall be subject to the grievance procedure.

D. Substitute or on-call employees are individuals who are hired to be available on an as needed basis to fill-in for regular employees during brief absences or staff vacancies or to assist from time to time in work units with excessive workloads. It is the intent of the Employer to minimize the use of substitute or on-call employees.

E. Probation: Employees shall be on probation for the first four (4) months of employment. After successful completion of this probationary period, employees other than contract employees shall be considered regular employees. During this period, the agency may terminate an employee without recourse to the grievance procedure. As warranted, the probationary period may be extended by mutual agreement of the parties for up to an additional six months, provided such is done in writing. During this period, employees shall be evaluated in writing by their immediate supervisor at the end of three months of employment and at the end of six months.



F. The dispute regarding classifications that fall under SEIU 1021 jurisdiction will be resolved through the grievance procedure as outlined in the MOU. Except that if the issue cannot be resolved through step 1 to 3, the parties may request a mutually agreed upon mediator from the Federal Mediation and Reconciliation Service to attempt to resolve the issue. If the parties are unable to resolve the issue through mediation and no later than 30 days upon conclusion of mediation, the parties shall proceed to Step 4 - Arbitration as outlined in the MOU.

### **Section 8: Discipline and Discharge**

A. Employees who have successfully completed their 4-month initial probation period with the Employer shall be moved to “regular” status. After that time, employees may not be discharged or otherwise disciplined except for just cause which includes, but is not limited to: (1) unsatisfactory attendance, (2) physical violence, (3) failure to perform job tasks, (4) intoxication during work hours, (5) unethical relationships with clients, (6) Inappropriate release of client information or other confidential or sensitive materials, (7) Dishonesty and or theft, (8) Unethical relationship between and employee and a client, (9) Violation of children’s personal rights, (10) Failure to supervise children 100% of the time, (11) Failure to follow Mandatory Reporting Requirements

B. Notice of discharge or suspension shall be served in person or by certified mail to the employee within twenty-four (24) hours of the disciplinary action and a copy of such notice shall be sent to the Union. The notice shall include the following information: (1) statement of the nature of the disciplinary action; (2) the effective date of the disciplinary action; (3) statement of the facts behind the disciplinary action (including date, time, place, etc.); (4) description in ordinary and concise language of the policies on which causes are based.

C. An employee shall have the right to a Union Representative or Steward, if the employee so requests, present at any meeting with supervisors or management representatives which is disciplinary or investigatory in nature. Prior to any such meeting, the Employer will inform the employee involved of such right. All disciplinary action other than for probationary employees may be reviewed in accordance with the grievance procedure.

D. Employees holding positions requiring certification, licensure, permits, or continuing education units, as specified in the employee’s job description, shall be required to maintain all standards for continued licensure. A loss of licensure or a permit may result in immediate termination. If the loss of licensure or permit is of short duration or through no fault of the employee FSA shall make a good faith effort to place the employee in an alternative assignment until the license or permit can be retained.

#### **E. Background (FDC Program)**

Over the past months FDC has experienced an increased number of incidents resulting in Type A violations as defined by Community Care Licensing. Continued Type A violations put FSA at risk for legal action including revocation of License unless FSA demonstrates that we have taken appropriate action that result in more serious consequences for employees who do not follow Health & Safety procedures as trained and instructed. At this point, every employee has been met with and has also have been informed of the seriousness of these violations. Everyone understands that it is CRITICAL that we ensure that the health and safety of children under our care is covered 100% of the time.

On October 18th, 2013, FSA and SEIU 1021 agreed that any employee who is found responsible and who’s gross misconduct results in a ***Type A violation for failure to provide proper supervision to children under his/ her care 100% of the time will result in a SUSPENSION and/or IMMEDIATE TERMINATION.***

### **DISCIPLINE- SUSPENSION FOR FDC PROGRAM EMPLOYEES**

**What is a suspension?**

A suspension is a cease of work mandated for a specific period of time on a without pay basis. It is considered an economic sanction.

**When will a suspension be used?**

A suspension will be used as an appropriate step to take after an employee has failed to provide 100% supervision to children under their care and who are found responsible in incidents that lead to a \* Type A violation which pose an immediate risk to the health and safety of children in our care. This disciplinary action is considered when an employee's behavior is so egregious (addressing behavioral and/or judgment deficiencies) that a lesser action is not appropriate.

**Who will issue a suspension?**

A suspension letter will be written by Human Resources in coordination with Program Director.

**How will the suspension be communicated to employee?**

The written notice will be given to the employee personally by the supervisor or manager.

**How long will the suspension be?**

The suspension will be for 20 work-days without pay, effective immediately after investigation of facts has been completed?

An employee's record will be considered when making a decision as to whether or not to consider a 20-day suspension or if the consequence is termination.

**Question that will be considered:**

Does the employee have a prior record of similar offenses, or is this a first offense?

**What happens if the employee fails to provide 100% supervision to children under their care 100% a second time?**

If an employee is found responsible and fails to provide 100% supervision under his/her care during a three-year period from the last incident, it will be grounds for immediate termination.

- G. Employees must be notified if they are under investigation within 30 days from the date of possible violation or the date Felton becomes aware of a violation. No action to impose discipline against an employee shall be initiated more than sixty (60) days from the date Felton knows of the conduct after diligent and timely investigation except for conduct which would constitute the commission of a crime. Initiation of discipline for the purposes of this provision is the date of the charging letter or notice of placement for investigation.
- H. Except for the specific disciplinary matters provided in Section A. materials relating to disciplinary actions in the employee's personnel file which have been in the file one (1) year or more shall not be used. At the request of the employee, materials relating to discipline actions which are one (1) or more years old shall be removed, provided there has been no reoccurrence of the conduct on which the discipline was based within the year.
- I. Notwithstanding the above, if an employee believes the employee's personnel file contains a personnel evaluation that negatively references employee's authorized and proper use of leave under the Family and Medical Leave Act (FMLA) or the California Family Rights Act (CFRA), the

employee should notify the employee's Department's Personnel Officer and/or Equal Employment Opportunity Officer, who shall review the matter and ensure any reference to such use of FMLA or CFRA leave is removed from the evaluation.

### **Section 9: Personnel File**

- A. Only one (1) official personnel file shall be maintained on any single employee. The official file shall be located in the Human Resources Department unless another location is designated and the employee is notified in writing. Each employee shall have the right to review the contents of the employee's official personnel file upon request. Nothing may be removed from the file by the employee, but copies of the contents shall be provided to the employee at the employee's request. Request shall be made in writing by the employee 10 business days prior to the appointment date.
- B. With the written authorization of the employee, a representative of the Union may review the employee's personnel file when in the presence of a departmental representative and obtain copies of the contents upon request. Request shall be made in writing by the employee 10 business days prior to the appointment date.
- C. An employee shall have the opportunity to review, sign and date any and all material to be included in the file except routine matters chronicling job and pay changes. The employee may also attach a response to such materials within thirty (30) days of receipt. All material in the file must be signed and dated by the author. Felton May transmit documents to the employee at the employee's last known address by means of U.S. mail, email, or hand-delivery, except disciplinary notification, which must be sent by certified mail when the employee is on leave.
- D. Upon approval from Management and Employee, the employee may include material relevant to the employee's performance of assigned duties in the file.

### **Section 10: Grievance Procedure**

A grievance is defined as a claim or dispute by any bargaining unit employee or the Union concerning the interpretation or application of this Agreement. The parties encourage open communication between employees and their supervisors. Prompt resolution of personnel issues is important for good relations, fairness and efficient operation.

Step 1. Grievances shall initially be taken up orally by the employee and/or the Union Steward and/or Union Representative with the immediate supervisor or the Program Manager in an attempt to settle the matter on an informal basis.

Step 2. If the grievance is not satisfactorily settled at Step 1, it shall be reduced to writing by the employee or his/her representative and submitted to the Division Director. Such written grievance shall contain a clear written statement of the nature of the grievance, the date of the alleged violation, the Section(s) of the Agreement on which the grievance is based, the proposed remedy to the grievance and the signature of the grievant, Shop Steward and/or Union Representative. In order to be valid, the grievance must be submitted within fifteen (15) calendar days, of the date that the alleged violation occurred or could be reasonably known to have occurred, except that in cases involving written discipline, discharge or suspension, there shall be a seven (7) calendar day time limit, of the date that the alleged violation occurred or could be reasonably known to have occurred. The Employer and/or the Shop Steward and/or the Union Representative will meet within seven (7) calendar days of such submission.

Step 3. If the grievance is not satisfactorily settled at Step 2, it may be presented in writing to the Executive Director or designee by the Union within seven (7) calendar days after Step 2 is completed.

The Executive Director or designee shall give a written response to the employee and the Union Representative within fourteen (14) calendar days after submission of the grievance to him/her.

Step 4. Provided a request is made in writing within fourteen (14) calendar days of the Executive Director's or designee's response, if the grievance still remains unresolved, it may be directly referred by the Union to binding arbitration. Upon receipt of a written request for arbitration of a grievance or dispute under this procedure, the Employer and the Union shall select a mutually agreeable impartial arbitrator. In the event that the parties cannot agree on an impartial arbitrator within seven (7) calendar days after receipt of the written request for arbitration, either party may request the Federal Mediation and Conciliation Service to submit a list of five (5) representative arbitrators. Each party shall alternately scratch two (2) names from the list, the first scratch being selected by lot, and the person remaining shall be the arbitrator. The arbitrator shall not have the power to add to, subtract from or modify the terms of this Agreement. All expenses of arbitration, excluding costs of representation and witnesses, shall be paid equally by the Employer and the Union. The decision of the arbitrator shall be final and binding upon the parties and shall be issued within thirty (30) calendar days of the arbitration hearing. Time limits may be extended or waived only by mutual agreement of the parties. If either party fails to comply with the grievance time limits, the grievance shall proceed through the Steps. The grievance procedure and arbitration provided for herein shall constitute the sole and exclusive method for determining settlements between the parties of any and all grievances herein defined.

Expedited Arbitration: By mutual agreement of the Employer and the Union, grievances which are referred to binding arbitration may be addressed using expedited rules, which will include the following characteristics: (1) Extensive efforts shall be made prior to the hearing to stipulate to the facts; (2) no attorneys will be used, however, the parties shall have the right to other representation; (3) there shall be no stenographic record of the proceedings; (4) only oral closing arguments will be used; no briefs; (5) only an oral bench decision shall be required.

### **Section 11: Job Posting and Promotion**

A. All positions, which become open at Felton Institute/FSA, either due to the departure of staff or due to the creation of new jobs, shall be made known to staff through memos posted on the agency bulletin boards and announced at staff meetings. Such memos shall be posted at least seven (7) calendar days before information about these openings is distributed publicly.

B. Current employees who apply for the posted position within the seven (7) calendar day posting period and who meet the qualifications in a posted job description shall be given consideration over outside applicants to fill posted vacancies in the bargaining unit, so long as said employees have satisfactory performance histories as reflected in their employee's performance evaluations. Both parties recognize, however, the Employer's necessity to comply with Affirmative Action goals and obligations, to which the Employer may also give consideration in hiring. If more than one qualified current employee applies for the position, selection shall be based on order of seniority, provided that merit, skills, ability, permit level and ECE units are equal. Management will present a written explanation when a less senior employee is awarded a preferred assignment.

C. Reclassification of a position to a higher level may be initiated by the employee or the Department Head. An employee who believes his or her job and duties are classified at an inappropriately low level may submit documentation to his or her supervisor of record justifying the reason for reclassification. The justification may include a comparison of similar jobs and salary scales in similar agencies. If the supervisor of record and Department Head concur, the documentation shall be forwarded to the

Executive Director who has final approval authority. Denial of a reclassification is subject to the grievance procedure. Reclassified employees shall retain their same anniversary date and will not be placed in orientation status.

## **Section 12: Seniority and Layoffs**

A. A layoff shall be defined as a non-disciplinary separation of an employee based upon legitimate business needs as determined by the employer. The Employer recognizes its obligation to bargain with the Union over the effects of any layoff on bargaining unit employees and in that regard it agrees to review its determination by the contract and/or funding source financially reduced, or eliminated, thereby causing the necessity for layoffs.

B. The parties agree to abide by the principle of classification and site seniority for layoffs except when the principle is in direct conflict with the goals of the Employer's Affirmative Action Policy. Seniority, for the purposes of layoff, is defined as the length of service in the affected classification.

C. Employee rights to authorized leaves of absence shall not constitute a break in their seniority rights based upon length of service; however, employees shall not accrue seniority during leaves granted by the Employer that are longer than thirty (30) calendar days.

D. The Employer shall endeavor to give the Union and the employees thirty (30) calendar days' notice prior to the effective day of layoff, unless the Employer is given less notice during funding negotiations or in the event of an unforeseen emergency or catastrophe.

E. Voluntary terminations include an absence of three (3) or more consecutive working days without notice, or failure to return from a leave of absence or layoff for a period of six months or more.

F. Involuntary terminations include release during the probation period or discharge whether pursuant to the Grievance Procedure or not.

G. In case of termination or layoff, employees shall receive accrued vacation leave and holiday leave and be advised of any extended coverage and conversion privileges of the health and dental benefit plans.

H. If an employee is laid off, the agency will continue to pay the employee's medical and dental benefits for an additional month. After that time, the employee will be eligible to extend their benefits through COBRA. Information on how to extend their benefits will be mailed directly to their home address prior to the termination of their agency benefits.

## **Section 13: Hours of Work, Overtime, and Pay Period**

### **A. HOURS OF WORK.**

- a. In general: FSA's regular business hours are established by contract obligations, bearing requirements and needs of the program. Employees may be required to work the hours specified by the contractor.
- b. Full-time employees: Employees hired to work at least 37-1/2 hours weekly.
- c. Part-time employees: Employees hired to work less than 37-1/2 hours weekly.
- d. Timekeeping Requirements. For FSA contract compliance purposes, all employees are required to record time worked on a semi-monthly time and attendance form. Employees must call in prior to 7:30 a.m. on a daily basis when they are not able to come to work, unless they are hospitalized. Verification is required for all absences.

- B. FSA will compensate all employees for approved overtime worked in the following manner:
- a. One and one-half (1-1/2) times their hourly rate of pay for all hours worked in excess of seven and one-half (7-1/2) hours on any regular working day; and
  - b. One and one-half (1-1/2) times their hourly rate of pay for all hours worked in excess of thirty-seven and one-half (37-1/2) hours during any period of five (5) consecutive days; and
  - c. Two (2) times their hourly rate of pay for all hours worked in excess of twelve (12) hours on any one (1) day, and for all hours worked in excess of seven and one-half (7-1/2) hours on the seventh consecutive day of work.

C. Due to the nature of the agency, it may be necessary for employees to work additional hours beyond regularly scheduled shifts. Overtime for non-exempt staff must be approved by the Division Director prior to the work being done and must be documented on the time sheet. If an employee must work overtime and is unable to notify the Division Director in advance (e.g., the next shift person is late), the supervisor must be notified within 24 hours.

D. Paydays are on the 15<sup>th</sup> and the last day of the month, or the last workday before the 15<sup>th</sup> and the last day of the month. If a regular payday falls on a weekend or holiday, the employees will be paid on the preceding weekday.

#### E. Compensatory Time for Exempt Employees

Felton Institute believes in creating and investing in an effective workforce. Although there is no legal requirement or obligation to offer employees occupying positions determined to be exempt from the Fair Labor Standards Act designated as exempt, FDC and TAPP programs shall permit exempt employees who are required to work more hours than regularly scheduled 7.5 hour work day to receive compensatory time off.

#### Granting Compensatory Time Off

A Supervisor may grant compensatory time off to exempt employees who are required to work in excess of any regular schedule for pre-approved or requested special projects, training during weekends or any normally scheduled time off. Compensatory time will be granted on an hour-for-hour basis. Request for use of accrued time off will not be unreasonably denied.

#### Procedures

The Program Supervisor who signs the timesheet is authorized to grant compensatory time off to exempt employees only. The supervisor's approval of the employee's timesheet will constitute the granting of the employee's compensatory time. All employees should record the appropriate time worked and time taken on the timesheet.

#### Using Compensatory Time Off

An employee who has accrued compensatory time and request use of the time must be permitted to use the time off within a "reasonable period" after making the request. Using the established "Leave Request" process, an employee will submit the leave request form marking "other leave".

Supervisors may deny the request if the use of compensatory time will "unduly disrupt" the program's operations. Supervisors can require an employee to take compensatory time off to manage the accrual limitation. All compensatory time earned by exempt employees in any work week is encouraged to be taken during the two-week period following the end of the work week during which the compensatory time was earned, but no later than 30 days. Compensatory time accrued is subject to an accrual limitation of 37.5 hours within a two-month period.

## **Section 14: Reimbursement of Expenses**

Work-related expenses incurred by employees may be reimbursed, if approved in advance by the Executive Director.

Employees who are required to have a vehicle for the performance of their job duties per their job description (commuting to/from work is not considered “required for the performance of their job”) will receive a mileage allowance at the rate established by the Internal Revenue Service as part of their compensation. Management shall identify those employees who are required to have vehicles for the performance of their job duties. This will be discussed with Local 1021 and a formal list will be provided.

## **Section 15: Annual Leave, Sick Leave and Holidays**

### **A. ANNUAL LEAVE.**

- a. Annual leave of 13.13 hours per month, which shall be pro-rated for eligible part-time employees, shall accrue to all regular employees up to a maximum of twenty-one (21) days. Once twenty-one (21) days are accrued by an employee, no more shall accrue until a portion are used, after which annual leave shall again begin to accrue up to twenty-one (21) days maximum. No annual leave shall be granted retroactively for the period during which the leave ceased accruing. Exceptions to this section may be made at the sole discretion of the Executive Director.
- b. Regular employees accrue annual leave from the date of their original employment, but no employee may use any accrued annual leave until the first day of the seventh month of employment, except with the advance approval of the employee’s Department Head. Upon termination, employees are paid for any accrued but unused annual leave.
- c. Employees in orientation status who terminate prior to completion of six (6) months will be paid for accrued annual leave. However, during the orientation period, an employee will not be entitled to take any annual leave unless approved in advance by his or her immediate supervisor and Department Head.
- d. Employees who were formerly regular employees but who are in orientation status due to a promotion or transfer will be eligible to take annual leave during their orientation status with the approval of their immediate supervisor. However, the orientation period will be extended by the number of annual leave days taken, unless the extension is waived at the discretion of the immediate supervisor.
- e. Employees must submit a written request to the immediate supervisor in advance before taking annual leave. Each employee’s staffing supervisor and Division Director must approve in advance his or her annual leave schedule. Annual leave shall be scheduled to adequately meet job responsibilities and staffing requirements. Employees who take annual leave without advance notice and approval may be subject to disciplinary action and may not be paid for such time.
- f. Volunteer/Parental Release Time

An employee, who is the parent, guardian (including domestic partners) or grandparents with custody of a child or children enrolled in a licensed day care center, in kindergarten, or in grades one through twelve, may take up to forty (40) hours of unpaid leave each

year, to participate in the licensed day care center or school activities. The employee must provide reasonable advance notice of the planned absence. If requested, the employee must provide documentation from the licensed day care center or school verifying the date and time of the school or day care center visit(s). The leave will be unpaid, but the employee may use accrued vacation time or paid personal business leave (PBL) for this purpose.

An employee who is the parent, guardian with custody (including domestic partners) or grandparent with a child who has been suspended from school and has received a notice from the child's school requesting that the employee attend a portion of a school day in the child's classroom, may take unpaid time off from work to appear at the school. The employee must, prior to the planned absence, give reasonable notice to the Agency that the employee has been requested to appear at the child's school. The employee will not be penalized in any way for taking this time off.

- B. SICK LEAVE: Sick leave may be used in the manner described below. Abuse or misuse of sick leave will not be tolerated by FSA and may be subject to disciplinary action.
- a. Sick leave of one and one-quarter (1-1/4) working days per month, or fifteen (15) working days per year, shall accrue to eligible employees, and may accumulate up to a maximum of sixty (60) working days. Terminating employees, regardless of the reason, are not entitled to payment for unused sick leave or for special merit days.
  - b. A regular employee may use accrued sick leave for the purpose of securing medical care or for attending to a family member, including domestic partners. Sick leave to care for ill family member(s), parent, domestic partner, or spouse is subject to all policies that apply to employee sick leave, including providing medical documentation.
  - c. Under exceptional circumstances, typically involving life-threatening or terminal illness, the HR Director may authorize an employee to accept and use sick leave donated to him or her by another FSA employee or employees. However, if an employee's request is denied, they may appeal to the CEO for a final decision. If the donation qualifies and is approved by HR, employees may request donations through their managers to cover the life threatening or terminal illness of the employee. Employees who leave the agency may not donate unused sick hours.
- C. PERSONAL BUSINESS LEAVE. Commencing on the first day of employment, each employee shall begin accruing personal business leave ("PBL") days at the rate of one-fourth (1/4) day per month, or three (3) PBL days per year. Once three (3) PBL days are accrued by an employee, no more shall accrue until a portion are used, at which time an employee may again accrue PBL days up to the three (3) day maximum. No PBL day shall be granted retroactively for the period during which they ceased accruing. Upon termination, employees are paid for any accrued but unused PBL days.
- D. SPECIAL MERIT DAYS. Regular employees (full-time or part-time) who accrue over twenty-four (24) days of sick leave may convert accrued days in excess of twenty-four (24) days to one special merit days per year on the following basis: one (1) special merit day may be exchanged for three (3) sick leave days; provided, however, that special merit days must be used within the pay period during which they are exchanged by the employee and recorded on the employee's time and attendance form and if not, are forfeited. Exceptions to this policy may be made at the sole discretion of the Executive Director. The Department Head is responsible for approving and determining when the special merit day may be taken



E. RECOGNIZED HOLIDAYS

- a. Twelve (12) holidays shall be observed annually, during which times FSA staff will, where practical, receive time off with pay for the full day. Actual holidays will vary based upon program needs and the feasibility of closing the program for the day. Each year, a schedule of holidays will be circulated to all FSA staff. These holidays will typically include:

|                        |                               |
|------------------------|-------------------------------|
| New Year's Day         | Veteran's Day                 |
| Martin Luther King Day | Thanksgiving Day              |
| Washington' Birthday   | Friday following Thanksgiving |
| Memorial Day           | Christmas Eve                 |
| Independent Day        | Christmas Day                 |
| Labor Day              | New Year's Eve                |

- b. For those programs, which must remain open on selected holidays, alternative holidays will be individually arranged for affected staff with the Department Head.
- c. A holiday falling on Saturday will be observed on the preceding Friday, except when that Friday is one of the holidays listed, in which case the holiday will be observed on the following Monday. A holiday falling on a Sunday will be observed on the following Monday, except when that Monday is one of the holidays listed, in which case the holiday will be observed on the preceding Friday.

**Section 16: Insurance Benefits**

A. Insurance: Insurance plans are offered to all regular employees working at least twenty (20) hours per week except where eligibility is determined at sixteen hours by the San Francisco Healthcare Accountability Ordinance, to cover their life, medical and dental. Thorough details of these benefits are provided in plan booklets and documents provided by the Administrative Office. These benefits shall not be changed during the life of this agreement.

B. Medical and Dental: Medical and dental coverage for full-time coverage shall be provided by the Agency. For medical and dental coverage, the agency will contribute the cost for full-time employees.

Per our discussion on March 3, 2020 on health care benefits for bargaining unit employees, it is mutually understood that

- The Current Health Reimbursement Account (HRA) benefit is \$5000 in addition to what is outlined in the 2019/2020 Benefits Guide;
- There will be no change to employee benefits during the duration of the agreement;
- If there's any change to the benefits as outlined in the 2019/2020 Benefits Guide due to a fiscal emergency, Felton will provide the Union reasonable and advance notice in writing and all changes must be based on mutual agreement subject to negotiations.

The Union is proposing that this mutual agreement be memorialized and along with the Benefits Guide, be added as an appendix to the CBA.

C. Part-time Employees: The employer shall adhere to the provisions of the San Francisco Health Care Accountability Ordinance for employees working less than full-time.

D. Life Insurance: Felton Institute/FSA provides a basic life insurance policy for all regular employees at no cost to employees. No dependent coverage is available. The amount of each employee's life insurance is equal to the employee's annual salary.

E. Tax Sheltered Annuity: The Employer will continue the current Tax Sheltered Annuity Program.

F. Flexible Spending Account: Felton Institute/FSA has a Flexible Spending Account (FSA) which allows regular full/part-time employees to have a cost-effective way to pay for expenses not covered by their medical/dental plan and dependent care expenses. This plan allows employees to pay for eligible expenses (per IRS guidelines) on a pre-tax salary reduction basis.

G. Workers' Compensation Benefits. A work-related injury or illness is one that occurs while an employee is performing his/her job duties or other activities within the scope of his/her employment. Employees are responsible for immediately notifying the supervisor or manager of any on-the-job injury or illness, in order to be eligible for workers' compensation benefits.

H. Pre-Tax Benefit Program: The employer will continue the procedure to permit employees covered by this agreement to reduce their taxable income to pay for certain permitted expenses. Of special importance is the purchase of MUNI fast passes with pre-tax income.

### **Section 17: Leave of Absence**

A. A leave of absence without pay may be granted by the Human Resources Director and/or Executive Director for the following reasons: FMLA, Military service, Pregnancy Disability, or Personal Necessity. The decision to grant a leave is based on the urgency of the request, the length of the leave requested and the affect on the agency's work requirements and staffing needs.

B. To apply for a leave of absence, an employee must make a written request addressed to the supervisor, who forwards the request to the Division Director, specifying the reason for the leave, the length of time needed and the expected date of return. For medical leaves, a doctor's statement will be requested. Extensions of leaves are ordinarily not granted unless there are critical circumstances, such as extended medical disability. The employee needs to notify the staffing supervisor two weeks before the end of a leave of the employee's intention to return. Upon expiration of an approved leave, employees will be re-employed in the same or a comparable position and rate of compensation as that which s/he occupied when the leave commenced. If an employee fails to report for work immediately after the period of the approved leave expires or if an employee obtains a leave based on false representations regarding the need for a leave, the employee will be considered to have voluntarily resigned.

C. Employees participating in benefit programs prior to an approved leave of absence may receive coverage under those programs depending on the terms of the specific program. Costs for such coverage are paid by the agency for paid leaves or by the employee for unpaid leaves. In addition, the employee may be eligible for state or long-term disability benefits.

### **Section 18: Family Care Leave/Paid Leave**

A. Any full-time or part-time employee who has completed at least one year and has worked at least 1,250 hours during that time may request (with appropriate documentation) family medical care leave without pay, of no more than 12 weeks in a rolling 12 month period. An eligible employee may request a family care leave for any of the following reasons: 1) the birth of the employee's child; 2) the placement of a child with the employee in connection with an adoption;

3) the serious illness of the employee's child; 4) the need to care for self, a parent, a spouse or domestic partner who has a serious health condition. If both parents are employed by the agency, only one employee is entitled to take a leave to care for a child. An employee who is granted a family care leave of absence must utilize any accrued vacation and personal necessity days during the period of the leave. For the purpose of this policy's 12-week limitation, any paid and unpaid portions of the leave of absence shall be added together whether or not they are taken consecutively.

**B. Paid Family Leave (PFL)**

For California employees covered by State Disability Insurance and have earned at least \$300 from which deductions were withheld, Paid Family Leave Insurance provides up to six weeks of benefits for individuals who must take time off to care for a seriously ill child, spouse, parent, or domestic partner, or to bond with a new minor child. Employees are not required to use their vacation time for this leave if they do not choose to. Employees on Paid Family Leave will also, if they have not exhausted their FMLA time, be considered to be on FMLA.

**Section 19: Leave for Organ Donation**

An employee who is donating an organ may be granted paid leave for up to 30 days in any one-year period. The employee may be required to use up to two weeks of accrued sick, vacation or personal leave pay. The employee must present medical certification confirming that the employee is an organ donor and needs time off for organ donation related purposes.

An employee is donating bone marrow may be granted paid leave for five working days in any one-year period. The employee may be required to use up to five days of accrued sick, vacation or personal leave pay. The employee must provide medical certification confirming that the employee's leave is related to the donation of bone marrow of the employee.

**Section 20: Military Leave**

A regular employee on active military reserve service may take up to two weeks of unpaid leave per year for military reserve training. An employee who volunteers or is called to active military duty in a branch of the U.S. Armed Forces will be granted a leave of absence according to applicable state and federal law for the period of active duty.

**Section 21: Jury Duty**

Felton Institute/FSA encourages employees to fulfill their civic responsibilities by serving jury duty when required. If called for jury duty, employees are excused for the time required to attend the court. Employees will be paid, up to ten (10) days, at their regular rate of pay provided that the supervisor is informed regarding the court's schedule and the employee submits documentation from the court regarding his/her length of service. An employee who is called to jury duty while on probation shall have his/her probationary period extended for the period of time while on jury duty. Employees may request paid jury duty leave once in any two-year period.

**Section 22: Bereavement Leave**

Leave up to three (3) working days may be granted to a regular employee if his or absence from work is caused by a death in the employee's family. Family shall include spouse, domestic partner, children, parents, grandparents, grandchildren, siblings, or any person who has served in the capacity of parents, brothers, and sisters, or other relatives living in the immediate household of the employee. Where the funeral in connection with the death necessitates travel, additional time, not to exceed two (2) days may be granted.

### **Section 23: Return to Work After Medical Leave**

Upon presentation of a doctor's statement verifying the need for leave, the Employer shall grant medical leave without pay to employees who have completed their probationary period and who have exhausted accrued paid sick leave benefits. Medical leave shall not be for more than three (3) months or 12 weeks maximum per the FMLA leave laws (must meet FMLA requirements).

In exceptional cases, the employee's medical leave time could be extended for a total of six (6) months at the discretion of the HR Director (and with appropriate medical certification of the need for extended leave).

Employees who return from medical and/or FMLA will be placed in the first available equivalent position (if returning after 12 weeks). Employees who return to work at the conclusion of the 12 weeks will be placed back into their former position held prior to their leave. Employees who return after the maximum six (6) months will be placed in a position that may or may not be the equivalent of their former position. This is based on the availability of a current job opening at the time the employee returns, and the current budget. Every effort will be made to secure a position in the department for these employees working with all managers in the Division.

The employee's medical and dental benefits will continue during the 3-month/12 week FMLA leave time. In exceptional cases, the medical and dental benefits of the employees who fall under the six (6) month leave exception may be able to continue their benefits. Otherwise, the employee's medical and dental benefits will continue for employees on leave for a maximum of 4 months, depending on the leave type.

### **Section 24: Education and Literacy Assistance Leave**

#### **A. Education:**

Employees are always encouraged to further their knowledge base at FSA. Employees can do this by furthering their education levels, participating in work-related conferences and attending training events. Based on this, Felton Institute/FSA agrees to annually allocate a maximum of \$250 per year per person to cover pre-approved courses not covered by CARES. Employees must pass the course with a grade of C or better, and must submit a receipt as proof of payment.

1. Employee must submit a Request for Reimbursement form to their Supervisor stating the need for the reimbursement.
2. The Controller in coordination with the employee's Supervisor and the Fiscal Director will approve/disapprove the request for reimbursement.
3. After completion of the course, the employee is required to provide proof of successful completion (passing grade) of the coursework at which time reimbursement will be made.

This fund is on a first come/first serve basis.

B. Literacy Assistance Leave:

If an employee reveals to the Agency that he or she has a problem with reading and writing, and request assistance in enrolling in an adult literacy program, the Agency will attempt to assist that employee. This assistance may, depending on the circumstances, include providing an employee with the locations of local literacy education programs or arranging for a literacy education provider to visit at work. The Agency does not, however, provide paid time off for participation in an adult literacy education program. Accrued vacation time must be used, or the leave will be unpaid. Any employee who reveals a problem with illiteracy and who satisfactorily performs his or her work will not be subject to termination of employment because of the disclosure.

**Section 25: Leave Pursuant to the Domestic Violence Employment Leave**

If an employee is a victim of domestic violence and needs to take time off from work, he or she may take an unpaid leave of absence. Accrued, but unused paid time off benefits (vacation, sick and personal business leave) may be used for this type of leave. Reasons for leave include:

- to obtain or attempt to obtain any relief, including but not limited to a temporary restraining order or other injunctive order
- to help ensure the health, safety or welfare of a domestic violence victim or his or her child
- to seek medical attention for injuries caused by domestic violence
- to obtain psychological counseling related to an experience of domestic violence
- to participate in safety planning and to take other actions to increase safety from future domestic violence.

As a condition of taking time off, an employee must, prior to his or her planned absence, provide reasonable advance notice to his or her supervisor. If an employee needs to take an unscheduled leave for one of the above reasons, he or she must, within a reasonable time, provide certification of the need for the absence to his or her supervisor.

**Section 26: Wages and Classifications**

A. 2019-2020 Wage Increase Plan for the FDC and TAPP bargaining unit employees.

Effective July 1<sup>st</sup>, 2019 all bargaining unit employees will receive a wage increase for the July 1<sup>st</sup>, 2019-June 30<sup>th</sup>, 2020 school year. This wage increase pertains to the FDC and TAPP bargaining unit employees and will have the following provisions:

1. Bargaining unit employees will receive an across the board wage increase of 5%. This increase will be retroactive back to July 1<sup>st</sup>, 2019. The retroactive portion of this increase will be processed in two employee batches via a separate direct deposit check on the following payroll period:

April 15<sup>th</sup>, 2020 and April 30<sup>th</sup>, 2020\*  
(30-35) → (30-35)

\*The retroactive portion of this increase was delayed to May 15 and May 30 payroll periods by mutual agreement due to the Covid19 pandemic emergency.

\*Salary adjustment will also support Felton to not only comply but exceed the Minimum Compensation Ordinance effective July 1<sup>st</sup>, 2019. As applicable, employees earning less than \$15.59 an hour will have a salary adjustment to a minimum of \$15.59.

2. Salary adjustment will continue to be processed as per Felton's FY2019-2020 Early Learning Scholarship Salary Matrix for staff who continue to attain higher permit levels or complete a degree that warrants an increase in compensation. As applicable, these increases will be effective on the date of any one of these changes.

All items in this section shall be considered wages and therefore negotiable items for the wage and benefit re-opener at the end of each contract year (no later than November 1<sup>st</sup>).

#### B. Longevity One-Time Salary Adjustment

During the 2019-2020 school year, bargaining unit employees with continuous service and contributions shall receive an additional ONE-TIME longevity salary adjustment in addition to any annual increases as negotiated between the parties, and based on the length of service as follows:

| <u>Number of years of continuous service</u> | <u>Adjustment</u> |
|--|-------------------|
| 5 years of service -                         | 1%                |
| 10 years of service -                        | 2%                |
| 15 years of service -                        | 3%                |
| 20 years of service -                        | 4%                |
| 30 years of service -                        | 5%                |

#### C. Longevity

Bargaining unit employees with continuous service and contributions shall receive an additional longevity retention stipend in addition to any annual increases as negotiated between the parties, and based on the length of service as follows:

| <u>Number of years of continuous service</u> | <u>Yearly Stipend</u> |
|--|-----------------------|
| 5 years of service -                         | \$100                 |
| 10 years of service -                        | \$200                 |
| 15 years of service -                        | \$300                 |
| 20 years of service -                        | \$400                 |
| 30 years of service -                        | \$500                 |

The anniversary date for determining the amount of longevity pay shall be determined on December 1<sup>st</sup> of every year. The yearly stipend will be paid on December of 2020.

### **Section 27: Beneficial Practices**

1. **Exclusivity:** The employer and the Union agree that any practice, policy or working condition in existence prior to the negotiation of this Agreement, that is beneficial to employees but not addressed in this Agreement, shall continue in force; unless or until the parties mutually agree otherwise. No employee shall suffer a loss in benefits as a result of the negotiation of this contract. This Agreement supersedes any prior agreement, whether oral, written or implied, concerning wages, hours or working conditions of employees covered by this Agreement.

2. **Amendment:** Subject to the provisions of this Section, the parties may, by mutual agreement, agree to amend or add to any provision of this Agreement. However, any such amendment or

modification must be in writing, executed by the duly authorized representative(s) of each party, and any oral modification shall be null force or effect.

### **Section 28: Personnel Policies**

The Employer agrees to notify the Union in writing at least 30 days prior to the effective date of any changes in the personnel policies. If requested, the Employer agrees to meet and confer prior to any changes being implemented. No changes in personnel policies shall be requested that violate the Beneficial Practices section of this agreement.

### **Section 29: Separability**

In the event that any of the provisions of this agreement shall be held to be in violation of any Local, State or Federal law or regulation or Local, Federal or State court of last resort decisions, such determination shall not in any way affect the remaining provisions of this Agreement. The parties shall meet and negotiate replacement language for any provision, which may be found to be in conflict with applicable law.

### **Section 30: Labor-Management Committee**

The Employer and the Union agree that communication is beneficial to the collective bargaining relationship. To that end, a Labor-Management Committee shall be established and shall be composed of two (2) management representatives of the Employer and two (2) to four (4) employee representatives of the Bargaining Unit- all employees of the Employer. They shall meet monthly for one (1) hour (unless otherwise mutually agreed upon) on paid time at a mutually agreed upon time and place to address topics of mutual interest and concern, including, but not limited to, health and safety, policies and procedures. The activities of the Committee are advisory and not subject to the Agreement's grievance procedure.

The Employer and the Union agree to convene one or more special meetings of the Labor-Management Committee beginning no later than January 31, 2016 to discuss and consider the possibility of health insurance coverage for member dependents, spouses, and domestic partners.

### **Section 31: Written Communications**

All written communications concerning the application and interpretation of this Agreement shall be sent to the Union addressed to the Union Field Representative, SEIU Local 1021, 447 29<sup>th</sup> Street, Oakland, CA 94609-3510, with copies to the designated chair of the Union Steward Council, and to FSA addressed to the Executive Director and HR Director at Felton Institute/FSA, 1500 Franklin Street, San Francisco, CA 94109 via certified USPS mail without otherwise changing the contract.

### **Section 32: Term of Agreement**

A. The Employer and the Union agree that as long as this Agreement is in full force and effect, there shall be no lockout by the Employer and no strike by the Union. The parties recognize that the grievance procedure in this Agreement is the appropriate means for resolving disputes involving contractual interpretation.

B. The Agreement shall be effective July 1, 2019 and shall remain in full force and effect until and through June 30, 2022 and shall extend year to year unless notice to amend or modify is served by either party upon the other at least sixty (60) calendar days prior to the expiration date of this Agreement via certified USPS mail to the Chief Operations Officer (COO), Chief Financial and Operations Officer (CFOO), and Vice President of Human Resources (VP of HR) of the Felton Institute/FSA and to the designated Field Representative and San Francisco Field Director of SEIU 1021.

During the term of the contract, there shall be a wage and health benefits reopener no later than November 1<sup>st</sup> of every year.

FELTON INSTITUTE/FSA

SERVICE EMPLOYEES INTERNATIONAL  
UNION LOCAL 1021

  
Hector H. Jimenez Cardenas (Nov 19, 2020 11:17 PST)

\_\_\_\_\_  
Al Gilbert, President and CEO

\_\_\_\_\_  
Hector Cardenas, Field Representative

*Marvin Davis*

  
Elizabeth Mendoza (Dec 2, 2020 11:24 PST)

\_\_\_\_\_  
Marvin Davis, CFO

\_\_\_\_\_  
Elizabeth Mendoza, Bargaining Team

*Liz Dalmacio-Julien*  
Liz Dalmacio-Julien (Jan 5, 2021 08:38 PST)

  
Reyna Ferreira (Jan 7, 2021 15:52 PST)

\_\_\_\_\_  
Lizatte Dalmacio, CPO

\_\_\_\_\_  
Reyna Ferreira, Bargaining Team

*Yohana Quiroz*  
Yohana Quiroz (Jan 6, 2021 18:14 PST)

\_\_\_\_\_  
Mariya Rebecca Semeit, Bargaining Team

\_\_\_\_\_  
Yohana Quiroz, COO

  
Xiu Min Li (Nov 19, 2020 09:23 PST)

\_\_\_\_\_  
Xiu Min Li, Field Supervisor

  
Jason Klumb (Nov 19, 2020 08:18 PST)

\_\_\_\_\_  
Jason Klumb, SF Region Field Director

*John Stead-Mendez*

\_\_\_\_\_  
John Stead-Mendez, Executive Director

Date: \_\_\_\_\_

Date: \_\_\_\_\_





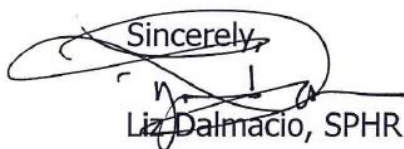


Welcome to the Employee Benefits Program for Felton Institute. Felton Institute is dedicated toward improving the quality of life for our employees. Part of our basic mission is to provide an exemplary program of comprehensive services to children and their families.

All of our employees have been carefully selected and not only have the skills needed to do the job but are passionate about our mission. Because we consider our employees our most valuable resource, Felton Institute strives to keep our benefits and compensation plans comprehensive.

Felton Institute encourages everyone to proactively participate. We welcome feedback and suggestions at all levels of the organization. There is always room for improvement and we are committed to quality. With everyone's help we can continue to operate at the highest possible level.

We are delighted that you have joined us and we hope that you will have a successful and rewarding career with Felton Institute.

Sincerely,  
A handwritten signature in black ink, appearing to read "Liz Dalmacio", is written over the word "Sincerely,". The signature is enclosed in a hand-drawn oval.

Liz Dalmacio, SPHR  
Vice President of Human Resources



# INTRODUCTION & EMPLOYEE RESOURCES

## Flexible Solutions For Your Benefits Needs

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our organization, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your employee benefits. We urge you to read this guide carefully and keep it as a reference. If you are well-informed, you will be able to make better benefit choices that best meet your needs.

## Gallagher Employee Support Center (ESC)

Gallagher Employee Support Center provides a dedicated team of specialized representatives ready to assist employees and dependents. Your Employee Support Center (ESC) is available to you via a toll free hotline Monday through Friday, 8a.m. to 4p.m. (PST) or via email inquiry.

The ESC team can support you as you utilize your employee benefits by providing education and issue advocacy when necessary. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information.

If you or your dependents have any questions or need assistance with selecting the right plan for you or your family, or need assistance with services listed on this page, please contact the Employee Support Center directly.

Committed to YOU.

## YOUR EMPLOYEE SUPPORT CENTER

Supporting You With...

- Benefits Inquiry
- Claims Assistance
- Eligibility
- Materials/Forms Request
- Plan Education
- Provider Network Inquiries
- Referral/Pre-authorization

...maximizing your benefits.

toll free  
**855.670.2222**  
email  
**LosAngeles.ESC@ajg.com**  
Monday-Friday | 8a-4p

Arthur J. Gallagher & Co.  
BUSINESS WITHOUT BARRIERS™

license #0036679

# ELIGIBILITY & ENROLLMENT

## New Hires/Newly Eligible for Benefits

All full-time employees who work on average at least 20 hours per week throughout the year are eligible for benefits. Your benefits are effective 1st of the month following 30 days of employment. Once you have completed your new hire waiting period, you have 30 days to enroll for benefits. If you do not enroll within that time period, you will not be eligible for benefits until the next Open Enrollment, unless you have a Qualifying Family Status Change.

## Eligible Dependents

Your eligible dependents include your legally married spouse, registered domestic partner, and children. Due to Health Care Reform, your medical plan covers dependents to age 26. However, for other plans, age limits may apply.

Coverage may be available for a mentally or physically disabled child who is age 19 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact your Benefits Administrator if you believe this applies to your family.

## Open Enrollment

During Open Enrollment, you will have the opportunity to make changes to your benefit elections. You must enroll by the Open Enrollment deadline for your benefits to be effective July 1st. Except for a Qualifying Status Change, you will not be able to change your elections until the next year's Open Enrollment.

## Qualifying Status Change

If you have a qualifying family status change, you may be able to change your benefits before the next Open Enrollment. You must notify Human Resources within 30 days of the change.

### Qualifying Status Includes:

- Newly hired as full-time benefits-eligible
- Change in work schedule for you or your spouse (part-time to full-time)
- Change in employment for you, your spouse or dependent (i.e. your spouse loses their job and benefits)
- Change in marital status
- Change in dependents
- Gaining other coverage through your spouse
- Loss of other coverage for your dependent
- Change in residence causing loss of coverage
- Medicare or Medicaid entitlement for you, your spouse or dependent
- Qualified Medical Child Support Order (QMCSO)





# BENEFITS AT A GLANCE

| BENEFITS  | COVERAGE OPTIONS  |
|---|---|
| <b>Costs Shared By You &amp; Felton Institute</b> |   |
| Medical   | <ul style="list-style-type: none"> <li>• Sutter Health Vista High Deductible HMO</li> <li>• Kaiser Deductible HMO HRA</li> <li>• Kaiser POS</li> </ul>  |
| Dental  | <ul style="list-style-type: none"> <li>• Cigna DHMO</li> <li>• Cigna Low DPPO</li> <li>• Cigna High DPPO</li> </ul>   |
| Vision  | <ul style="list-style-type: none"> <li>• Cigna</li> </ul>   |
| <b>Benefits Provided By Felton Institute</b>      |   |
| Basic Life and AD&D                               | <ul style="list-style-type: none"> <li>• MetLife – \$50,000 Benefit (non-SEIU)</li> <li>• MetLife – 1x annual salary (SEIU-only)</li> </ul>   |
| Employee Assistance Plan (EAP)                    | <ul style="list-style-type: none"> <li>• MetLife – 24 hour toll-free telephone consultations and referral service available 7 days a week; 5 sessions per issue per person</li> </ul>   |
| Chiropractic & Acupuncture                        | <ul style="list-style-type: none"> <li>• Landmark Health Plan</li> </ul>  |
| <b>Voluntary Employee-Paid Benefits</b>           |   |
| Worksite Benefits                                 | MetLife: <ul style="list-style-type: none"> <li>• Supplemental Life and AD&amp;D</li> <li>• Supplemental Dependent Life and AD&amp;D</li> <li>• Accident</li> <li>• Critical Illness</li> <li>• Hospital Indemnity</li> </ul> |
| Legal/ID Theft                                    | <ul style="list-style-type: none"> <li>• Legal Shield – Legal Shield and ID Shield</li> </ul>   |
| <b>Additional Benefits</b>                        |   |
| Entertainment & Hospitality Benefit               | <ul style="list-style-type: none"> <li>• Tickets at Work – Access to discounted tickets and hotel rates</li> </ul>  |
| Pet Insurance                                     | <ul style="list-style-type: none"> <li>• United Pet Care</li> </ul>   |



# MEDICAL PLAN OPTIONS

You have three medical plans to choose from. The medical plans provide comprehensive coverage but are different in how they are designed.

You decide which Sutter Health or Kaiser plan best meets your needs:

**Sutter Health Vista High Deductible HMO**  
**Kaiser Deductible HMO**  
**Kaiser POS**



## **Sutter Health HMO**

If you choose the Sutter Health HMO, you must select a primary care physician who will manage your care and refer you to a specialist when it is needed.

## **Kaiser Deductible HMO**

If you choose the Kaiser Deductible HMO, you must select a physician, hospital, and pharmacy which is contracted exclusively with Kaiser. Unlike a standard HMO plan which assigns you to a specific doctor and/or hospital, with Kaiser you are able to seek services with any Kaiser doctor and/or hospital at any time. Most services are covered at 100% after you pay a copayment.

## **Kaiser POS Plan**

The Kaiser POS (Point-of-Service) plan offers the convenience and predictable out-of-pocket costs of an HMO, along with access to the extensive PPO network. You have the option to visit either your HMO Personal Physician at Kaiser or a PPO provider or non-contracted provider each time you access care. Costs depend on which type of provider you choose:

- Costs are lower when you use your HMO Personal Physician rather than PPO or non-PPO providers.
- You pay less to see a PPO provider than to see a non-PPO provider.
- For covered services from a non-PPO provider, you pay the plan's calendar-year deductible, the applicable copayment plus any charges that exceed Kaiser's allowable amount.

# OPT-OUT

Eligible full-time employees who have the minimum essential coverage, as required by law, through a spouse or parent, and who do not wish to be covered by any of the plans offered by Felton Institute, may decline coverage and receive a \$110 per pay period stipend in lieu of health benefits. This amount is considered taxable income. It is paid in installments through the employee's regular payroll checks .

Opting out of health coverage is optional and not permanent. Employees may choose to enroll in coverage through Felton Institute during the annual Open Enrollment period or due to a Qualifying Family Status Change.

## **Special Enrollments**

You must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing towards the other coverage). If you do not do so, you will not be able to enroll until your employer's next open enrollment period.

Please be aware that under the provisions of the Affordable Care Act (ACA), individuals who do not have minimum essential coverage for themselves and their dependents either through a group sponsored plan, the individual market or through the exchange beginning in January 2014 may have to pay a tax penalty. For more information about the ACA please visit: [HealthCare.gov](http://HealthCare.gov) or [The Tax Penalty for Remaining Uninsured](#).

**In order to receive the opt-out bonus of \$110 per pay period, you must complete the Waiver of Group Health Benefits Opt-Out Qualification Form attesting that you and your tax dependents are enrolled in minimum essential coverage that is not individual medical insurance.**

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, please contact your HR Department for further assistance.

# CONTRIBUTIONS PER PAY PERIOD



| MEDICAL COVERAGE      | Sutter HMO    | Deductible HMO HRA | POS           |
|-----------------------|---------------|--------------------|---------------|
|                       | Employee Cost | Employee Cost      | Employee Cost |
| Employee              | \$0.00        | \$90.00            | \$477.92      |
| Employee + Spouse     | \$292.86      | \$343.68           | \$1,364.77    |
| Employee + Child(ren) | \$243.96      | \$290.16           | \$1,216.43    |
| Employee + Family     | \$488.44      | \$557.75           | \$1,958.15    |



| DENTAL COVERAGE                 | CIGNA HMO     | CIGNA LOW OPTION PPO 1000 | CIGNA HIGH OPTION PPO 1500 |
|---------------------------------|---------------|---------------------------|----------------------------|
|                                 | Employee Cost | Employee Cost             | Employee Cost              |
| Employee                        | \$7.03        | \$20.49                   | \$25.97                    |
| Employee + 1 dependent          | \$13.35       | \$36.48                   | \$45.65                    |
| Employee + 2 or more dependents | \$19.26       | \$58.16                   | \$76.52                    |



| VISION COVERAGE       | BASE PLAN     |
|-----------------------|---------------|
|                       | Employee Cost |
| Employee              | \$3.75        |
| Employee + Spouse     | \$7.49        |
| Employee + Child(ren) | \$7.57        |
| Employee + Family     | \$12.08       |



# CONTRIBUTIONS PER PAY PERIOD



| <b>VOLUNTARY WORKSITE COVERAGE</b> | <b>LOW ACCIDENT</b> | <b>HIGH ACCIDENT</b> | <b>HOSPITAL INDEMNITY</b> |
|------------------------------------|---------------------|----------------------|---------------------------|
|                                    | Employee Cost       | Employee Cost        | Employee Cost             |
| Employee                           | \$2.55              | \$4.31               | \$19.37                   |
| Employee + Spouse                  | \$5.25              | \$8.98               | \$36.61                   |
| Employee + Child(ren)              | \$5.26              | \$8.83               | \$30.62                   |
| Employee + Family                  | \$6.58              | \$11.05              | \$50.68                   |

| <b>VOLUNTARY CRITICAL ILLNESS COVERAGE</b> |               |                   |                       |                   |
|--|---------------|-------------------|-----------------------|-------------------|
| <b>Per Pay Premium Rates per \$10,000</b>  |               |                   |                       |                   |
| Age Band                                   | Employee Only | Employee + Spouse | Employee + Child(ren) | Employee + Family |
| Under 25                                   | \$1.95        | \$3.25            | \$3.35                | \$4.70            |
| 25-29                                      | \$2.05        | \$3.55            | \$3.50                | \$4.95            |
| 30-34                                      | \$2.85        | \$4.80            | \$4.30                | \$6.25            |
| 35-39                                      | \$4.20        | \$6.95            | \$5.65                | \$8.40            |
| 40-44                                      | \$6.85        | \$10.90           | \$8.25                | \$12.30           |
| 45-49                                      | \$9.65        | \$15.60           | \$11.05               | \$17.05           |
| 50-54                                      | \$13.75       | \$22.50           | \$15.15               | \$23.90           |
| 55-59                                      | \$18.30       | \$30.75           | \$19.75               | \$32.20           |
| 60-64                                      | \$25.05       | \$43.00           | \$26.45               | \$44.45           |
| 65-69                                      | \$35.65       | \$61.40           | \$37.05               | \$62.80           |
| 70+  | \$51.85       | \$87.05           | \$53.30               | \$88.45           |

# SUTTER HEALTH

## SUTTER HEALTH HIGH DEDUCTIBLE VISTA HMO PLAN BENEFITS

| WHAT YOU PAY   | HMO Network   |
|--|---|
| Calendar Year Deductible<br>(Individual/Member/Family)   | \$2,500/\$2,800/\$5,000   |
| Employer HRA Deductible Funding  | \$2,500/employee<br>\$300,000/year  |
| Calendar Year Out-of-Pocket Maximum<br>(Individual/Member/Family)                                      | \$4,000/\$4,000/\$8,000   |
| Preventive Services  | No Charge   |
| Office Visits (Primary/Specialist)   | \$40 <sup>1</sup>   |
| Lab & X-ray  | \$15 <sup>1</sup>   |
| Complex Radiology<br>(Includes CT, PET and MRI)  | \$50 <sup>1</sup>   |
| Inpatient Hospital Services<br>(Includes maternity)  | \$500 <sup>1</sup> /day<br>(5 day maximum)  |
| Outpatient Surgery   | \$40 <sup>1</sup>   |
| Urgent Care<br>(Co-pay waived if admitted)   | \$40 <sup>1</sup>   |
| Emergency Room<br>(Co-pay waived if admitted)  | \$100 <sup>1</sup>  |
| Ambulance  | \$100 <sup>1</sup>  |
| PRESCRIPTION DRUGS   |   |
| Retail Prescription: After Deductible<br>(Up to a 30-day supply)<br>(Tier 1/Tier 2/Tier 3/Tier 4)      | \$10 <sup>1</sup> /\$30 <sup>1</sup> /\$60 <sup>1</sup> /20% up to \$100 <sup>1</sup> |
| Mail-Order Prescription: After Deductible<br>(Up to a 100-day supply)<br>(Tier 1/Tier 2/Tier 3/Tier 4) | \$20 <sup>1</sup> /\$60 <sup>1</sup> /\$120 <sup>1</sup> /Not Covered                 |

<sup>1</sup>Calendar Year Deductible Applies

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

[sutterhealthplus.org](http://sutterhealthplus.org)

# SUTTER HEALTH PLUS PROVIDER SEARCH

Use the below steps to find In-Network physicians, urgent cares, and hospitals.

| SUTTER HEALTH PLUS NETWORK |  |
|----------------------------|--|
| STEP 1                     | Go to <a href="http://www.sutterhealthplus.org">www.sutterhealthplus.org</a> and click on “Find a Provider”  |
| STEP 2                     | Enter your Zip Code or City  |
| STEP 3                     | If you know what kind of doctor you are interested in select an option from the “Primary Care Specialties” box   |
| STEP 4                     | Click on the “Accepting new patients” box and then click “Search Doctors” and a list of contracted providers that are accepting new patients will be generated |

*Provider contracts are always changing with the carriers. Please call your provider to ensure that they are still in network before going to see them.*



If you would like provider search assistance, please contact the Employee Support Center at (855) 670-2222 or by email at [LosAngeles.ESC@ajg.com](mailto:LosAngeles.ESC@ajg.com)

# KAISER HMO

## KAISER HRA/HMO PLAN BENEFITS

| WHAT YOU PAY   |   |
|--|---|
| Calendar Year Deductible<br>(Individual/Member/Family)                         | \$3,000/\$3,000/\$6,000   |
| Employer HRA Deductible Funding  | \$3,000/employee<br>\$342,000/year  |
| Calendar Year Out-of-Pocket Maximum<br>(Single/Family)                         | \$6,000/\$12,000  |
| Preventive Services  | No Charge   |
| Office Visits<br>(Primary/Specialist)  | 30% <sup>1</sup>  |
| Lab & X-ray  | 30% <sup>1</sup>  |
| Complex Radiology<br>(includes CT, PET and MRI)                                | 30% <sup>1</sup>  |
| Inpatient Hospital Services<br>(includes maternity)                            | 30% <sup>1</sup>  |
| Outpatient Surgery   | 30% <sup>1</sup>  |
| Urgent Care<br>(Co-pay waived if admitted)                                     | 30% <sup>1</sup>  |
| Emergency Room<br>(Co-pay waived if admitted)                                  | 30% <sup>1</sup>  |
| Ambulance  | 30% <sup>1</sup>  |
| PRESCRIPTION DRUGS   |   |
| Retail Prescription – Deductible doesn't apply<br>(up to a 30-day supply)      | 30% (not to exceed \$50 for generic and \$100 for brand and specialty)          |
| Mail Order Prescription – Deductible doesn't apply<br>(up to a 100-day supply) | 30% (not to exceed \$50 for generic and \$100 for brand; specialty not covered) |

<sup>1</sup>Calendar Year Deductible Applies

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

[www.kp.org](http://www.kp.org)

# YOUR SUTTER HEALTH PLUS PLAN

Sutter Health Plus, a not-for-profit HMO, offers competitively priced health plans that give you access to a network of high-quality health care providers, including many of Sutter Health's affiliated hospitals, doctors and health care services. Here, providers work together to offer you easily accessible and personalized care.

## Affiliated Medical Groups

When you choose a PCP, you are also choosing the PCP's affiliated medical group. Your PCP refers you, as needed, for specialty care, X-ray, laboratory and other services. Many covered services, including visits to a specialist, require a referral or prior authorization from your medical group. Your PCP will refer you in-network for most services. If services aren't available, your PCP will refer you for out-of-network services and will request authorizations when necessary.

## Care Centers

In your community, you may have access to conveniently located care centers that provide a wide variety of services including primary care, specialty care, lab, and X-ray—all under one roof.

## Walk-In Care

Quality care where you need it, when you need it with same-day visits for simple, everyday health needs. Enjoy a relaxing environment with free Wi-Fi, comfortable seating and complimentary coffee and tea. For a list of Sutter Walk-In Care clinics near you, visit [sutterhealthplus.org/walk-in](http://sutterhealthplus.org/walk-in).

## Urgent Care

Convenient access to high-quality urgent care services, offering timely care for unforeseen illnesses or injuries that require prompt medical attention. For a list of urgent care centers near you, visit [sutterhealthplus.org/urgent](http://sutterhealthplus.org/urgent).



# KAISER POS

## KAISER POS PLAN BENEFITS

| WHAT YOU PAY   | KAISER Network            | PHCS Network                   | Out of Network           |
|--|---------------------------|--------------------------------|--------------------------|
| Calendar Year Deductible (Single/Family)                                       | None                      | \$500/\$1,000                  | \$1,000/\$2,000          |
| Calendar Year Out-of-Pocket Maximum (Single/Family)                            | \$1,500/\$3,000           | \$2,500/\$5,000                | \$5,000/\$10,000         |
| Preventive Services  | No Charge                 | No Charge                      | 40%                      |
| Office Visits (Primary/Specialist)   | \$20                      | \$30                           | 40% <sup>1</sup>         |
| Lab & X-ray  | No Charge                 | \$30                           | 40% <sup>1</sup>         |
| Complex Radiology (Includes CT, PET and MRI)                                   | No Charge                 | \$30                           | 40% <sup>1</sup>         |
| Inpatient Hospital Services (Includes maternity)                               | \$250/admit               | \$250 + 20% <sup>1</sup>       | \$500 + 40% <sup>1</sup> |
| Outpatient Surgery   | \$100                     | 20% <sup>1</sup>               | 40% <sup>1</sup>         |
| Urgent Care (Co-pay waived if admitted)  | \$20                      | 20% <sup>1</sup>               | 40% <sup>1</sup>         |
| Emergency Room (Co-pay waived if admitted)                                     |                           | \$100                          |                          |
| Ambulance  |                           | \$150                          |                          |
| PRESCRIPTION DRUGS   |                           |                                |                          |
| Retail Prescription (Up to a 30-day supply) (Tier 1/Tier 2/Tier 3/Tier 4)      | \$10/\$30/20% up to \$200 | \$20/\$40/\$50/30% up to \$250 | Not Covered              |
| Mail-Order Prescription (Up to a 100-day supply) (Tier 1/Tier 2/Tier 3/Tier 4) | \$20/\$60/Not Covered     | Not Covered                    |                          |

<sup>1</sup>Calendar Year Deductible Applies

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

[www.kp.org](http://www.kp.org)

# KAISER TELEMEDICINE

Connect to care anytime, anywhere



## How to join a video visit:

We recommend joining your appointment 5 to 10 minutes early.

### Phone or tablet:

1. Download the Kaiser Permanente app.
2. Sign on to the app using your **kp.org** user ID and password.
3. Go to "Appointments" and tap "Join" to start your video visit.

### Computers or laptops:

1. Click the link in your confirmation email or sign on to **kp.org**
2. Download and install the **Vidyo** web plug-in (first visit only).
3. Click "Join Your Video Visit" to start your visit.

## Some examples of conditions:\*

- Allergies
- Colds and coughs
- Some follow-up visits
- Upper respiratory infections

## When you call us, we will:

- Make sure you're 18 and over
- Confirm you've had at least 1 face-to-face visit with us
- Schedule a 1-hour window for the doctor to call you

*\*Telephone appointments are not appropriate for emergency conditions, such as severe shortness of breath, severe abdominal pain, severe bleeding, or urgent conditions— like sprains, falls, or cuts needing stitches.*



### 24/7 care advice

We're here 24/7 to guide you. Call us at **1-866-454-8855** (TTY 711).



### In-person visit

Same-day appointments are often available. Sign on to **kp.org** anytime, or call us to schedule a visit.



### Email

Message your doctor's office with nonurgent questions anytime. Sign on to **kp.org** or use our mobile app.



### Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.

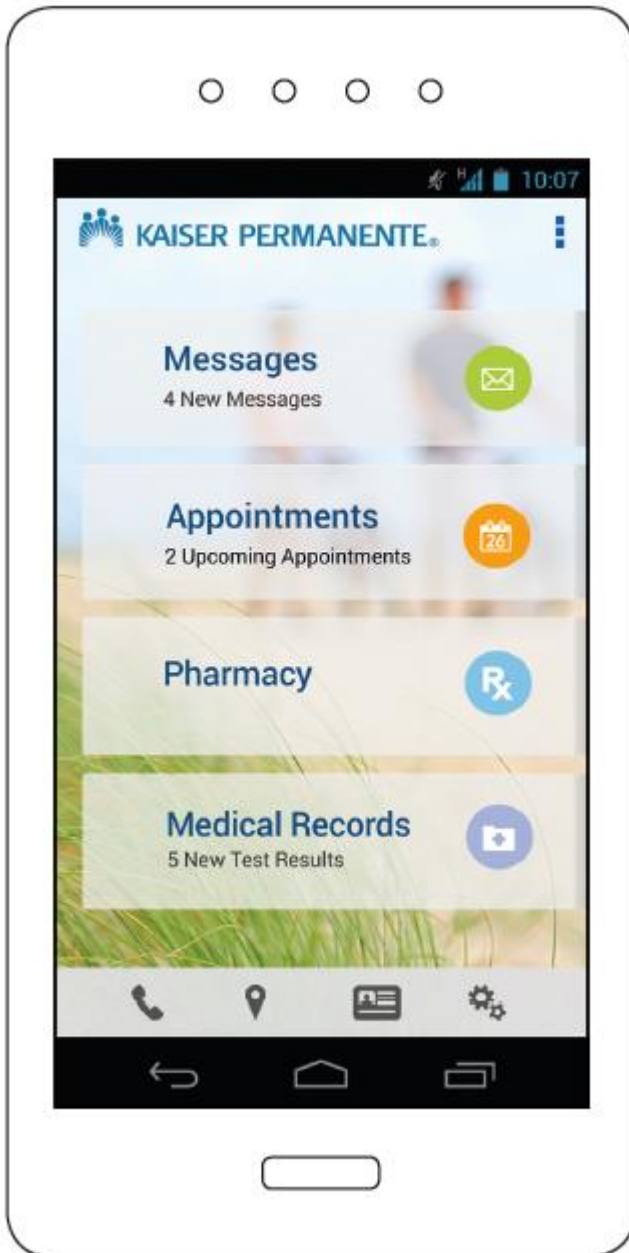


### Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.

# KAISER MOBILE TOOLS

## GOOD HEALTH IS IN YOUR HANDS



Use the convenient features of “My Health Manager” right from your smartphone or other mobile device.

- Email your doctor’s office.
- View most lab results.
- Schedule or cancel routine appointments.
- Refill most prescriptions.
- View past visits.
- Print vaccination records for school, sports, or camp.
- Manage a family member’s care

Just download the Kaiser Permanente app at no cost from your preferred app site.



Are you registered? If you’re already registered on [kp.org](http://kp.org), you’re all set to start using your Kaiser Permanente app. If not, you’ll need to go to [kp.org/registernow](http://kp.org/registernow) to set up your account from a computer. Then use your new user ID and password to activate the app.



# KAISER NATIONAL VISITING MEMBER



## How do I get care in other Kaiser Permanente service areas?

Call the Away from Home Travel Line 2 at 951-268-3900 and let them know you plan to visit another Kaiser Permanente service area for care.

- You'll get a medical record number (MRN) or health record number (HRN) for the other Kaiser Permanente service area and information on making an appointment.

You'll only use this MRN or HRN in the service area you're visiting. You'll use the same MRN or HRN whenever you visit the service area. There's no need to get a new MRN or HRN if you visit the service area again.

When you get back home, you'll use your home MRN or HRN to get care

## Outside Kaiser Permanente service areas

You're covered for urgent and emergency care anywhere in the world.

**Routine services aren't covered**, so make sure to get them before your trip if you're traveling elsewhere. Routine services include prevention, exams, checkups, and services for ongoing medical conditions

### States Participating in this Program<sup>1</sup>

- California
- Colorado
- Georgia
- Hawaii
- Maryland
- Oregon
- Virginia
- Washington
- Washington, D.C.

You can get care in these areas and find Kaiser Permanente locations at [kp.org/kpfacilities](https://www.kp.org/kpfacilities). You're also covered for urgent and emergency care from any non-Kaiser Permanente provider.

<sup>1</sup> These states may have regions that are not covered. Therefore, applicants can still be denied coverage if the region within the guest state does not have Away From Home Care (AFHC) providers.

# KAISER TOOLS

## SIMPLE STEPS TO CONNECT WITH YOUR HEALTH

### Register for “My Health Manager” on [kp.org](http://kp.org) from your computer

With “My Health Manager” on [kp.org](http://kp.org), you can take charge of your health securely online- 24 hours a day, seven days a week.

### It only takes a few minutes

Visit [kp.org/registernow](http://kp.org/registernow) from your computer to set up your account. Just have your medical record number handy and follow the five simple steps to the right. Then you can start using the convenient tools of “My Health Manager” from any computer, smartphone, or mobile device.

Registration is safe and secure— we’ll ask a few questions only you could answer, and you’ll have a set time to respond. If you need help or have any questions, just give us a call at **1-800-556-7677**.

### You’re in charge

Once you’re registered, you can start using “My Health Manager” to stay on top of the care you receive at Kaiser facilities.

- Email secure, routine messages to your doctor’s office with non-urgent health questions.
- Request appointments and check past office visit information for recommended follow-up steps.
- View most lab test results as soon as they are available (many on the same day).
- Order your prescriptions and have most of them mailed to your home.
- Use all these tools on the go! Just download the free Kaiser Permanente app.



### 1 Enter your membership information

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Birth date: (mm-dd-yyyy)  
Month: [Select a month] Day: \_\_\_\_\_ Year: \_\_\_\_\_

Area: [Select an area]

Health/Medical Record number: \_\_\_\_\_

### 2 Accept the terms and conditions

By checking this box and clicking the “Submit” button, I indicate that I have read and agree to the summary and the [entire Terms and Conditions](#) for use of this website, and I have reviewed the [Privacy Statement](#) for this website.

### 3 Create your user ID

User ID: \_\_\_\_\_  
[Here about choosing a user ID](#)

E-mail address: \_\_\_\_\_  
[Here about e-mail addresses](#)

Retype e-mail address: \_\_\_\_\_

### 4 Secure your account

**Get your password online now**  
Confirm basic information about yourself, then answer up to 3 security questions, in 90 seconds per question.  
[Here about this method](#)

I want my password now.

**Get your password by mail (3 to 7 days)**  
Confirm your mailing address, and we'll mail you a temporary password.  
[Here about this method](#)

Mail me a password (U.S. Mail, 3 to 7 days).

### 5 Sign on

User ID: \_\_\_\_\_

Password: \_\_\_\_\_

[Forgot your user ID or password?](#)

[Sign on here](#)

# KAISER PHARMACY TOOLS

## RETHINK REFILLS

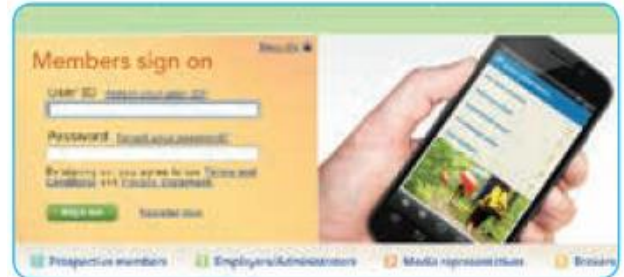
### Skip the trip, get it quick.

When you receive care at KP facilities, you can get most of your prescription refills mailed to you at no additional charge. You can place your order by going online at kp.org, calling the number on your prescription label, or using the KP app on your mobile device.

### Just click and kick back.

Once you're registered to use "My Health Manager" on kp.org, it's easy to order most of your prescription refills. Just sign on kp.org or the KP mobile app and follow these simple steps.

### Step 1



### Enter your User ID and Password

Once you're signed on, click "Pharmacy center" to continue.

### Step 2



### Choose the refills you need

Then click "Go to cart" to verify your order. Then click "Checkout."

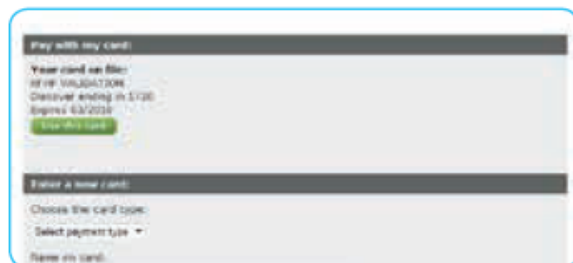
### Step 3



### Choose your preferred address

Your home address is already included. Up to four addresses can be saved.

### Step 4



### Choose a credit card to use

Enter your card information in the fields provided. Then click "Use this card."

### Step 5



### Review your refill order

Click "Place my order" to finalize your order and view your confirmation.

# KAISER PROVIDER SEARCH

Use the below steps to find In-Network physicians, urgent cares, and hospitals.

|        | HMO NETWORK  |
|--------|--|
| STEP 1 | Please visit <a href="http://www.kp.org">www.kp.org</a>  |
| STEP 2 | Click on <i>Doctors &amp; Locations</i> .  |
| STEP 3 | Choose the Search type you are looking for   |
| STEP 4 | Choose the Region you are searching in, and enter your zip code.   |
| STEP 5 | Once you press "Search" you will get a listing of doctors. You can refine your search results after you get a listing. |



If you would like provider search assistance, please contact the Employee Support Center at (855) 670-2222 or by email at [LosAngeles.ESC@ajg.com](mailto:LosAngeles.ESC@ajg.com)

# MEDICAL PREVENTIVE SERVICES

The following are examples of Preventive Services covered by your policy. For a complete list of these services, please refer to your combined Evidence of Coverage and Disclosure Form. Preventive Services are covered 100%.

| CHILD<br>PREVENTIVE CARE   | MEN & WOMEN'S<br>PREVENTIVE CARE   | ADULT<br>PREVENTIVE CARE   |
|--|--|--|
| <p><b>Screening Tests</b></p> <ul style="list-style-type: none"> <li>○ Behavioral counseling to promote a healthy diet</li> <li>○ Blood pressure</li> <li>○ Cervical dysplasia screening</li> <li>○ Cholesterol and lipid level</li> <li>○ Depression screening</li> <li>○ Type 2 diabetes screening</li> <li>○ Hearing screening</li> <li>○ Height, weight and body mass index (BMI)</li> <li>○ Hemoglobin (blood count)</li> <li>○ HPV screening</li> <li>○ Lead testing</li> <li>○ Newborn screening</li> <li>○ Screening and counseling for obesity</li> <li>○ Oral (dental health) assessment</li> <li>○ Screening and counseling for STIs</li> <li>○ Vision screening</li> </ul> <p><b>Immunizations</b></p> <ul style="list-style-type: none"> <li>○ Diphtheria, tetanus and pertussis (whooping cough)</li> <li>○ Haemophilus influenza type b</li> <li>○ Hepatitis A and Hepatitis B</li> <li>○ Human papillomavirus (HPV)</li> <li>○ Influenza</li> <li>○ Measles, mumps and rubella</li> <li>○ Meningococcal (meningitis)</li> <li>○ Pneumococcal (pneumonia)</li> <li>○ Polio</li> <li>○ Rotavirus</li> <li>○ Varicella (Chicken Pox)</li> </ul> | <p><b>Men</b></p> <ul style="list-style-type: none"> <li>○ Aortic aneurysm screening (men who have smoked)</li> <li>○ Prostate cancer</li> </ul> <p><b>Women</b></p> <ul style="list-style-type: none"> <li>○ Well-woman visits</li> <li>○ Breast cancer testing for BRCA 1 and BRCA 2 when certain criteria are met</li> <li>○ Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling</li> <li>○ Contraceptive (birth control) counseling</li> <li>○ FDA-approved contraceptive services provided by a doctor</li> <li>○ Counseling related to chemoprevention for women with a high risk of breast cancer</li> <li>○ Counseling related to genetic testing for women with a family history of ovarian or breast cancer</li> <li>○ HPV screening</li> <li>○ Screening and counseling for interpersonal and domestic violence</li> <li>○ Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, iron deficiency, anemia, and STDs</li> <li>○ Pelvic exam and Pap test, including screening for cervical cancer</li> </ul> | <p><b>Screening Tests</b></p> <ul style="list-style-type: none"> <li>○ Behavioral counseling to promote a healthy diet</li> <li>○ Blood pressure</li> <li>○ Bone density test to screen for osteoporosis</li> <li>○ Cholesterol and lipid (fat) level</li> <li>○ Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)</li> <li>○ Depression screening</li> <li>○ Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965</li> <li>○ Type 2 diabetes screening</li> <li>○ Eye chart test</li> <li>○ Obesity</li> <li>○ STIs</li> <li>○ Tobacco use: related screening and behavioral counseling</li> <li>○ Violence, interpersonal and domestic: related screening and counseling</li> </ul> <p><b>Immunizations</b></p> <ul style="list-style-type: none"> <li>○ Diphtheria, tetanus and pertussis</li> <li>○ Hepatitis A and Hepatitis B</li> <li>○ HPV</li> <li>○ Influenza</li> <li>○ Meningitis</li> <li>○ Measles, mumps and rubella</li> <li>○ Pneumococcal</li> <li>○ Varicella (Chicken pox)</li> <li>○ Zoster (shingles)</li> </ul> |



# CHIROPRACTIC & ACUPUNCTURE BENEFITS



## Additional coverage for your medical plans (must elect one of the health plans offered by Felton Institute).

Landmark Healthplan Chiropractic and Acupuncture Care coverage lets you self-refer to a network of more than 4,000 licensed chiropractors and acupuncturists.

### How the Program Works

You can visit any participating chiropractors and/or acupuncturists from the Landmark Healthplan network without a referral from your Primary Care Physician (PCP). Simply call a participating provider to schedule an initial exam.

Landmark Healthplan does not issue ID cards. At the time of your first visit, you'll need to provide your name, date of birth, employer's name and group number (**LA0018\*000**). Since participating chiropractors and acupuncturists bill Landmark Healthplan directly, you'll never have to file claim forms.

If you need further treatment, the participating practitioner will submit a proposed treatment plan to Landmark Healthplan and obtain the necessary authorization from Landmark Healthplan to continue treatment up to a maximum of 30 annual visits.

### What's Covered

The plan covers medically necessary chiropractic & acupuncture services including:

- Examinations
- Manipulation/Conjunctive Physiotherapy
- Acupuncture/Electro-acupuncture
- Moxibustion/Cupping/Acupressure

| BENEFIT PLAN DESIGN                                       |   |
|---|---|
| Maximum Annual Visits                                     | 30 Visits                                     |
| Annual Deductible   | No Deductible                                 |
| Durable Medical Equipment Purchase or Rental <sup>1</sup> | \$50 annual maximum benefit                   |
| Chiropractic X-Ray Benefit <sup>1</sup>                   | \$75 annual maximum benefit                   |
| Covered Services  | Member Co-pay                                 |
| Chiropractic & Acupuncture Services                       | No Co-pay                                     |
| Acupuncture Herbal Therapies <sup>3</sup>                 | \$5 per bottle (\$500 annual maximum benefit) |
| Out of Network Coverage                                   | None  |

<sup>1</sup> Must be prescribed by a Participating Chiropractor.

<sup>2</sup> Acupuncture Herbal Therapies must be prescribed by a Participating Acupuncturist.

**When you need chiropractic and acupuncture care, you can visit any participating chiropractor and acupuncturist in California from Landmark Healthplan's network without referral from your HMO Primary Care Physician.**

**To locate participating practitioners in your area, you can access a continuously updated directory on Landmark's website at [www.LHP-CA.com](http://www.LHP-CA.com) under the "Member" option. You can also contact Landmark's Customer Service Department at 1-800-298-4875, Monday through Friday, 5:30am to 5:00pm (PST), and a representative will assist you with your search.**

# ACCESSING YOUR HRA ACCOUNT (CONT.)

## HEALTH REIMBURSEMENT ARRANGEMENT (HRA) HIGHLIGHTS

(The most important information about Health Reimbursement Arrangements is listed below)

**Accessing Care** – you will receive medical membership ID card(s) from the health carrier (Kaiser or Sutter) . This card should be presented to any service provider including pharmacy for eligibility verification.

**Account Contributions (\$5,000)** — only your employer contributes to your HRA account. This can be used only for approved in-network medical expenses.

**Healthcare Payment Card** — you will receive a payment card to access account funds to pay for your copays. Your card is mailed to your home address approximately two weeks after you complete your enrollment. If you have elected coverage for your spouse/registered domestic partner, you will receive an additional Visa debit card.

- Card is valid for three years.
- Card can be used to pay for eligible expenses at healthcare providers.
- You will be required to submit documentation for your card purchases – **Always Save Your Receipts!**
- If your card is used for an ineligible expense, you may be required to refund your account. If you do not refund the account in a timely manner, your card may be suspended.



**Eligible Expenses** — medical expenses including doctor office visits, urgent care visits, outpatient laboratory fees, hospital charges, prescriptions, etc.

**Ineligible Expenses** — over-the-counter treatments, dental and vision care, cosmetic treatments and any other non-medical items or services including teeth whitening, vitamins, exercise equipment and gym memberships. **Services accessed with non-contracted providers are not eligible!**

**Submitting Receipts** — you will receive notification that additional information or copy of a receipt is needed for a specific service. If you don't submit your receipts in a timely manner, your card will be suspended.

**Reimbursement Requests** — when you do not use your healthcare payment card, you can pay out of pocket and request reimbursement through your online account. Your reimbursement can be paid to you as a check or direct deposit. To enroll in direct deposit, please complete the direct deposit authorization form.

**Mobile App** — download the free mobile app on your smart phone to view your account information and file a claim at any time.

### CUSTOMER SERVICE

Customer service representatives are available to assist you during normal business hours at the toll-free number located on the back of your healthcare payment card.



# HRA KEY FACTS



## Why do I need the take care® Card?

Participants who use the take care Card won't have to pay for qualified expenses out of their personal funds and then wait for a reimbursement. The Card can only be used by the participant (or their dependent(s) including spouse/registered domestic partner) at IRS-qualified providers to pay for qualified expenses from their HRA account.

## Where is the take care® Card accepted?

The take care Card can be used only at qualified locations. The Card may not be used at all merchants that accept Visa. For example, it works at providers like pharmacies, doctor's offices, hospitals, IAS retailers, etc. These IRS-imposed limitations help to insure that the Card is used only when paying for qualified expenses. When the Card is swiped at a qualified location and there is a sufficient balance available in the participant's take care account, the Card swipe is approved. An informative insert with "Important Tips for Using the Card" is mailed along with the participant's take care Card.

## How do we verify that the take care® Card is used ONLY for qualified expenses?

The IRS requires that The Advantage Group, as your plan service provider, verify all Card swipes. The Advantage Group will send you a letter in the mail requesting verification of your purchases on the HRA Card. You must provide a copy of your health plan's Explanation of Benefits (EOB) for the specific services requested. **If you do not submit this requested documentation, your claims will be denied.**

## What happens if the take care® Card is used to pay for services that are NOT IRS qualified?

If it is determined that a portion of a Card transaction is not qualified, or the participant does not respond, they will be asked to repay the amount. The amount they owe may be repaid by logging into the website. It may also be repaid by deducting it from the participant's future claim. If the participant does not respond by the deadline, their Card may be suspended until the amount they owe is repaid.

## Can participants file claims when the take care® Card is not used?

Yes, participants may also pay expenses from their personal funds and then file a claim for reimbursement. This will be necessary if a merchant does not accept Visa cards, or the participant did not elect the option to use the take care Card.

## What if the take care® Card is lost, stolen or was not received by a participant?

To report a lost or stolen Card, or if a participant did not receive their Card in the mail at their home address on record, call 877-506-1660, Monday through Friday, 8:00am to 5:00pm (PST).



# HRA ONLINE ACCOUNT SETUP

All active participants have access to the online account features at [www.myflexonline.com](http://www.myflexonline.com).

Your online account provides fast and easy access to all of your accounts activities. Users can view up-to-date account balance information, pending claims status, claims history, and submit for claims reimbursement from your personal account page.

## Step 1

Logon to [www.myflexonline.com](http://www.myflexonline.com) and select “New User Registration”

## Step 2

You will be prompted to enter your name, home zip code and the last four digits of your SSN. Select Next and create your username and password.

## Step 3

Your login is now established and you will be directed to your personal account page where you can view up to date account information and access a variety of additional account features.

## Step 4

**Mobile Access:** with MyFlexMobile, you can access your account anytime or anywhere to check your balance, see your spending and submit claims by taking a picture of your receipt and hit submit! Once you create the login to your online account (Steps 1-3), download the free mobile app from AppStore or Google Play to manage your account from your phone.

# HRA ONLINE CLAIMS & PAYMENTS

## HOW TO SUBMIT CLAIMS, EOB'S, OR REQUEST REIMBURSEMENTS ONLINE

When you do not use your healthcare payment card, you can pay out of pocket and request reimbursement through your online account.

Your reimbursement can be paid to you as a check or direct deposit.

### Step 1

Login to [www.myflexonline.com](http://www.myflexonline.com) and select “Claims & Payments” from the drop down menu and click on “Submit a Claim”. Review the 3 steps and click “Next”

The screenshot shows the 'Submit a Claim' page with a navigation bar at the top containing 'Benefits', 'Claims & Payments', 'Card Center', 'Go Mobile', 'Settings', and 'Contact Us'. Below the navigation bar, there are two numbered steps: '1 About' and '2 Receipt'. The main heading is 'Submit a Claim'. Underneath, it says 'About Submitting a Claim'. There are three numbered instructions:

1. Enter information from one receipt at a time.  
You can enter any number of expenses for each itemized bill or explanation of benefits.
2. You must provide proof of service to submit a claim.  
Your proof may be an itemized bill or explanation of benefits that contains date of service, description of service, provider's name, cost, and name of person receiving care.
3. Proof of service must be received by a plan's claim-it-by date to be considered for payment.  
Refer to your itemized bill or explanation of benefits as you enter your claim.

### Step 2

Enter your receipt information (beginning date of service, ending date of service, merchant or provider name, expense description, name of participant or eligible dependent, amount) and then click “Add”. Please note: you can enter one expense at a time and you will be able to track each expense separately. After all expenses are entered, click “Next”

The screenshot shows the 'Enter Your Receipt Information' form. It has a navigation bar at the top with 'Benefits', 'Claims & Payments', 'Card Center', 'Go Mobile', 'Settings', and 'Contact Us'. Below the navigation bar, there are four numbered steps: '1 About', '2 Receipt', '3 Review', and '4 Proof'. The main heading is 'Submit a Claim'. Underneath, it says 'Enter Your Receipt Information'. There is a text box for 'For each eligible expense, enter the following information, and then click Add.' Below this are several input fields: 'Beginning date of service', 'Ending date of service', 'Merchant or provider name', 'Expense description', 'Name of participant or eligible dependent', and 'Amount'. There is an 'Add' button. Below the form is a table with the following data:

| Description      | Beginning Date | Ending Date | Merchant or Provider Name | Participant Name or Dependent | Amount                      |                |
|------------------|----------------|-------------|---------------------------|-------------------------------|-----------------------------|----------------|
| 1 Medical Co-pay | 1/1/2017       | 1/1/2017    | Kaiser                    | LISA SUE                      | \$20.00                     | Delete         |
|                  |                |             |                           |                               | <b>Total for this claim</b> | <b>\$20.00</b> |

### Step 3

Follow the **Upload Instructions** to upload your receipt(s) and click “Next”

The screenshot shows the 'Upload Your Receipt' page. It has a navigation bar at the top with 'Benefits', 'Claims & Payments', 'Card Center', 'Go Mobile', 'Settings', and 'Contact Us'. Below the navigation bar, there are four numbered steps: '1 About', '2 Receipt', '3 Review', and '4 Proof'. The main heading is 'Submit a Claim'. Underneath, it says 'Upload Your Receipt'. There is a text box for 'This is the fastest way to get your claim paid.' Below this is a section titled 'Upload Instructions' with four numbered instructions:

1. Save an electronic receipt on your computer.
  - Scan a PDF or an Explanation of Benefits (EOB) from your health plan's website.
  - Scan a paper receipt and save it as a TIF, TIF, JPG, JPEG, BMP, GIF, PNG or PDF file.
  - Files must be no larger than 5MB (5,120KB). If the file is too big, try compressing it.
2. Click **Upload Receipt Now**, and then select the files you want to upload.
3. Your claim will be processed within a few days of receiving your form and receipt.
4. Return to this Web site to view the status of your claim and payment.

Below the instructions is a blue button labeled 'Upload Receipt Now'.

### Step 4

Once Receipt is uploaded correctly, it will be referenced below “Uploaded Receipt Files for This Claim”. Please click on “Submit Receipt for this Claim” to complete the process.

The screenshot shows the 'Uploaded Receipt Files for This Claim' table. It has a navigation bar at the top with 'Benefits', 'Claims & Payments', 'Card Center', 'Go Mobile', 'Settings', and 'Contact Us'. Below the navigation bar, there are four numbered steps: '1 About', '2 Receipt', '3 Review', and '4 Proof'. The main heading is 'Submit a Claim'. Underneath, it says 'Uploaded Receipt Files for This Claim'. There is a table with the following data:

| Name                       | Size    |        |
|----------------------------|---------|--------|
| LisaSue Sample Receipt.pdf | 65.0 KB | Remove |

Below the table is a blue button labeled 'Submit Receipts for this Claim'.

# HRA MOBILE TOOLS

## The healthcare app that's made for mobile but designed for you

Want to check your HRA balances and submit receipts anywhere, anytime? Whether on your couch or at the store, the MyFlex App for iPhone or Android smartphones makes it easy to manage your benefit accounts on the go.

The MyFlex App enable you to easily and securely access your accounts. You can view accounts balances and detail, submit account claims, and capture and upload pictures of your receipts anytime, anywhere on any iPhone, Android or tablet device.

### But wait, there's more to it...

The newest mobile app provides time-saving options for you to:

- Check current account balances
- View HRA transaction details
- File new claims with receipt images
- Submit claim and upload receipts using the mobile device's camera
- Manage expense receipts

The app provides you with seamless account access since it is an extension of the consumer portal – and doesn't require you to setup any additional credentials.

### Get started with MyFlex Mobile App in minutes

Simply download the MyFlex App for your Android or iPhone (also compatible with iPad and iPod touch) and log in using the same password you use to access the consumer portal.



TAG Participant Support  
Phone: (877) 506-1660  
Email: [support@enrollwithtag.com](mailto:support@enrollwithtag.com)



## DENTAL & VISION PLANS

### Cigna HMO Dental

Dental HMOs are designed to help you and your family maintain oral health and reduce your out-of-pocket costs, and they're simple to use. Just select a participating (network) dentist at enrollment and refer to your Schedule of Benefits to determine your benefits for each covered service.

This type of insurance requires some type of prepayment from you. In exchange, you get dental care from a network of dental care providers. If you want to use a dentist outside the approved network, you must pay your entire dentist's bill yourself.

### Cigna PPO Dental

You may see any dentist, but you will have a higher benefit level and lower out-of-pocket costs if you visit a Cigna PPO network dentist. Savings are greater when you visit an In Network provider because Cigna's contracted dentists have agreed to provide care at a negotiated rate.

Out of Network benefit amounts are subject to the Cigna contracted fee schedule. You will be responsible for the difference between the plan payment and the dentist's usual charge.

### Cigna Vision Plan

A vision plan is one of the most requested benefit options. We are pleased to provide an affordable vision plan. The plan utilizes the Cigna Vision Network.

Cigna has one of the largest networks of private practicing optometrists, ophthalmologists, and opticians. In addition to the vision plan benefits provided through your benefits program, Cigna offers a number of non-covered services at a discount



# CIGNA DENTAL HMO

| DENTAL HMO PLAN BENEFITS*   | WHAT YOU PAY |
|---|--------------|
| <b>Plan Maximums</b>  |              |
| Calendar Year Deductible  | None         |
| Calendar Year Maximum Benefit   | None         |
| <b>Preventive Procedures</b>  |              |
| Office Visit  | \$0          |
| D1110/D1120 Cleaning Adult/Child  | \$0          |
| D0210 – D0330 X-rays & Imaging  | \$0          |
| <b>Restorative Procedures</b>   |              |
| D2391 White Filling (posterior)   | \$45         |
| D3330 Molar Endodontics (root canal)  | \$195        |
| D4261 Periodontal Osseous Surgery (gum disease)   | \$195        |
| D4342 Periodontal Scaling & Root Planning (gum disease) - one to three teeth per quadrant | \$25         |
| <b>Major Procedures</b>   |              |
| D5110 – D5120 Complete Denture (maxillary or mandibular)                                  | \$135        |
| D5211 – D5212 Partial Denture (maxillary or mandibular)                                   | \$135        |
| D6240 Pontic (porcelain fused to high noble metal)  | \$130        |
| D6750 Crown (porcelain fused to high noble metal)   | \$130        |
| D7220 Surgery to remove impacted tooth (soft tissue)                                      | \$40         |
| <b>Orthodontia</b>  |              |
| Comprehensive Orthodontic Treatment (child)   | \$1,614      |
| Comprehensive Orthodontic Treatment (adult)   | \$2,118      |

\* Please view the carrier's schedule of benefits for a complete list of covered procedures and costs.

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

[www.mycigna.com](http://www.mycigna.com)

# KEY FACTS ABOUT DENTAL HMO



## How the plan works

- You **must** choose a DHMO network general dentist. You won't be covered if you go to a dentist who's not in the DHMO network. If you do not select a DHMO dentist when you first enroll, Cigna will choose a dentist for you.
- Each family member can choose their own dentist.
- After you enroll, you will receive an ID card in the mail from Cigna. This ID card will have the name of the DHMO dentist you are assigned to on the plan.
- **You must seek all dental services with the dentist you are assigned to.** You may change the dentist you are assigned to for any reason. The change will become effective the first of the following month. To make the change, visit **myCigna.com** or call 1.800.Cigna24 (1.800.244.6224) to speak with a representative or use the automated Quick Transfer option.
- Referrals are required for specialty care services.
- You can request a second opinion from a different network general dentist by calling customer service; they will help you make the necessary arrangements.

## More about your DHMO coverage

- No deductibles - You don't have to reach an out-of-pocket cost before your insurance starts.
- No dollar maximums - Your coverage isn't limited by a dollar amount. No matter the amount of your covered expenses.
- No claim forms to file - And no waiting periods for coverage.
- No age limit on sealants - Helps prevent tooth decay.
- Cancer detection - Your plan covers procedures such as biopsy and light detection to help find oral cancer in its early stages.
- 24/7 access to dental information line - Trained professionals can help answer your questions about dental treatment and clinical symptoms.

**Finding a DHMO network dentist is easy!**  
Visit [www.myCigna.com](http://www.myCigna.com) to find a network general dentist.  
Call (800) Cigna24 (800.244.6224) to speak with a customer service representative. You can ask for a customized dental directory to be sent to you via email.



# CIGNA PPO LOW OPTION

## DENTAL PPO - LOW PLAN BENEFITS

## WHAT YOU PAY

|   | Advantage Network           | In Network*      | Out of Network*  |
|---|-----------------------------|------------------|------------------|
| <b>Plan Maximums</b>  |                             |                  |                  |
| Calendar Year Deductible (Single/Family)  | \$25/\$75                   |                  |                  |
| Calendar Year Maximum Benefit   | \$1,000 + Progressive Max** |                  |                  |
| Orthodontia Lifetime Maximum  | Not Covered                 |                  |                  |
| <b>Preventive Procedures</b>  |                             |                  |                  |
| Oral Examinations, X-rays (Bitewing or Full Mouth), Cleanings   | 0%                          | 0%               | 0%               |
| <b>Basic Procedures</b>   |                             |                  |                  |
| Fillings, Endodontics (Root Canal Therapy), Periodontics, Sealants, Simple Oral Surgery, Simple Extractions | 10% <sup>1</sup>            | 15% <sup>1</sup> | 15% <sup>1</sup> |
| <b>Major Procedures</b>   |                             |                  |                  |
| Crowns, Inlays, Onlays, Cast Restorations, Bridges, Dentures  | 40% <sup>1</sup>            | 50% <sup>1</sup> | 50% <sup>1</sup> |
| <b>Orthodontic Procedures</b>   |                             |                  |                  |
| Orthodontia (Child & Adult)   | Not Covered                 |                  |                  |

<sup>1</sup>Calendar Year Deductible Applies

\*Reimbursement is based on PPO contracted fees for PPO dentists, and Out-of-Network reimbursement is based on provider charges at the 50<sup>th</sup> percentile.

\*\* Each family member needs to complete preventive services to receive the increased maximum the following year. The Progressive Max is \$150 per year with a 3 year maximum.

**Sign up as a member online to print ID cards, locate providers, and view benefits and claims.**

[www.mycigna.com](http://www.mycigna.com)

# CIGNA PPO HIGH OPTION

## DENTAL PPO -HIGH PLAN BENEFITS

## WHAT YOU PAY

|   | In Network*                 | Out of Network*  |
|---|-----------------------------|------------------|
| <b>Plan Maximums</b>  |                             |                  |
| Calendar Year Deductible (Single/Family)  | \$25/\$75                   |                  |
| Calendar Year Maximum Benefit   | \$1,500 + Progressive Max** |                  |
| Orthodontia Lifetime Maximum  | \$1,500                     |                  |
| <b>Preventive Procedures</b>  |                             |                  |
| Oral Examinations, X-rays (Bitewing or Full Mouth), Cleanings   | 0%                          | 0%               |
| <b>Basic Procedures</b>   |                             |                  |
| Fillings, Endodontics (Root Canal Therapy), Periodontics, Sealants, Simple Oral Surgery, Simple Extractions | 10% <sup>1</sup>            | 10% <sup>1</sup> |
| <b>Major Procedures</b>   |                             |                  |
| Crowns, Inlays, Onlays, Cast Restorations, Bridges, Dentures  | 40% <sup>1</sup>            | 40% <sup>1</sup> |
| <b>Orthodontic Procedures</b>   |                             |                  |
| Orthodontia (Child & Adult)   | 50%                         |                  |

<sup>1</sup>Calendar Year Deductible Applies

\*Reimbursement is based on PPO contracted fees for PPO dentists, and Out-of-Network reimbursement is based on provider charges at the 90<sup>th</sup> percentile.

\*\* Each family member needs to complete preventive services to receive the increased maximum the following year. The Progressive Max is \$150 per year with a 3 year maximum.

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

[www.mycigna.com](http://www.mycigna.com)



# HMO OR PPO DENTAL?

Choosing the right dental plan can be challenging. Everyone's needs are different, and each dental plan works differently. Use this tool to help compare HMO and PPO dental plans. For additional support, contact our Employee Support Center at (855) 670-2222 or by email at [LosAngeles.ESC@ajg.com](mailto:LosAngeles.ESC@ajg.com).

|                                  | DHMO   | DPPO   |
|----------------------------------|--|--|
| <b>Premium</b>                   | Lower  | Higher   |
| <b>Can I see any Dentist?</b>    | No, you must only see DHMO dentists.   | Yes, you can see any dentist in or out of network.   |
| <b>Can I see any specialist?</b> | No, you must receive a referral from you Dentist.                                  | Yes, you can see any specialist in or out of network and self-refer.   |
| <b>Annual Maximum</b>            | No maximum, as long as you can pay the copays the plan will continue to cover you. | The PPO insurance will cover up to \$1,500. Once this maximum has been met, your plan will turn off for the rest of the calendar year. |



***Always contact Cigna ahead of time to confirm if a procedure is covered on your plan and what your out of pocket cost will be before having the service done!***

# CIGNA DENTAL HMO & PPO TOOLS

## Convenience at your fingertips

Cigna has launched new online tools to assist you with dental care decisions. The new technology offers the same transparencies and tools that customers expect in every part of their lives: convenient online scheduling, insightful customer reviews to guide smart decisions, transparent pricing to avoid surprise charges, etc.

*This innovative technology is available on Cigna.com, myCigna.com, and the mobile app.*

| Dentist Name   | Brighter Score | Checkup - Adult |
|----------------|----------------|-----------------|
| Smith, Susan   | 9.3/10         | \$0             |
| Doe, John      | 7.9/10         | \$100           |
| Stuart, Andrew | 8.4/10         | \$0             |

- **Brighter Score™ ranking.** Use this scoring method to compare dentists. The score is derived from factors such as affordability, patient experience and professional history. This is a third-party tool, developed by Brighter.com.
- **Dental office reviews and comparisons.** Find detailed information to compare dental offices. View dentist profiles with pictures and video content. Read verified patient reviews.
- **Online appointment scheduling.** Book an appointment online with participating dentists.\*
- **Enhanced search and transparent pricing.** Search for a dentist by a procedure or group of procedures. Information is personalized for your specific plan. Shows “all-in” price including coinsurance / copays and deductibles.
- **Easy access.** These features are available anytime, anywhere. 24/7 access on the go – on mobile phones or tablets.

For illustrative purposes only



**The all-new myCigna Mobile App gives you a simple way to personalize, organize, and access important dental information—on the go.**

**myCigna Mobile App**  
Your Health Has Met Its App.®

The myCigna Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere. Download it today.

- Find a doctor, dentist or health care facility
- View ID card information for the entire family
- Review deductibles, account balances and claims
- And, much more!

Get it now:

Download on the App Store | ANDROID APP ON Google play | Available at amazon | Get it at BlackBerry World

# MYCIGNA

Make myCigna your personal health place!

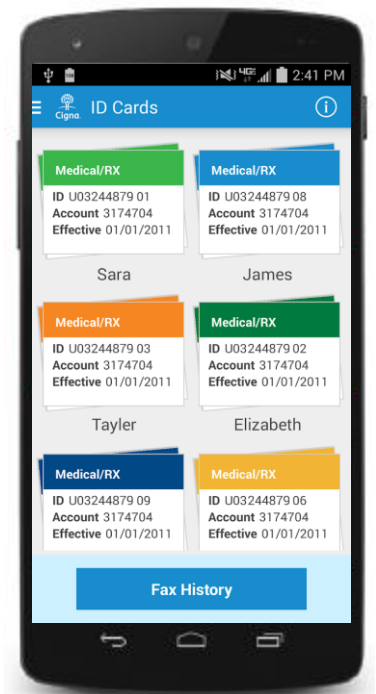
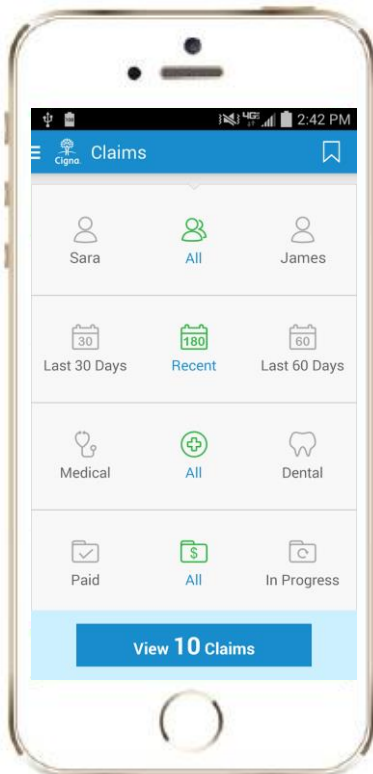
Enjoy a simple way to personalize, organize and access your important plan information.



Register on myCigna.

Once you do, you can log in anytime, anywhere to:

- **Manage** and track claims
- **View** ID card information
- **Find** doctors and compare cost and quality ratings
- **Review** your coverage
- **Track** your account balances and deductibles
- **Refill** your prescription drugs online and check order status with Cigna Home Delivery PharmacySM



**New 1-touch log-in to myCigna**

Now with fingerprint access, the myCigna app makes it easier than ever to stay in-network—and save. Download the app today.



# CIGNA DENTAL PROVIDER SEARCH

Use the below steps to find In-Network dentists, specialists and orthodontists

|               | DENTAL HMO NETWORK   | DENTAL PPO NETWORK   |
|---------------|--|--|
| <b>STEP 1</b> | From the <a href="http://www.cigna.com">www.cigna.com</a> home page, click on “Find a Doctor, Dentist or Facility” at the top right of the screen.                   | From the <a href="http://www.cigna.com">www.cigna.com</a> home page, click on “Find a Doctor, Dentist or Facility” at the top right of the screen.   |
| <b>STEP 2</b> | Under “Choose a plan type to search,” select “Plans through your employer or school”   | Under “Choose a plan type to search,” select “Plans through your employer or school”   |
| <b>STEP 3</b> | On the next screen enter your Zip code or City in the box under “Search Location”. Select the type of provider, provider name, or location type you are looking for. | On the next screen enter your Zip code or City in the box under “Search Location”. Select the type of provider, provider name, or location type you are looking for.                           |
| <b>STEP 4</b> | Under “Select a Plan,” select the “ <b>Cigna Dental Care Access (formerly Cigna Dental Care HMO)</b> ” link.   | Under “Select a Plan,” select the “ <b>Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)</b> ” link. To located just Advantage Dentists, select the “ <b>Cigna DPPO Advantage</b> ” link. |
| <b>STEP 5</b> | A list of contracted providers will be generated.  | A list of contracted providers will be generated.  |



If you would like provider search assistance, please contact the Employee Support Center at (855) 670-2222 or by email at [LosAngeles.ESC@ajg.com](mailto:LosAngeles.ESC@ajg.com)

# CIGNA VISION PLAN

| VISION PLAN BENEFITS                               | WHAT YOU PAY                             |  |
|--|--|--|
|  | In Network                               | Out of Network                               |
| <b>Exams</b>                                       |  |  |
| Vision Exam<br>(every 12 months)                   | \$10                                     | Reimbursement up to: \$45                    |
| <b>Lenses</b>                                      |  |  |
| Single<br>Bifocal<br>Trifocal<br>(every 12 months) | \$10                                     | Reimbursement up to:<br>\$40<br>\$65<br>\$75 |
| <b>Frames</b>                                      |  |  |
| Frames<br>(every 12 months)                        | \$150 allowance, then 20%<br>off balance | Reimbursement up to:<br>\$83                 |
| <b>Contacts (In Lieu of Glasses)</b>               |  |  |
| Medically Necessary<br>(every 12 months)           | Covered in full                          | Reimbursement up to:<br>\$210                |
| Elective<br>(every 12 months)                      | \$150 allowance                          | Reimbursement up to:<br>\$120                |

Sign up as a member online to print ID cards, locate providers, and view benefits and claims.

[www.mycigna.com](http://www.mycigna.com)

# CIGNA VISION PROVIDER SEARCH

Use the below steps to find In-Network optometrists and retailers.

| CIGNA VISION NETWORK |  |
|----------------------|--|
| TO BEGIN             | Visit <a href="http://www.cigna.com">www.cigna.com</a>   |
| STEP 1               | Click on <i>Find a Doctor, Dentist or Facility</i> .   |
| STEP 2               | Under “Additional Directories” select <b>Cigna Vision Directory</b> .  |
| STEP 3               | Enter your <i>City, State and Zip Code</i> . You may also pre-fill the additional options to narrow your search.         |
| STEP 4               | Once you press “Search” you will get a listing of providers. You can refine your search results after you get a listing. |





# FLEXIBLE SPENDING ACCOUNTS

## What is an FSA?

An FSA is an account that allows you to set aside money, before taxes, to use on eligible health care and dependent care expenses. You elect how much you want to contribute, and your employer deducts the amount from your paychecks for the plan year. Since you use pretax dollars you lower your taxable income, and you use tax-free money for expenses.

## Health Care Reimbursement FSA

*The annual maximum contribution to the Health Care Reimbursement FSA is \$2,750.*

The Health Care Reimbursement FSA allows you to pay for certain health care services and items for you, spouse and dependents. These are items such as:

- Prescriptions, Co-pays, Dental care, Vision care, & Certain over-the-counter items, and medications

## Dependent Care Reimbursement FSA

*The annual maximum contribution to the Dependent Care Reimbursement FSA is \$5,000.*

The Dependent Care Reimbursement FSA allows you to use pre-tax dollars toward qualified dependent care. Care must be for a tax-dependent child under age 13 who lives with you, or a tax-dependent, spouse or child who lives with you and is incapable of caring for themselves. Also, the care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours and cannot be provided by another of your dependents. Typical expenses include:

- Before- and after-school care, Daycare, preschool, nursery school, and Adult day care

## “Use-It-or-Lose-It” Rule

The Health Care and Dependent Care Reimbursement FSAs run on a calendar basis. The current plan year is from July 1, 2020 through June 30, 2021; claims can only be for services/expenses incurred in 2020-2021 plan year. Any funds left unclaimed will be forfeited. Felton Institute has elected to offer a \$550 rollover option for Health Care Reimbursement, which will allow you to roll over up to \$550 of unused contributions into the next plan year.

## Run-Out Period

Due to COVID-19, Felton Institute will provide additional time for employees to submit claims for reimbursement under the plan’s generally applicable claims procedures; essentially extending the run-out period for the FSA until the end of the outbreak.

## Commuter Benefits

Felton Institute provides a benefit to allow employees to set aside pre-tax compensation for transportation that includes fees paid at or near your workplace. Transit maximum contributions are set by the IRS and are generally adjusted annually for inflation. In 2020, IRS has set the maximum transit monthly contributions at \$270 per month.



Have leftover funds at the end of the year?  
Visit [www.fsastore.com](http://www.fsastore.com) to purchase FSA-eligible items before the end of the plan year, and also review the updated FSA Eligibility list.



## Why should I enroll in an FSA?

Calculate your potential savings:

<https://fsastore.com/services/FSACalculator.aspx>

# FSA WORKSHEET

When determining how much you would like to contribute to your Flexible Spending Account, you should keep in mind the following:

- In most cases, an employee may not make a mid-year change in the amount he or she has elected to contribute to a Flexible Spending Account.
- Money remaining in a Flexible Spending Account at the end of the plan year must be forfeited.
- Over-the-counter medicines and drugs (other than insulin) are only reimbursable if accompanied by a prescription.

This worksheet can be used to estimate how much you should elect to contribute to your Flexible Spending Accounts.

## Health Flexible Spending Account

### Expenses not covered by insurance may include:

|   |    |
|---|----|
| Deductibles, coinsurance or copayments  | \$ |
| Dental care (exams, fillings, crowns)   | \$ |
| Hearing care (exams, hearing aids and batteries)                              | \$ |
| Infertility treatment   | \$ |
| Insulin and diabetic supplies   | \$ |
| Prescription drugs (e. g. generic, brand, formulary, injectables)             | \$ |
| Transportation expenses (to receive medical care)                             | \$ |
| Vision care (exams, contacts, eyeglasses, laser surgery)                      | \$ |
| Weight loss program (done at doctor's direction to treat an existing disease) | \$ |
| <b>Total:</b>   | \$ |

### Dependent Care Flexible Spending Account

Annual maximum allowable expense of \$5,000

\$

### Total pre-tax contributions to Flexible Spending Accounts:

\$



# COMMUTER BENEFITS PROGRAM



## HOWA COMMUTER BENEFITS PROGRAM WORKS

Participant's use money in their TAG Commuter Benefits Account for all eligible work-related transit and parking expenses. Each paycheck, participant's elect to set aside a portion of pay, before taxes, to use for eligible transit and/or parking expenses.

Since the money used to fund the program isn't taxed, you save between 25% and 40% on every purchase. If, for example, you spend \$200 a month on your commute, you can save nearly \$1,000 per year with the program.

**The maximum allowable contribution is \$270 per month.**

## EXPENSES A COMMUTER PROGRAM CAN HELP PAY FOR

The great thing about a commuter program is that it covers just about every possible way you can travel to and from work. The simple rule is that if you take a form of public transit to work, park and ride, or park near work, you can save.

- Bus, light rail, regional rail, trolley, subway or ferry
- Vanpool, RideShare (uberPOOL / LyftLine)
- Parking at or near work
- Parking at or near public transportation for your commute

## USING A COMMUTER PROGRAM IS EASY

When signing up for the program, you determine the amount of parking and/or transit expenses you would like deducted each pay period. As the amount is deducted from each paycheck, the money is put into your account and is available to use for eligible expenses. Accessing account funds is easy:



**REIMBURSEMENT REQUEST.** File a claim online, by fax or mail for reimbursement.



**MOBILE APP.** Use your smart phone to view your account information.



SIMPLE & EASY  
DOWNLOAD THE  
"MYFLEX" APP TODAY!

  
THE ADVANTAGE GROUP

CONTACT A  
TAG REPRESENTATIVE:



BY PHONE:  
(877) 506-1660



BY EMAIL:  
support@enrollwithtag.com

[www.enrollwithtag.com](http://www.enrollwithtag.com)

# COMMUTER BENEFITS PROGRAM FAQ

## What are Transit and Parking Accounts?

The Transportation Equity Act for the 21<sup>st</sup> Century allows you to save taxes on your transit and parking expenses related to your daily commute to work. There is one account for each type of expense: a Transit Account and a Parking Account.

## How do I Save Money?

Because your account deductions are pretax, you can save on the out-of-pocket commuting and parking expenses that you incur. Your money goes further because you never have to pay tax on the money set aside for these accounts.

## What are the Maximum Contributions?

The IRS limits the amount of funds that you can contribute and be reimbursed with these accounts. Currently the 2020 limits are:

- Transit Account is \$270 per month
- Parking Account is \$270 per month

If you don't spend all the money you set aside, you may carry it forward to a future month for qualified expenses. Amounts remaining in accounts upon your termination are forfeited.

## When do I get reimbursed?

The Advantage Group (TAG), our plan administrator, pays all claims according to a schedule established the company. TAG processes all claims within one business day of receipt. Unless your claim is denied, you can expect to receive reimbursement on our next scheduled payout date.

In Transit and Parking Accounts, since claims are reimbursed based on what has been deducted from your paycheck and services fully rendered, there may be a delay in getting claims reimbursed. You can minimize this by submitting claims in a timely manner.

**How does money get into my account?** You choose the *monthly* amount you want to contribute to each account. Each pay period, your contributions to the account are deducted from your paycheck and applied to your account. You may change your election for future pay periods by contacting TAG.

## What commuting expenses are eligible?

Transit expenses include mass transit costs, such as trains, subways and buses. Parking expenses include costs for parking at mass transit facilities, parking lots at (or near) your work or where you access your car/vanpool.

## How do I get reimbursed?

Step 1: Submit a reimbursement claim through TAG's website or via fax or mail.

Step 2: Include required documentation for expense verification purposes

Step 3: Receive reimbursement via direct deposit or mailed check.

*Note: Expenses must be submitted within 180 days from date of purchase to be eligible for reimbursement.*

## Additional Information:

- Access your account by visiting [www.myflexonline.com](http://www.myflexonline.com)
- For account support please call (877) 506-1660 or email [support@enrollwithtag.com](mailto:support@enrollwithtag.com)
- For additional information about commuter program benefits please visit [www.enrollwithtag.com](http://www.enrollwithtag.com)



# ONLINE ACCOUNT SETUP INSTRUCTIONS

## Online Account Services

All active participants have access to their online account features at [www.myflexonline.com](http://www.myflexonline.com). Your online account provides fast and easy access to all of your accounts activities. Users can view up-to-date account balance information, pending claims status, claims history, and submit for claims reimbursement from your personal account page.

## New User Setup Instructions

1. Logon to [www.myflexonline.com](http://www.myflexonline.com) and select [New User Registration](#).

2. You will be prompted to enter your name, home zip code and the last four digits of your SSN. Select [Next](#) and create your username and password.

3. Your login is now established and you will be directed to your personal account page where you can view up to date account information and access a variety of additional account features.





# BASIC LIFE INSURANCE

This benefit is paid for 100% by Felton Institute. There is no cost to you, the employee.

All benefit eligible employees with Felton Institute are provided with employer-paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans.

## Employee Basic Life Insurance

- Benefit amount of:
  - \$50,000 (non-SEIU)
  - 1x annual salary (SEIU only)

## Accidental Death and Dismemberment (AD&D)

- 100% of the Basic Life benefit
- Provides specified benefits for a covered accidental bodily injury that directly causes dismemberment.
- In the event of death that occurs from a covered accident, both Life and AD&D benefit would be payable each in the amount of the basic life insurance.

## Benefits After Age 65

Your life benefits will reduce after age 65, and the reduction schedule is as follows:

- Reduce by 35% at age 65
- Reduce by 50% at age 70

Refer to the MetLife plan documents for a complete description of this plan.



Consider updating your Life Insurance beneficiary by completing a Beneficiary Designation form





# SUPPLEMENTAL LIFE INSURANCE

This benefit is paid for 100% by the employee.

As an added benefit, Felton Institute offers Supplemental Life and Accidental Death & Dismemberment (AD&D) insurance for employees, their spouse, and child(ren). This benefit is voluntary and paid for 100% by eligible employees through payroll deductions. **Employees must elect Voluntary Life/AD&D coverage for themselves in order to be eligible to purchase additional coverage for any dependents.**

## Supplemental Employee Life/AD&D

Employees may purchase additional coverage in \$10,000 increments not to exceed the lesser of 5x annual salary or \$500,000

- Guaranteed Issue amount\* of \$100,000

## Supplemental Spouse Life/AD&D

You may purchase additional coverage for your spouse in \$5,000 increments to the lesser of 50% of employee coverage or \$250,000

- Guaranteed Issue amount\* of \$25,000

## Supplemental Child(ren) Life/AD&D

You may purchase additional coverage for your child(ren) in the following amounts:

- 15 days or younger - \$250
- 15 days to 6 months - \$1,000
- 6 months to 26 years (if you are a full-time student) \$ \$10,000



Refer to the MetLife plan documents for a complete description of this plan.

**\*If you choose to elect an amount over the guaranteed issue amount, you or your spouse will need to complete the Evidence of Insurability Form for medical underwriting purposes.**

# WORKSITE VOLUNTARY BENEFITS

**This benefit is paid for 100% by the employee.**

## CRITICAL ILLNESS INSURANCE

A new Insurance Option Brought to You by MetLife.

What's a critical illness? Some common examples are heart attack, stroke and cancer. But this coverage also includes serious conditions like permanent paralysis – the kind of injury that can happen to a healthy person in a car or skiing accident, for example. The medical treatment for these conditions can be very expensive. Critical illness insurance can help by paying a lump sum payment directly to you at the first diagnosis of a covered condition. You decide how to spend it. You can use this coverage more than once for different conditions, but each condition is payable once per lifetime.

- Lump sum payment to use as you see fit upon diagnosis verification
- **You have a choice of a \$10,000, \$20,000 or \$30,000 Initial Benefit Amount**
- Your Total Benefit Amount will be **3 times** the Initial Benefit Amount you selected
- Recurrence benefit\*
- Guaranteed issue coverage
- No waiting periods or age restrictions
- No limitations between filing claims for covered conditions
- No pre-existing condition
- Same level of coverage for the entire family\*
- Portable (continuation of coverage)

### Covered Conditions

- Cancer\*
- Heart Attack
- Stroke\*
- Major Organ Transplant
- Alzheimer's Disease\*
- Coronary Artery Bypass Graft\*
- Kidney Failure
- Plus 22 Listed Conditions\*



**\*Please refer to the MetLife Plan Documents for a complete description of this plan.**

# WORKSITE VOLUNTARY BENEFITS

This benefit is paid for 100% by the employee.

## GROUP HOSPITAL INDEMNITY INSURANCE

A new Insurance Option Brought to You by MetLife.

MetLife provides employees with a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive.

| Covered Benefits *   | High Plan<br>MetLife Hospital Indemnity Insurance<br>Pays YOU        |
|--|--|
| <b>Hospital Coverage (Accident)</b>  |  |
| <b>Admission</b><br>must occur within 180 days of accident   | Non-ICU - \$1,000 per accident<br>ICU - 2,000 per accident           |
| <b>Confinement</b><br>must occur within 180 days of accident   | Non-ICU - \$200/day up to 31 days<br>ICU - \$400/day up to 31 days   |
| <b>Inpatient Rehab</b><br>stay must occur immediately following hospital confinement and occur within 365 days of accident | \$200 day, up to 15 days per accident and 30 days per calendar year  |
| <b>Hospital Coverage (Sickness)*</b>   |  |
| <b>Admission</b><br>Payable 1x per calendar year   | Non-ICU - \$1,000<br>ICU - \$2,000                                   |
| <b>Confinement</b><br>Paid per sickness  | Non-ICU - \$200/day, up to 31 days<br>ICU - \$400/day, up to 31 days |



\*Please refer to the MetLife Plan Documents for a complete description of this plan.

# WORKSITE VOLUNTARY BENEFITS

MetLife provides employees with a choice of two comprehensive Accident plans which provide payments in addition to any other insurance payments you may receive.

## ACCIDENT PLANS: Low Plan and High Plan

| Covered Benefits                                 | Low Plan<br>MetLife Accident Insurance<br>Pays YOU                       | High Plan<br>MetLife Accident Insurance<br>Pays YOU                      |
|--|--|--|
| <b>Injuries</b>                                  |  |  |
| Fractures <sup>2</sup>                           | \$50-\$3,000   | \$100-\$6,000  |
| Dislocations <sup>2</sup>                        | \$50-\$3,000   | \$100-\$6,000  |
| Second and Third Degree Burns                    | \$50-\$5,000   | \$100-\$10,000   |
| Concussions                                      | \$200  | \$400  |
| Cuts/Lacerations                                 | \$25-\$200   | \$50-\$400   |
| Eye Injuries                                     | \$200  | \$300  |
| <b>Medical Services &amp; Treatment</b>          |  |  |
| Ambulance  | \$200-\$750  | \$300-\$1,000  |
| Emergency Care                                   | \$25-\$50  | \$50-\$100   |
| Non-Emergency Care                               | \$25   | \$50   |
| Physician Follow-Up                              | \$50   | \$75   |
| Therapy Services<br>(including physical therapy) | \$15   | \$25   |
| Medical Testing Benefit                          | \$100  | \$200  |
| Medical Appliances                               | \$50-\$500   | \$100-\$1,000  |
| Inpatient Surgery                                | \$100-\$1,000  | \$200-\$2,000  |
| <b>Hospital<sup>3</sup> Coverage (Accident)</b>  |  |  |
| Admission  | \$500 (non-ICU)-\$1,000 (ICU) per<br>accident                            | \$1,000 (non-ICU)-\$2,000 (ICU) per<br>accident                          |
| Confinement                                      | \$100 a day (non-ICU)- up to 31 days<br>\$200 a day (ICU)- up to 31 days | \$200 a day (non-ICU)- up to 31 days<br>\$400 a day (ICU)- up to 31 days |
| Inpatient Rehab<br>(paid per accident)           | \$100 a day, up to 15 days   | \$200 a day, up to 15 days   |

<sup>2</sup>Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit

<sup>3</sup>Hospital does not include certain facilities such as nursing homes, convalescent care or extend care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.





# EMPLOYEE ASSISTANCE PLAN (EAP)

All members of your household can utilize the benefits of this program.

All benefit eligible employees with Felton Institute are provided with employer paid Employee Assistance Plan (EAP) through MetLife. All eligible employees are automatically enrolled in the EAP.

Life is full of challenges and sometimes balancing it is difficult. The EAP is there when you need it. MetLife offers the appropriate assistance for a wide range of issues and provides referrals to professional counselors or services that can help you resolve emotional health, family and work issues.

**Along with unlimited telephonic access, the EAP also offers 5 face-to-face visits with a counselor per person per issue.**

Work or Life Needs, Clinical Counseling, Financial Information, Legal Information, etc.

## TOTALLY CONFIDENTIAL



Member Services  
Available 24/7

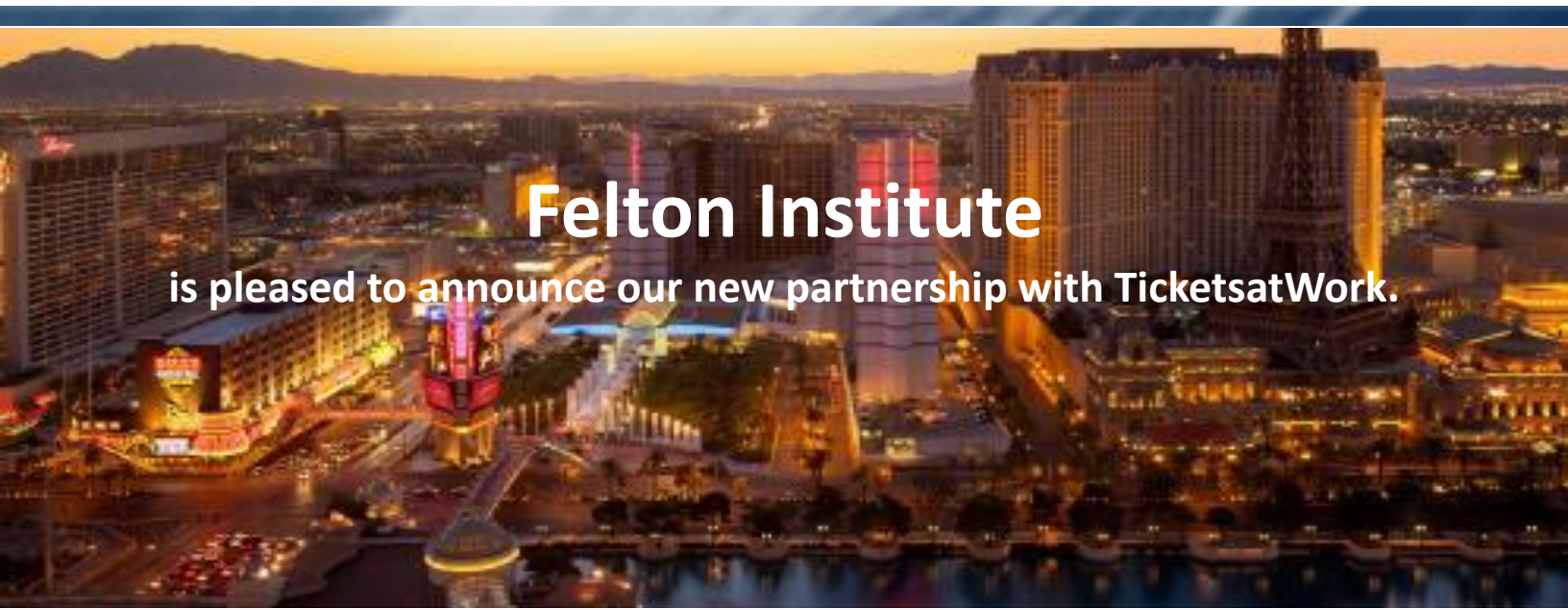
Online: [metlifeeap.lifeworks.com](https://metlifeeap.lifeworks.com)

Username: **metlifeeap**

Password: **eap**

Toll free: **888-319-7819**

# TICKETS AT WORK



## Felton Institute

is pleased to announce our new partnership with TicketsatWork.

Now you'll have access to exclusive savings on:

- Movie Tickets
- Theme Parks
- Hotels
- Tours
- Broadway
- Vegas Shows & More



Be sure to visit often as new products and discounts are constantly being added!

### SIGN UP TODAY IN 60 SECONDS!

- 1 Visit [www.ticketsatwork.com](http://www.ticketsatwork.com).
- 2 Click on the **"Become a Member"** box at the top of the homepage.
- 3 You will then be prompted to create an account with you email address and company code.
- 4 Or, you can place your order by phone. Call customer service at **800-331-6483**. Orders are taken from **8:30am-12am/7 days a week** (holidays included). Eastern Standard Time.

**MEMBERS  
HAVE MORE  
FUN!**

Company Code: feltonfun  
Customer Service: 1-800-331-6483  
Email: [customerservice@ticketsatwork.com](mailto:customerservice@ticketsatwork.com)





# PET CARE PLAN

This benefit is paid for 100% by the employee.

Felton Institute is pleased to offer our employees the opportunity to save on their veterinary care with United Pet Care’s veterinary savings program. This program includes preventative, accident and sick care. Employees receive instant savings of 20-50% off every veterinary visit! United Pet Care features no claim forms, no costly deductibles, no waiting period, no age exclusions and no exclusions due to pre-existing or breed specific conditions. **ALL PETS ARE ELIGIBLE!**



| UNITED PET CARE PROGRAMS  | PREFERRED PROGRAM                                  | SELECT PROGRAM | PARTNER PROGRAM     |
|---|--|----------------|---------------------|
| <b>Procedures Covered:</b>  | <b>Employee Payment (\$)/ Employee Savings (%)</b> |                |                     |
| Office Visits   | 50%  | \$40           | 25%                 |
| Annual Exams  | 50%  | 20%            | 25%                 |
| Vaccinations  | 50%  | 20%            | 25%                 |
| All Surgeries/Hospitalization   | 25%  | 20%            | 25%                 |
| Dental Cleaning/Extractions   | 25%  | 20%            | 25%                 |
| Diagnostic Testing/Lab Work   | 25%  | 20%            | 25%                 |
| Allergies/Infections  | 25%  | 20%            | 25%                 |
| Radiology   | 25%  | 20%            | 25%                 |
| Medications   | 25%  | 20%            | In house only – 25% |
| Spay/Neuter   | 25%  | 20%            | 25%                 |
| Puppy/kitty<br>(Under age 1 year, series of vaccinations including rabies- may vary with each facility) | 25%  | 20%            | 25%                 |

| SPECIAL SEMI-MONTHLY RATES FOR FELTON INSTITUTE EMPLOYEES | PREFERRED PROGRAM | SELECT PROGRAM | PARTNER PROGRAM |
|---|-------------------|----------------|-----------------|
| One Pet   | \$6.25            | \$5.38         | \$6.25          |
| Two Pets  | \$12.10           | \$10.30        | \$12.10         |
| Three Pets  | \$17.80           | \$15.15        | \$17.80         |
| Each Additional Pet                                       | \$5.65            | \$4.85         | \$5.65          |

# LEGAL & ID THEFT SERVICES

This benefit is paid for 100% by the employee.



Everyone deserves legal protection. And now, with LegalShield, everyone can access it. Proven, professional advice is just a phone call away on all matters, from the trivial to the traumatic.

## The Legal Plan Membership Includes:

- Legal Advice – personal legal issues
- Letters/calls made on your behalf
- Contracts & documents reviewed (up to 10 pages)
- Residential Loan Document Assistance
- Attorneys prepare your Will, your Living Will and your Health Care Power of Attorney
- Moving Traffic Violations (available 15 days after enrollment)
- Trial Defense including Pre-Trial & Trial
- Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
- IRS Audit Assistance
- 25% Preferred Member Discount (Bankruptcy, Criminal Charges, Other Matters, etc.)
- 24/7 Emergency Access for covered situations

## The IDShield<sup>SM</sup> Membership Includes:

- **Full Service Restoration**  
Completed Identity recovery services by Kroll Licensed Private Investigators and our \$5 million service guarantee to ensure that if your identity is stolen, it will be restored to its pre-theft status.
- **Privacy Monitoring**  
Monitoring your name, SSN, date of birth, email address (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.
- **Security Monitoring**  
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle.
- **Consultation**  
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.

**LegalShield Identity Theft plans cover the member, member's spouse and up to 10 dependents.  
You also have the option to select Legal plus Identity Theft Combined Membership.**

## LEGALSHIELD RATES PER PAY PERIOD

| Legal Shield Only | IDShield Plan | LegalShield and IDShield |
|-------------------|---------------|--------------------------|
| \$7.98            | \$7.48        | 12.95                    |

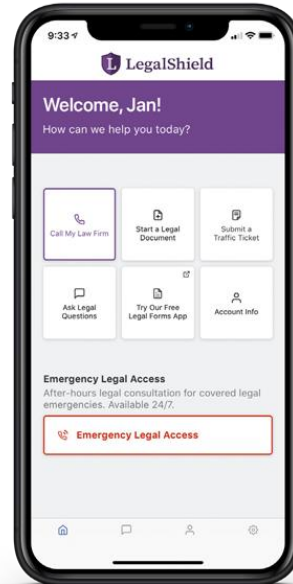
# LEGALSHIELD & IDSHIELD MOBILE APP

Legal protection is just a tap away.

Follow these steps to create your LegalShield account.

## Create your LegalShield account

1. **Download** the LegalShield mobile app.
2. **Click "Create Account"** followed by "Activate Account." Enter your member number and requested information, then create your login credentials.
3. **Open** the LegalShield app and login with your newly created credentials. Access your provider law firm, Will preparation steps and more!



Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are trademarks of Google Inc.

Guarding your personal information is as EASY as 1-2-3!

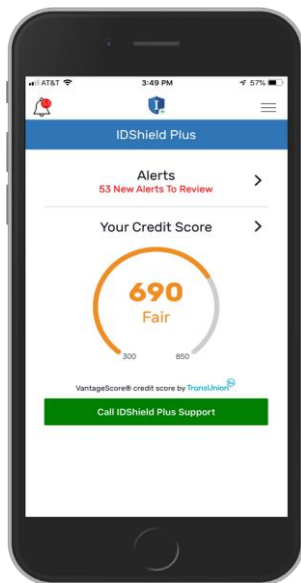
Follow these steps to activate your IDShield account.

## Create your IDShield account

1. **SET UP** your account at [idshield.cloud/activate](https://idshield.cloud/activate) using your member number.
2. **ADD** the personal information you want to monitor, including your social media accounts.
3. **DOWNLOAD** the IDShield Plus mobile app for immediate alerts and to track your monthly credit score.



Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are trademarks of Google Inc.



If you have questions about setting up your account or forgot your member number, please call call LegalShield Member Services at 1-800-654-7757 or IDShield Member Services at 1-888-494-8519, available 7 a.m. - 7 p.m. CT, Monday-Friday.

# HEALTH INSURANCE MARKETPLACE

## Notice of Medical Coverage Options:

## THE NEW HEALTH INSURANCE MARKETPLACE

Under federal law, beginning January 1, 2014, individuals are required to have minimum essential health coverage, or else be subject to a penalty. This is referred to as the “individual mandate.” Covered California is intended to help individuals meet the individual mandate requirement by providing another marketplace to purchase coverage, and possibly qualify for federal assistance. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) may opt out of the employer plan during their renewal period and go to Covered California to purchase health insurance (note employers are not required to pass on their employer contribution towards an employee's coverage election in Covered California). Based upon your specific income level and household size, you may receive more affordable coverage for yourself and/or dependents through Covered California. Individuals who have insurance through their employers (or who are eligible for insurance through their employers) are not eligible for federal assistance through the individual mandate.

The Covered California website will help people find out whether they qualify for federal financial assistance that will reduce their costs for medical coverage. Depending on your income and family size, you could be eligible for no-cost Medi-Cal or for tax credits to help reduce your monthly premium costs. You do not need to purchase coverage through Covered California if you already have medical coverage. However, you have the option to do so if you wish.

If you are interested in looking at the plans and potential costs with Covered California medical plans, please visit the link below. By using the “Health Plan Calculator,” you can see what your options are and how much coverage would likely cost you.

<http://www.coveredca.com/fieldcalc/#calculator>

If you have questions, please visit the Covered California website at [www.coveredCA.com](http://www.coveredCA.com)

If you can afford health insurance but choose not to buy it, you must pay a fee called the individual shared responsibility payment. To calculate your estimated penalty if you choose not to elect health coverage, visit: <https://www.healthcare.gov/fees/estimate-your-fee>



# IMPORTANT EMPLOYEE NOTIFICATIONS

## Model General Notice Of COBRA Continuation Coverage Rights

Introduction: You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?: COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.



# IMPORTANT EMPLOYEE NOTIFICATIONS

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?: The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation coverage provided?: Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

1. Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

2. Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.



# IMPORTANT EMPLOYEE NOTIFICATIONS

Are there other coverage options besides COBRA Continuation Coverage?: Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions: Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

Keep your Plan informed of address changes: To protect your family's rights, let the Plan Administrator know about 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.

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Contact your Benefits Administrator for more information.

# IMPORTANT EMPLOYEE NOTIFICATIONS

## Newborns' and Mother's Health Protection Act of 1996

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

## Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Sutter Health and Kaiser. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to July 1, 2020.

For more information, contact Sutter Health and Kaiser.

## Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Benefits Administrator.

## Lifetime Limit No Longer Applies and Enrollment Opportunity

The lifetime limit on the dollar value of benefits under Sutter Health and Kaiser no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment.

For more information, contact Sutter Health and Kaiser.

## Primary Protection

Sutter Health generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Sutter Health designates one for you.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Sutter Health.

You do not need prior authorization from Sutter Health or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Sutter Health.

# IMPORTANT EMPLOYEE NOTIFICATIONS

## Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

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

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877- KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

## Out of Network Balance Billing

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out of network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out of network provider. Your out of network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

## Prescription Drug Coverage and Medicare Part D

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

# IMPORTANT EMPLOYEE NOTIFICATIONS

2. Felton Institute has determined that the prescription drug coverage offered by Sutter Health and Kaiser is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Felton Institute coverage may be affected.

If you decide to join a Medicare drug plan and drop your current Felton Institute coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Felton Institute and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact the person listed below for further information. Note: you will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Felton Institute changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. Additional resources: [www.medicare.gov](http://www.medicare.gov). Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; Call **1-800-663-4227 (TTY 1-877-486-2048)**. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Am I eligible for Medicare if I am under 65? There are three ways you can get Medicare coverage if you are under 65 years of age.

1. You are eligible for Medicare if you are a U.S. citizen or have your resident visa, have lived in the U.S. for five years in a row, and you have a disability and have been receiving Social Security Disability Insurance (SSDI) for more than 24 months. Your eligibility begins during the month you receive your 25th SSDI check. You do not need to contact anyone. Social Security should automatically mail you your Medicare card three months before you become eligible.

**Note:** If you are receiving railroad disability annuity checks, whether you are eligible for Medicare and when you get it, depends on how your disability has been classified by the Railroad Retirement Board.

# IMPORTANT EMPLOYEE NOTIFICATIONS

OR

2. You have been diagnosed with End-Stage Renal Disease (ESRD) and you are getting dialysis treatments or have had a kidney transplant; apply for Medicare benefits (up to 12 months retroactively); and you

- are eligible to receive SSDI;
- are eligible to receive railroad retirement benefits; or
- are otherwise considered to be fully insured by Social Security, as defined by the length of time you have worked and the amount of money you have made (you need a certain amount of Social Security work credits depending on how long you have worked).

**Note:** If you are a railroad worker with ESRD, you must contact Social Security, not the Railroad Retirement Board, to find out if you are eligible for Medicare because you have been diagnosed with ESRD.

When your Medicare benefits begin depends on the circumstance.

OR

3. You have been diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's Disease. You will automatically be enrolled in Medicare the first month you receive SSDI or, if you are a railroad worker, the first month you receive a railroad disability annuity check.

**Note:** Because Social Security and Medicare eligibility rules are complex, you should call Social Security at **800-772-1213** to get the most accurate information regarding your particular situation.

|                 |  |
|-----------------|--|
| Sender:         | Human Resources Department                       |
| Name of Entity: | Felton Institute   FSA                           |
| Address:        | 1005 Atlantic Ave., Alameda, CA 94501            |
| Phone Number:   | 415-474-7310                                     |
| Email:          | <a href="mailto:hr@felton.org">hr@felton.org</a> |
| Date:           | July 1, 2020                                     |

*This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of Gallagher Benefit Services (GBS). Policy forms for your reference will be made available upon request.*









# BENEFIT PLAN CONTACT INFORMATION

| Provider   | Coverage Type   | Phone and Web   |
|--|---|---|
|  Sutter Health Plus<br>Your Health Plan | Medical<br>Group# 256204  | Sutter Health<br>855-315-5800<br><a href="http://www.Sutterhealthplus.org">www.Sutterhealthplus.org</a>                                   |
|  KAISER PERMANENTE.                     | Medical<br>Group# 604427  | Kaiser<br>800-464-4000<br><a href="http://www.kp.org">www.kp.org</a>  |
|  LANDMARK<br>HEALTHPLAN™                | Chiropractic & Acupuncture<br>Group# LA0018E*000  | Landmark Healthplan<br>800-298-4875<br><a href="http://www.lhp-ca.com">www.lhp-ca.com</a>   |
|  Cigna.                                 | Dental<br>Group# 3341917  | Cigna<br>800-244-6224<br><a href="http://www.cigna.com">www.cigna.com</a>   |
|  Cigna.                                 | Vision<br>Group# 3341917  | Cigna<br>800-244-6224<br><a href="http://www.cigna.com">www.cigna.com</a>   |
|  MetLife                              | Basic Life/AD&D<br>Supplemental Life/AD&D<br>Voluntary Accident<br>Voluntary Critical Illness<br>Voluntary Hospital Indemnity<br>Group# 5918840 | MetLife<br>800-275-4638<br><a href="http://www.metlife.com">www.metlife.com</a>   |
|  MetLife                              | Employee Assistance Plan (EAP)  | MetLife<br>888-319-7819<br>User ID: metlifeeap<br>Password: eap<br><a href="http://Metlifeeap.lifeworks.com">Metlifeeap.lifeworks.com</a> |
|  THE ADVANTAGE GROUP                   |  take care<br>4000 1234 5678<br>VISA                         | HRA/FSA/Dependent Care<br>The Advantage Group<br>877-506-1660<br><a href="http://www.myflexonline.com">www.myflexonline.com</a>           |
|  LegalShield                          |  IDShield  | Legal/ID Theft<br>Legal Shield<br>800-654-7757<br><a href="http://www.legalshield.com">www.legalshield.com</a>                            |
|  United Pet Care                      | Pet Insurance   | United Pet Care<br>888-781-6622<br><a href="http://www.unitedpetcare.com/felton">www.unitedpetcare.com/felton</a>                         |

**Employee Support Center**  
Call 855.670.2222  
Monday - Friday | 8am - 4pm  
[LosAngeles.ESC@ajg.com](mailto:LosAngeles.ESC@ajg.com)



Prepared by Gallagher Insurance—CA License #0D36879