Human Resources & Development
COUNTY OF TULARE
AGENDA ITEM

BOARD OF SUPERVISORS

KUYLER CROCKER
District One

PETE VANDER POEL
District Two

AMY SHUKLIAN
District Three

EDDIE VALERO
District Four

DENNIS TOWNSEND
District Five

AGENDA DATE: June 25, 2019 - **REVISED**

Public Hearing Required	Yes ☐	N/A ☒
Scheduled Public Hearing w/Clerk	Yes ☐	N/A ☒
Published Notice Required	Yes ☐	N/A ☒
Advertised Published Notice	Yes ☐	N/A ☒
Meet & Confer Required	Yes ☐	N/A ☒
Electronic file(s) has been sent	Yes ☒	N/A ☐
Budget Transfer (Aud 308) attached	Yes ☐	N/A ☒
Personnel Resolution attached	Yes ☒	N/A ☐
Agreements are attached and signature line for Chairman is marked with tab(s)/flag(s)	Yes ☒	N/A ☐

CONTACT PERSON: Rhonda Sjostrom PHONE: 636-4900

SUBJECT: Approval of Salary Increases for Unrepresented Employees in Bargaining Units 9, 10, 11, 19, 20 and 21 and Other Compensation and Benefit Changes, Revisions to the Personnel Rules, and the Section125 Benefits Plan Document

REQUEST(S):

That the Board of Supervisors approve salary increases for Unrepresented Employees in Specified Bargaining Units and other benefits and compensation changes, revisions to the Personnel Rules, and the Section 125 Benefits Plan in accordance with the following:

1. For Unrepresented employees in Bargaining Units 9, 10, 11, 19, 20 and 21 a 2% salary increase effective July 7, 2019 and a 2% salary increase effective July 5, 2020. (This does not apply to County Elected Officials and the Board of Supervisors.)

2. Sunset of the Sick Leave Buy Back program with the last payouts occurring in February 2020.

3. Continuation of the County's matching contribution ($1.00 County dollar contributed for every $4.00 employee dollars contributed, up to a maximum of $1,500 County dollars per calendar year) in the Deferred Compensation program, but an increase from a maximum match of $1,500 County dollars per calendar year, to $1,750 per calendar year beginning January 1, 2020.

4. Continuation of the funding for the Minimum Benefit Amount for Health Plan

Years 2020 and 2021 for employees participating in the County health plan whose Benefit Amount may be less than the premium amount for $1,000 deductible employee-only plan. The County shall contribute an additional $100 per pay period (24 pay periods) for employees selecting Employee + Spouse, Employee + Child, or Employee + Family coverage effective with the 2020 Health Plan Year. The additional contribution of $100 per pay period will continue in the 2021 Health Plan Year to address employees who have dependents & family.

5. Increase life insurance from $10,000 to $30,000 for Unrepresented employees, effective January 1, 2020.

6. Reinstating "Code of Ethics" Policy for HHSA Unrepresented employees.

7. Revisions to Personnel Rules 13 "Employee Grievance Procedure" and Rule 14 "Equal Employment Opportunity/Discrimination/Sexual Harassment Policy" as detailed in the attached Resolution. This applies to Unrepresented employees upon adoption by the Board and upon completion of meet and confer for employees in represented Bargaining Units (attached).

8. Revision to the Section 125 Benefits Plan-Revised and Restated Document as detailed in the attached Resolution. This applies to Unrepresented employees upon adoption by the Board and upon completion of meet and confer for employees in represented Bargaining Units (attached).

9. Implementation of Medical Monitoring program for Unrepresented classifications. (attached)

10. Implementation of DMV Pull Program for Unrepresented classifications. (attached)

SUMMARY:

The County Administrative Office has determined that the County is in a position to grant salary increases and other compensation changes for Fiscal Years 2019-20 and 2020-21. There are 732 full time allocated positions in Bargaining Units 9, 10, 11, 19, 20 and 21.

The Sick Leave Buy Back program provides for a monetary incentive for those employees that are able to use less sick time and desire to convert sick hours to additional compensation. However, this program does not benefit employees with dependents/ families that require the employee to utilize sick leave for multiple medical appointments or to stay home with a sick child. Upon review, the HRD and CAO recommends sunsetting the program and shifting funds for increases to health

benefits to reduce employee premiums for employee with child, employee with spouse, and employee with family.

The County's match contribution in the Deferred Compensation program encourages more employees to participate in the program and to save for retirement. The match for Unrepresented employees will increase by $250, from $1,500 to $1,750 effective January 1, 2020.

The Minimum Benefit Amount for the Health Plan is to ensure that employees will have a benefit amount that is sufficient to pay for the premium charged for the $1,000 deductible employee-only medical, dental, vision, and life insurance coverage. *Effective with the 2020 Health Plan Year the County will contribute an additional $100 per pay period (24 pay periods) toward insurance premiums for those enrolled in the County employee plus child, employee plus spouse, or employee plus family plans. The contribution of the additional $100 per pay period will continue in the 2021 Health Plan Year.

Additionally, the County will increase the life insurance coverage for Unrepresented employees who were receiving $10,000 coverage to $30,000 coverage, effective January 1, 2020.

Revisions to the Personnel Rules 13 and 14, and the Section 125 Benefits Plan are the result of a departmental review to ensure compliance with Federal and State employment laws. County Counsel reviewed and recommended proposed changes for Personnel Rules. HRD, County Counsel and the law firm of Liebert, Cassidy, and Whitmore worked on the revisions of the 125 Benefit Plan Document which was last updated in 2011.

FISCAL IMPACT/FINANCING:

If approved, the salary increases will result in increased salary costs of approximately $3,137,232 and increased benefits of $734,000 for the 2019-20 and the 2020-21 budgets.

LINKAGE TO THE COUNTY OF TULARE STRATEGIC BUSINESS PLAN:

These recommendations link to the County's Strategic Plan, under Organizational Performance 4.2: Provide a qualified, productive and competitively compensated County workforce.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
Human Resources Director

SUBJECT: Approval of Salary Increases for Unrepresented Employees in Bargaining Units 9, 10, 11, 19, 20 and 21 and Other Compensation and Benefit Changes, Revisions to the Personnel Rules, and the Section 125 Benefits Plan Document

DATE: June 25, 2019

Attachment(s)
Revisions to Personnel Rule 13 and 14
Revisions to 125 Benefit Plan Document
Updated HHSA Code of Ethics Policy
Medical Monitoring Program
DMV Pull Program

cc: County Administrative Office
Human Resources & Development
Auditor-Controller
County Counsel
All Department Heads

BEFORE THE BOARD OF SUPERVISORS
COUNTY OF TULARE, STATE OF CALIFORNIA

IN THE MATTER OF APPROVAL OF SALARY INCREASES FOR UNREPRESENTED EMPLOYEES IN BARGAINING UNITS 9, 10, 11, 19, 20, AND 21 AND OTHER COMPENSATION AND BENEFIT CHANGES, REVISIONS TO THE PERSONNEL RULES, AND THE SECTION 125 BENEFITS PLAN DOCUMENT

Resolution No. _____
Agreement No. _____

UPON MOTION OF SUPERVISOR _____, SECONDED BY SUPERVISOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF SUPERVISORS, AT AN OFFICIAL MEETING HELD June 25, 2019, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST: JASON T. BRITT
COUNTY ADMINISTRATIVE OFFICER/
CLERK, BOARD OF SUPERVISORS

BY: _____
Deputy Clerk

* * * * * * * * * * * * * * * * * * *

That the Board of Supervisors approved:

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2. Sunset of the Sick Leave Buy Back program with the last payouts occurring in February 2020.

3. Continuation of the County's matching contribution ($1.00 County dollar contributed for every $4.00 employee dollars contributed, up to a maximum of $1,500 County dollars per calendar year) in the Deferred Compensation

program, but an increase from a maximum match of $1,500 County dollars per calendar year, to $1,750 per calendar year beginning January 1, 2020.

4. Continuation of the funding for the Minimum Benefit Amount for Health Plan Years 2020 and 2021 for employees participating in the County health plan whose Benefit Amount may be less than the premium amount for $1,000 deductible employee-only plan. The County shall contribute an additional $100 per pay period (24 pay periods) for employees selecting Employee + Spouse, Employee + Child, or Employee + Family coverage effective with the 2020 Health Plan Year. The additional contribution if $100 per pay period will continue in the 2021 Health Plan Year to address employees who have dependents & family.

5. Increase life insurance from $10,000 to $30,000 for Unrepresented employees, effective January 1, 2020.

6. Reinstating "Code of Ethics" Policy for HHSA Unrepresented employees.

7. Revisions to Personnel Rules 13 "Employee Grievance Procedure" and Rule 14 "Equal Employment Opportunity/Discrimination/Sexual Harassment Policy" as detailed in the attached Resolution. This applies to Unrepresented employees upon adoption by the Board and upon completion of meet and confer for employees in represented Bargaining Units (attached).

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9. Implementation of Medical Monitoring program for Unrepresented classifications. (attached)

10. Implementation of DMV Pull Program for Unrepresented classifications. (attached)

AGENCY CODE OF ETHICS

Posted: MM/DD/YYYY
Replaces: 20-11 AGENCY CODE OF ETHICS

I. PURPOSE

This code is intended to serve as a guide to the everyday conduct of staff employed by the Health & Human Services Agency (HHSA). It represents a minimum standard of ethical behavior in working relationships with clients, colleagues, and employers, and with the community as a whole.

HHSA's Vision:
Healthy children and adults, supportive families, thriving communities.

HHSA's Mission:
Dedicated to protecting and strengthening the well-being of the community through development of effective policies, practices, and services delivered in a culturally and linguistically competent manner.

HHSA's Core Values:

- HHSA sponsors services and policies that are: collaborative, community-driven, evidence-based.
- HHSA promotes service delivery that is: culturally competent, respectful, a model of excellence.
- HHSA supports a work environment that demonstrates: diversity, integrity, accountability, teamwork and mutual respect, staff development and recognition.

The guidelines provided within this policy acknowledge that, although diverse as individuals, we hold shared values that inform and further our commitment to clients, coworkers, and the community.

II. SCOPE

This policy applies to all HHSA staff.

III. REFERENCE

United States Sentencing Commission, Guidelines Manual, §8B2.1 (Nov. 2016).

IV. DEFINITIONS

"Client(s)" refers to, but is not limited to, consumers, patients, and customers.
"Employee(s)" refers to HHSA staff, including a person occupying an allocated position in HHSA, a person temporarily hired as Extra Help, or a volunteer.

V. POLICY

All HHSA staff shall abide by the following policy when dealing with other employees or when dealing with clients.

A. Employee-Client Relationships

1. Employees shall not participate in, condone, or be in any way associated with dishonesty, fraud, deceit, or misrepresentation in their work responsibilities.

2. Employees must distinguish clearly between statements made and actions taken as a private citizen and those statements made and actions taken as a representative of the Health & Human Services Agency.

3. Employees must not exploit work relationships with clients for monetary gain or any other personal advantage.

4. Employees are strictly forbidden from engaging in social or sexual relationships with any client with whom they have a professional relationship or those deemed to have vulnerable mental capabilities and/or mental disabilities.

5. Employees must seek advice, counsel, and/or supervisorial intervention whenever necessary to provide the best possible outcome for a client.

6. Employees must provide clients with accurate and complete information regarding the extent and nature of the services available to them. Staff must ensure that all persons seeking services have full access to the resources and services offered by the Health & Human Services Agency and associated community programs.

7. Employees must not discriminate against, nor give preferential treatment to, any client on the basis of race, color, sex, sexual orientation, gender identity, age, religion, national origin, marital status, mental or physical disability, or for any other reason.

8. Employees must strictly protect client confidentiality. Client information must be shared only with those directly involved in client care, and employees may release information only in keeping with County policy and in compliance with federal, state, and local law.

9. Employees are prohibited from accessing, reviewing, or working on any case or medical record not assigned to their individual workload. They are also prohibited from accessing the cases of acquaintances, friends, relatives, and their own case.

10. Employees must ensure that their personal values or biases are not imposed upon their clients.

11. Employees must obtain informed consent from clients before any taping, recording, or permitting of third-party observation of the client's interaction with an Agency representative.

B. Employee-Employee Relationships

1. Employees will deal honestly and in good faith with each other in the course of their work.

2. Employees must use discretion in their conversation at all times, protecting the privacy and confidence of their coworkers and clients. The sharing of sensitive, private, or confidential information must not take place in public areas where it could be overheard.

3. Employees must be familiar with and adhere to County of Tulare policies, especially Sexual Harassment, Discrimination, and Workplace Violence policies. Any observed violation shall be immediately reported to a supervisor.

4. Employees must accept responsibility for their words, actions, and performance of job duties. Any employee who does not understand a task or work assignment must inform his or her supervisor.

5. Employees are expected to work in a cooperative, collaborative, and constructive manner to achieve the common goal of providing quality service to the public.

6. Any employee who experiences an unresolved interpersonal or other work-related difficulty is to report the difficulty to his or her supervisor. Gossip does not present a positive resolution and will not be tolerated in the workplace.

VI. PROCEDURES

A. If, during the course of providing services, the relationship between an Agency staff member and a client appears to be of a social or personal nature, the employee must immediately notify his or her supervisor so as to be removed from providing any further services to said client.

B. If a supervisor receives notification of a personal or social relationship between a client and an Agency employee assigned to that client's case, the supervisor must immediately reassign the client to an employee who has no such conflict.

C. An employee must not access the case or medical record of an acquaintance, friend, or relative. If requested to do so, the employee must report this request to his or her supervisor.

D. Employees assigned to cases must treat all clients in a fair and objective manner, regardless of any relationship of clients to coworkers. No employee may give preferential treatment nor provide less than the best possible service to any client, for any reason.

E. When employees are also receiving services as clients of HHSA, their cases will be handled by a supervisor within the service unit. The files of employees who are receiving Agency services will be locked and accessible only to Agency supervisory and management staff.

F. Employees will respect the time of their clients and coworkers by reporting on time and ready to work at their scheduled start time, including scheduled start times of meetings, trainings, and mandatory functions.

G. Employees will respect the workflow and efficiency of the Agency by communicating clearly and listening actively to clients, coworkers, and the community.

H. Employees will respect the trust of the public by using County property and resources for the purpose of conducting County business.

I. Employees will respect the trust of the public by using their work time productively and engaging in the work duties for which they were hired.

J. Employees will respect the dignity of the Agency and participate in creating a safe and harmonious workplace by speaking respectfully, dressing professionally, and behaving courteously.

K. Employees will respect the confidences of their clients and coworkers by keeping personal, sensitive, or confidential information out of common areas, social media, or any other venue that could expose a client or coworker to embarrassment, ridicule, or danger, or otherwise violate any other legal protection.

L. Employees will abstain from any behavior that could be perceived as violent, threatening, or hostile by respecting personal boundaries and cultural differences, as well as keeping speech free from profanity.

M. All reports of unethical or discriminatory behavior will be investigated and an appropriate level of disciplinary action allowed for this violation will apply.

AGENCY CODE OF ETHICS

Posted: MM/DD/YYYY
Replaces: 20-11 AGENCY CODE OF ETHICS

Revised by: Agency Policy Committee Date: March 15, 2018

The above policy is approved for immediate implementation.

	Title	Date
	Title	Date
	Title	Date

PERSONNEL RULE 13 & 14

Rule 13 - EMPLOYEE GRIEVANCE PROCEDURE

13.1 DEFINITION, SCOPE, AND RIGHT TO FILE

13.1.1 A grievance is a claimed violation, misinterpretation, inequitable application or non-compliance with provisions of a County:

1) Collective bargaining agreement,

2) Ordinance,

3) Resolution,

4) Written Rule,

5) Written Regulation,

6) Written Policy.

13.1.2 The following are not grievable through this process:

1) Matters, such as Disciplinary Actions and Performance Evaluations, reviewable under some other established County administrative appeal procedure.

2) Employment examinations

3) Appointments to a position

4) The Board of Supervisors exercise of legislative or judicial authority and the authority to appropriate funds and adopt the budget

5) Discrimination complaints reviewable under the County's discrimination complaint procedure.

13.1.3 A grievance may be filed by an employee in his own behalf, or jointly by any group of employees. At the employee's request, a union representative may assist in the preparation of the grievance during non-work time.

13.2 DISCRIMINATION COMPLAINTS

If a complaint alleges discrimination, the Human Resources Director shall be immediately informed and, upon completion of his investigation and review, shall advise the County Administrative Officer (CAO), the department and the employee of the resolution of the complaint.

13.3 **TIMELINES FOR FIRE PERSONNEL**

The provisions of this article when applied to Fire fighter personnel who work 24 hours shifts or 48 hour tours of duty shall be converted to calendar days such that for every 5 work days applied to 40 hour employees shall be converted to 8 calendar days (a ratio of 1:1.6).

13.4 **INFORMAL GRIEVANCE**

13.4.1 Within five (5) work days of the event giving rise to the grievance, the grievant shall present the grievance informally for disposition by the immediate supervisor or at any appropriate level of authority within the department. The immediate supervisor (or other appropriate level of authority) shall respond informally within five (5) work days.

13.4.2 Except as provided in 13.2 above, presentation of an INFORMAL grievance shall be a prerequisite to the institution of a formal grievance.

13.5 **FORMAL GRIEVANCE**

13.5.1 If the grievant believes that the issue(s) of the grievance have not been resolved within five (5) work days of the informal presentation the grievant may initiate a formal grievance within five (5) work days thereafter. A formal grievance can be initiated by completing and filing a County Employee Grievance Form with the Human Resources & Development Department. The form shall contain:

1) Name(s), class title(s), department(s) and mailing address(s) of the grievant(s),

2) A clear statement of the nature of the grievance (citing the applicable ordinance, rule, regulation, or contract language),

3) The date upon which the event giving rise to the alleged grievance occurred,

4) The date upon which the informal discussion with the supervisor or Human Resources Officer took place,

5) A proposed solution to the grievance,

6) The date of the execution of the grievance form,

7) The signature of the grievant(s),

8) The name of the organization, if any, representing the grievant followed by the signature of the organization's representative.

13.5.2 Step 1

Within ten (10) working days after a formal grievance is filed, the Supervisor or Manager shall investigate the grievance, confer with the grievant in an attempt to resolve the grievance, and make a decision in writing. The Appointing Authority may first seek to resolve the issue(s) through a meeting including the grievant and such staff as the grievant's supervisor, a manager of that supervisor and/or a department Human Resources specialist.

13.5.3 Step 2

a) If the grievance is not resolved in Step 1 to the satisfaction of the grievant, the grievant may, within not more than five (5) work days from receipt of the Supervisor's or Manager's decision, request consideration of the grievance by the Appointing Authority, by so notifying the Human Resources & Development Department in writing.

b) Within ten (10) work days after such notification, the Appointing Authority shall commence investigation of the grievance, confer with the grievant and other persons affected and their representatives (if any) to the extent he deems necessary, and render a decision in writing.

c) If the written decision of the Appointing Authority resolves the grievance to the satisfaction of the grievant, it shall end the grievance process.

13.5.4 Step 3

a) A final appeal may be filed by the grievant, in writing, with the Human Resources & Development Department not more than five (5) work days from receipt of the Appointing Authority's decision.

b) The grievance will be reviewed by the Grievance Panel, which shall serve as the neutral factfinder, consisting of one County employee selected by the grievant, one person appointed by the department and one member appointed by the Board of Supervisors. Persons selected to serve on the Grievance Panel shall not have any personal knowledge or interest in the matter being aggrieved. The Board appointed member shall serve as the Panel Chair.

c) A grievant shall have the opportunity to present the grievant's argument before the Grievance Panel. The parties shall have the right, but is not required to, submit evidence, call witnesses to provide sworn testimony, and submit legal briefs on the aggrieved matter. The parties shall exchange witness names and contact information, scope of witness testimony, and any other evidence to be presented at the hearing no later than 20 days prior to the date of the hearing. If the grievant chooses to waive these rights, he or she must sign a waiver and acknowledgement that the grievant is knowingly and voluntarily accepting the panel's resolution as final and binding.

d) Failure on the part of the County or the grievant to appear before the Grievance Panel, without good cause as determined by the Panel Chair, shall result in forfeiture of the case.

e) The decision of the Grievance Panel shall be made in writing within thirty (30) calendar days after the grievance appeal hearing record has closed. The decision of the Grievance Panel shall be final and binding on all parties, subject to ratification by the Board of Supervisors if the decision requires an unbudgeted expenditure.

13.6 **GENERAL CONDITIONS**

13.6.1 The Human Resources & Development Department shall act as the central repository for all grievance records. The Human Resources & Development Department will be sent a copy of the decision at each level or step.

13.6.2 Any time limit may be extended only by mutual agreement in writing.

13.6.3 An aggrieved employee may be represented by any person or by the organization certified as the representative for the Representation (Bargaining) Unit in which the aggrieved employee is included. The representative shall be a non-attorney lay advocate unless otherwise mutually agreed in advance that both parties may be represented by attorneys. The representative is entitled to be present at all formal meetings, conferences and hearings pertaining to the grievance.

13.6.4 At any level, in order to provide a timely and appropriate response, the named County official may delegate the handling of the grievance.

13.6.5 At any level, should either party raise a procedural issue such as, but not limited to, whether the other party filed or responded in a timely manner or whether a particular issue falls within the jurisdiction of the grievance procedure; the County Administrative Officer (CAO), or his designee, shall meet with the parties within five work days solely to hear and rule on the procedural issue(s). The CAO will issue a ruling within five (5) work days. The decision of the CAO shall be final and binding on all parties.

13.6.6 The processing of an appeal shall be considered County Business with the aggrieved employee and the representative (if a County employee) receiving reasonable release from duty for this purpose without loss of pay.

Rule 14 - EQUAL EMPLOYMENT OPPORTUNITY / DISCRIMINATION / SEXUAL HARASSMENT POLICY

14.1 GENERAL POLICY ON EQUAL EMPLOYMENT OPPORTUNITY

Purpose

The purpose of this Policy is to: establish a strong commitment to prohibit and prevent discrimination, harassment, and retaliation in employment; to define those terms; and to establish a procedure for investigating and resolving internal complaints. The County encourages all covered individuals to report—as soon as possible—any conduct that is believed to violate this Policy.

Policy

It is the policy of the County of Tulare (hereinafter "County") to provide equal employment opportunity for all applicants and employees.

Harassment or discrimination against an applicant, unpaid intern, volunteer or employee by a supervisor, management employee, elected or appointed official, co-worker, member of the public, or contractor on the basis of race, religion, color, sex (including gender, gender identity, gender expression, transgender, pregnancy, and breastfeeding), national origin, ancestry, citizenship status, disability, medical condition, genetic characteristics or information, marital status, age, sexual orientation (including homosexuality, bisexuality, or heterosexuality), military or veteran status, or any other protected classification will not be tolerated.

All County recruitment, hiring, training, promotion, transferring, and related personnel transactions shall be done without regard to any of the bases listed above or or other criteria prohibited by law not constituting bona fide occupational qualifications. All personnel policies, procedures, and practices shall be administered accordingly.

The County recognizes its responsibility to provide equal employment opportunities, to take affirmative and direct action at all levels of County government, regarding job classifications, salaries, training, fringe benefits, and other personnel policies, and to improve employment and career opportunities for minority group persons and women according to affirmative action principles. Appointing Authorities are required to assure that equal employment opportunity concepts are supported by their departments.

14.2 GENERAL POLICY ON DISCRIMINATION AND SEXUAL HARASSMENT

The County, as part of its continuing affirmative action efforts and pursuant to the guidelines on harassment, discrimination and retaliation issued by the Equal Employment Opportunity Commission (hereinafter "EEOC"), the Department of Fair Employment and Housing (hereinafter "DFEH"), and/or the Labor Commissioner, fully supports efforts to protect and safeguard the rights and opportunities of all people to seek, obtain and hold employment without harassment, discrimination or retaliation. This includes sexual harassment (which includes harassment based on pregnancy, perceived pregnancy, childbirth, breastfeeding,

or related medical conditions) and harassment based on gender, gender identity, and gender expression. It is the policy of the County that all applicants and employees are entitled to a work environment which is free from unlawful harassment, discrimination, and/or retaliation and to provide reasonable accommodation to qualified employees with physical or mental disabilities.

Discrimination, retaliation, and sexual harassment are violations of both state and federal laws. Supervisors and co-workers are prohibited from engaging in unlawful behavior. Harassment, discrimination and/or retaliation against an applicant or employee by a supervisor, management employee, elected or appointed official, co-worker, intern, volunteer, member of the public, or contractor on any of the bases listed above, will not be tolerated. The County has zero tolerance for any conduct that violates this Policy. Conduct need not arise to the level of a violation of law to violate this Policy. A single act may violate this Policy.

Any retaliation against a person for filing a complaint or participating in the complaint resolution process is prohibited. Individuals found to be retaliating in violation of this Policy will be subject to appropriate sanction or disciplinary action up to and including termination.

Harassment, discrimination or retaliation can decrease work productivity, undermine the integrity of employment relationships, decrease morale and cause severe emotional and physical stress.

1. All employees shall be informed of the complaint process under this Policy and be assured of their right to file complaints or participate in an investigation without fear of reprisal. All employees, including supervisors and managers, should be trained regarding behavior that constitutes harassment, discrimination and/or retaliation. Employees should also understand the importance of reporting incidents immediately to ensure that further incidents do not occur.

2. County Department Heads must convey to their employees that harassment, discrimination and/or retaliation is unacceptable, and to clearly inform them that behavior constituting harassment, discrimination and/or retaliation will not be tolerated. The Department Head shall make employees aware that harassment, discrimination and/or retaliation towards another employee, a client or a member of the public while the employee is on duty and/or representing the County is unacceptable and may be grounds for disciplinary action up to and including termination.

14.3 TERMS AND DEFINITIONS

Harassment

Harassment includes any conduct which creates an intimidating, offensive, or hostile working environment or that interferes with an employee's work performance. Such conduct constitutes harassment when (1) submission to the conduct is made either an explicit or implicit condition of employment; (2) submission or rejection of the conduct is used as the basis for an employment decision; or (3) the harassment interferes with an employee's work performance or creates an intimidating, hostile, or offensive work environment.

Harassing conduct can take many forms and may include, but is not limited to, the following (when based upon an employee's protected status as noted above): slurs, jokes, statements, gestures, assault, impeding or blocking another's movement or otherwise physically interfering with normal work, pictures, drawings, or cartoons, violating someone's "personal space," foul or obscene language, leering, stalking, staring, unwanted or offensive letters or poems, offensive email or voicemail messages. Harassment also includes, unwanted sexual advances, requests for sexual favors and other acts of a sexual nature, where submission is made a term or condition of employment, where submission to or rejection of the conduct is used as the basis for employment decisions, or where the conduct is intended to or actually does unreasonably interfere with an individual's work performance or create an intimidating, hostile, or offensive working environment.

Discrimination

Discrimination, is any unlawful consideration or use of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status.

This Policy prohibits treating individuals differently because of the individual's protected classification as defined in this Policy.

Retaliation

Any adverse conduct taken because an applicant, employee, or contractor has reported harassment or discrimination, or has participated in the complaint and investigation process described herein, is prohibited. "Adverse conduct" includes but is not limited to: taking sides because an individual has reported harassment or discrimination, spreading rumors about a complaint, shunning and avoiding an individual who reports harassment or discrimination, or real or implied threats of intimidation to prevent an individual from reporting harassment or discrimination. Employees will not be retaliated against for the complaining of, who make good faith reports of, or for participating in the investigation of, harassment or discrimination.

Mental Disability

"Mental disability" includes, but is not limited to, all of the following:

1) Having any mental or psychological disorder or condition, such as mental retardation, organic brain syndrome, emotional or mental illness, or specific learning disabilities, that limits a major life activity. For purposes of this section:
    a) "Limits" shall be determined without regard to mitigating measures, such as medications, assistive devices, or reasonable accommodations, unless the mitigating measure itself limits a major life activity.
    b) A mental or psychological disorder or condition limits a major life activity if it makes the achievement of the major life activity difficult.
    c) "Major life activities" shall be broadly construed and shall include physical, mental, and social activities and working.
2) Any other mental or psychological disorder or condition not described in

paragraph 14.3 that requires special education or related services.

3) Having a record or history of a mental or psychological disorder or condition described in paragraph (1) or (2), which is known to the employer or other entity covered by this part.
4) Being regarded or treated by the employer or other entity covered by this part as having, or having had, any mental condition that makes achievement of a major life activity difficult.
5) Being regarded or treated by the employer or other entity covered by this part as having, or having had, a mental or psychological disorder or condition that has no present disabling effect, but that may become a mental disability as described in paragraph (1) or (2).
6) "Mental disability" does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psycho active substance use disorders resulting from the current unlawful use of controlled substances or other drugs.

Physical Disability

"Physical disability" includes, but is not limited to, all of the following:

1. Having any physiological disease, disorder, condition, cosmetic disfigurement, or anatomical loss that does both of the following:
    a) Affects one or more of the following body systems: neurological, immunological, muscular skeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine.
    b) Limits a "major life activity". For purposes of this section:
        (i) "Limits" shall be determined without regard to mitigating measures such as medications, assistive devices, prosthetics, or reasonable accommodations, unless the mitigating measure itself limits a major life activity.
        (ii) A physiological disease, disorder, condition, cosmetic disfigurement, or anatomical loss limits a major life activity if it makes the achievement of the major life activity difficult.
        (iii) "Major life activities" shall be broadly construed and includes physical, mental, and social activities and working.
2. Any other health impairment not described in paragraph (1) that requires special education or related services.
3. Having a record or history of a disease, disorder, condition, cosmetic disfigurement, anatomical loss, or health impairment described in paragraph (1) or (2), which is known to the employer or other entity covered by this part.
4. Being regarded or treated by the employer or other entity covered by this part as having, or having had, any physical condition that makes achievement of a major life activity difficult.
5. Being regarded or treated by the employer or other entity covered by this part as having, or having had, a disease, disorder, condition, cosmetic disfigurement, anatomical loss, or health impairment that has no present disabling effect but may become a physical disability as described in paragraph (1) or (2).
6. "Physical disability" does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.

14.4 IMPROPER CONDUCT

A County official, manager, supervisor, or employee may be subject to disciplinary action for:

1. Failing to take corrective action when the officials or supervisory employees know, or reasonably should have known, that an employee or applicant for employment is being subjected to prohibited harassment or discrimination or retaliation on the job by anyone, or

2. Retaliating against an employee or applicant for employment who complained of sexual harassment or discrimination, or who testified on behalf of one who made a complaint, or who assisted or participated in any manner on behalf of a complainant in an investigation, proceeding or hearing conducted under this Policy.

14.5 EMPLOYEE ACTION

Many persons are not aware their behavior is offensive or potentially discriminatory or harassing. Often simply advising someone of the offensive nature of their behavior will resolve the problem. Whenever possible, employees should inform the discriminator/harasser that his or her behavior is unwelcome, offensive, in poor taste or highly inappropriate. If this does not resolve the concern or if an employee feels threatened, or has difficulty expressing his or her concern and therefore does not feel comfortable confronting the discriminator/harasser, the complaint procedure should be used.

14.6 COMPLAINT PROCEDURE

The complaint procedure has been determined as the most appropriate means for registering a complaint of discrimination, sexual harassment or retaliation to ensure an appropriate and timely investigation and resolution. Complainants pursuing other methods will be redirected to this procedure.

Nevertheless, Department Heads, other managers and supervisors have a legal obligation to effectively deal with any and all reported or observed incidents that may constitute sexual harassment or discrimination whether or not a complaint has been registered through the appropriate procedure. All complaints will be followed by a fair, complete, and timely investigation.

Complaint Procedure

A. An employee, job applicant, contractor volunteer or unpaid intern, who believes he or she has been harassed, discriminated and/or retaliated against may make a complaint verbally or in writing with any of the following. There is no need to follow the chain of command.

1. Immediate supervisor;
2. Any supervisor or manager within or outside of the department;
3. Department Head; or
4. Director of Human Resources

B. Managers and Supervisors shall:

1. Immediately report all reported and/or observed incidents falling under this Policy and their supporting facts to their Department Head.
2. Thoroughly document all reported and/or observed incidents and their supporting facts.

Department Heads shall:

1. Immediately report all reported and/or observed incidents and their supporting facts to the Human Resources Officer who will inform the Director of Human Resources.
2. Thoroughly document all reported and/or observed incidents and their supporting facts.

C. Upon receiving notification of a harassment complaint, the Director of Human Resources shall:

1. Authorize and supervise the investigation of the complaint and/or investigate the complaint. The investigation will include interviews with: 1) the complainant; 2) the accused harasser; and 3) other persons who have relevant knowledge concerning the allegations in the complaint.

2. Review the factual information gathered through the investigation to determine whether the alleged conduct constitutes harassment, discrimination, or retaliation giving consideration to all factual information, the totality of the circumstances, including the nature of the conduct, and the context in which the alleged incidents occurred.

3. Report a summary of the determination as to whether harassment occurred to appropriate persons, including the complainant, the alleged harasser, the supervisor, and the Department Head. If discipline is imposed, the level of discipline will not be communicated to the complainant.

   a. The results of the investigation shall be reported to the County Administrative Officer (CAO) along with a recommended action and remedy, if deemed appropriate. The CAO will review the results of the investigation and any recommended actions, then take whatever action he or she deems necessary and appropriate.

   b. Upon conclusion of the investigation, the Director of Human Resources will notify the Appointing Authority and employee in accordance with the restrictions set forth in federal and state law.

4. If conduct in violation of this Policy occurred, take or recommend to the appointing authority prompt and effective remedial action. The remedial action will be commensurate with the severity of the offense.

5. Take reasonable steps to protect the complainant from further harassment, discrimination, or retaliation.

6. Take reasonable steps to protect the complainant from retaliation as a result of communicating the complaint.

D. The County takes a proactive approach to potential policy violations and will conduct an investigation if its officers, supervisors, or managers become aware that harassment, discrimination, or retaliation may be occurring, regardless of whether the recipient or third party reports a potential violation.

E. Option to Report to Outside Administrative Agencies: An individual has the option to report

harassment, discrimination, or retaliation to the EEOC or DFEH. These administrative agencies offer legal remedies and a complaint process. The nearest offices are listed in the government section of the telephone book or employees can check the posters that are located on employer bulletin boards for office locations and telephone numbers.

Confidentiality

Every possible effort will be made to maintain the confidentiality of complaints made under this Policy. Complete confidentiality is not guaranteed, however, due to the need to fully investigate and the duty to take effective remedial action. As a result, confidentiality will be maintained to the extent possible.

Responsibilities

Managers and supervisors are responsible for:

1. Informing employees of this Policy.
2. Modeling appropriate behavior.
3. Taking all steps necessary to prevent harassment, discrimination, or retaliation from occurring.
4. Receiving complaints in a fair and serious manner, and documenting steps taken to resolve complaints.
5. Monitoring the work environment and taking immediate appropriate action to stop potential violations, such as removing inappropriate pictures or correcting inappropriate language.
6. Following up with those who have complained to ensure that the behavior has stopped and that there are no reprisals.
7. Informing those who complain of harassment or discrimination of his or her option to contact the EEOC or DFEH regarding alleged Policy violations.
8. Assisting, advising, or consulting with employees and the Director of Human Resources regarding this Policy and Complaint Procedure.
9. Assisting in the investigation of complaints involving employee(s) in their departments and, if the complaint is substantiated, recommending appropriate corrective or disciplinary action in accordance with County Personnel Rules, up to and including termination.
10. Implementing appropriate corrective action if the allegations are founded.
11. Reporting potential violations of this Policy of which he or she becomes aware, regardless of whether a complaint has been submitted, to the Human Resources Department or the Department Head.
12. Participating in periodic training and scheduling employees for training.

Dissemination of Policy

All employees shall receive a copy of this Policy when they are hired. The Policy may be updated from time to time and redistributed.

TULARE COUNTY
SECTION 1245 BENEFITS PLAN
REVISED AND RESTATED PLAN DOCUMENT

ARTICLE I – INTRODUCTION

1.1 Creation and Title. The Employer hereby restates its Section 125 Benefits Plan under the terms and conditions set forth in this document. The Plan is to be known as the Tulare County Section 125 Benefits Plan.

1.2 Effective Date. This Plan was approved by the Tulare County Board of Supervisors on December 12, 1995 and adopted as of~~on~~ January 1~~1~~, 1996. A Plan Amendment~~,~~ and Restatement was approved by the Board~~most recently restated~~ on January 15~~1~~, 2008 and adopted as of October 29, 2008, effective January 1, 2008. A second Amendment was approved by the Board on June 28, 2011 and adopted as of January 1, 2011.

Supersession of prior Plan Documents. This restatement Plan shall replace and supersede all previous Plan Documents and Amendments.~~.~~

~~1.2~~1.3 Purpose. This Plan is designed to permit a Participant to pay his or her share of Contributions related to qualified benefits on a pre-tax salary reduction basis. Participants may also elect to pay their share of the benefits cost on an after-tax basis outside of this Plan. Participation in the Plan is offered to current and former employees only. The provisions of the Plan apply to all participants uniformly. Participants must read this entire Plan Document to ensure that all requirements and conditions of the Plan are fully understood.

~~1.3~~1.4 Legal Status. This Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health Flexible Spending Account (Health FSA) is intended to qualify as a "self-insured medical reimbursement plan" under Code 105, and the eligible expenses reimbursed thereunder are intended to qualify for exclusion from the participating Employees' gross income under Code 105(b). The Dependent Care Assistance Program (DCAP) is intended to be eligible for exclusion from participating Employees' gross income under Code 129(a).

Although reprinted within this document, the Health FSA and the DCAP Program are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code 105 and 129. The Health FSA is also a separate plan for purposes of applicable provisions of HIPAA and COBRA.

This Plan has been established for the benefit of employees, including employees who are represented by collective bargaining as well as those not represented by collective bargaining.

1.5 Non-Discrimination. This Plan is intended to be considered a non-discriminatory Section 125 Plan. The Plan does not intend to discriminate in favor of Highly Compensated Employees as it relates to eligibility, contributions, and benefits as described under the Code's provisions. The Employer may take actions(s) in order to comply with the nondiscrimination rules of the Code.

~~1.4~~

ARTICLE II - DEFINITIONS

As used in this Plan Document, the following terms shall have the following meanings:

2.1 "Benefit Entry Date" means the date an Eligible Employee may actually join the Plan once each of the eligibility requirements are met

2.2 "Benefits" means cash and the various qualified benefits under Section 125(f) of the Code sponsored by the Employer and made available by the Employer through the Plan as adopted by the Plan Administrator, ~~on [DATE],~~ including, but not limited to, medical, dental, vision, group life insurance, long term disability, qualified supplemental benefits, Health FSA and the Dependent Care Assistance programs. Detailed descriptions of each benefit under the Plan, in any given Plan year, are contained in separate written documents or agreements such as the County benefits guide or individual bargaining unit MOU's. Some benefits may be "bundled" (meaning offered as a "package" such as medical/dental/vision).

2.3 "Benefits Accounts" means the accounts established by the Plan Administrator under the Plan for each Participant's Benefits for purposes of administering the Plan.

2.4 "Benefit Amount" means the number of dollars that the County contributes on behalf of a Participant towards the Participant's health insurance premium.

2.5 "Benefits Enrollment Form" means the form or forms, evidencing an Eligible Employee's selections from among the various Benefits and the amount to be contributed towards various Benefits for a Plan Year or portion of a Plan Year.

2.6 "Business Associate" – any organization or person working in association with or providing services to a covered entity who handles or discloses PHI or personal health records.

~~2.4~~2.7 Cash in Lieu means the cash received as a result of the Eligible Employee waiving enrollment in the County's health insurance coverage utilizing an Eligible Opt Out Arrangement. Such Cash in Lieu shall be treated as taxable income to the Employee.

~~2.5~~2.8 "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan.

a. Legal marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;
b. Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;
c. Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement

of employment; (2) a change in worksite; (3) switching from full-ti.me to part-ti.me (or vice versa); (4) incurring a reduction or increase in hours of employment; or (5) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;

d. Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

e. Change in Residence. A change in the place of residence of the Participant only if such change results in a loss of eligibility in the plan in which the participant is a member.

~~2.6~~2.9 "COBRA" means the Consolida~~4&~~ted Omnibus Budget Reconciliation Act of 1985, as amended from time to ti.me.

~~2.7~~2.10 "Code" means the Internal Revenue Code of 1986, as amended from ti.me to time.

~~2.8~~2.11 "Compensation" generally means any wages, salary, or other amounts paid by the Employer and reportable on a Participant's W-2.

~~2.9~~2.12 "Contract Administrator" means the company hired to provide the Plan with administrative services.

~~2.10~~2.13 "Contributions" means the amount contributed to pay for the cost of Benefits.

~~2.11~~2.14 "~~DCAP" means Dependent Care Assistance Program.~~Dependent Care Assistance Program" or "DCAP" means the program which allows Employees to hold pre-tax salary contributions that can be spent on the needs of the Employee's child or disabled dependent who requires daily care.

~~2.12~~2.15 "Dependent" means any individual who is a tax dependent of the Participant as defined in Code 152, and shall include any child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under a Health FSA as allowed by reason of the Affordable Care Act with the following exceptions~~means any individual who is a tax dependent of the Participant as defined in Code 152, with the following exceptions~~:

a. For purposes of accident or health coverage including the Health FSA. (1) a dependent is defined as in Code 152, determined without regard to subsections (b)(l}, (b}(2}, and (d}(l)(B) thereof, and (2) any child to whom Code 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) and is treated as a Dependent of both parents. Notwithstanding the foregoing, the Health FSA will provide benefits in accordance with the applicable requirements of any qualified medical support order even if the child does not meet the definition of "Dependent".

(1) A Participant's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Participant or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

(2) The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Participant of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

b. Ffor purposes of the Dependent Care Assistance Program, a Dependent means a "qualifying individual" as defined in Code 21(b)(l} with respect to the Participant, and in the case of divorced parents, a qualifying individual who is a child shall, as provided in Internal Revenue ~~Code~~ Code § 21~~l~~(e)(5}, be treated as a qualifying individual of the custodial parent (within the meaning of Internal Revenue Code §~~Code~~ 152 (e)(l) and shall not be treated as a qualifying individual with respect to the non-custodial parent

~~2.13~~2.16 "Eligible Expense" in general, healthcare expenses for a Participant and eligible Dependents if they meet the following requirements:

a. The expenses were incurred on or after the effective date of the Participant's participation in the Plan;
b. They would qualify as medical expenses for federal income tax purposes under Section 213 of the Internal Revenue Code;
c. They have not been and will not be paid by the Participant's health benefit plans(s) or by another employer's group health benefit plan or by any other insurance policy or Program; and
d. They have not and will not be deducted on the Participant's tax return.

Eligible expenses under the Dependent Care Assistance Program are expenses related to the care of a qualifying person only if their main purpose is the person's well-being and protection, and must be incurred to enable the Participant (and Spouse, if applicable) to be gainfully employed.

These expenses include:

- Work-related babysitting (i.e. not social) and licensed daycare center costs;
- After-school daycare costs which pertain to the care for a child.

Expenses that are not eligible include:

- Babysitting for social reasons;
- Expenses incurred on or after a child's 13th~~13111~~ birthday;
- Overnight camp;
- Education, food or clothing expenses that are not incidental to and inseparable part of the care;
- Costs of transportation;
- Tuition for children in kindergarten or beyond kindergarten; and
- Payment made for care provided by someone eligible to be claimed as a Dependent on the Participant's income tax form or to any of his children age eighteen(l8) or younger.

~~2.14~~2.17 "Eligible Employee" means an employee that regularly works at least 40 hours per bi-weekly pay period and who is on the Employer's W-2 payroll.

~~2.15~~2.18 "Employer" means Tulare County.

~~2.16~~2.19 "FMLA" means the Family and Medical Leave Act of 1993, as amended from time to time.

~~2.17~~ "Health ~~FSA~~Flexible Savings Arrangement~~"~~ ~~means Health Flexible Savings Account.~~or "Health FSA" means a medical expense reimbursement plan designed to hold employee contributions during the Plan Year, up to a monetary limit, which can be used to pay for qualified medical expenses not covered by the County's health insurance plan.

2.20 "Health Information" means any oral or recorded in any form or medium created or received by a health plan, provider, clearinghouse, employer, etc. that relates to: ß an individual's past, present, or future physical or mental health or condition; ß the provision of health care to an individual; or ß the past, present, or future payment for the provision of health care to an individual

~~2.18~~2.21 "Highly Compensated Employee" means, for the purposes of determining discrimination, an employee described in Code Section 125 and the Treasury Regulations thereunder.

~~2.19~~2.22 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

~~2.20~~2.23 "HSA" means Health Savings Account as described in Code Section 223(d).

~~2.21~~2.24 "O~~0~~pen Enrollment Period" is the period during which elections can be made I>Y Participants. The period will be determined by the Plan Administrator once each calendar year.

~~2.22~~2.25 "Participant" means an Employee who has satisfied the eligibility requirements of this Plan and has made an election to participate in the Plan.~~.~~

~~2.23~~2.26 "Period of Coverage" means the Plan Year, with the following exceptions: (a) for eligible employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date of which participation commences (Benefits Entry Date); and (b) for employees who terminate participation it shall mean the portion of the Plan Year prior to the date on which participation terminates.

~~2.24~~2.27 "Plan" means Tulare County's Section 125 Benefits Plan, as described herein.

~~2.25~~2.28 "Plan Administrator" means Tulare County or its appointed designee.

~~2.26~~ "Plan Year" means January 1 - December 31.

2.29

~~3.1~~

~~3.1~~ "Premium Payment Plan" means the plan by which the contributions associated with qualified benefits can be deducted on a pre-tax basis.

2.30

2.31 "Protected Health Information" or "PHI" means any health information matched with another piece of information that identifies the individual or from which the individual could reasonably be identified. For ex. name, SSN, address, DOB, certificate number, etc.

~~3.2~~2.32 "Salary Reduction" means the amount by which the Participant's compensation is reduced and applied by the Employer under this Plan to pay for one or more of the qualified benefits on a pre-tax basis.

~~3.3~~2.33 "Salary Reduction Agreement" means the agreement which states that a Participant agrees to have their compensation reduced by the amount necessary to pay for the elected benefits.

~~3.4~~ "Spouse" means an individual who is legally married to a Participant who is treated as a spouse under the Code. Notwithstanding the above, for purposes of the DCAP Component the tenn "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

2.34

2.35 "Summary health information" mean any PHI which is stripped of all information that could identify or reasonably identify an individual, and summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer provides health benefits under a group health plan.

~~3.5~~2.36 "Timely Submitted" means, unless the Plan Administrator has specific and special cause to alter the definition of this phrase, within 30 calendar days of event that has triggered the Change in Status.

ARTICLE III-ELIGIBILITY AND PARTICIPATION

~~4.1~~ Eligibility. An individual is eligible to participate once they have satisfied their waiting period and eligibility requirements under the Plan and any applicable Memorandum of Understanding, in addition to regularly working at least 40 hours per bi-weekly pay period on the Employer's W-2 payroll. ~~The waiting periods are as follows:~~

~~5.1~~

~~6.1~~3.1 Tulare County Employees (~~except for members of the Tulare County Collections Association and the Tulare County Deputy Sheriff's Association~~unless otherwise specified in any applicable Memorandum of Understanding with a Represented Bargaining Unit) are subject to the following waiting period:~~:~~ 1st day of the month following 30 calendar days of employment or other date as specified by the plan administrator in its sole discretion and on a uniform and consistent basis determines are permitted under IRS regulations and under this Plan.

~~a. Tulare County Collections Association: 1st day of the month following 60 calendar days of employment with the Probation Department.~~

~~b. Tulare County Deputy Sheriff's Association: 111 full day of regular service with the Sheriff's Department.~~

~~6.1~~3.1 Commencement of Participation. An Eligible Employee shall become a Participant in the Plan after providing the Plan Administrator with an executed Benefits Enrolment Form/Salary Reduction Agreement setting forth the Benefits elected by the Eligible Employee for the immediately following Plan Year or the remaining portion of the Plan Year.

~~6.2~~3.2 Benefits Entry Date. The benefits entry date is the date a Participant actually joins the Plan after satisfying each of the eligibility requirements.

~~6.3~~3.3 Benefits Enrollment Information. An individual is required to file a Benefits Enrollment Form before either one of two dates. If plans have different eligibility requirements, there will be different entry dates for each benefit if the eligibility requirements are the same, the benefit entry dates will be the same. The Benefits Enrollment Form needs to be filed before any applicable benefit or plan entry dates with certain exceptions applying with respect to special enrollment rights under HIPAA. The form is an agreement between the Participant and the Employer. It specifies the amount a Participant has agreed to contribute towards the cost of benefits in the Salary (or Wage) Reduction Agreement part of the form. Elections to participate under the Health FSA or DCAP programs must be made prior to the beginning of each Plan Year. In the case of newly eligible employees, the Benefits Enrollment Form needs to be submitted to the Plan Administrator in advance of participation in accord with the requirements of each specific plan or program.

With respect to premium and/or contribution elections, if an individual fails to elect to have such costs deducted on a pre-tax basis (a) the County's Contribution amount does not apply: and (b) the payment for such premiums contributions by an individual will be on a post-tax basis. If an individual voluntarily elects to have their Contributions applied on a post-tax basis, the County's Contribution still applies.

~~2.5~~3.5 Termination of Participation. A Participant will cease to be a Participant in this Plan upon the earlier of:

a. the termination of this Plan; or

b. The date on which the Employee ceases (because of retirement, termination of employment, layoff; reduction of hours, or any other reason) to be an eligible employee. Certain circumstances may permit participation to continue under the Plan as a result of meeting COBRA's requirements.

- Termination of participation in this Plan will automatically revoke the Participant's elections. Reimbursements from the Health FSA and DCAP programs after termination of participation will be made pursuant to the filing deadlines and forfeiture provisions of this Plan. Distributions from a Participant's HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are to be handled by the Participant and his or her trustee-custodian in accordance with the agreement between them. Medical, dental, and vision benefits will terminate as of the date specified in those plan.

3.6 Treatment of Rehired Employees. A Participant whose employment terminates and who is subsequently re-employed with less than 30 days of separation from service will immediately rejoin the Plan with the same Benefit elections. A Participant whose employment terminates and who is

subsequently re-employed 30 or more days after separation from service will need to re-satisfy Plan eligibility requirements to rejoin the Plan. Any unused reimbursement Benefits Accounts balance(s) prior to the initial separation of service date will be forfeited.

3.7 COBRA Continuation Coverage.

Health Insurance Benefits - Contributions for federal COBRA coverage may be paid on a pre-tax basis for current Employees receiving taxable compensation where federal COBRA coverage arises either: (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals, contributions for federal COBRA coverage shall be paid on an after-tax basis.

Health FSA - The Plan may be subject to a special limited COBRA obligation. COBRA continuation coverage generally will not be offered to participants in the Health FSA if the account is "overspent" at the time of the qualifying event. An overspent account occurs when the remaining annual benefit is less than the maximum COBRA premium that can be charged. As an example, if the annual benefit amount equals $2,400 and a person (after five months) has contributed $1,000 (5 x $200 per month) with reimbursable claims equaling $1,050, the person has overspent their account. (The maximum COBRA premium= 7 months remaining @ $200 per month = $1,400, plus an administrative fee of 2% or $28 totaling $1,428. This amount ($1,428) is greater than the remaining benefit amount of$1,350 ($2,400 - $1,050). As a result the account is "overspent" and COBRA is not offered.

3.8 Family Medical Leave Act (FMLA). The payment option for continuing coverage while on unpaid Family Medical Leave Act leave is on a "pay-as-you-go" basis as outlined below:

a. Pay-as-you-go. Under this option, an individual pays their share of contributions on a monthly basis (subject to any grace period as approved by the Employer). If the individual fails to make payments under this pay-as-you- go option, the Employer is not required to continue coverage. However, if the Employer chooses to continue coverage, the Employer is entitled to collect these amounts from the individual after their return from the FMLA leave.

b. If an individual takes a leave under the Family and Medical leave Act (FMLA), they may revoke or change their existing election related to the Health FSA. If their participation ends while on leave, they will be permitted to reinstate their participation for the remaining part of the Plan year upon their return. Coverage can be resumed at its original election amount and additional payments can be made for the period of time the individual was on leave. For example, if an individual elected $1,200 for the year and are out on leave for three (3) months, then return and elect to resume under the Health FSA at the original amount, the remaining payments will be increased to cover the difference (i.e. the $300 which was not paid) will be taken out of the remaining time left of the plan year. Alternatively, the maximum amount ($1,200) will be reduced proportionately for the time that the individual was gone. As an example, if an individual elected $1,200 for the year and are out on leave for three (3) months, the amount would be reduced to $900.The expenses an individual incurs during the time they are not in the Health FSA are not reimbursable.

3.9 Non-FMLA Leaves Of Absence Without Pay. Such leaves will be treated in the same manner as leaves taken under the Family and Medical Leave Act (FMLA) described above.

3.10 Uniformed Services Employment and Reemployment Rights Act (USERRA). Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Benefits Department.

ARTICLE IV - CONTRIBUTIONS

4.1 Source of Contributions.

Employer Contributions: For purposes of this Plan, the Employer's contribution is the County's Benefit Amount as defined in Article II, Section 2.4~~. The Benefit Amount is the number of dollars that the County contributes on behalf of a Participant~~.

Participant Contributions: A Participant's contribution under this Plan equals the amount elected by the Participant on a salary or wage reduction basis. The contribution(s) apply to each benefit selected by the Participant.

4.2 Funding the Plan. Nothing herein will be construed to require the Employer to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claims against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made.

4.3 Maximum Contribution. The Maximum Contribution any individual can make under this Plan is an amount equal to the sum of the costs for each of the highest cost eligible premium-type Benefit Options offered under the Plan plus the maximum allowances related to the Health FSA and DCAP programs.

~~4.3~~4.4 Salary Reduction. Each Eligible Employee may make a salary reduction as set forth in the Plan.

ARTICLE V - ELECTION INFORMATION

5.1 Elections When First Eligible. An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more benefits on the first day after such eligibility requirements have been satisfied. The eligible employee must submit to the Plan Administrator a Benefits Enrollment Form/Salary Reduction Agreement in accord with the requirements of each specific plan or program. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period, unless an even occurs that would justify a mid-year election change, as described within the section. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods of the other benefit plans.

5.2 Elections during Open Enrollment Period. The election requirements are outlined at section 3.4.

~~5.2~~5.3 Eligible Opt Out Arrangement. Employees may elect to waive enrollment in the County's health insurance coverage in any given Plan Year. Employees who elect to waive enrollment in the County's health insurance coverage must provide evidence -the Employee and the Employee's tax

dependents have or will have minimum essential coverage other than individual market coverage during the Plan Year.

Reasonable evidence of minimum essential coverage means a copy of a health card or other evidence , along with an attestation from the employee, showing that the Employee and the Employee's tax dependents have health insurance coverage. Minimum essential coverage includes government sponsored programs such as most Medi-Cal coverage, Medicare part A, CHIP, and most TRICARE coverage.

The Employee's tax dependents are defined by the IRS as any individual for whom the Employee expects to claim a personal exemption deduction.

Employees who elect to waive enrollment may receive an opt-out payment as designated by the Plan Administrator. The opt-out payment cannot be made if the County knows or reasonably believes that the Employee or family member of the Employee does not have the required alternative coverage. An election to opt out shall be irrevocable for the Plan Year, except as outlined in Section 5.6, below.

~~5.3~~5.4 Irrevocability of Elections. Except as described below (i.e. "Change in Status" and other qualifying events), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

a. Participation in this Plan; or
b. Salary reduction amounts.

However, an election to contribute to an HSA can be changed on a prospective basis.

~~5.4~~5.5 Procedure for Making New Elections(s) If Exception to Irrevocability Applies.

a. Timeframe for Making New Elections. A Participant (or an Eligible Employee who, when first eligible or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of a qualifying event as described in this Article. The election must be made on a new Benefits Enrollment Form/Salary Reduction Agreement and is made on account of and is consistent with the event. Notwithstanding the foregoing, A Change in Status (e.g. divorce or a dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under a qualified health care or insurance benefit plan, shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

b. Effective Date of New Election. Elections shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided as a result of HIPAA special enrollment right in the event of birth, adoption, or placement for adoption, or under the HSA, all election changes shall be effective on a prospective basis only. Election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may

become effective later to the extent that the coverage in the applicable benefit commences later.

~~5.5~~5.6 Events Permitting Exception to Irrevocability of Elections (other than HSA). A Participant may change an election as described below upon the occurrence of the stated events: (Note: in order to determine which benefit is affected by a certain event, refer to the chart at the end of this Article.

a. Open Enrollment Period. A Participant may change an election during the Open Enrollment Period in accordance with the open enrollment provision.

b. Termination of Employment. A Participant's election will terminate under the Plan upon termination of employment in accordance with the termination of participation provision.

c. Leaves of Absence. A Participant may change an election under the Plan upon a FMLA leave or a non-FMLA leave in accordance with the leave of absence provisions. Such changes only apply to medical plan elections only.

d. Change in Status. A Participant may make a new election upon the occurrence of certain events described below as they pertain to the applicable benefit as shown on the chart of permitted election changes. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code 125 or regulations issued thereunder, which the Plan Administrator, affirmatively and in writing approves as an amendment to this plan, in its sole discretion and on a uniform and consistent basis determines are permitted under IRS regulations and under this Plan:

- Legal marital Status. A change in a Participants legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;
- Number of Dependents. Events that change a Participants' number of Dependents, including birth, death, adoption, and placement for adoption;
- Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1)termination or commencement of employment; (2) a change in worksite only if such change results in a loss of eligibility in a plan in which the participant is a member.; (3) switching from full-time to part-time (or vice versa); (4) incurring a reduction or increase in hours of employment; or (5) any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and
- Change in Residence. A change in the place of residence of the Participant only if such change results in a plan in a loss of eligibility in which the participant is a member.

Change in status does not apply to DCAP elections. Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child up to the end of the year in which a child attains age 26, as allowed under Code Sections 105(b) and 106 and IRS Notice 2010-38, shall qualify as a change in status.

e. HIPAA Special Enrollment Rights. A Participant may change an election in accordance with any special enrollment rights that are provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which meet the consistency requirements as outlined in this document.

f. Affordable Health Care Act Exception. A Participant may revoke election of a medical plan if the Participant's average hours of work are reduced to less than 30 per week, but the Participant remains eligible to participate in the Plan. This change in status does not apply to Health FSA elections.

~~f.~~g. Certain Judgments, Decrees, and Orders. If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requires benefit coverage (including an election for Health FSA Benefits) for a Participant's child, then a Participant may change his or her election to provide coverage for the child (provided the QMCSO requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the QMCSO requires that another individual (including the Participant's Spouse or former spouse) provide coverage under that individual's plan and such coverage is actually provided.

~~g.~~h. Medicare or Medicaid. If a Participant or his or her Spouse or Dependent who is enrolled under a health plan under this Plan becomes entitled to (i.e. becomes enrolled in) Medicare or Medicaid, then the Participant may prospectively reduce or cancel the health plan coverage of the person becoming entitled to Medicare or Medicaid ~~and/or the Participant's Health FSA coverage may be cancelled (but not reduced)~~. Notwithstanding the foregoing, such health plan cancellation will not ~~not become effective~~affect the Health FSA election to the extent it would reduce future contributions to the Health FSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the benefit coverages of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

~~h.~~i. Cost Changes. For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individuals (e.g. family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a Health FSA is not similar coverage with respect to an accident or health plan; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer may be treated as similar coverage if it otherwise meets the requirements of similar coverage. (NOTE: Dropping coverage is not permitted under the Plan due to changes in cost if an individual changes to an HMO or insurance company who currently provides coverage to the County.)

1. Increase or decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing salary reductions) to reflect insignificant increases in their required contribution for their benefit choices, and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the

surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically implement this increase or decrease in affected employees' elective contributions on a prospective basis.

2. Significant Cost Increases. If the Plan Administrator determines that the cost charged to an employee for the benefit plan(s) or DCAP benefits significantly increases during the Plan Year, then the Participant may choose to do any of the following: (a) make a corresponding increase in his or her contributions; (b)revoke his or her election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of a Spouse's employer, or (c) drop coverage (subject to the consequences, if any, under the employer's health benefits waiver policy), if there is no other benefit package option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

3. Significant Cost Decreases. If the Plan Administrator determines that the cost of any benefit package option (such as the health plan)significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in the benefit package option may make a corresponding prospective decrease in their elective contributions (by decreasing salary reductions); (b) Participants who are enrolled in another benefit package option (such as an HMO, but not the Health FSA) may change their election on a prospective basis to elect the benefit package option that has decreased in cost. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

4. Limitation related to Cost Change and DCAP benefits. The above "Cost Change" provisions apply to DCAP benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the employee. For this purpose, a relative is an individual who is related as described in Code 152(d)(2)(A) through (G), incorporating the rules of152(f)(l) and 152(f)(4).

~~i.~~j. Change in Coverage. (Notes: The same definition applies to "similar coverage" as in the previous provision. Also, dropping coverage is not permitted under the Plan due to changes in coverage if an individual changes to an HMO or insurance company who currently provides coverage to the County).

1. Significant Curtailment. If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another benefit package option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage ifno similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant", and whether a loss of coverage has occurred.

a. Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a benefit package option under this Plan (or the Participants' Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket limit under a health plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another benefit package option that provides similar coverage (such as an HMO, but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

b. Significant Curtailment with a Loss of Coverage. If the Plan Administrator determines that a Participant's benefit package option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and · may either prospectively elect coverage under another benefit package option that provides similar coverage (such as an HMO, but not the Health FSA) or drop coverage ifno other benefit package option providing similar coverage is offered by the Employer.

c. Definition of Loss of Coverage: For purposes of this section, a "Loss of Coverage" means complete loss of coverage (including the elimination of a benefit package option or a Participant or his or her Spouse or Dependent losing all coverage due to a plan's lifetime maximum being satisfied). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a loss of coverage:

- A substantial decrease in the number of providers participating in an HMO or a PPO network;
- A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment' or
- Any other similar fundamental loss of coverage.

2. Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election if group health coverage is lost which was sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHJP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code 7701 (a)(40), the Indian Health Service, or a tribal organization; a state health benefits risk pool subject to the terms and limitations of the applicable benefit package option.

3. Gain in Coverage Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or

Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification if incorrect.

4. Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage if such a change is permitted under the benefit plan of the Plan Administrator. The Plan Administrator, in its sole discretion and on a uniform and consistent basis will decide whether a requested change made under the other employer plan, in accordance with prevailing IRS guidance.

5. Change in HSA Elections. If you have enrolled in the Plan during Open Enrollment and have elected HSA Benefits, then you may increase, decrease, or revoke your HSA Benefits election on a prospective basis at any time during the Plan Year, such changes must be in accordance with the Plan's administrative procedures for processing election changes. No other benefit package option election changes can be made as a result of a change in your HSA Benefits election unless permitted as a result of the events.

6. DCAP Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, then the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, then the Participant may cancel coverage.

~~5.6~~5.7 Consistency Rule. Election changes must satisfy the Treasury regulations' consistency rules.

The consistency rules found at Treasury Regulation 1.125-4 require that election changes must be on account of and correspond with a change in status that affects eligibility for coverage under an employer's plan. Additionally, specific rules apply to benefits such as Group Term Life insurance, DCAP benefits, events such as divorce, death, dependents ceasing to be eligible and a gain of eligibility under a family member's plan. This Plan will comply with the rules as they apply to the permitted election changes described in this document.

For example, if the participant's change in status event is a dependent ceasing to be eligible for health plan coverage, the participant may be permitted to change her election to discontinue coverage for that dependent. However, the participant could not use this event to justify dropping coverage for her spouse or some other dependent, because there is no connection between the change in status event and these types of changes.

~~5.7~~5.8 Submitted Election Changes. Election changes must be submitted within 30 days of a permitted election change.

~~5.8~~5.9 Chart of Qualified Status Events and Allowable Election Changes.

Description of Allowable Changes under Section 125:

All election changes must be consistent with, and due to, the qualified status change.
Yes = Plan allows election changes consistent with event
No = Plan does not allow any changes
Decrease = Plan only allows election to be decreased
Increase = Plan only allows election to be increased
Restricted = Special restrictions apply. Contact the Benefits Department

Change in Number of Dependents	**Changes Allowed to Pretax Dollars**			
Qualified Status Change Events	**Medical, Dental, Vision**	**Life, AD&D, Disability**	**Health FSA**	**Dependent Care FSA**
	(Premium/Contributions)			
Gain Spouse (Marriage)	Yes	Yes	Yes	Yes
Lose Spouse (divorce, legal separation, annulment, death of spouse)	Yes	Yes	Yes	Yes
Gain Dependent (birth, adoption)	Yes	Yes	Yes	Yes
Lose Dependent (death)	Decrease	Yes	Decrease	Decrease
Dependent Satisfies Eligibility under Employer's Plan (specified age, becoming single, becoming a student)	Increase	Yes	Increase	Increase
Dependent Ceases to Satisfy Eligibility of Employer's Plan (over age, getting married, no longer a student)	Decrease	Yes	Decrease	Decrease

Leave of Absence	**Changes Allowed to Pretax Dollars**			
Qualified Status Change Events	**Medical, Dental, Vision**	**Life, AD&D, Disability**	**Health FSA**	**Dependent Care FSA**
	(Premium/Contributions)			
Return from Unpaid Leave of Absence Triggering Eligibility	Restricted	Restricted	Restricted	Restricted

Commencement of Unpaid Leave Resulting in Loss of Eligibility	Restricted	Restricted	Restricted	Restricted
Employee's Commencement of FMLA Leave	Yes	Yes	Yes	Yes
Employee's Return from FMLA Leave	Restricted	Restricted	Restricted	Restricted

Change in Employment Status	**Changes Allowed to Pretax Dollars**			
Qualified Status Change Events	**Medical, Dental, Vision**	**Life, AD&D, Disability**	**Health FSA**	**Dependent Care FSA**
	(Premium/Contributions)			
Commencement of Employment by Employee or other change in Employment Status (PT to FT) Triggering Eligibility	Increase	Yes	Increase	Increase
Commencement of Employment by Spouse or Dependent or Other Event Triggering Eligibility Under Their Employer's Plan	Decrease	Yes	Decrease	Yes
Termination of Employee's Employment or Other Change in Unemployment (unpaid leave, FT to PT) Resulting in Loss of Eligibility	Restricted	Restricted	Restricted	Restricted
Termination and Rehire Within 30 Days	Restricted	Restricted	Restricted	Restricted
Termination and Rehire After 30 Days	Yes	Yes	Yes	Yes
Termination of Spouse's or Dependent's Employment (or other change in employment resulting in losing eligibility)	Increase	Yes	Increase	Yes

Benefit Plan Changes	**Changes Allowed to Pretax Dollars**			
Qualified Status Change Events	**Medical, Dental, Vision**	**Life, AD&D, Disability**	**Health FSA**	**Dependent Care FSA**
	(Premium/Contributions)			
Cost Change without Automatic Increase/Decrease in Elective Contribution	Yes	Yes	No	Restricted
Significant Cost Changes	Yes	Yes	No	Restricted
Significant Coverage Curtailment	Yes	Yes	No	Yes
Addition of New Benefit Package Option or Other coverage Option	Yes	Yes	No	Yes
Addition of Health Savings Account (HSA)	Yes	Yes	Restricted	No
Other Employer's Cafeteria Plan Increases Coverage	Decrease	Decrease	No	Decrease
Other Employer's Cafeteria Plan Decreases or Ceases Coverage	Increase	Increase	No	Increase
Open Enrollment under Cafeteria Plan of Spouse's or Dependent's Employer	Restricted	Restricted	No	Restricted
Loss of Coverage Under:	Increase	No	No	No

1. State children's health Program or state health benefits risk pool 2. Medical care program of an Indian Tribal government				
Employee, Spouse or Dependent Enrolled in Employee's Plan Entitled to Medicare or Medicaid	Decrease	No	Yes	No
Employee/Spouse/Dependent Loses Eligibility for Medicare or Medicaid	Increase	No	Yes	No

Other Allowable Changes	**Changes Allowed to Pretax Dollars**			
Qualified Status Change Events	**Medical, Dental, Vision**	**Life, AD&D, Disability**	**Health FSA**	**Dependent Care FSA**
	(Premium/Contributions)			
HIPAA Special Enrollment for Loss of Other Health Coverage	Restricted	No	Restricted	No
HIPAA Special Enrollment of New Dependent due to Birth, Marriage, Adoption or placement for Adoption	Restricted	No	Restricted	No
COBRA Events	Restricted	No	No	No
Order that Requires Coverage for the Child Under Employee's Plan	Increase	No	Increase	No
Order that Requires Spouse, Former Spouse or Other Individual to provide Coverage for the Child	Decrease	No	Decrease	No
Move Triggers Eligibility	Increase	Yes	No	No
Move Causes Loss of Eligibility (employee or dependent moves outside of Coverage area)	Yes	Yes	No	No
Change in Dependent Care Provider	No	No	No	Restricted
Change in Dependent Care Rates	No	No	No	Restricted

NOTE: Contact the Benefits Department for questions concerning restrictions that apply to certain benefits.

ARTICLE VI - BENEFITS

Tulare County offers its eligible employees several benefit programs including:

- ~~•~~ Medical, Dental, and Vision
- Group Life Insurance
- ~~•~~ Group Term Life Insurance
- ~~•~~ ~~Group~~ Long Term Disability Insurance

- Group Long-Term Disability Insurance
- ~~Qualified Supplemental Plans~~
- ~~Section 125 Plan (further information below)~~
- ~~Health Flex Spending Account~~SA
- ~~Dependent Care Assistance Program~~

Each of the benefits includes certain coverages, exclusions and limitations. For specific details related to each benefit, please refer to the applicable Summary Plan Description or Certificate of Coverage. They are available by contacting the Benefits Staff.

6.1 Reimbursement Programs

The Section 125 Benefits Plan allows an individual to direct some of their salary or wages on a pre-tax basis in order to pay for certain allowed expenses called qualified expenses.

In order for an expense to be eligible for reimbursement it must be "qualified", as explained below. It must also be incurred during the period of coverage. This means that a person must have received services, such as having seen the doctor or had a child in day care, on a date during the Plan Year. As an example, assume that an individual's enrollment is effective as of February 1. If they saw a doctor on January 28, that expense would not be eligible for reimbursement, even if the individual received an invoice dated after February I. There are certain circumstances under which expenses may be qualified under the Plan such as orthodontia care where actual services have not yet been performed. Contact the Benefits Staff for additional information related to specific claim issues.

6.2 Health Flexible Spending ~~Account~~ Arrangement (Health FSA). Money directed into the Health FSA is intended to pay for any qualified healthcare expenses that are not covered or reimbursed by a benefit plan. The maximum amount that maybe elected under this program is the annual amount allowed by the IRS for the Plan Year, which is $2,700 for 2019.~~$2,500.00 per Plan Year~~.

Qualified expenses under the Health FSA might include medical expenses that are not covered under a medical plan. Thus, co-payments, deductibles, certain excluded coverages, expenses for prescriptions or medical supplies that are not paid for by a medical plan could be considered expenses that can be reimbursed under the Health FSA.

Examples of expenses eligible for reimbursement under this benefit would include: hospitalization and clinical care; prescription and over-the-counter drugs; transportation expenses (such as an ambulance) incurred to get medical services; home improvement costs that are recommended by a doctor and necessary for treatment or rehabilitation, to the extent such improvement does not increase the value of a person's home.

The following examples would usually not qualify as expenses eligible for reimbursement, even though recommended by a doctor: expenses for cosmetic surgery or cosmetic items, maternity items (unless ordered by a doctor as essential to health); vacation or travel expenses, even if for rehabilitation or prescribed by a doctor; meals and lodging (unless included as part of a hospital bill or while traveling between distant hospitals) at a location away from home, even if prescribed by a doctor or received as an outpatient.

The Plan is required to pay benefits up to the maximum elected amount at any time during the Plan year with some limited exceptions. For example, assume that an employee has elected to establish a Health FSA account of$ 600.00 for the Plan Year, $50.00 each month. During the first month when there is only $50.00 in the account, the individual has qualified medical expenses of$ 300.00.The Plan must reimburse the employee the full $300.00 and assume the liability that a person may terminate employment before the full $300.00 has been contributed.

Notwithstanding anything in the Plan to the contrary, a Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code Section 106(f) or is not insulin. In addition, only medicine or drugs considered to be prescription drugs under Code Section 106(f) (not "over-the-counter" drugs obtained under prescription) shall be able to be purchased by debit and/or credit cards issued to be used in conjunction with the Plan.

6.3 Dependent Care Assistance Pro~~2~~gram (DCAP). A dependent eligible for these expenses includes a qualified child or any other qualified relative for whom the employee can take a tax deduction on their tax return. Dependents eligible under this program include children under the age of 13, and physically or mentally incapacitated individuals who are in need of supervised care. A person is a dependent of an employee if they provide them with at least 50% of their living expenses over the course of the year.

Before deciding to participate in the Dependent Care Assistance Program, an employee should know that there is a provision in the Federal Income Tax Code that allows them to take a credit against taxes for Dependent Care Assistance Expenses. Section 21 of the Internal Revenue Code allows taxpayers to take a tax credit. These tax credits may vary from year to year. This allowable tax credit may be more advantageous for lower-paid Participants in this Plan. Consulting a person's tax advisor to determine if participating in this Program or taking the tax credit under Internal Revenue Code Section 21 is preferable, is vital.

The Plan is required to pay benefits up to the amount that has been credited to the participant's DCAP account. For example, assume that an employee has elected to establish a DCAP account of$ 600.00 for the Plan Year, $50.00 each month. During the first month when there is only $50.00 in the account, the individual has qualified dependent care expenses of$ 300.00.The Plan must reimburse the employee only the amount credited in the participant's DCAP account, $50.00. Unlike a Health FSA account, the Plan does not assume the liability that a person may terminate employment before the full $300.00 has been contributed.

Also, ~~the tax laws further limit how much a person can contribute to this Program. Under the law and the terms of the Plan, an employee can elect no more than the lesser of their actual (or, if married, and if less, a spouse's) income for the year or $5,000.00 per year to this Program ($2,500.00 if married and filing separate).~~the IRS limits the amount Participants can exclude from your taxable income. The maximum salary reduction for the DCAP election may vary by employee and shall be adjusted pursuant to the IRS maximum contribution. Generally, the amount an Employee can elect to pay into DCAP is limited to the smallest of:

- The total amount of dependent care benefits you received during the year,
- The total amount of qualified expenses you incurred during the year for dependent care,
- Your earned income,

- Your spouse's earned income, or
- $5000 ($2,500 if married filing separate).

Normally, a person cannot receive reimbursements under this Program if they are married and their spouse doesn't work. However, if a spouse is a full-time student or unable to work, then the spouse is deemed to have a monthly income of$250.00, if they have one dependent, $500.00 if there are two or more dependents.

A person can apply for reimbursement for household service expenses, including payments to baby-sitters, maids, nurses and cooks who work in their house, at least to the extent their services are for the care of a qualified individual. Household service expenses would not include payments to a gardener or chauffeur.

Certain out-of-home expenses that may apply for reimbursement could include nursery school, day-care centers, and certain summer camp expenses. This does not include expenses for educational expenses for children in kindergarten or beyond, or food, clothing and transportation expenses.

In order to qualify as a day care center, the center must care for at least six individuals who do not live on the premises, and comply with all applicable state and local laws.

Out-of-home care expenses for a spouse or dependents over the age of 12 who are unable to care for themselves qualify under this Program only if the caregivers regularly spend at least eight hours each day in your home. Therefore, nursing home expenses do not qualify under this Program. However, in-home expenses for these individuals would qualify.

A person cannot receive reimbursement for dependent care services provided by their child under the age of 19, even if that child is providing otherwise qualified dependent care assistance.

The law requires that a person give the name, address and taxpayer identification number for any person or organization that is used for dependent care assistance on their tax return. If they fail to get this information from any party who provided dependent care assistance, they will have to include any amounts they paid through reimbursement under the Dependent Care Assistance Program (or had paid directly by the Dependent Assistance Program) to that party in their gross income for the year. Thus, it is very important that they get this information as soon as possible from those parties providing dependent care assistance to them or their family. It is the employee's responsibility to get this information. The Plan Administrator will not be liable for any additional taxable income that a person may be assessed which may have been avoided if the proper information had been furnished.

NOTE: The eligibility of certain expenses varies so it is best to seek assistance as necessary.

6.4 Benefits Offered Under The Section 125 Plan (Flexible Benefits Plan). When a Participant meets the eligibility requirements as outlined in this document, they will be given the opportunity to elect one or more of the following benefits:

- Premium Payment Plan (pre-tax of contributions)
- Health FSA
- Dependent Care Assistance Program (DCAP)

- HSA Component
- ~~Cash-In-Lieu Option~~Eligible Opt Oupt Payments

6.5 Premium Payment Plan. An eligible employee can elect benefits under the premium payment plan by electing to pay for his or her share of the contributions related to the various benefit programs offered by the County on a pre-tax basis. An eligible employee can also elect to pay his or her share of the contributions with after-tax deductions outside of this Plan.

6.6 RSA Component. An eligible employee can elect to participate in the HSA component by electing to pay the contributions on a pre-tax salary or wage reduction basis to the employee's HSA established and maintained outside the Plan by a trustee-custodian to which the employer can forward contributions to be deposited. Such an election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

The annual contribution for a participant's HSA is equal to the annual benefit amount elected by the Participant In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the participant's high deductible health plan coverage option (i.e. single or family) for the calendar year in which the contribution is made. As of 2019, the statutory maximum contribution that can be deposited into the HSA is $3,500 for self, and $7,000 for families, with an additional $1,000 allowable for participants who are age 55 or older. Contact the Benefits Staff to find out the current year statutory maximum amounts or for specific details.

~~Contact the Benefits Staff to find out the statutory maximum amounts that can be deposited into the HSA An additional catch-up contribution ($800 for 2007, increasing by $100 each year until $1,000 in 2009 and thereafter) may be made for participants who are age 55 or older. Contact the Benefits Staff for specific details.~~

6.7 Use of Electronic Debit Cards for Health FSA and DCAP. It is the intent of the Plan that this form of payment is offered in a manner which will allow Participants to exclude from gross income any amounts expended for medical care paid for using electronic payment cards for Health FSA and DCAP. Participants may use electronic payment cards for Health FSA and DCAP. Such cards shall be used and issued in a manner consistent with Treasury Regulation § 1.105-2, IRS Notice 2006-69, and any subsequent IRS notices, decisions, or Treasury Regulations issued or adopted impacting the use of such payment methods.

ARTICLE VII - PARTICIPANTS' ACCOUNTS AND FORFEITURES

7.1 Establishment of Accounts. If a Participant elects benefits under one of the Programs, the Plan Administrator shall establish an account on the books of the Plan with respect to such an election(s). Any such accounts(s) are for recordkeeping purposes only and do not involve any actual segregation of assets.

7.2 Crediting of Accounts. The account(s) of a Participant shall be credited with an amount equal to the election(s) made by the Participant.

7.3 Forfeiture of Benefits. Once elections have been made related to one of the benefits above, an individual cannot change that election, subject to the exceptions mentioned previously in Article V. Any money left over at the end of the Plan Year (forfeitures) in these programs becomes the property of the employer. The Plan Administrator will finish the accounting for the plan year 120 days after the last day of the Plan Year. Any remaining claims for reimbursement must be submitted within the dates described under "filing claims for reimbursement". Should the employee fail to spend all the elected amounts under the reimbursement programs before the end of a Plan Year, those amounts (the balance) cannot be carried over to the next Plan Year. It is, therefore, very important that an employee determines as accurately as possible, how much to elect (contribute) towards the reimbursement programs. Any forfeitures may be used by the Plan to pay reasonable administrative expenses, including, but not limited to reduction of premiums for subsequent years, reimbursement of claims incurred above the participants elective limits (subject to non-discrimination rules), or other permitted uses.

ARTICLE VIII - PLAN ADMINISTRATION

8.1 Plan Administrator. The Plan Administrator shall be responsible for the administration of the Plan.

8.2 Plan Administrator's Duties. In addition to any rights, duties or powers specified throughout the Plan Document , the Plan Administrator shall have the following rights, duties and powers:

a. to interpret the Plan, to determine the amount, manner and time for payment of any benefits under the Plan, and to construe or remedy any ambiguities, inconsistencies or omissions under the Plan;
b. to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the Plan;
c. to determine the rights of any Participant, Spouse, Dependent or beneficiary to benefits under the Plan;
d. to develop review procedures for any Participant, Spouse, Dependent or designated beneficiary denied benefits under the Plan;
e. to provide each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's compensation has been reduced in order to provide benefits under this Plan;
f. to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing; and
g. to maintain the books of accounts, records, and any other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

8.3 Information to be Provided to Plan Administrator. The Employer, or any of its agents, shall provide to the Plan Administrator any employment records of any employee eligible to participate under the Plan. Such records shall include, but will not be limited to, any information regarding period of

employment, leaves of absence, salary history, termination of employment, or any other information the Plan Administrator may need for the proper administration of the Plan. Any Participant or Dependent or any other person entitled to benefits under the Plan shall furnish to the Plan Administrator their correct post office address, date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof: or any other data the Plan Administrator might reasonably request to ensure the proper and —efficient administration of the Plan. The Plan Administrator may rely on information provided by Participants and is not responsible for this information.

8.4 Decision of Plan Administrator Final. Subject to applicable State or Federal law, and the provisions contained in this Plan Document, any interpretation of any provision of this Plan made in good faith by the Plan Administrator as to any Participant's rights or benefits under this Plan is final and shall be binding upon the parties. Plan Administrator will not incur any liability for acts or failures, except as to willful misconduct or willful breach of the Plan. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator that it considers equitable and practicable.

8.5 Claims for Reimbursement. A Participant shall obtain reimbursement of a qualifying expense by submitting a claim on a form provided by the Plan to the named Contract Administrator. Claims for Reimbursement must be submitted by no later than~~within~~ 90 days after the end of the plan year for expenses incurred during the previous plan year~~[TIME PERIOD] after the date the expense was incurred~~. Each claim must include:

a. a description of the qualifying expense, the amount of the expense and the date on which the expense was incurred.
b. the person paid or to be paid.
c. the name of the person who incurred the expense.
d. bills, invoices, receipts or other documentation showing the amounts of the expenses incurred.
e. if the expense is a qualifying medical care expense, a certification that the expense has not already been reimbursed by another health plan and is not eligible for reimbursement under any other health plan.
f. if the expense is a qualifying dependent care expense, the name, address and taxpayer identification number of the dependent care provider.

8.6 Incurred Expense. A claim may be submitted before or after a Participant has paid a qualifying expense, but not before the expense has been incurred. A qualifying expense shall be deemed incurred at the time the services giving rise to the expense are rendered.

8.7 Review Procedures. In cases where the Plan Administrator denies a benefit under this Plan for any Participant, Spouse or Dependent or any other person eligible to receive benefits under the Plan, the Plan Administrator shall furnish in writing to said party the reasons for the denial of benefits. The written denial shall be provided to the party within 30 days of the date the benefit was denied by the Plan Administrator. The written denial shall refer to any Plan or section of the Code upon which the Plan Administrator relied in making such denial. The denial may include a request for any additional data or material needed to properly complete the claim and explain why such data or material is necessary, and explain the Plan's claim review procedures. If requested in writing, and within 30 days of the claim denial, the Plan Administrator shall afford any claimant whose request for claim was denied a full and fair review of the Plan Administrator's decision, and within 60 days of

the request for review of the denied claim, the Plan Administrator shall notify the claimant in writing of its final decision related to the reviewed claim.
With respect to the denial of any claim for benefits insured by or provided by an insurance company or other third-party benefit provider, the review procedures of the insurance company or other third-party benefit provider shall apply.

8.8 Extensions of Time. In a situation where the Plan Administrator determines special circumstances apply, the Plan Administrator may extend the amount of time any Participant, Spouse, Dependent or designated beneficiary may need to appeal a claim, upon proper application to the Plan Administrator.

8.9 Rules to Apply Uniformly. The Plan Administrator shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all Participants similarly situated under the Plan.

~~8.9~~8.10 Limitations Period for Filing Suit. Participants of the Plan who wish to challenge a decision on a claim shall have no more than 1 year from the date of decision on the claim to file suit.

8.11 HIPAA and HITECH Privacy and Security Standards. This Plan (and its agents) will use information that is "Protected Health Information" ("PHI") for purposes of the privacy rules issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) only as permitted by HIPAA and HITECH. Specifically, the Plan will use and disclose PHI and Electronic PHI for purposes related to health care treatment, payment for healthcare and health care operations as defined under –HIPAA and HITECH. The Plan (and its agents) will follow all applicable Federal and State Privacy and Security standards.

8.10.2 The Plan will disclose PHI to the Employer only upon receipt of a certification from the Employer that Plan documents assure ~~have been amended to provide that the Employer will:~~that the Employer will:

a. Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;~~:~~
b. Ensure that any agents, including a subcontractor, to whom the Employer provides PHI or Electronic PHI from the Plan agree to the same restrictions and conditions that apply to the Employer regarding the use and disclosure of PHI or Electronic PHI;
c. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
d. Not use or disclose protected health information in connection with any of the Employer's other benefit plans unless authorized by an individual;
e. Report to the Plan any use or disclosure of PHI or Electronic PHI that the Employer becomes aware of;
f. Make PHI available to an individual in accordance with HIPAA's access -requirements;
g. Make PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;
h. Make available the information required to provide an accounting of disclosures; make internal practices, books and records relating to the use and disclosure of PHI received from the Plan

available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

i. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of the PHI when no longer needed for the purposes for which its disclosure was made (or, if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

In accordance with HIPAA, only those employees designated by the Employer shall be given access to PHI. At present, the only authorized individuals so designated are employees ~~of the Benefits Division of~~ the Tulare County Human Resources ~~department~~& Development Department. ~~A listing of the actual individuals so designated is maintained by the Human Resources Director and is available upon request.~~ Said employees ~~are Employees~~ may use and disclose PHI or Electronic PHI only for Plan Administration functions that the Employer performs with respect to the Plan. The Employer shall provide a mechanism for resolving issues of noncompliance including disciplinary sanctions.

In addition, the County's Health FSA administrative may disclose PHI to Responsible Employees only after the County provides certification to the Health FSA.

8.10.3. Notifications in the Event of a Breach. Following a breach of unsecured PHI, the County shall provide notification of the breach to affected individuals, the Secretary, and, in certain circumstances, the media. In addition, the County will require business associates to notify it if a breach occurs at or by the business associate. Contents of the notice of breach shall be consistent with applicable HIPAA and HITECH provisions. Notice may occur in any of the following ways, depending upon the nature of the breach:

a. Individual Notice. Individual written notice will be provided by first-class mail, or alternatively, by e-mail if the affected individual has agreed to receive such notices electronically. In the event the County has inaccurate contact information for 10 or more individuals, substitute individual notice will be provided by either posting the notice on the County Human Resources & Development Department website for at least 90 days, or by providing the notice in major print or broadcast media where the affected individuals likely reside. The County will include in the published notice a toll-free phone number that remains active for at least 90 days where individuals can learn if their information was involved in the breach. If the County has inaccurate contact information for fewer than 10 individuals, it may provide substitute notice by an alternative form of written notice, by telephone, or other means. Such notice will be provided without unreasonable delay, but no later than 60 days following the discovery of a breach.

b. Media Notice. In the event of a breach affecting more than 500 residents of a State or jurisdiction are, in addition to notifying the affected individuals, the County will provide notice to prominent media outlets serving the County. Media notification will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach.

c. Notice to the United States Secretary of Health and Human Services. The County notify the Secretary of breaches of unsecured protected health information. The County will notify the completing a breach report form and submitting it to the United States Secretary of Health and Human Services. If a breach affects 500 or more individuals, the County will notify the Secretary without unreasonable delay and in no case later than 60 days following a breach. If, however, a

breach affects fewer than 500 individuals, the County will notify the Secretary of such breaches on an annual basis.

d. Notification by a Business Associate. Business Associates will be required to notify the County of any breach of unsecured health information in a manner consistent with the procedures outlined in its Business Associate Agreement consistent with the requirements of the HIPAA and HITECH Act.

ARTICLE IX - GENERAL PROVISIONS

9.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time, subject to the limitation that no amendment shall change the terms and conditions of payment of any benefit a Participant. Spouse, Dependent or designated beneficiary who was or might have been entitled to under the Plan at the time of the amendment or termination. The Employer may also make amendments apply retroactively to the extent necessary so that the Plan remains in compliance with Section 125 of the Code or any other provision of the Code applicable to the Plan.

9.2 Nonassignability. Any benefits to any Participants under this Plan shall be nonassignable and for the exclusive benefit of Participants, Spouses, Dependents and designated beneficiaries. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

9.3 Not an Employment Contract. By creating this Plan and providing benefits under the Plan, the Employer in no way guarantees employment for any employee or Participant under this Plan. Participation in this Plan shall in no way assure continued employment with the Employer.

9.4 Addresses. Notice and Waiver of Notice. Each Participant shall furnish the Employer with his correct post office address. Any communication, statement or notice addressed to a Participant at his last post office address as filed with the Employer will be binding on such person. The Employer or Plan Administrator shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this Plan. Any notice required under the Plan may be waived by such person entitled to such notice.

9.5 Required Information. Each Participant. Spouse or Dependent shall furnish to the Employer such documents, evidence or information as the Employer considers necessary or desirable to ensure the efficient operation and administration of the Plan and for the protection of the Employer.

9.6 Severability. In any case where any provision of this Plan is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the Plan and shall not apply to any remaining provisions of the Plan, and the Plan shall be construed as if such illegal or invalid provision had never existed under the Plan.

9.7 Applicable Law. The Plan shall be construed under the laws of the State of California, to the extent not preempted by the Code or any other Federal law.

9.8 No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of Participant under the Plan will

be excludable from the Participant's gross income for income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

9.9 Indemnification of Employer. If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold taxes from such payments or reimbursements.

9.10 Expenses. All reasonable expenses incurred in administering the Plan are currently paid by forfeitures and then by the Employer. For HSA benefits, a separate HSA trustee/custodial fee may be assessed by the Participant's HSA trustee/custodian.

ARTICLE X - GENERAL INFORMATION

10.1 General Plan Information

The name of this Plan is Tulare County's Section 125 Benefits Plan.

The Plan is subject to the Internal Revenue Code.

The provisions of this restated Plan became effective on January 11 2008. The Plan's records are maintained on a 12-month period known as the Plan Year. The Plan Year is January 1st through December 31st.

10.2 Employer Information. The name, address and tax identification number of the Employer are:

Tulare County
2900 W Burrel
Visalia, CA 93291
559-733-6266
94-600545

10.3 Plan Administrator Information. The name, address and telephone number of the Plan Administrator are:

Tulare County
2900 W Burrel
Visalia, CA 93291

559-733-6266

The Plan Administrator is responsible for the administration of the Plan. Should a person need to see any records or have any questions regarding the Plan, the Plan Administrator and/or Benefits Coordinator must be contacted.

10.4 Benefits Coordinator. The ~~Employee Benefits Manager~~Manager of the Human Resources and Development benefits unit has been named as the Plan's Benefits Coordinator.

10.5 Agent For Service Of Legal Process:

Tulare County Counsel
2900 W. Burrel
Visalia, CA 93291

10.6 Contract Administrator. (The company who processes reimbursement requests and other functions related to this Section 125 Plan on a day-to-day basis)

The name, address and telephone number of the Contract Administrator are:

Administrative Solutions, Inc. (ASI)
555 West Shaw Avenue, Suite C-1
Fresno, CA 93704
(559)256-1320

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Medical Monitoring Program

Site:	Choose an item.
Address:	Choose an item.
Safety Officer:	Choose an item.
Revision Date:	1/1/2018

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PREFACE

The following Medical Monitoring Program template has been approved by Tulare County's County Counsel and is maintained by Tulare County's Risk Management Division. Guidelines for medical monitoring of employees are contained in many of sections of Title 8, California Code of Regulations and various other Regulatory Agencies. The Medical Monitoring Program addresses the following:

- Monitoring for exposure to hazardous substances unique to each work site
- Recordkeeping procedures
- Program review procedures

In consideration of the varied workplace exposures encountered by the multiple departments of Tulare County, County departments will ensure each location's specific Medical Monitoring Plan complies with Title 8 or other Regulatory Agency requirements for all hazardous materials exposures unique to them. This may be accomplished by adding any department-specific monitoring requirements, policies, and procedures for each location to the template.

Each Department Head will designate a Program Manager for each location or unit requiring medical monitoring to:

1. Consult with Risk Management regarding the customization of the Medical Monitoring Plan for their facility.
2. Review and revise their Medical Monitoring Plan when work processes or procedures change, or at a minimum, annually.
3. Notify employees when required medical examinations are needed.

Each department will ensure that employees included in the program are trained on the requirements for their respective worksites and that they participate in any required examinations.

Questions regarding customizing this template can be directed to:

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3530 W. Mineral King Ave.
Suite E
Visalia, CA 93291
slcox@co.tulare.ca.us

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I. Program Implementation

The purpose for performing medical monitoring of employees is to detect physiological changes in an employee which may be the result of exposure to hazardous levels of physical, chemical, or radioactive stresses the employee may experience on the job. Supervisors will make every effort to minimize the occupational exposure of employees to hazardous environmental stresses by utilizing engineering and administrative controls for processes associated with the hazard.

Medical monitoring of employees is also used to measure the effectiveness of engineering and administrative controls. Biological monitoring is part of the medical monitoring program. Biological monitoring can provide a reasonable indication of exposures to hazardous environmental stresses the employee might encounter on the job. Biological monitoring is also an attempt to quantify an employee's exposure for a period of time either before or as a result of employment with Tulare County.

All required medical monitoring shall be provided without cost to the employee, without loss of pay, and at a reasonable time and place.

A. Hazard Identification

Each department is responsible for conducting a hazard evaluation to determine whether there is an exposure to physical and/or physiological hazards which require medical monitoring. Assessments may be performed by:

- Completing the County of Tulare Medical Monitoring Program Survey.
- Reviewing packing slips and shipping manifests to identify exposures.
- Evaluating results of any environmental monitoring conducted (if applicable).

After the initial assessment has been conducted, ongoing evaulations will be administered at least annually, if work practices or procedures change, or if a new hazard has been introduced/identified. A list of Title 8 regulations and a synopsis of the medical monitoring requirements for **Enter Department/Facility Information**, is contained in Appendix A.

B. Department Responsibilities

a. Department Head

The Department Head shall be responsible for the implementation of this policy by:

- Appointing a Designated Program Manager to ensure effective implementation of the program.
- Ensuring there is an efficient system for identifying workplace exposures.

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- Ensuring all employees in their department who are required to participate in the program are actively participating.

b. **Designated Program Manager**
Under the direction of the Department Head, the Designated Program Manager (DPM) shall be responsible for the implementation of this policy by:

- Ensuring hazard assessments are conducted.
- Communicating any new or previously unrecognized hazard to Risk Management for evaluation.
- Provide all employees working in areas with identified exposures a complete required examination before being allowed to work in the area.
- Maintaining appropriate calendar controls for follow up examinations.
- Forwarding ongoing hazard assessments to Risk Management for review, as needed.

c. **Risk Management**
Risk Management Safety Analysts will partner with County Departments and assist with implementation by:

- Assisting County Departments with program creation and implementation, if requested.
- Identifying appropriate physician/medical clinics who can perform required medical testing/examinations.
- Maintaining employee medical examination records, as appropriate.

d. **Employee Responsibilities**
All County employees whose job description requires participation in the Medical Monitoring program shall:

- Participate in the Medical Monitoring Program as required.
- Wear/use any prescribed Personal Protective Equipment.
- Promptly report any accidental occupational exposure to their supervisor or another member of management.

C. Program Participants

The following Enter Department/Facility Name employees will participate in the medical surveillance program:

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- All employees who are, or may be, exposed to hazardous substances or health hazards at or above the permissible exposure limits or published exposure levels for those substances, without regard for the use of respirators, for 30 days or more a year.
- All employees who wear a respirator for 30 or more days per year.
- Any employee who is injured, becomes ill, or develops signs or symptoms due to possible overexposure involving hazardous substances or health hazards from an emergency response or hazardous waste operation.
- Members of the designated HAZMAT teams and "Hazardous Materials Specialists" as defined by Title 8 §5192.
- Environmental Health Specialists assigned to business plan checking (Hazardous Materials).
- Environmental Health Specialists designated by the Deputy Director of Environmental Health to the emergency response on-call list.
- Environmental Health Specialists/Technicians assigned to Environmental Quality.

Any employee who is injured or becomes ill due to possible overexposure must report the injury or illness to their supervisor immediately.

D. Frequency of Exams

- Employees identified above will receive a baseline examination before the job assignment.
- Periodic examinations for those employees will be conducted at least every 12-months unless an Occupational Medicine Physician believes that a longer interval (no more than 24-months), or a shorter interval is appropriate.
- At reassignment or termination of employment, if the employee has not had an exam within the last 6-months.
- As soon as possible after an employee is injured, becomes ill, or develops signs or symptoms due to a potential overexposure involving hazardous substances, and at additional times if the Occupational Medical Physician deems it necessary.

E. Scheduling the Medical Surveillance Examination

The DPM will:

- Set and maintain appropriate calendar controls for the on-going follow-up examinations.
- Notify the employee one month in advance of the upcoming exam.
- Contact the medical clinic to set up an appointment for the examination and notify the employee of date and time.

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- Complete the Medical Monitoring Program Passport (form located on the Risk Management Intranet site, tcriskmanagement/risk/safety/forms/...); provide a copy to the employee, and mail a copy to Risk Management at riskpreemployment@co.tulare.ca.us.

The employee will:

- Complete the Medical/Work History Information Form prior to the baseline examination.
- Complete the Medical Release Form.
- Present the passport and the above-mentioned form to the clinic at the time of the appointment.

F. Physician's Written Report

The Occupational Medicine Physician shall provide the employee a copy of the written opinion containing:

- Any detected medical conditions which would place the employee at increased risk of impairment of health from work in hazardous materials operations, emergency response or respirator use.
- Recommended work restrictions, if any, related to the employee's assigned work.
- Results of the medical examination and tests if requested by the employee.
- A statement that the employee has been informed by the physician of the results of the examination and any medical conditions which require further examination or treatment.

The written opinion shall not reveal specific findings or diagnosis that are unrelated to occupational exposures.

The Occupational Medicine Physician shall provide Tulare County Risk Management a copy of the written opinion which shall include:

G. Recordkeeping

An accurate record of the medical surveillance of each employee will be retained by Risk Management? for the duration of the employee's employment, plus 30 years. The records shall include:

- The employee's name and Social Security Number. (last four only?)
- The physician's written opinions, recommended limitations, and results of the examination and tests.

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- Any employee medical complaints related to hazardous substance exposure.
- Copies of the Medical/Work History Release form completed by the employee.

H. Program Review

The Enter Department and Facility Medical Monitoring Program will regularly be evaluated to determine its overall effectiveness by the following:

- Determine that each accident, exposure and or illness was promptly investigated to determine the cause and make necessary changes in processes or procedures.
- Evaluate the efficacy of specific medical testing in the context of potential site exposures.
- Add or delete medical tests as suggested by current Industrial Hygienist and/or Occupational Medicine Physician.
- Review potential exposures and site safety plans at all sites to determine if additional testing is required.
- Review emergency treatment procedures and update lists of emergency contacts.

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Appendix A

Medical Examination Protocols

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General Medicine:

All employees will undergo a baseline examination before beginning work in areas with potential/or known exposure to hazardous substances, chemicals, or physical hazards (i.e., noise). The exam shall include CBC, liver function, and urinalysis for general metabolic constituents. Employees will complete and bring the Initial Medical Questionnaire for Pre-Placement Exam or the Periodic Medical Questionnaire for subsequent exams to the clinic at the time of their scheduled appointment. The baseline exam may be waived if the employee has recently undergone an exam and testing for another purpose. In these situations, the employee is required to complete the Occupational/Medical History Questionnaire and provide results of previous exams to the clinic/physician for review.

Respiratory Function Testing (Title 8 CCR §5144):

Any employee who is required to use any form of respiratory protective equipment shall undergo respiratory function testing. Employees should not be assigned to tasks requiring the use of respirators unless it has been determined they are physically able to perform the work while using the necessary respiratory equipment. A licensed physician shall determine what health and physical conditions are pertinent. OSHA recommends that no employee should be assigned work requiring respirators without first receiving a physical examination and approval by a licensed physician. It should be noted that medical approval becomes mandatory when employees are required to work with specific contaminants such as asbestos and those listed in Title 8 CCR Article 10 Regulated Carcinogens.

Frequency: The medical status of employees' assigned use of respiratory equipment should be reviewed at least annually.

Content of exam: Although not specified as to the examinations content in the CCR, the following are suggested as a minimum:

Mandatory Tests:

- Medical history pertaining to a condition that could affect the employee's ability to wear a respirator. Physical examination with emphasis on the respiratory and cardiovascular condition.
- Spirometry test for forced vital capacity (FVC) and forced expiratory volume in one second (FEV 1).

Optional Tests:

- Single view (PA) chest x-ray depending on the medical history.
- Electrocardiogram (EKG) may be obtained depending on medical history.

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Note: Chest x-rays and EKGs are an optional consideration and should only be done when medical conditions indicate necessity.

Physician's report: The report should indicate if there are any restrictions to the wearing of respiratory protective equipment, and should indicate what levels of respiratory equipment may be worn.

Blood Lead (Title 8 CCR Section §5216):

All employees who are or may be exposed at or above the action level for more than 30 days per year shall be tested for elevated levels of lead in the blood.

Frequency:

- At least annually for each employee for whom a blood sampling test conducted at any time during the preceding 12 months indicated a blood lead level at or above 40 µg/100 g
- Prior to assignment for each employee being assigned for the first time to an area in which 8-hour time-weighted concentrations of airborne lead are at or above the action level.
- At least every six (6) months for employees who are or may be exposed at or above the action level for more than 30 days per year.
- Every two (2) months for each employee whose blood lead level was at or above 40 ug/100 g until two samples in a row are less than 40 ug/100 g.
- At least monthly during the removal period for each employee removed from exposure to lead due to an elevated blood lead.
- As soon as possible when either the employee has developed signs or symptoms commonly associated with lead.

The employee may designate a second physician to review any findings, determinations, or recommendations of the initial physician and to conduct a second examination.

Content of exam: Biological monitoring shall consist of a zinc protoporphyrin and blood lead level performed at least every six months or as scheduled above. Medical examinations shall be performed upon initial exposure, and annually, for blood lead levels greater than 40 ug/100 g., or as otherwise required above.

Components of the examination:

- Detailed work history and medical history with particular attention to past lead exposure (occupational and non-occupational), personal habits (smoking, hygiene), and previous gastrointestinal, hematologic, renal, cardiovascular, reproductive, and neurological problems.

- A thorough physical examination with particular attention to teeth, gums, hematologic, gastrointestinal, renal, cardiovascular, and neurological systems. Pulmonary status should be evaluated if respiratory protection will be used and neurological systems.
- Blood pressure
- Blood sample to include:
    - blood lead level
    - hemoglobin and hematocrit, red cell indices and peripheral smear morphology
    - zinc protoporphyrin (ZPP)
    - blood urea nitrogen and creatinine
    - urinalysis with microscopic examination
    - any laboratory or other tests which the examining physician deems necessary by sound medical practice

The contents of the examinations made available because of concerns about symptoms or reproductive hazards shall be determined by the examining physician and, if requested by the employee, shall include pregnancy testing or laboratory evaluation of male fertility.

Medical removal:

The employer shall remove an employee from work having an exposure to lead:

- At or above the action level on each occasion that the average of the last three blood sampling tests (or the average of the last 3 blood tests over the previous 6 months whichever is longer) indicates that the employee's blood lead level is at or above 50 ug/100 g; an employee need not be removed if the last blood sampling indicated a level at or below 40 ug/100 g.
- At or above the action level on each occasion that a final medical determination results in a medical finding or opinion that the employee has a detected medical condition which places the employee at increased risk of material impairment to health from exposure.

Return to former:

The employee shall be returned to the former job status:

- If removed for a blood lead level at or above 80 ug/100 g when the employee's blood lead level is at or below 60 mg/100 g of whole blood;
- If removed for a level at or above 70 ug/100 g when two consecutive tests indicate the blood lead level is at or below 50mg/100 g;
- If removed due to a level at or above 60 ug/100 g or due to an average blood lead level at or above 50 ug/100 g when two consecutive blood tests indicate the level is at or below 40 ug/100 g;

DRAFT

- When removed due to a final medical determination when a subsequent final medical determination states that the employee no longer has a detected medical condition which places the employee at increased risk of material impairment to health.

Pesticides (Title 8 CCR Section §6728):

All employees who are or may be exposed at or above the action level for more than 30 days per year shall be tested for elevated levels of lead in the blood.

DRAFT

OFFICE MEMORANDUM
TULARE COUNTY COUNSEL
RISK MANAGEMENT DIVISION

Office: (559) 636-4950
Fax: (559) 713-3719

To: Susan Cox, Risk Manager
Rhonda Sjostrom, Director HR

Date: May 6, 2019

From: Kim A. Starr
Risk Management Analyst

Subject: Employer Pull Notice Program (EPN)

RE: Program Requirements

The EPN program is a driver safety program that is required by the DMV under CVC 1808.1. It is designed to allow organizations to monitor the driving record/status of employees who drive on their behalf. The goal of the program is to improve public safety, monitor license status, notify employer of driving behavior and reduce the employer's liability. The program is monitored by the California Highway Patrol who conducts periodic audits of the employer's records.

A report on a driver is generated and available to the employer:

- On driver enrollment
- Annually from the date of employment
- When there is activity against the driver (convictions, suspension of license…)

Drivers holding the following are required to be enrolled in the EPN program:

- Class A license
- Class B license
- Class C with hazardous materials endorsement
- Class C with special endorsements (under age of 18 with permit, school bus, farm labor vehicle, tow truck, paratransit vehicle)
- Driver of vehicle of no more than 10 persons including the driver operated for compensation by charter-party carrier of passengers
- Passenger charter vehicles

In addition, the DMV permits the enrollment of non-mandated drivers under these conditions:

- The driver consents to being enrolled in EPN
- The driver is an employee of the EPN account holder or if the driver is not an employee, (e.g., volunteer, the person operates a vehicle on behalf of the employer's business).
- Information is used exclusively for business reasons.
- Driver is immediately deleted from EPN account when no longer employee.

Enrollment of employees who drive on behalf of the County will allow us to monitor who we are allowing to operate County vehicles. It will assist the County in ensuring compliance with our driving policies, and can protect us from the liability of having a person with problem driving behavior behind the wheel of a County vehicle.

DRIVING STANDARDS ACKNOWLEDGMENT
COUNTY OF TULARE

Employee:_____ SSN:_____

Department:_____ Position:_____

I acknowledge that I have received a copy of the **"County of Tulare Driving Standards"** and that I have carefully read and reviewed the standards.

I particularly understand that the position to which I am being assigned requires operation of a motor vehicle. A satisfactory driving record is required for appointment to and for continued employment in County positions which require the operation of a motor vehicle in the course of County business. The driving record will be evaluated against the standards listed below.

DEFINITIONS

Major or Capital Violations: Major or capital violations are serious convictions which indicate a disregard for public safety. Examples include, but are not necessarily limited to the following: reckless driving where bodily injury or property damage result; hit and run; negligent homicide; assault with a motor vehicle.

Incidents: An incident is defined as a preventable accident or moving violation.

Accident: Accidents will be determined to be non-preventable where there is no corresponding citation date under the abstract section of the Department of Motor Vehicle report.

Moving Violation: A moving violation is defined as a citation issued under the California Motor Vehicle Code, or similar code of another state, and includes citations for unregistered vehicles, expired licenses, licenses not in possession, suspended licenses, or revoked licenses. Citations for faulty equipment shall be considered moving violations except those involving unlit tail lamps, turn signals, brake lights, or license plate lights. All other citations will be considered as moving violations.

STANDARDS

Except where the law may require a higher standard, the following criteria will be utilized as a definition of an UNSATISFACTORY driving record:

1. One conviction of a major or capital violation during the preceding 36 month period is considered unsatisfactory.

2. Two convictions of driving under the influence of alcohol or drugs during the preceding 36 month period is considered unsatisfactory.

3. For County positions which normally require the operation of a motor vehicle for *less* than 4000 miles per year, five or more incidents during the preceding 36 months will be considered unsatisfactory.

4. For County positions which normally require the operation of a motor vehicle for *more* than 4,000 miles per year, three or more incidents during the preceding 36 months will be considered unsatisfactory.

I certify that my personal driving record is satisfactory as described by the County of Tulare Driving Standards.

_____ _____

Signature Date

DMV PULL PROGRAM

UNREPRESENTED CLASSIFICATIONS

CLASSIFICATIONS
EH Maintenance Worker I
Facilities Mgr
EH Maintenance Worker I
EH Maintenance Worker II
Capital Projects Coordinator I
CapProjectsFacilitiesMgr
Capital Projects Coord III
Capital Projects CoordinatorII
Custodial Services Manager
EH Parks & Grounds Worker
EH Gate Attendant
EH Parks & Grounds Worker
EH Parks & Grounds Worker
EH Parks & Grounds Worker
Parks & Recreation Div Mgr
EH Museum Assistant
EH Gate Attendant
EH Parks & Grounds Worker
EH Parks & Grounds Worker
Community Outreach Specialist
Probation Institution Supervisor
Probation Officer-Supervisor
Probation Division Manager
Deputy Chief Probation Officer
Assistant Chief Probation Officer
Chief Probation Officer