Employee Leave of Absence Request

Employees may request a leave of absence pursuant to Personnel Rule 7 – Leaves. Employees on leave without approval are considered Absent Without Leave (AWOL) and are subject to disciplinary action, up to and including termination. To request a leave of absence, please complete and submit this form, along with supporting documentation, to your department personnel representative prior to the start of your leave. This form must be completed when requesting a leave of absence (LOA), whether it is paid or unpaid.

Contact your department personnel representative with any leave-related questions. You may also contact Employee Benefits at (559) 600-1810 with questions related specifically to your health insurance coverage or other benefits.

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	EMPLOYEE ID
DEPARTMENT	EMPLOYEE PHONE	JOB TITLE

I am requesting: ☐ New Leave ☐ New Intermittent Leave ☐ Extension of my current leave

Last Day Worked: __________ Paid Leave Begin Date: __________ Anticipated End Date: __________

Unpaid Leave Begin Date: __________ Anticipated End Date: __________

REASON FOR REQUEST

☐ My Own Serious Health Condition
☐ Pregnancy Disability; Estimated Delivery Date: _____
☐ Baby Bonding; Baby's Date of Birth: _____
☐ Adoption or Foster Care Placement; Date of Adoption or Placement: _____
☐ Care for a Family Member or Designated Person with a Serious Health Condition: Relationship to Employee:_____
☐ On-the-Job Injury; Date of Injury: _____ ☐ Pending ☐ Approved ☐ 4850
☐ Military Leave
☐ Military Exigency Leave
☐ Military Leave to Care for a Covered Service Member
☐ Other (e.g., personal leave); Please specify: _____

PAY DESIGNATIONS
Check all that apply: Note: Annual leave must be used, unless you are collecting disability benefits (SDI, PFL etc.)

☐ Annual Leave Accrual
☐ Annual Leave Donations (donation request form required)
☐ Paid State or Federal Benefits Only (paid disability, paid family leave, etc.)
☐ Integrating Annual Leave with State Disability Insurance or Paid Family Leave
☐ Integrating Annual Leave with On-the-Job Injury Benefits
☐ Other; Please specify: _____

EMPLOYEE ACKNOWLEDGEMENT

By signing below, I certify that I understand that it is my responsibility to read the information in the Leave of Absence Packet as it contains important information about my health insurance coverage, rights and responsibilities, eligibility for protected leave, and other benefit information.

____
Employee Signature / Date

Leave of Absence Acknowledgment

EMPLOYEE NAME

IT IS MY UNDERSTANDING THAT:

A. **If I wish to request an extension of my leave**, I must submit a leave of absence request to my department prior to but no later than when my leave expires, along with the supporting documentation. Failure to timely submit a request will impact my health insurance eligibility. I further understand that if I fail to return to work when my leave expires or I do not submit a timely request for leave extension, I will be considered absent without leave (AWOL) and subject to disciplinary action up to and including termination.

B. **If I am eligible for disability insurance payments**, it is my responsibility to file a claim and send the necessary documentation to the carrier. If I am eligible to integrate my disability benefits with annual leave, it is my responsibility to complete and submit the appropriate documentation.

C. **If my leave is protected under FMLA and/or CFRA**, I am eligible to receive the County contribution towards health insurance premiums for up to 12 weeks if the leaves run concurrently, or up to 24 weeks if they run separately. If my leave is protected under PDL, I am eligible to receive the County contribution for up to 4 months. If I am eligible for military care giver leave under FMLA, I am eligible for up to 26 weeks.

D. **If my leave is protected under FMLA, CFRA and/or PDL and I elect to continue health insurance coverage**, I understand that I am responsible to pay my contribution towards the premium. (Note: Any dependents enrolled in the County health plan prior to my protected leave cannot be dropped during the protected leave period).

E. **If my leave is unpaid under FMLA, CFRA, and/or PDL**, the County's third-party administrator, ASI, will bill me for my contribution towards the health insurance premium. I understand that when my leave is unpaid, my health insurance coverage will be terminated and will not be reinstated until I make the required timely payment to ASI. If I fail to make payment to ASI by the due date, my health insurance coverage will remain terminated until I return to work or am eligible for COBRA.

F. **If I am on paid leave under FMLA, CFRA, and/or PDL**, and my paycheck sufficiently covers my health insurance deductions, my contribution towards the health insurance premium will continue to be taken from my biweekly paycheck deductions. If my earnings are not enough for the health insurance premium to be taken, I understand my health insurance coverage will be terminated and the County's third-party administrator, ASI, will bill me for my contribution towards the premium. My health insurance will not be reinstated until I make the required timely payment to ASI. If I fail to make payment to ASI by the due date, my health insurance coverage will remain terminated until I return to work or am eligible for COBRA.

G. **Once my protected leave expires**, or if I am on any other type of approved, unpaid leave, and want to maintain my health coverage, I understand that I may have the option to elect COBRA health coverage within 60 days after the date my previous health coverage ends or 60 days after the date of the COBRA election Notice, whichever is later. I also understand that if I choose to elect COBRA coverage, I must send my request to elect coverage, and any applicable premium, to the County's third-party administrator, Navia Benefit Solutions (Navia), before my enrollment can be processed. While on COBRA, I understand that failure to pay my contribution of the health insurance premiums in the timeframes required will result in the termination of my health insurance coverage and I will not be eligible to be re-enrolled until I return to work or receive a paycheck with sufficient pay to deduct my contribution towards the health insurance premiums. I also understand that while on COBRA, the County no longer pays any contribution towards the health insurance premiums.

(Continued)

Leave of Absence Acknowledgment (Page 2)

H. **Should I experience a qualifying life event that would allow me to make various health plan changes (e.g., birth, marriage, death, divorce, etc.) during my leave of absence**, I understand that it is my responsibility to contact the Department of Human Resources – Employee Benefits to complete and submit the required documentation to make any changes within the qualifying event time frame (e.g., 30 days). Failure to submit the required documentation within the allotted time frame may result in a denied request for any health insurance changes. Information on qualifying events can be found on the Human Resources – Employee Benefits website.

I. **If my disability is a result of an *on-the job* injury (OJI) and my leave qualifies for protection under FMLA/CFRA**, I understand that my FMLA/CFRA leave time will run concurrent with my OJI leave and will begin with the date of my disability (excluding 4850 Leave). I also understand that my workers compensation disability benefits will automatically be integrated with my accrued paid leave time unless I complete and submit the declination form.

J. **If I qualify for CFRA protected leave to care for a "Designated Person"**, I understand that I am designating this individual for a 12-month period beginning on the first date of approved leave. I also understand that I am limited to one (1) designation per rolling 12-month period and may not designate an alternate individual until this 12-month period expires.

K. **If I fail to return to work at the end of my approved leave**, I will be absent without leave (AWOL) and subject to disciplinary action up to and including termination. Moreover, if I have received any County contributions paid towards my health insurance premiums during my protected leave under FMLA, CFRA, and/or PDL, and I fail to return to work for at least 30 days following my leave, the County may recover from me the cost of premiums paid on my behalf. However, I will not be liable for the premiums if my failure to return to work is due to a continuation of my own serious health condition or other reasons beyond my control.

EMPLOYEE ACKNOWLEDGEMENT

By signing below, I certify that I understand that it is my responsibility to read the information included in the Leave of Absence Acknowledgement form as it contains important information about my leave of absence and health insurance.

____
Employee Signature / Date

COUNTY OF FRESNO NOTICE I

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA) AND THE CALIFORNIA FAMILY RIGHTS ACT (CFRA)

It is the County of Fresno's policy to provide a leave of absence to eligible employees in accordance with the Federal Family and Medical Leave Act of 1993 (FMLA) and the California Family Rights Act of 1993 (CFRA). This notice sets forth employee rights and obligations under these **protected leaves** and pursuant to County policy and/or Memorandum of Understanding (MOU).

Eligibility

Employees are eligible for FMLA/CFRA if they have at least 12 months of service and have worked at least 1,250 hours during the last 12 months prior to the requested leave. The 12 months need not be consecutive and prior County service for up to 7 years can be used to meet the 12 months of service.

Purpose of Leave – Qualifying Events

FMLA:

- For the employee's own serious health condition
- The birth of the employee's child and to care for a newborn
- The placement of a child with the employee in connection with adoption or foster care
- To care for an eligible family member (spouse, child, or parent) who has a serious health condition. A dependent child over the age of 18 must be incapable of self-care because of a mental or physical disability.
- For a "qualifying military exigency": the employee's spouse, son, daughter, or parent is a military member on covered active duty (or notified of an impending call or order to covered active duty) in support of a contingency operation
- To care for a service member or a veteran with a serious injury or illness, if the employee is the service member's spouse, son, daughter, parent or next of kin. Leave for this purpose can be for a period of 26 weeks in a 12-month period.

CFRA:

- For the employee's own serious health condition
- Birth of a child for purposes of bonding
- The placement of a child with the employee in connection with adoption or foster care
- To care for a qualifying family member or designated person, as defined by California Government Code section 12945.2, who has a serious health condition.
- For a "qualifying military exigency" for reasons related to deployment or military activities of employee's spouse, domestic partner, child, or parent who is a member of the Armed forces. Leave for this purpose can be up to 12 weeks in a 12-month period.

Length of Leave

FMLA/CFRA:

- The County utilizes the "rolling" 12-month period measured backward for determining protected leave eligibility for FMLA/CFRA. The 12-month period measured backward is from the date an employee uses any FMLA leave. Under the ''rolling'' 12-month period, each time an employee takes FMLA leave, the remaining leave entitlement would be the balance of the 12 weeks which has not been used during the immediately preceding 12 months.
- FMLA and CFRA will always run concurrently (i.e., at the same time), when leave is covered for the same qualifying reason under both acts. When leave is for Pregnancy (PDL), FMLA runs concurrent with PDL but CFRA does not.

Length of Leave (Continued)

FMLA/CFRA:

- The employee is entitled to a maximum of 12 work weeks when FMLA/CFRA protected leaves run concurrently. If FMLA/CFRA run separate, an employee can be entitled for up to 24 weeks.
- Leave on an intermittent basis or on a reduced work schedule may be requested when medically necessary for a serious health condition. When possible, the employee will attempt to schedule medical treatments in a way that would minimize disruption to their department.
- For bonding leave under FMLA, if married and both parents work for the County, the parents must share the 12 weeks of bonding leave. For bonding leave under CFRA, parents are entitled to a separate 12 weeks for bonding (sharing does not apply to CFRA).
- For CFRA baby bonding time, the minimum leave duration taken by the employee must be at least two (2) weeks. An employee may request and employer must allow a leave of less than two weeks duration on two (2) separate occasions. Additional requests must meet the required two-week minimum duration. If the employee requests to take bonding on an intermittent or reduced schedule basis (e.g. hours, days), the employer (department) must agree to the schedule.
- Eligible employees under the Military Caregiver Leave (FMLA) are entitled for up to 26 weeks of leave to care for a covered service member in a single 12-month period.
- Under FMLA/CFRA, eligible employees are entitled for up to 12 weeks for Military Exigency Leave.

Pay

FMLA/CFRA is normally unpaid leave; however, the employee may request or be required to utilize paid leave (e.g., annual leave, vacation, comp time, and sick leave) for all or a portion of the unpaid leave in accordance with the appropriate policies and Memorandum of Understanding.

The employee may be eligible for temporary disability payments under California State Disability Insurance (SDI), and/or California Paid Family Leave (PFL), or another disability plan which may cover the employee during their leave of absence. If eligible for SDI and/or PFL, the employee may elect to integrate their benefit with annual leave.

Advance Notice

A 30-day notice is required if the need for FMLA, and/or CFRA is foreseeable (e.g., the birth/adoption of a child or a planned medical treatment). If the employee fails to provide 30-day notice for a foreseeable leave, their department may postpone the leave until 30 days after the date on the notice. The 30-day notice does not apply to leave for "qualifying exigency"; the employee requesting this leave must provide notice as soon as practicable. If the need for leave is not foreseeable, the employee is required to provide notice within a reasonable time after learning of the need for leave. It is recommended that notice be submitted in writing.

Medical Certification

Written certification from a health care provider is required for either the employee's own serious health condition or the serious health condition of a family member or designated person. It is required that a written certification include a statement of the medical facts supporting the need for protected leave. Failure to provide required certification within 15 calendar days of the date this notice is received may result in delay or denial of leave until the certification is provided. If the certification does not include the medical facts, the County, at its own expense, may require the employee to obtain the opinion of a second health care provider. If the second opinion differs from the original certification, the opinion of a third health care provider may be required. The opinion of the third health care provider shall be final and binding.

Recertification of the employee's own serious health condition or the serious health condition of a family member or designated person may be required periodically. If required, the employee's department will provide the employee with the County's Health Care Provider Medical Certification form.

If the leave request is for bonding, the employee may be asked to provide written verification of the child's birth, such as a copy of a birth certificate, foster care placement court order, custody order, etc.

Under Federal and State regulations, a “health care provider” is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated to exist by x-ray), clinical psychologist, optometrist, nurse practitioner, nurse-midwife, clinical social worker, a physician assistant , or a Christian Science practitioner who is authorized to practice by the State and performing within the scope of the practice as defined by State law.

Medical Certification (Continued)

In addition, any health care provider from whom the County or the employee’s group health plan will accept medical certification to substantiate a claim of benefits; and a health care provider who practices in a country other than the United States, who is licensed to practice in accordance with the laws and regulations of that country.

Health Benefits

County health insurance benefits (medical, dental, vision, and prescription) will be maintained during protected leave (FMLA/CFRA) to the extent coverage would be maintained if the employee had been actively at work during the protected leave period. As long as the employee pays their portion of the health insurance premium for self and dependent(s), the County will continue to make its usual contribution towards the premium during the protected leave. If the employee fails to pay for their portion of the health insurance premium, including their dependent(s), their health benefits coverage will be terminated, and the employee will be responsible for the full cost of any services utilized.

If the employee is on a paid protected leave and their earnings are insufficient to deduct the entire health insurance premium from their paycheck, the employee will be billed for the premium.

When protected leave expires, the employee is no longer eligible to receive the County contribution towards their health insurance premium. If the employee remains on a leave of absence, if eligible, they will have the opportunity to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance benefits. By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s). Note: If the employee fails to remit premium payment while on protected leave, the employee will not be eligible to continue coverage under COBRA until the protected leave period expires. Navia Benefit Solutions (Navia) will bill the employee when eligible for COBRA, and the employee will remit payment directly to Navia. Refer to employee’s leave packet, “Important Information Regarding Health Benefits While on Leave of Absence”, for important information on the employee’s responsibility for premium payment and COBRA election (continued health coverage).

If the employee’s health insurance coverage lapses due to non-payment of the employee’s portion of the premium while the employee is on leave of absence, the employee’s health insurance coverage will automatically reinstate when the employee returns to work (providing the employee has sufficient net pay to cover their portion of the health insurance premium).

If the employee does not return to work at the end of their protected leave the County may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from the employee’s unpaid wages, if any, vacation/annual leave/comp time pay, or other pay due to the employee, or by initiating legal action. However, the employee will not be liable for the premiums if their failure to return to work is due to continuation of their own serious health condition or other reasons beyond their control. The employee will be considered to have returned to work if they work for at least 30 calendar days commencing with their scheduled return date.

Administrative Solutions, Inc. (ASI), the County’s third-party administrator, will bill the employee for health insurance premiums while the employee is on unpaid leave or when their earnings are insufficient to deduct the entire health insurance premium from their paycheck.

For questions on health insurance coverage for protected leave or coverage when not eligible for protected leave, contact Employee Benefits at (559) 600-1810.

Reinstatement

The employee must be reinstated to the same position they had prior to taking the leave, or to an equivalent / comparable position provided that the employee returns to work immediately following the conclusion of their protected leave. If the employee’s position is unavailable (e.g., due to a temporary or indefinite layoff), they have no greater right to reinstatement than had they been continually employed during their protected leave.

Return to Work Clearance

If employee's leave was for their own serious health condition, they are required to present medical certification that clearly states the employee is able to return to work and perform the essential functions of their job. A return-to-work medical certification form is included in this packet. It is recommended that the employee use the form. If the employee elects not to use the form, a written release from the employee's health care provider is required.

County Designation of Protected Leave

By law, the County has an affirmative duty to designate leave as protected (FMLA/CFRA) if the leave meets the requirements listed above, regardless of whether the employee specifically requests a leave under FMLA and/or CFRA.

Privacy of Information

The principal purpose for requesting the information on the attached forms is to process requests for leaves of absence that are eligible for protection pursuant to FMLA/CFRA statutes and regulations, and County policy. The information employees provide may be subject to applicable privacy laws including, but not limited to, the California Confidentiality of Medical Information Act (as amended) and the Federal Health Insurance Portability and Accountability Act (HIPAA), as amended. Copies of the County's HIPAA Privacy Notice are available upon request. Information furnished on these notices may be used by various County departments for benefits, payroll, and human resources administration, and will be transmitted to the Federal and State governments if required by law.

Individuals have the right to review their own records in accordance with County Personnel Rules. Information on applicable policies may be obtained from the employee's department (human resources office), the Department of Human Resources, and the Human Resources web page.

The Department of Human Resources is responsible for maintaining the information contained on these forms.

Military Exigency Leave under FMLA/CFRA

Under FMLA/CFRA eligible employees with a spouse, child, parent, or domestic partner (under CFRA), on covered active duty or called to covered active-duty status in the National Guard, Reserves, or Regular Armed Forces in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, attending post-deployment reintegration briefings, and to care for a military member's parent who is incapable of self-care when the care is necessitated by the member's covered active duty. Contact your department Human resources to obtain the required certification form.

Military Caregiver Leave under FMLA

Under FMLA eligible employees may use their 12-week entitlement under FMLA, plus an additional 12 weeks for up to 26 weeks to take leave to care for a covered service member during a single 12-month period. A covered service member is either:

- a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, or is otherwise on the temporary disability retired list, for a serious injury or illness; or
- a covered veteran who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.

To be eligible for Military Caregiver Leave, the employee must be the spouse, son, daughter, parent, or next of kin of the covered service member. "Next of kin" means the nearest blood relative of the service member, other than the service member's spouse, parent, son, or daughter. Contact your department Human Resources to obtain the required certification form.

COUNTY OF FRESNO
HEALTH CARE PROVIDER MEDICAL CERTIFICATION FORM

Dear Health Care Provider:

To determine employee eligibility for state and/or federal protected leave, please complete the Health Care Provider Section on pages 1-2 of this form. If you have any questions, please call the department contact listed below. Thank you for your assistance.

EMPLOYEE SECTION

EMPLOYEE NAME	PATIENT NAME (IF NOT EMPLOYEE)	PATIENT RELATIONSHIP TO EMPLOYEE

REQUESTED LEAVE BEGIN DATE	ANTICIPATED LEAVE END DATE
DEPARTMENT CONTACT NAME	**PHONE**

☐ By checking the box to the left, I voluntarily authorize this provider to share information necessary to confirm **chiropractic care** qualifications pursuant to FMLA and CFRA definitions.

____
Employee Signature / Date

HEALTH CARE PROVIDER SECTION

LEAVE DESIGNATION

Leave is for: ☐ Employee's own serious health condition ☐ Family member or designated person's serious health condition

☐ Employee's own pregnancy disability

QUALIFYING REASON (at least one box must be checked below)

A serious health condition as defined by FMLA/CFRA is an illness, injury, impairment, or physical or mental condition that involves one or more of the following conditions. A pregnancy-related disability is defined by PDL/FMLA as any disability resulting from pregnancy, childbirth, or any other related medical condition. If the patient is under your care and meets any of these conditions, please check all appropriate boxes. If no conditions apply, please check "None of the above."

- ☐ **Inpatient Care** - Overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with the overnight stay.
- ☐ **Incapacity Plus Treatment** - A period of incapacity for more than three consecutive, full calendar days, with treatment two or more times within 30 days of the first day of incapacity; or treatment on at least one occasion within 7 days of the first day of incapacity and results in a regimen of continuing treatment under the supervision of the health care provider.
- ☐ **Chronic Condition** - Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period. A chronic condition may cause episodic rather than a continuing period of incapacity.
- ☐ **Permanent or Long-Term Condition** - Continuing treatment for a long-term period of incapacity in which treatment may not be effective.
- ☐ **Condition Requiring Multiple Treatments** - Multiple treatments (including period of recovery) due to restorative surgery after an accident or other injury.
- ☐ **Pregnancy** - Continuing treatment for a period of incapacity due to pregnancy, childbirth, or a related medical condition.
- ☐ **Chiropractic** - Treatment consisting of manual manipulation of the spine to correct a subluxation confirmed by x-ray.
- ☐ **None of the Above**

CAREGIVER INFORMATION

If leave is for a **family member or designated person's serious health condition,** is the employee's presence necessary or beneficial to the patient? This may include, but is not limited to, psychological comfort and/or arranging for third-party care.

☐ Yes ☐ No

HEALTH CARE PROVIDER SECTION *(CONTINUED)*
COMPLETION OF THIS SECTION IS REQUIRED

PATIENT NAME

DURATION OF LEAVE

Please specify the type and duration of leave required.

Temporary and Total Disability/Care

If the patient's condition warrants the need for continuous and unbroken leave/care, please designate the period below.

LEAVE BEGIN DATE ______

ANTICIPATED LEAVE END DATE ______

Intermittent Time Off

If the patient's condition warrants the need for periodic or episodic leave/care, please provide in detail the medical necessity, duration, and frequency needed.

MEDICAL NECESSITY (E.G., FLARE UPS, REHABILITATION, DOCTOR APPOINTMENTS, ETC)

______

INTERMITTENT LEAVE BEGIN DATE ______

ANTICIPATED INTERMITTENT LEAVE END DATE ______

INTERMITTENT SCHEDULE REMARKS (E.G., EXCUSED 2 HRS/DAY IF NEEDED, UP TO 5 DAYS/MONTH; OFF 2 DAYS MONTHLY; ETC.)

______

Reduced Work Schedule

If the patient's condition warrants the need for a reduced work schedule, please provide in detail the medical necessity, duration, and frequency needed.

MEDICAL NECESSITY (E.G., LIMITED CAPACITY, RECOVERY, REHABILITATION, ETC.)

______

REDUCED SCHEDULE LEAVE BEGIN DATE ______

ANTICIPATED REDUCED SCHEDULE LEAVE END DATE ______

REDUCED SCHEDULE REMARKS (MAY WORK MAX 4 HOURS PER DAY; MAX 3 DAYS/WEEK, ETC.)

______

Printed Name of Health Care Provider: ______________________________

Signature of Health Care Provider: ______________________________

Medical Health Care Specialty: ______________________________

Date: ______________________________

Phone: ______________________________

Place Stamp Here

COUNTY OF FRESNO
RETURN TO WORK MEDICAL CERTIFICATION FORM

Health Care Provider:

Complete this form only when releasing employee to return to work.

Employee Name: ____

Is the employee able to perform the essential functions of their job with or without reasonable accommodations?

☐ Yes, no restrictions and/or accommodations.

☐ Yes, with restrictions and/or accommodations (please describe below)

Are the restrictions: ☐ Permanent ☐ Temporary – until what date: ______________________________

Please describe the restrictions/accommodations below (please be as specific as possible):

____

____

____

☐ No **If "No", do not complete this "Return to Work" Certification**. Please complete County Medical Certification Form or provide qualifying medical note to excuse employee from work.

Date Employee is Released to Return to Work: ________________________________

Printed Name of Health Care Provider: ___________________________________

Signature of Health Care Provider: ___________________________________

Medical Health Care Specialty: ___________________________________

Date: ___________________________________

Phone: ___________________________________

Place stamp here

IMPORTANT INFORMATION REGARDING HEALTH BENEFITS WHILE ON LEAVES OF ABSENCE

HEALTH BENEFITS UNDER FMLA/CFRA/PDL (*PROTECTED*)

Coverage under the County's health benefit plan (medical, dental, vision and prescription) is maintained during any leave covered by FMLA, CFRA, and/or PDL, for up to 12 weeks under FMLA/CFRA if running concurrently, or up to 24 weeks if FMLA and CFRA run separately, and up to 4 months for PDL, to the extent coverage would be maintained if the employee had been actively at work during the leave period. As long as the employee pays their portion of the health insurance premium for self and dependent(s), the County will continue to make its usual contribution towards the premium during the protected leave. If the employee fails to pay for their portion of the health insurance premium, including their dependent's coverage, their health benefits coverage will be terminated, and the employee will be responsible for the full cost of any services they received.

If the employee's health benefits coverage lapses due to non-payment of the employee portion of the premium while the employee is on leave of absence, the employee's coverage will automatically resume when the employee returns to work (providing the employee has sufficient net pay to cover their portion of the health insurance premium deduction from their paycheck).

Once the protected leave (FMLA/CFRA/PDL) expires, the employee is no longer eligible to receive the County contribution towards their health insurance premium. If the employee remains on a leave of absence, and if they are eligible, they will have the opportunity to elect Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance benefits. By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s).

If the employee does not return to work at the end of their protected leave (FMLA/CFRA/PDL), they will be liable for payment of the health plan premiums (medical, dental, vision, etc.) paid by the County during any unpaid portion of the employee's leave. The County may recover its share of health plan premiums by taking deductions, to the extent permitted by law, from unpaid wages (if any), vacation/annual leave/comp time pay, or other pay due to the employee, or by initiating legal action. However, the employee will not be liable for the premiums if their failure to return to work is due to the continuation of their own serious health condition or other reasons beyond their control. The employee will be considered to have returned to work if they work for at least 30 calendar days commencing with their scheduled return date. Contact Employee Benefits at 600-1810 for additional information.

HEALTH BENEFITS WHILE ON UNPAID LEAVE (*NON-PROTECTED)*

If eligible, the employee will have the opportunity to continue their health benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA). By electing COBRA, the employee is required to pay the full cost of the health insurance premium for self and/or dependent(s).

CONTINUED HEALTH BENEFITS UNDER COBRA

If eligible and the employee elects COBRA coverage (continued health benefits while on a leave of absence) under the County's health benefits plan (medical, dental, vision and prescription), coverage will be maintained ONLY if the employee elects to continue coverage by completing a COBRA election form within 60 days after the date plan coverage ends or 60 days after the date of the COBRA election Notice, whichever is the later of the two. When eligible for COBRA the County's COBRA administrator, Navia Benefit Solutions (Navia), will mail the employee a COBRA election form (for the employee and enrolled dependents). Should the employee elect COBRA for self and dependent(s) they will be responsible to pay for the entire premium. ***NOTE: COBRA law does not require that separate billing/invoices be sent to COBRA-eligible beneficiaries. The COBRA Notice issued to employees contains all necessary information about COBRA benefits and enrollment requirements, including the health benefit premium amount and at what time premium payments are due; please carefully review the COBRA Notice.*** If the employee fails to continue to make payments, health benefit coverage will be terminated, and the employee will be responsible for the full cost of any services they received. **Contact Navia at (425) 452-3490** for more information on submitting COBRA premium payments. Contact Employee Benefits at (559) 600-1810 for questions regarding health coverage while on a leave of absence.

HEALTH PREMIUM BILLING: ADMINISTRATIVE SOLUTIONS, INC. (ASI) AND NAVIA

While Navia administers the COBRA leave billing, ASI, will bill employees for their health insurance premiums while they are on an unpaid protected leave (e.g. FMLA/CFRA/PDL) and for employees on paid leave when their earnings are insufficient to deduct the entire health insurance premium from their paycheck. Employees billed by ASI for health insurance premiums shall make their payments directly to ASI. Employees who have elected COBRA coverage will receive invoices from and make their payments to Navia. If the employee fails to pay for their premiums by the due date, their health insurance coverage will be terminated.

The employee must ensure they complete all necessary leave of absence paperwork and submit to their supervisor and/or department's human resources office. Contact Risk Management at (559) 600-1850 for information related to on-the-job injury or illness. Note: OJI leave runs concurrently (i.e., at the same time) with FMLA/CFRA.

EMPLOYEE COST – PLAN YEAR 2024
LOA HEALTH PLAN PREMIUM RATES

RATE INFORMATION

- Employees in Unit 1, 14, 35, 37 or 38, please contact DiBuduo & DeFendis Group at (559) 437-6750.
- Part-time employees, please contact Administrative Solutions, Inc. (ASI) at (559) 256-1320.
- All other employees covered under County Health Plans, please see below.

STANDARD BIWEEKLY RATES

Bargaining Units 2, 3, 4, 7, 10, 11, 12, 19, 22, 25, 30, 31, 36,39, 42, 43, UNR, MGT and SMG:

	PLAN 1		PLAN 2		PLAN 3	
Medical / Mental Health Prescription / Vision	Anthem EPO Yosemite EmpiRx / VSP		Anthem EPO Sierra EmpiRx / VSP		Anthem EPO Pismo EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 82.37	$ 71.80	$ 17.54	$ 6.97	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 259.17	$ 244.09	$ 140.50	$ 125.42	$ 96.48	$ 81.40
Employee + Child(ren)	$ 145.39	$ 135.22	$ 41.36	$ 31.19	$ 2.81	$ 0.00
Employee + Family	$ 365.99	$ 350.47	$ 209.14	$ 193.62	$ 151.19	$ 135.67

	PLAN 4		PLAN 5	
Medical / Mental Health Prescription / Vision	Anthem PPO 250 EmpiRx / VSP		Anthem HDPPO 3000 EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 147.08	$ 136.51	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 532.94	$ 517.86	$ 20.75	$ 5.67
Employee + Child(ren)	$ 419.88	$ 409.71	$ 0.00	$ 0.00
Employee + Family	$ 800.57	$ 785.05	$ 83.21	$ 67.69

	PLAN 6		PLAN 7	
Medical / Mental Health Prescription / Vision	Kaiser Permanente HMO Kaiser / Kaiser		Kaiser Permanente HDHP Kaiser / Kaiser	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 94.61	$ 84.04	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 267.31	$ 252.23	$ 44.45	$ 29.37
Employee + Child(ren)	$ 157.65	$ 147.48	$ 0.00	$ 0.00
Employee + Family	$ 379.51	$ 363.99	$ 84.60	$ 69.08

Bargaining Unit 13:

	PLAN 1		PLAN 2		PLAN 3	
Medical / Mental Health Prescription / Vision	Anthem EPO Yosemite EmpiRx / VSP		Anthem EPO Sierra EmpiRx / VSP		Anthem EPO Pismo EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 107.37	$ 96.80	$ 42.54	$ 31.97	$ 18.23	$ 7.66
Employee + Spouse / DP	$ 409.17	$ 394.09	$ 290.50	$ 275.42	$ 246.48	$ 231.40
Employee + Child(ren)	$ 295.39	$ 285.22	$ 191.36	$ 181.19	$ 152.81	$ 142.64
Employee + Family	$ 515.99	$ 500.47	$ 359.14	$ 343.62	$ 301.19	$ 285.67

	PLAN 4		PLAN 5	
Medical / Mental Health Prescription / Vision	Anthem PPO 250 EmpiRx / VSP		Anthem HDPPO 3000 EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 172.08	$ 161.51	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 682.94	$ 667.86	$ 170.75	$ 155.67
Employee + Child(ren)	$ 569.88	$ 559.71	$ 99.81	$ 89.64
Employee + Family	$ 950.57	$ 935.05	$ 233.21	$ 217.69

	PLAN 6		PLAN 7	
Medical / Mental Health Prescription / Vision	Kaiser Permanente HMO Kaiser / Kaiser		Kaiser Permanente HDHP Kaiser / Kaiser	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Employee Only	$ 119.61	$ 109.04	$ 0.00	$ 0.00
Employee + Spouse / DP	$ 417.31	$ 402.23	$ 194.45	$ 179.37
Employee + Child(ren)	$ 307.65	$ 297.48	$ 111.18	$ 101.01
Employee + Family	$ 529.51	$ 513.99	$ 234.60	$ 219.08

EMPLOYEE COST – PLAN YEAR 2024
LOA HEALTH PLAN PREMIUM RATES CONT.

COBRA MONTHLY RATES:

All Bargaining Units:

	PLAN 1		PLAN 2		PLAN 3	
Medical / Mental Health Prescription / Vision	Anthem EPO Yosemite EmpiRx / VSP		Anthem EPO Sierra EmpiRx / VSP		Anthem EPO Pismo EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Participant Only	$ 1,138.12	$ 1,114.75	$ 994.84	$ 971.47	$ 941.11	$ 917.75
Participant + Spouse / DP	$ 2,048.20	$ 2,014.87	$ 1,785.94	$ 1,752.60	$ 1,688.67	$ 1,655.34
Participant + Child(ren)	$ 1,796.73	$ 1,774.24	$ 1,566.82	$ 1,544.33	$ 1,481.64	$ 1,459.15
Participant + Family	$ 2,693.15	$ 2,658.84	$ 2,346.50	$ 2,312.20	$ 2,218.44	$ 2,184.14

	PLAN 4		PLAN 5	
Medical / Mental Health Prescription / Vision	Anthem PPO 250 EmpiRx / VSP		Anthem HDPPO 3000 EmpiRx / VSP	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Participant Only	$ 1,281.13	$ 1,257.76	$ 735.87	$ 712.50
Participant + Spouse / DP	$ 2,653.25	$ 2,619.92	$ 1,521.32	$ 1,487.99
Participant + Child(ren)	$ 2,403.38	$ 2,380.88	$ 1,364.53	$ 1,342.03
Participant + Family	$ 3,653.56	$ 3,619.26	$ 2,068.21	$ 2,033.91

	PLAN 6		PLAN 7	
Medical / Mental Health Prescription / Vision	Kaiser Permanente HMO Kaiser / Kaiser		Kaiser Permanente HDPPO Kaiser / Kaiser	
Dental Plans	Delta Dental DPPO	DeltaCare USA DHMO	Delta Dental DPPO	DeltaCare USA DHMO
Participant Only	$ 1,165.18	$ 1,141.81	$ 890.72	$ 867.35
Participant + Spouse / DP	$ 2,066.20	$ 2,032.87	$ 1,573.68	$ 1,540.34
Participant + Child(ren)	$ 1,823.86	$ 1,801.37	$ 1,389.64	$ 1,367.15
Participant + Family	$ 2,723.02	$ 2,688.72	$ 2,071.25	$ 2,036.95

Notice to Employees

Employment Development Department
State of California

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

UI

Unemployment Insurance

(funded entirely by employers' taxes)

Unemployment Insurance (UI) is paid for by your employer and provides partial income replacement when you are unemployed or your hours are reduced due to no fault of your own. To claim UI benefit payments you must also meet all UI eligibility requirements, including that you must be available for work and searching for work.

How to File a New UI Claim

Use one of the following methods:

- **Online:** UI Online[SM] is the fastest and most convenient way to file your UI claim. Visit UI Online (edd.ca.gov/UI_Online) to get started.
- **Phone:** Representatives are available at the following toll-free numbers, Monday through Friday between **8 a.m. to 12 noon** (Pacific Standard Time) except during state holidays.

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

- **Fax or Mail:** When accessing UI Online to file a new claim, some customers will be instructed to fax or mail their UI application to the EDD. If this occurs, the *Unemployment Insurance Application* (DE 1101I), will display. For faster and more secure processing, fax the completed form to the number listed on the form. If mailing your UI application, use the address on the form and allow additional time for processing.

Important: Waiting to file your UI claim may delay benefit payments.

DI

Disability Insurance

(funded entirely by employees' contributions)

Disability Insurance (DI) is funded by employees' contributions and provides partial wage replacement benefits to eligible Californians who are unable to work due to a non-work-related illness, injury, pregnancy, or disability.

Your employer must provide the *Disability Insurance Provisions* (DE 2515) brochure, to newly hired employees and to each employee who is unable to work due to a non-work-related illness, injury, pregnancy, or disability.

How to File a New DI Claim

Use one of the following methods:

- **Online:** SDI Online is the fastest and most convenient way to file your claim. Visit SDI Online (edd.ca.gov/SDI_Online) to get started.
- **Mail:** To file a claim with the EDD by mail, complete and submit a *Claim for Disability Insurance (DI) Benefits* (DE 2501) form. You can obtain a paper claim form from your employer, physician/practitioner, visiting a State Disability Insurance office, online at EDD Forms and Publications (edd.ca.gov/Forms), or by calling 1-800-480-3287.

Note: If your employer maintains an approved Voluntary Plan for DI coverage, contact your employer for assistance.

For more information about DI, visit State Disability Insurance (edd.ca.gov/disability) or call 1-800-480-3287.
State government employees should call 1-866-352-7675.
TTY (for deaf or hearing-impaired individuals only) is available at 1-800-563-2441.

PFL

Paid Family Leave

(funded entirely by employees' contributions)

Paid Family Leave (PFL) is funded by employees' contributions and provides partial wage replacement benefits to eligible Californians who need time off work to care for seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner. Benefits are available to parents who need time off work to bond with a new child entering the family by birth, adoption, or foster care placement. Benefits are also available for eligible Californians who need time off work to participate in a qualifying event resulting from a spouse, registered domestic partner, parent, or child's military deployment to a foreign country.

Your employer must provide the *Paid Family Leave* (DE 2511) brochure, to newly hired employees and to each employee who is taking time off work to care for a seriously ill family members, to bond with a new child, or to participate in a qualifying military event.

How to File a New PFL Claim

Use one of the following methods:

- **Online:** SDI Online is the fastest and most convenient way to file your claim. Visit SDI Online (edd.ca.gov/SDI_Online) to get started.
- **Mail:** To file a claim with the EDD by mail, complete and submit a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) form. You can obtain a paper claim form from your employer, a physician/practitioner, visiting a State Disability Insurance office, online at EDD Forms and Publications (edd.ca.gov/Forms), or by calling 1-877-238-4373.

Note: If your employer maintains an approved Voluntary Plan for PFL coverage, contact your employer for assistance.

For more information about PFL, visit State Disability Insurance (edd.ca.gov/disability) or call 1-877-238-4373.
State government employees should call 1-877-945-4747.
TTY (for deaf or hearing-impaired individuals only) is available at 1-800-445-1312.

Note: Some employees may be exempt from coverage by the above insurance programs. It is illegal to make a false statement or to withhold facts to claim benefits. For additional information, visit the EDD (edd.ca.gov).

SDI BENEFITS & INTEGRATION PACKET

State Disability Insurance & Paid Family Leave Benefits:
Integrating Accrued Paid Leave

California State Disability Insurance (SDI) provides short-term Disability Insurance (DI) and Paid Family Leave (PFL) wage replacement benefits to eligible workers who need time off work for qualifying non work-related illness or injuries.

ELIGIBILITY CRITERIA

- You must be covered by SDI. Employees in Units 2, 3, 4, 7, 11, 12, 13, 19, 22, 25, 30, 31, 36, 37, 39, 42, 43, as well as Unrepresented employees and Management employees (excluding Department Heads and Elected Officials) are currently covered by SDI;
- You must be on an approved leave of absence (LOA). Complete all required leave paperwork;
- You must have an approved SDI claim;
- DI benefits: you must have an illness or injury, either physical or mental, which prevents you from performing your regular and customary work. Disability also includes elective surgery, pregnancy, childbirth, or other related medical conditions;
- PFL benefits: your request must be to take time off from work to care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner) or to bond with a new child entering the family through birth, adoption, or foster care placement.

BENEFITS

	Disability Insurance	Paid Family Leave
Benefit Period	Payable up to 52 weeks.	Payable up to 8 weeks within a 12-month period.
Waiting Period	7 days (annual leave hours must be used during this time). Subsequent claims filed within the same 12-month period may be subject to a new waiting period.	None.
Weekly Benefit Amount	Approximately 60-70% (depending on income) of wages earned 5-18 months prior to the claim start date.	Approximately 60-70% (depending on income) of wages earned 5-18 months prior to the claim start date.

PAY OPTIONS

You must select one of the options below by completing the DI / PFL Benefits Integration Election Form and returning it to your department's Personnel office.

1. Integrate paid leave with DI / PFL benefits;
2. Decline to use paid leave and collect only DI / PFL benefits; or
3. Receive only paid leave until balances are exhausted (this is the default option).

INTEGRATION

The DI / PFL Program allows for integration of benefits with your paid leave and has the effect of approximating full compensation by combining paid leave and SDI benefits. Please be advised that you will not accrue paid time off during your period of integration.

SDI Benefit	County Benefit (paid leave)	Total Benefit	Timesheet Coding
60% of your salary	Up to 40%* (submission of EDD benefit statement within 30 days of receipt is required)	Up to 100% of salary	Up to 40% paid leave, with 60% dock time (the waiting period, if applicable, is coded as paid leave)
70% of your salary	Up to 30%* (default)	Up to 100% of salary	Up to 30% paid leave, with 70% dock time (the waiting period, if applicable, is coded as paid leave)

*County Benefit dependent upon employee's available paid leave balance

EMPLOYEE RESPONSIBILITIES

1. **Complete the DI / PFL Benefits Integration Election Form** (required even if you are not electing to integrate).
    a. Option #1: If you elect to integrate, you must complete and submit the form timely, and you must continue integration until your LOA ends or your leave balances are exhausted. If your form is submitted late, integration of hours will begin once submitted (retroactive integration requests are not granted). If you receive more paid leave hours than you are eligible for due to your late request for integration, you must work with the State Employment Development Department (EDD) to return any overpayments.
    b. Option #2: If you elect to not use your paid leave and instead receive DI / PFL benefits only, you will be placed on an unpaid LOA. This election is irrevocable and will stay in effect until you return to work. There is one exception: you may elect to integrate your paid leave upon extension of your LOA by completing a new form; however, your form must be submitted before your extension begins, as retroactive integration requests are not granted.
    c. Option #3: If you elect to use your paid leave hours only, you will not collect SDI /PFL benefits and will be placed on a paid leave until your leave hours are exhausted.
2. **File a claim with SDI**.

    It is your responsibility to file an SDI claim. The County is not involved in the application/benefit payment processes. The role of the County is limited to verifying employment, pay rate, dates of absence, and integrating your annual leave (if applicable).
3. **Remit Health Premium Payment** (if necessary).

    If earnings are not sufficient to cover your premium deduction while integrating, health benefits will be terminated, and you will receive a billing notice. It will be your responsibility to remit premium payment timely to have your health coverage reinstated. Please ensure you provide your department with the required leave of absence documentation, including a medical note.

STATE DISABILITY INSURANCE
DISABILITY INSURANCE (DI) & PAID FAMILY LEAVE (PFL)
INTEGRATION ELECTION FORM

Name (Print): ______________________________ **Employee ID:** ______________________

Last Day of Work: ______________________ **Duration of LOA:** ____________________

Please elect one of the options below (required):

1. **INTEGRATE**: I elect to integrate my paid leave with DI/PFL benefits during my LOA.	____
2. **DI / PFL ONLY**: I elect to not use my paid leave with DI/PFL benefits during my LOA.	____
3. **PAID LEAVE ONLY**: I do not intend to file a claim for DI/PFL benefits. I understand that I must use the maximum amount of paid leave that I'm eligible for during my LOA.	____

In addition to your election above, by signing this form you agree to the following conditions:

1. Once you elect integration (Option #1 above), you may not alter this election until your paid leave is exhausted or until you return to work. There are no exceptions to this rule.
2. If you choose Option #2 above:
   a. You must use the lesser of forty (40) hours of paid leave or your entire leave balance to cover the waiting period for DI benefits (there is no waiting period for PFL benefits); and
   b. You may only change your election upon extension of your current LOA.
3. If you submit this Integration Election Form late, there is no retroactive integration – the County will not process a payroll adjustment to restore your leave balances.
4. If you are eligible for the 60% DI / PFL benefit and you submit your EDD benefit statement to your department within thirty (30) days of receipt, your integration formula will be adjusted to 40% paid leave and 60% dock time. (The default is 70% DI / PFL.)
5. During your LOA, you may choose the order in which your leave balances are exhausted by completing the table below:

Order	Type	Order	Type
	Annual Leave I		Sick Leave
	Annual Leave II		Vacation
	Annual Leave III		Time Off Bank
	Annual Leave IV		Other (specify):

I have read, understand, and will comply with the terms and conditions described in the SDI Benefits & Integration packet and Integration Election Form.

____ ________________

Signature **Date**