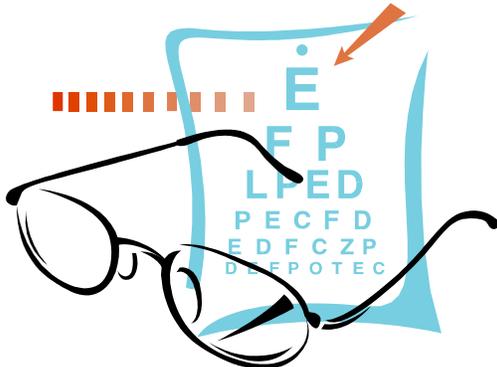


County of Kern



HEALTH BENEFITS ELIGIBILITY POLICY FOR ACTIVE EMPLOYEES



Date: March 2015

To: Kern County Health Benefits Plan Participants

From: Kern County Administrative Office
Health Benefits Division

Subject: Revised Eligibility Policy

This revised Kern County Health Benefits Eligibility Policy was prepared by the County Administrative Office and reviewed by the employee bargaining units through the meet and confer process. The Board of Supervisors approved the original policy on July 9, 1996 and approved revisions on October 29, 1996, August 4, 1997, August 26, 1997, April 21, 1998, October 10, 2000, January 4, 2005, June 29, 2010 January 1, 2011, November 15, 2011, September 11, 2012, June 18, 2013, and March 24, 2015.

Each participant in the plan should carefully review this document to assure understanding of the eligibility rules for Kern County's health benefits plans (medical, dental and vision). Some of the important items to note are:

➔ Employee Responsibilities are listed on page 1.

Please keep this with your other documents relating to your health benefits coverage for future reference or refer to the electronic version at www.KernCountyHealthBenefits.com

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PURPOSE

It is the intention of this policy to provide eligibility guidelines which apply to participants in the County's health plans. While the Employee Benefits Plan Document and the Kern County Policy and Administrative Procedures Manual (Procedures Manual) provide rules regarding eligibility of participants and dependents, they do not adequately address implementation of those rules or related issues which frequently arise in the administration of the plan.

Further, the intent of this policy is to document procedures which will prevent the use of the County's health plans by individuals who are not eligible. The purpose is not to dissuade eligible persons from participating in the County's health care plans, but to prohibit use by ineligible persons by establishing documented minimum requirements for proof of eligibility.

In recognition of the fiduciary responsibility to assure the proper use of public funds, the Kern County Board of Supervisors adopts this policy.

APPLICATION

This policy applies to all participants and potential participants in the County of Kern health plans, regardless of status (e.g., active, COBRA, Family Medical Leave Act ("FMLA") leave, Special District, etc.).

This policy is intended to supplement the Employee Benefits Plan Documents. Any portion(s) which conflict(s) will be governed by this document. Should any eligibility rules established by an insured plan conflict with this policy, the insured plan rules will govern.

MODIFICATION

This policy may be modified at any time by Kern County Board of Supervisors' action, after appropriate meet and confer with the unions or as required by law.

EMPLOYEE RESPONSIBILITIES

Employees are responsible for notifying the CAO-Health Benefits Division of any changes in eligibility for themselves or their dependents. Dependents who become ineligible must be removed by the employee to avoid incurring a financial obligation for benefits received by an ineligible dependent (see section entitled "Important" below). Retroactive refunds of participant contributions will not be made if a dependent is not timely removed, even if coverage is terminated retroactively. Additionally, COBRA rights are lost if ineligible dependents are not removed during the COBRA time limit, which begins on the date they become ineligible.

It is **mandatory** that employees who will be eligible for health benefits participate in a benefits orientation within two (2) weeks of their initial hire date. Because the orientations include information on other benefits, this applies to employees who plan to decline health benefits coverage. An employee's initial hire date is their initial opportunity to enroll themselves and eligible dependents in the health plan. This is further described under "Eligibility Date" and "Definitions" elsewhere in this policy. Health Benefits orientations will be presented by the Health Benefits Division of the County Administrative Office. For questions regarding the orientation, please call (661) 868-3182.

Employees who have disabled dependents age 26 or older are responsible for submitting periodic certifications of the dependent's status and other documentation if requested by the CAO-Health Benefits Division. Failure to timely submit the documentation will cause coverage to be retroactively canceled for the dependent(s).

Important

Important

Covering Ineligible Dependents: Any employee who obtains or continues coverage for any dependent who is not eligible for coverage is subject to disciplinary action up to, and including, dismissal per Civil Service Rule 1700. In addition, such employee will be liable to the County for ① actual claims paid and ② other costs incurred by the County for coverage provided to the ineligible dependent.

Misuse of County-paid coverage: Any employee who obtains or continues County-paid coverage for any dependent who is not eligible for County-paid coverage is subject to disciplinary action up to, and including, dismissal per Civil Service Rule 1700. In addition, such employee will be liable to the County for the amount which would have been paid by the employee if the employee had timely paid for such coverage.

In either instance noted above, at the County's discretion, coverage may be terminated retroactively to the date the dependent became ineligible or the first date the employee failed to pay for coverage. In this instance, all payments made to providers on behalf of such dependent will be refunded to the County plan(s) and the employee will be responsible to the providers as if no health coverage had been in effect. Any employee who does not submit payment for amounts due under the plan is subject to cancellation of benefits.

Employees are responsible for submitting the forms and documents required by the policy. Employees must furnish Social Security numbers for any persons they enroll in any of the County plans. A Social Security number, or official documentation from the Social Security Administration confirming the person is attempting to enroll and is not eligible to receive a Social Security number, must be received before health plan coverage becomes effective. If a Social Security number is not available, other documentation may be required. For newborn dependents, employees must furnish a Social Security number within 90 days of enrolling the newborn in the health plan.

COUNTY RESPONSIBILITIES AND GUIDELINES

It is the County's responsibility to process documents received in a timely manner and adhere to rules established by the Plan Document, the Procedures Manual, and policies adopted by the Board of Supervisors. Situations which are not specifically described by the Plan Document or the policy will be treated in a manner consistent with the policy. Departments must submit accurate termination documentation in a timely manner to avoid continuing charges beyond an employee's termination date. If employment termination documents are not processed timely by a County department, the department will not be refunded any charges made through payroll for the employee's health benefits, regardless of the date the employee's benefits were terminated.

County department heads are required to assure that all newly hired employees, who are eligible for health benefits, participate in a benefits orientation within two (2) weeks of their hire date. Benefits orientations will be presented by the Health Benefits Division of the County Administrative Office. If the employee is unable to participate in orientation within this time frame, the department will contact the Health Benefits Division at (661) 868-3182 to make alternative arrangements.

The Employee Benefits Plan Documents, Procedures Manual, and this Eligibility Policy will be interpreted by the Administrator in accordance with its terms and their intended meaning. If due to errors in drafting, a provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations by the Administrator or other evidence of intention, the provision will be considered ambiguous and will be interpreted by the Administrator in a fashion consistent with its intent.

Delay of enforcement of any of these provisions will not limit the Administrator's authority to require compliance with the policy. Waiver of any provision of this policy will not limit the Administrator's authority to require compliance with other provisions of the policy.

POLICY

ELIGIBLE PARTICIPANTS

Persons eligible for coverage are defined as:

Employees and terminated employees:

- ① elected officials; or
- ② persons employed and paid for services by the County in a probationary, permanent, temporary, provisional or elected/appointed status who work at least 40 hours per bi-weekly payroll period and whose compensation is not fixed at a rate by the day, hour or meeting; or
- ③ persons employed and paid for services by the County as an employee and whose services are rendered pursuant to a contract which specifically designates health benefits are to be provided by the County; or
- ④ persons on leave of absence or suspension who have paid the employee contribution on a timely basis and who were eligible prior to commencing leave of absence or suspension; or
- ⑤ persons eligible for COBRA continuation coverage who have paid for COBRA coverage on a timely basis, or
- ⑥ persons employed by a Special District or other public entity under written agreement with the County for participation in the County's health plans who work at least 40 hours per bi-weekly payroll period and are certified and reported to CAO Health Benefits as eligible by the employing Special District or other public entity within 30 days of date of hire, or
- ⑦ persons designated by Board of Supervisors action.

Dependents:

Dependents include the spouse, registered domestic partner (see definitions below and the "Definitions" section of this policy), or child (see definition below and Definitions) of an employee who:

- ① is not in the active military or like forces of any country or of any subdivision of any country; and
- ② lives in the United States; unless the dependent is a covered student attending school overseas; and
- ③ is not incarcerated; and
- ④ is not excluded as a Dependent Not Eligible (see heading below).

Note that ex-spouses are not eligible and must be removed from coverage immediately upon the date the judgment indicates the divorce is final (the spouses could remarry).

Dependent Definitions:

A '*Child of an Employee*' entitled to coverage is limited to someone who is under the age of 26 or an over-age disabled dependent. Additionally, they must be one of the following: ① the employee's natural-born child, ② the employee's stepchild, ③ a legally adopted child of the employee or employee's spouse or domestic partner, ④ a child placed by a government agency or court order in foster care with the employee or employee's spouse or domestic partner or ⑤ a child for whom the employee has legal guardianship. The relationship of child must be established before the child turns 18.

An '*Over-age disabled dependent*' is a person who is 26 years of age or older who: ① remains unable to work in self-sustaining employment (permanently disabled) by reason of mental or physical disability as certified by a physician and approved by the plan. (Certification must be provided as requested but not more often than annually) and ② remains chiefly dependent upon the employee or employee's spouse or registered domestic partner for support, as defined elsewhere in this policy, and ③ is unmarried and has never been married, and (4) met the definition of a 'child of an employee on the day prior to their 26th birthday and continues to meet the definition of a 'child of an employee except for the age rule. If the dependent is age 26 or over, the dependent must be enrolled in the plan continuously to remain covered. An over-age disabled dependent cannot be re-enrolled at a future date if removed from the plan at any time.

A '**Domestic Partner**' as defined in Article 297 of the California Family Code. The partnership must be registered by filing a Declaration of Domestic Partnership with the Secretary of State.

REQUIRED FORMS/DOCUMENTS

Certain forms and/or documents will be required to establish eligibility. Standard internal forms used by the County will be made available by the CAO-Health Benefits Division. Other forms/documents which are required to determine eligibility are to be supplied at employee's expense. Employees who furnish non-English documents may be required to provide ① authentication which may include, but is not limited to, authentication by the secretary of an embassy or consul; and ② a certified translation.

Stated time limits for submitting forms/documents do not provide for additional delivery time. All forms must be **received by** CAO-Health Benefits Division within the stated time limits.

The County reserves the right to verify the accuracy and validity of any information and/or documents submitted. The CAO-Health Benefits Division **will** conduct audits of forms submitted. Forms may be selected for audit on a random (or other) basis. Employees whose forms are selected for audit may be required to submit documents substantiating the information on the form.

In addition to standard internal forms, other forms and/or documents will be provided by the employee in the following circumstances, with further documentation required if selected for audit.

Enrollment of Dependents:

A Social Security number must be furnished for any persons enrolled in the plan, or official documentation from the Social Security Administration confirming the person attempting to enroll is not eligible to receive a social security number, before coverage will be effective.

- A) Enrollment of Spouse: A copy of the marriage certificate.
- B) Enrollment of Registered Domestic Partner: A copy of the registration form provided by the Secretary of State.
- C) Enrollment of employee's child under the age of 26: ① A copy of the birth certificate indicating the employee and/or the employee's spouse or registered domestic partner are/is the legal parent(s) of the child.
- D) Enrollment of employee's or spouse's or registered domestic partner's legally adopted child under the age of 26 additionally requires: copies of court documents indicating final adoption. If the adoption is not final, court documents dated within 60 days preceding an enrollment request indicating the adoption is pending. If either of these documents does not exist, other documents and/or statements, if deemed acceptable by the County Administrative Office, may be accepted, with final documents to be submitted when they come into existence. In no event will eligibility commence prior to the date the employee or spouse or registered domestic partner obtains physical custody AND the birth parent signs a release document.
- E) Enrollment of a child who has been placed in foster care with the employee, employee's spouse or employee's registered domestic partner: copies of the current legal foster child order.
- F) Enrollment of child under age 26 for whom employee or spouse or registered domestic partner has guardianship additionally requires: copies of court documents indicating a guardianship has been established. If the court documents indicate a temporary guardianship, eligibility will expire when the guardianship documents indicate the temporary guardianship ends, unless further documents are provided prior to that date.

Note: If, before reaching the age of 26, a child was never enrolled in the health plan either during the employee's initial opportunity to enroll, or enrolled during an eligible open enrollment period, they are considered a dependent not eligible

for health benefits coverage. An employee's initial hire date is the employee's initial opportunity to enroll in the health plan, as described elsewhere in this policy.

- G) Enrollment of a child who is already age 26 or older and is permanently disabled: May only be enrolled upon employee's initial opportunity to enroll. An employee's initial hire date is the employee's initial opportunity to enroll in the health plan, as described elsewhere in this policy. If the dependent is not continuously enrolled after reaching the age of 26, they are not eligible to be re-enrolled at any future time. Documentation must be provided which would have been required by Section (B), (C), or (D) above (as applicable) if the child had been enrolled on the day preceding their 26th birthday, **and** certification by a physician of the permanent disability.

Dis-enrollment:

- A) Dis-enrollment of Employee: An employee represented by a bargaining unit that requires participation in medical plan coverage can only refuse coverage if they provide a signed Declination Form that they have other employer medical plan coverage. A blank certification form must be obtained from the CAO-Health Benefits Division and must be filled out completely to be valid.
- B) Dis-enrollment of Spouse or Registered Domestic Partner: ① An insurance change form indicating date of either a court ordered legal separation, final divorce (based on the date the parties could remarry) or termination of domestic partnership. In the event of a legal separation, an employee may remove dependents, but is not required to do so; and ② court recorded documents indicating a legal separation, final divorce date (based on the date the parties could remarry) or termination of domestic partnership.
- C) Dis-enrollment of Child: Enrollment change form. Form should indicate permitting event (reason) and permitting event date for removing child.

Upon Child's 26th Birthday:

Upon child's 26th birthday if initial enrollment occurred when child was under the age of 26 years: ① Certification by a physician of a *permanent* disability.

DEPENDENTS NOT ELIGIBLE

The following dependents are not eligible for health benefits coverage:

- A) Any dependent for whom enrollment documentation (as specified under "*Enrollment of Dependents*") cannot be produced.
- B) Child(ren) of an employee who, on the employee's initial plan eligibility date, was/were 26 years old (or older) and not eligible for coverage by the plan. The initial plan eligibility date is described under Eligibility Date. A dependent may not be enrolled if they are 26 years of age or older and have never been covered by the plan, except upon employee's initial opportunity to enroll. (An employee's initial hire date is their initial opportunity to enroll themselves and/or eligible dependents in the health plan).
- C) A child who is 26 years of age or older who is not an Over-age Disabled Dependent (as defined in the "Dependent" definitions above).
- D) No one shall be eligible as a dependent if they are denied enrollment in their employer sponsored medical plan and alternatively required to be covered by their employer's Medical Expense Reimbursement Plan (MERP) or

other plan whose design shifts all comprehensive medical plan coverage to the County medical plan and which does not have standard coordination of benefit rules.

Disabled Dependents over the age of 26 may not be added except upon an employee's initial opportunity to enroll. They may not be reinstated at a later date.

ELIGIBILITY DATE

The eligibility date for all components of health benefits coverage (medical, dental, vision) is the same, as follows:

Employee:

Employees are eligible for coverage the first day of the bi-weekly payroll period that coincides with or next follows one calendar month of continuous service, beginning on the day the employee physically reports to duty in the benefits eligible position. An employee's initial hire date is the initial opportunity to enroll in the health plan.

If an employee is on Leave of Absence before coverage commences, they are eligible for coverage the first day of the bi-weekly payroll period coincident with or next following the day they return to work as long as that date is on or after their original eligibility date.

If employment is terminated and the employee is rehired within 30 days of termination, the employee must complete a new enrollment form. IF the employee's vacation accrual seniority date is adjusted in the payroll system to recognize their prior service, the effective date of health benefits will be the first day of the pay period, following the date all documentation is received in the CAO-Health Benefits Division, and will not require the one month new hire waiting period. The Personnel Department will determine employee's vacation accrual seniority date. Otherwise, if the break in service is longer than 30 days or their vacation accrual rate is not adjusted, their health benefits effective date and employee contribution will be set in the same manner as a newly hired employee. If an employee transfers between County employment and Special District employment (that allows County benefit participation), the employee will be treated the same as a new hire, and will have a waiting period identical to a new hire of the County or the Special District.

Dependent: Dependents who otherwise meet all other eligible guidelines become eligible as of the later of: the employee's eligibility date or the date an employee first acquires a dependent through a permitting event

EFFECTIVE DATE OF BENEFITS

The effective date for all components of health benefits coverage (medical, dental, vision) is the same, as follows:

Employee:

An employee's benefits will become effective on the employee's eligibility date.

Dependent:

Employees must request Dependent Benefits in writing on a form provided by the CAO-Health Benefits Division. Subject to 'Dependent Effective Date Exceptions' below, requests must be made within 30 days of an employee's initial opportunity to enroll (hire date) or within 30 days of a permitting event. If the request to add a dependent is made more than 30 days after the permitting event, the employee must wait until the next eligible open enrollment period to add the dependent. Properly and timely requested Dependent Benefits will become effective on the first day of the bi-weekly payroll period coincident with or next following the later of:

- ① the Dependent Benefits Eligibility date; and
- ② the effective date of the employee's benefits; and
- ③ the date of the employee's request.

Time Limits:

Subject to 'Effective Date Exceptions' below, if request is not made within 30 days of an employee's initial opportunity to enroll (hire date) or within 30 days of a permitting event, it will not be valid. If the request is not complete or if required documents are not attached, it will not be valid. In either of these circumstances, the employee will then have to wait until Open Enrollment, which is held from time to time, to request Benefits, and may only enroll dependents otherwise eligible as described in this policy.

Effective Date Exceptions:

Newborn Children: An eligible Dependent child will be covered for Dependent Benefits for 30 days following the date of birth of that Dependent child. At the expiration of such 30 day period, Dependent Benefits will end for that Dependent child unless a request for such Dependent Benefits is made within 60 days of the permitting event. If no proof of eligibility is submitted, the child will not be considered a Dependent child and the child will not be eligible for the initial 30 days of coverage.

Guardianship: A child who is added as the result of a court appointed guardianship will be effective as of the effective date of the court action establishing the guardianship, if the employee submits forms within 30 days of that effective date. If the employee does not submit documents within 30 days of the first court action establishing guardianship, the enrollment request will not be valid and the employee will be required to wait until Open Enrollment, which is held from time to time, to request Dependent coverage.

If the child is added as the result of a court appointed temporary guardianship, coverage will be temporary, lasting only until the next court date (or the date stated in the temporary guardianship documents, if there is no future court date). The permanent appointment of guardianship document must be submitted within 30 days of the related court action in order for health benefits coverage to be continuous. If the employee does not submit permanent documents within 30 days, the coverage, which lapsed at the end of the temporary guardianship, will not be continuous. Coverage will be reinstated as of the first day of the bi-weekly payroll period following the date the permanent guardianship documents are submitted to the CAO-Health Benefits Division.

Employees enrolling due to loss of other coverage: If an employee has no other employer medical coverage, AND they are represented by a bargaining unit whose MOU requires participation in medical benefits, County health benefits coverage will be put in force for the employee outside of open enrollment. If the employee requests the coverage within 30 days of the loss of the other coverage, County coverage may include dependents and will be effective pursuant to Section titled "Effective Date of Benefits" above. If the County is notified after 30 days following the loss of coverage, the employee will be enrolled without dependents and the effective date will be the first day of the bi-weekly payroll period that coincides with or next follows a one calendar month waiting period. The one calendar month waiting period starts the day the CAO-Health Benefits Division is notified in writing of the absence of other employer group coverage.

Automatic Enrollment:

Automatic Enrollment does NOT apply to employees who are NOT represented by a bargaining unit whose MOU requires participation in medical benefits (e.g., employees who are management, confidential, contract, etc. are NOT automatically enrolled in health benefits).

County employees represented by a bargaining unit whose MOU requires participation in medical benefits who do not submit required forms and/or documents on or before the eligibility date of their benefits will be enrolled by the County in health benefits with the then current information available in the payroll system as of the eligibility date. Dependents will not be enrolled and requests for Dependent Benefits will not be accepted until Open Enrollment, and only for those dependents otherwise eligible as described in this policy. The employee will be enrolled in the least expensive County self-insured medical plan, the County's self-insured dental plan, and the vision plan. Requests for plan changes will not be accepted until Open Enrollment. An employee may request a correction to their automatic enrollment within 7 days of being sent a notice of such. (Notice will be a letter or memo from the CAO-Health Benefits Division.) Requests for corrections received after the 7 day period will not be accepted and should be resubmitted during Open Enrollment.

If an employee declines benefits by submitting documentation that they have other employer group coverage, then loses the other coverage (Special Event), they are required to apply within 30 days of this Permitting Event for County coverage if they are represented by a bargaining unit whose MOU requires participation in medical benefits. Coverage will become effective the first day of the bi-weekly payroll period following the application date, but not prior to the loss of the qualifying other coverage. If they do not apply within 30 days of the loss of qualifying other coverage, the date the CAO-Health Benefits Division is notified in writing, or has obtained evidence that is deemed reliable at the discretion of the County Administrative Officer, that the employee no longer has any qualifying other coverage will be treated as a Special Event date. In this circumstance, the County will automatically enroll the employee in the least expensive County self-insured medical plan, the County's self-insured dental plan and the vision plan. No dependents will be enrolled. The coverage will be effective the first day of the bi-weekly payroll period that coincides with or next follows the day that is one calendar month after this Special Event date.

PERMITTING EVENTS FOR CHANGES IN COVERAGE

Other than at open enrollment, employees must have a permitting event to make any change in coverage. Coverage changes will be effective pursuant to Section titled "Effective Date of Benefits" above. In addition to gaining or losing eligible status based on the "Eligible Participants – Dependents" section above, the following are considered permitting events.

The "***permitting event date***" to request to ADD or INCREASE coverage or to ADD dependents not previously eligible will be one of the following:

- 1) the date of marriage to a spouse for spouse and new step-children;
- 2) the registration date of the registered partnership for a registered domestic partner
- 3) the child's birth date for a newborn natural child;
- 4) the latter of (a) the date physical custody is obtained and (b) the date a release is signed for adopted children (both events must occur for eligibility to commence);
- 5) the date a court order is received by the CAO-Health Benefits Division establishing court ordered coverage;
- 6) the date of the court decree establishing a guardianship;
- 7) the date the dependent arrives in the U.S. as a permanent resident for dependents residing outside the U.S. on the employee's eligibility date;
- 8) the date coverage involuntarily ceases under another employer plan, as documented by the other insurance company or employer, because of: cancellation of the dependent's plan, the dependent's loss of employment or change of eligible status (losing eligibility), cessation or significant reduction of the employer's contribution (not changes in plan benefits) toward dependent's coverage, the dependent's death, divorce, the termination of the domestic partnership, or a dependent's open enrollment period. For purposes of this paragraph, a dependent is a spouse, domestic partner or adult child.; or
- 9) the date coverage ceases for a dependent under Medi-Cal or Healthy Families IF the loss of coverage was involuntary. Involuntary loss does not include failure to respond to requests from Medi-Cal or Healthy Families or failure to pay for such coverage. If dependents are added to County Health Benefits outside of open enrollment under this provision, they may not be removed outside of open enrollment based on another change in eligibility for Medi-Cal or Healthy Families.

- 10) For spouses who are both Kern County employees and both are eligible for health benefits coverage, but one has declined coverage, the date of loss of coverage due to leave of absence.
- 11) the date a child is legally placed in foster care by government agency placement or court order.
- 12) the date a dependent is released from incarceration.

The ***“permitting event date”*** to request to REMOVE or REDUCE coverage or dependents will be one of the following:

- 1) the date a divorce becomes final (e.g., the date the employee can remarry) for a spouse and natural or step-children who are not the children of the employee;
- 2) the date of final termination of the registered domestic partnership for the registered domestic partner and natural or step-children who are the children of that registered domestic partnership;
- 3) the date of a court ordered legal separation;
- 4) the date of death of any dependent;
- 5) the date a court order is received by the CAO-Health Benefits Division removing court ordered coverage;
- 6) the date of a court decree ending a guardianship;
- 7) the date the dependent leaves the U.S. as a permanent resident;
- 8) the date coverage begins under another employer plan, as documented by the other insurance company or employer, because of: the inception of the dependent’s plan, the dependent’s start of employment or change of eligibility status (becoming eligible), the start of or significant increase in the employer’s contribution toward dependent’s coverage or marriage to a new spouse, or registration with a new registered domestic partner, or a dependent’s open enrollment period. For purposes of this paragraph, a dependent is a spouse, domestic partner or adult child.; or
- 9) For spouses who are both Kern County employees and both are eligible for health benefits coverage, when one has enrolled due to loss of the other’s coverage due to leave of absence, the date the canceled coverage is reinstated because the employee has returned to duty from the leave of absence.
- 10) the date a foster care placement is revoked or otherwise terminated.
- 11) the date a dependent is incarcerated.

Employees who make their employee contribution on a post-tax basis or employees who do not contribute toward the cost of health benefits may remove adult children **if they wish** because the child has: 1) permanently moved out of the employee’s household, 2) stopped being financially dependent upon the employee or employee’s spouse, 3) quit attending school full-time; 4) gotten married; or 5) been legally emancipated. Employees who make their employee contribution on a pre-tax basis may not make changes based on the events listed in this paragraph. Changes must be requested within 30 days of one of the events in this paragraph. These changes are considered to be special permitting events, allowed because the employee may wish to stop paying for benefits for an adult child. They are NOT required changes. If an employee voluntarily removes an adult child from coverage for one of the reasons in this paragraph, the adult child may not be added back to coverage until an Open Enrollment. A subsequent mid-year change to, or reversal of, one of these provisions is NOT a permitting event to add the adult child back to health benefits coverage.

Change of address into or out of a plan’s service area may be a ***“permitting event”***. If the new address is not a covered service area, the participant may request a change to a new health plan that includes the new address in their covered network service area. If the new address is still a covered service area, no plan change is allowed. For participants on the County self-insured POS plan, who are enrolled as Out-of-Area participants, if the new address is in the POS network service area, coverage will be changed to POS coverage effective the first day of the bi-weekly pay period following the date the CAO-Health Benefits Division is notified of the address change.

WHEN BENEFITS END

- 1) When separating from employment, benefits as an employee will end on the last day of the bi-weekly payroll period during which an employee works or is entitled to terminal vacation (see Continuation of Coverage Notice).

Note that terminal vacation is not allowable unless an employee is retiring, and vacation paid after the last day worked for other employment terminations will not be counted toward health benefits eligibility.

- 2) Benefits as an employee will end on the due date of any unpaid employee contribution (see "Leave of Absence"). If any portion of an employee's contribution is paid by check and the check is returned unpaid, the employee will be charged the current returned check fee in effect for the County. Benefits will not be reinstated until all other eligibility criteria are met and any unpaid balance of employee contributions is repaid, including any returned check fee.
- 3) Any affected benefits will end if any plan ends in whole or part.
- 4) All Dependent Benefits will end on the date that Dependent ceases to be an eligible Dependent.
- 5) Except as otherwise provided by the Board of Supervisors, e.g., Resolution #2002-016, all benefits will end on the day before an employee enters the military service on active duty. For employees on temporary active duty, the County will continue to contribute toward health benefits coverage for a period of six (6) full bi-weekly payroll periods in accordance with the Procedures Manual.
- 6) Due to Health Care Reform, coverage will not be termed retroactively unless the employee performs an act of fraud, intentionally misrepresents a material fact or/and fails to pay required contributions or premiums. If an employee performs an act of fraud, intentionally misrepresents a material fact or fails to pay contributions, coverage will be retroactively terminated to the appropriate date.

NOTICE FOR CONTINUATION OF COVERAGE ("COBRA")

A Federal Law, usually called COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (Called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to summarize participants' rights and obligations under the continuation coverage provisions of COBRA. Employees and eligible dependents should take the time to read this notice carefully.

WHO MAY CONTINUE COVERAGE AND WHEN

Employees covered by health benefits have a right to choose this continuation coverage if they lose group health coverage because of a reduction in hours or the termination of employment (for reasons other than gross misconduct).

The spouse of an Employee covered by health benefits has the right to choose continuation coverage if group health coverage is lost for any of the following four reasons:

- (1) Death of spouse;
- (2) Termination of spouse's employment (for reasons other than gross misconduct) or reduction in spouse's hours of employment;
- (3) Divorce or court ordered legal separation from spouse; or
- (4) Spouse becoming entitled to Medicare.

In the case of a Dependent child of an employee covered by health benefits, he or she has the right to continuation coverage if group health coverage is lost for any of the following five reasons;

- (1) The death of a parent;
- (2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with the Employer;
- (3) Parents' divorce or court ordered legal separation;
- (4) A parent becomes entitled to Medicare; or
- (5) The Dependent ceases to be eligible.

A child who is born to or placed for adoption with the covered employee during a period of continuation coverage will be deemed a Qualified Beneficiary (or eligible) for COBRA coverage. The newborn or adopted child must be added to

COBRA coverage within the time frame and with the appropriate forms and attachments stated for active employee coverage.

WHEN NOTICES MUST BE GIVEN

Under COBRA, the Employee or a family member has the responsibility to inform the Employer of a change in eligibility, including, but not limited to, divorce, court ordered legal separation under which the Employee wishes to cancel any Spouse, or Dependent coverage, or a child losing Dependent eligibility within 60 days of the happening of any such event. If notice is not received within that 60-day period, the Dependent will not be entitled to choose continuation coverage.

When the Employer is notified that one of these events has happened, the Employer or COBRA administrator will in turn, send notice of the right to choose continuation coverage. Under COBRA, the participant has at least 60 days from the date of loss of coverage, due to one of the events described above, to inform the Employer that continuation coverage is wanted.

If continuation coverage is not chosen, group health coverage will end effective at midnight of the last day of the bi-weekly payroll period during which the employee last worked or was entitled to terminal vacation.

THE LENGTH OF CONTINUATION COVERAGE

If continuation coverage is chosen, the Employer is required to give coverage which, as of the time coverage is being provided, is identical to the coverage provided to similarly situated Employees or Dependents. COBRA requires that participants be afforded the opportunity to maintain continuation coverage for 18 months (36 months for dependents) if group health coverage was lost due to termination of employment or reduction in hours. Participants may be charged up to 102% of the applicable premium for the continuation coverage on a monthly basis.

If, during that 18-month period, another event takes place that would also entitle a spouse, or Dependent child (other than a spouse, or child who became covered after continuation coverage became effective) to his or her own continuation coverage (for example, the former Employee dies, is divorced or legally separated, or becomes entitled to Medicare, or a Dependent ceases to be eligible), this continuation coverage may be extended. However, in no case will any period of continuation coverage be more than 36 months.

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

If an employee, employee's spouse, or Dependent child is determined to be disabled under the terms of the Social Security Act as of the date employment terminated (or the date hours of employment were reduced), the disabled person is eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, the disabled person must notify the Employer within 60 days after receiving a determination of disability from the Social Security Administration, provided notice is given before the end of the initial 18 months of continuation coverage.

During the additional 11 months of continuation coverage, the cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

WHEN CONTINUED COVERAGE UNDER COBRA ENDS

COBRA also provides that continuation coverage may be cut short for any of the following four reasons:

- (1) The Employer no longer provides group health coverage to any of its Employees;
- (2) The cost for continuation coverage is not paid in a timely fashion;
- (3) Coverage commences under another group health plan, unless that other plan contains an exclusion or limitation with respect to any preexisting condition affecting the Employee or a covered Dependent; or
- (4) A participant becomes entitled to Medicare.

PAYMENTS AND CONVERSION

Demonstration of good health is NOT required to choose continuation coverage. However, under COBRA, the participant may have to pay all or part of the cost for continuation coverage. There is an initial grace period of 45 days, starting with the date continuation coverage is chosen, to pay any costs. COBRA continuation coverage is not effective until the enrollment process is completed and the initial premium is paid. After that initial 45-day grace period, there is a grace period of at least 30 days to pay any subsequent cost. COBRA also says that, at the end of the 18-month or 36-month continuation coverage period, enrollment must be allowed in any individual conversion health plan which may be provided. However, the County does not have any individual plans available.

Any questions about COBRA should be directed to the CAO-Health Benefits Division or the COBRA administrator. Also, any changes in marital status, Dependent eligibility, or address should be sent to the CAO-Health Benefits Division.

COMPONENT PARTICIPATION

With the exception of COBRA participants or Leave of Absence participants who pay premiums through the COBRA administrator, all participants and potential participants in the County of Kern health benefit plans are subject to the following guidelines on component plan (i.e., medical, dental and vision) participation:

All persons enrolling in the County's health benefit plans must enroll in all components (medical, dental, vision) offered by their employer. No participant will terminate coverage in an individual component plan (medical, dental, vision) unless terminating all participation in County plans.

Special Districts are additionally subject to the following guidelines:

On or after December 3, 1996, when a Special District requests inclusion of their employees in the County's health benefit plans, the request must include coverage under all components (medical, dental, vision) of the County's plans. The request will not be valid unless the Special District participates (or begins participating) in the County payroll system. When a Special District requests termination of participation in any current County health benefits coverage, the request must be for all components (medical, dental, vision) in which the District is currently participating.

Special District participants do not participate in the Kern County Employee Assistance Program or the Kern County Employee Wellness Program.

COST

The employee share of the cost of health benefits will be determined by any applicable Memorandum of Understanding or employer-employee contract. For most County employee bargaining units, the employee share of cost is 10% or 20% of the current bi-weekly County employee premium amount. Contribution amounts for County employees can be obtained from the CAO-Health Benefits Division.

Beginning January 1, 2016, Special Districts and other public entities will be eligible to participate in County employee health plan options under individual written agreements with the County. Such agreements will provide that the employer may continue to offer any County health plan options available to that Special District or other public entity's employees as of December 31, 2015 and may also include the Kern Legacy Health Plan employee medical plan as a new option, subject to that employer's collective bargaining with employees.

Special Districts and other public entities' employees are not covered by County employees' Memoranda of Understanding. Special Districts and other public entities' employees will make payment as appropriate under applicable Memoranda of Understanding or employer-employee contract specific to that Special District or public entity.

With the exception of Kern Medical Center employees during the 24 month transition period after the transfer of control of Kern Medical Center from the County to the Kern County Hospital Authority, the employing Special District or other public entity will pay the full, 100% County employee premium amount for the plan and level of coverage (single, two-party, or family) under which the employee is enrolled, for all non-County employees covered under a County health plan.

During the 24 month transition period after the transfer of control of Kern Medical Center from the County to the Kern County Hospital Authority, the Kern County Hospital Authority will pay the County departmental composite rate for all non-County employees covered under a County health plan, after which time the Kern County Hospital Authority will pay the full, 100% County employee premium amount for the plan and level of coverage (single, two-party, or family) under which the employee is enrolled, for all non-County employees covered under a County health plan.

Any Special District or other public entity that is not using County payroll and is not subject to automatic charges through the County payroll system must agree to make advance payments of the bi-weekly premium amount on an either monthly or quarterly basis and must make payment within 30 days of being invoiced. The County will not refund premium payments for coverage that should have been terminated prior to notification by the Special District or other public entity.

Coverage will only be terminated prospectively beginning with the benefits coverage period following the date that CAO Health Benefits receives notification to terminate coverage. Corrections to advance payments due to changes in enrollment will be made on the following billing cycle.

LEAVE OF ABSENCE

Any employee who will be taking a Leave of Absence must complete a Health Benefits Leave of Absence form, which is available from payroll/personnel clerks and the CAO-Health Benefits Division. The County will continue to contribute toward coverage as outlined in the Health Benefits Leave of Absence form.

While benefits are continuing at the start of a leave, if an employee is paid for at least 40 hours (regular, vacation, sick leave or comp time) during a bi-weekly Health Benefits Period, that will not be counted as a "leave of absence" period for the purpose of health benefits. If an employee is paid for less than 40 hours during a bi-weekly Health Benefits Period, that period will be counted as one of the "leave of absence" periods for health benefits purposes. *For example*, any bi-weekly Health Benefits Period during which the employee is paid less than 40 hours will: ① count as one of the six bi-weekly payroll periods for approved FMLA leave; OR ② count as one of the twenty-six bi-weekly payroll periods for an approved workers' compensation leave (see Definitions); OR ③ result in no County contribution for a personal leave. Approved FMLA leave and workers' compensation leave run concurrently and a new leave period will not be granted within a rolling 12 month period. If at any time an employee exceeds the number of Health Benefits Periods for which there is a County contribution, the employee becomes responsible for payment of COBRA premiums to maintain health coverages and eligibility. Should this result in an employee receiving less than 12 full weeks of County contribution while on a FMLA leave of absence, one additional two-week period will be granted.

Note: The ***Health Benefits Period*** is the two weeks period ending on the Friday following each payday. The hours for which the employee is paid on that payday were earned in the previous two weeks period on the job. In other words, the "Health Benefits Period" is the two week period following the last workday (Friday) of any bi-weekly payroll period.

While on a Leave of Absence during which the County contributes toward coverage, an employee must continue their coverage unchanged. Additionally, leave of absence by itself is not a Permitting Event for Change in Coverage, and employees may not make changes to their active coverage as a result of taking a leave of absence only. For example, an employee may not change dental plans or drop dependents for any period during which there is a County contribution toward their benefits in response to their taking a leave of absence. However, if a Permitting Event occurs during the leave of absence, the employee should request desired changes within the time limit allowed for that permitting event. For example, if an employee gets married while on a leave of absence and coverage is desired for the new spouse, the employee must request enrollment of the spouse within 30 days of the marriage, even if it will not be in effect until a later date due to the leave of absence.

Once the Health Benefits staff is notified that an employee is on an approved medical leave of absence, two of the six bi-weekly pay periods available will be extended in good faith, and the employee will be notified of the need to pay the applicable employee contribution for the two coverage periods. If the employee does not pay the employee contribution for the two bi-weekly pay periods that were extended in good faith before returning to work, the necessary amount to pay for the coverage will be deducted from the employee's pay, once the employee has returned to work. The remaining periods of available coverage will not be extended unless the employee pays the applicable contribution(s). Applicable employee contributions are due every two weeks on payday and are accepted as 'late' payments until the Friday following payday. If payment is not received timely, the COBRA administrator will be notified that coverage has been canceled with the COBRA event date being the due date of the unpaid premium. In no event will late payments be accepted after the COBRA administrator has been notified.

In the event the employee chooses not to pay the employee contribution for the remaining periods of available coverage, coverage will be terminated and reinstated when the employee returns to work, as described elsewhere in this policy.

While on a Leave of Absence which would require employee payment of COBRA premiums to maintain health coverages and eligibility, as described in the Procedures Manual, an employee will be offered the following options by the COBRA administrator: ① Purchasing full coverage; ② Purchasing all current coverages for employee only; ③ Purchasing medical coverage only while dropping dental and vision coverage; or ④ A combination of ② and ③.

Reinstatement of Coverage: In the event any County contribution toward coverage is or will be dropped/lapsed, whether voluntarily, for lack of sufficient hours worked, or for non-payment of premiums, the County contribution toward coverage will be reinstated on the first of the bi-weekly payroll period in which the employee returns to duty and works at least 40 hours. Vacation, sick leave, and comp time hours paid are not considered hours worked for the purposes of reinstatement. Lapsed benefits will not be reinstated due to an employee being paid vacation, sick leave or comp time during a leave. Benefits are reinstated retroactively after payroll information is transmitted to the CAO-Health Benefits Division. Refer to the Health Benefits Leave of Absence form for information on timing of reinstatement of benefits.

SUSPENSIONS

In the event an employee is placed on suspension, the County will continue to contribute toward the cost of health benefits for up to two bi-weekly Health Benefits Periods. The employee will be required to contribute toward coverage in a manner consistent with employees on leave of absence. If benefits are canceled during the suspension, whether voluntarily or for non-payment of premiums, the County contribution toward coverage will be reinstated on the first of the bi-weekly payroll period *following* the bi-weekly payroll period in which the employee returns to duty and works at least 40 hours. Vacation, sick leave, and comp time hours paid are not considered hours worked for the purposes of reinstatement.

RETIREMENT PROVISIONS

Persons must apply for coverage as a Retiree if they wish to continue County group coverage after retirement from County service. Coverage does not continue automatically upon retirement. Eligibility is controlled by the County of

Kern Health Benefits Eligibility Policy for Participants without Active Employee Medical Coverage and the Retiree Health Benefits Eligibility Policy.

NOTICES

Notices to individual employees relating to County Health Benefits plans will be deemed to have been made upon deposit into U.S. Mail by the County. The notice will have first class postage affixed and will be addressed to the employee at the address listed in the payroll master file at the time the mailing is being processed.

Notices to employees (e.g., open enrollment) will be made by deposit of such notice into U.S. Mail by the County with postage affixed. Such notice will be addressed to employees at the address listed in the payroll master file at the time the notice is prepared.

Notices to the County will be mailed or delivered to:

Kern County Administrative Office
Health Benefits Division
1115 Truxtun Avenue, 5th floor
Bakersfield, California 93301

DISAGREEMENTS OVER ELIGIBILITY

If an employee disagrees with the processing of their eligibility (or their dependent's eligibility) for health benefits, they may submit a request for review in writing to the County Administrative Office - Health Benefits Division. The request should indicate the reasons for their disagreement and include the words "Formal Request for Review" at the top. The Formal Request for Review must be submitted within 30 days. The decision of the County Administrative Officer, or his designee, is final.

DISAGREEMENTS OVER BENEFITS PAID

Disagreements over benefits paid under any of the plans should be submitted to the individual plan provider with which the employee has the disagreement, following the appeal rules indicated by such provider.

DEFINITIONS

‘Actively at work’ is further defined to include any time during which the employee is not on a reduced schedule due to leave of absence or suspension (e.g., during regularly scheduled vacation an employee is considered to be actively at work).

‘Address’ is defined as the address in the County payroll system.

A **‘Child of an Employee’** entitled to coverage is limited to someone under the age of 26.

‘COBRA’ (Consolidated Omnibus Budget Reconciliation Act) is a Federal law that requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

A **‘Day’** will be defined as a calendar day for purposes of this policy, unless specifically noted otherwise.

A **‘Domestic Partner’** as defined under Article 297 of the California Family Code as a couple who meets the following requirements: be of the same sex or at least one over 62 years old, share a residence, not be married or officially partnered with anyone else, be over 18, not be related by blood and consent to the partnership.

The **‘Employee Eligibility Date’** is the first day of the bi-weekly payroll period coincident with or next following the day the employee completes one month of continuous service. In other words, following one month of continuous service, the eligibility date is the first day of the bi-weekly payroll period (Saturday).

‘FMLA’ is the Family and Medical Leave Act.

A **‘Health Benefits Period’** is a two week period ending on the Friday following each payday. The hours for which the employee is paid on that payday were earned in the previous two week period on the job. In other words, the “Health Benefits Period” is the two weeks period following the last workday (Friday) in any bi-weekly payroll period.

The **‘Initial Opportunity to Enroll’** is the employee’s initial hire date. If the employee has worked for the County at different times, the initial hire date is the most recent time the employee was hired by the County in a benefits eligible position.

‘Month’ A month is defined as one calendar month, and may be 28, 29, 30 or 31 calendar days in length, depending on which month is applicable.

‘Open Enrollment’ is that period of time designated by Kern County during which dependents may be added to or deleted from an employee’s health benefits and changes may be made in the plans selected. Open enrollment is not a guaranteed annual event, but is held from time to time. Open enrollment is not the employee’s initial opportunity to enroll in the health plan.

‘Other Employer Group Coverage’ is other coverage that must be documented by a represented employee who is declining Health Benefit coverage. Other Employer Group Coverage is a group plan that covers medical and prescription services, and is offered by another employer (e.g., spouse’s coverage, coverage offered through other employment, etc.). Medi-Cal is not Other Employer Group Coverage. Medicare does qualify under this provision. However, if health benefits are declined based on having Medicare, the only Permitting Event to reinstate health benefits will be loss of Medicare. Loss of any related Medicare related plans will not be a Permitting Event to add health benefits.

An **‘Over-age disabled dependent’** is a person who is 26 years of age or older who: (1) remains unable to work in self-sustaining employment (permanently disabled) by reason of mental or physical disability as certified by a physician and approved by the health plan administrator (certification must be provided as requested but not more often than annually) and (2) remains chiefly dependent upon the employee or employee’s spouse or registered domestic partner for support, as

defined elsewhere in this policy, (3) is unmarried and has never been married, and (4) met the definition of a Child of an Employee on the day prior to their 26th birthday and continues to meet the definition of a Child of an Employee except for the age rule.

A **‘Registered Domestic Partner’** must meet all the requirements of Section 297 of the California Family Code. The partnership must be registered by filing a Declaration of Domestic Partnership with the Secretary of State.

The **‘Spouse’** of an employee is the person to whom the employee is legally married, as recognized for tax purposes by the State of California and Internal Revenue Service. If a judgment of dissolution (divorce) is granted, an employee must remove the dependent from coverage immediately effective as of the date the marital status ends because they are no longer an eligible dependent.

‘30 days of continuous service’ is modified from the plan document to ‘one calendar month of continuous service’.

A **‘Transfer during Probationary period’** is a relocation from one County department to another County department while the employee is on "Probationary" status as defined by their payroll status code. Such a transfer will qualify the employee for continuation of health benefits without interruption ONLY if the employee ① is eligible for health benefits before and after the transfer and ② does not take off more than 5 days that are not paid between positions. Should the employee take more than 5 days that are not paid, the employee will be required to complete enrollment as a new employee.

An **‘Unmarried Child’** is a child who is not currently married and has never been married.

A **‘Workers’ Compensation leave’** for the purposes of qualifying for continuation of health benefits is defined as one of the following situations when a workers’ compensation claim is in the accepted status:

- 1) The employee is receiving Total Temporary Disability (TTD) payments paid by the County, or
- 2) the employee has not been released to return to duty by the County workers’ compensation physician and either:
 - has not reached Maximum Medical Improvement (“MMI”) or
 - has reached MMI, has applied for a disability retirement with the Kern County Employees’ Retirement Association (“KCERA”) and is waiting for a KCERA board determination on the disability filing or has been denied a disability retirement by KCERA.
- 3) The employee has been released to return to duty with restrictions by the County workers’ compensation physician and the employee’s department is not able to accommodate the restrictions and either:
 - has not reached Maximum Medical Improvement (“MMI”) or
 - has reached MMI, has applied for a disability retirement with the Kern County Employees’ Retirement Association (“KCERA”) and is waiting for a KCERA board determination on the disability filing or has been denied a disability retirement by KCERA and has applied for alternate work with County Personnel and been denied.

Health Benefits will not be continued under the workers’ compensation leave provision if the employee:

- 1) does not meet one of the definitions above; or
- 2) has been released to return to duty but fails to return to work; or
- 3) has been released to return to duty with restrictions and the department is able to accommodate the restrictions but the employee fails to return to work; or
- 4) has reached MMI and has not been released to return to duty but has either not applied for disability retirement with KCERA or has been granted a disability retirement by KCERA; or
- 5) has reached MMI and has been released to return to duty with restrictions where the employee’s department cannot accommodate them if:
 - the employee has either not applied for disability retirement with KCERA or has been granted a disability retirement by KCERA; or
 - the employee has not applied for alternate work with County Personnel or has not reported for work offered.

Health Benefits will not be continued under the workers' compensation leave provision if the employee has settled their workers' compensation case leaving only future medical covered.

HOW TO OBTAIN MORE INFORMATION

More information is available in plan documents which are available on-line at www.KernCountyHealthBenefits.com. Specific questions about health benefits coverage or eligibility may also be directed to the Kern County Administrative Office-Health Benefits Division at (661) 868-3182.



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Revised 3/2015
