SELF-INSURED PAID FAMILY LEAVE
Statement of Coverage

THIS IS A STATEMENT OF COVERAGE FOR THE CITY COLLEGE OF SAN FRANCISCO PAID FAMILY LEAVE (PFL) PLAN. THE PROVISIONS DESCRIBED APPLY TO PFL BENEFIT PERIODS BEGINNING ON OR AFTER JANUARY 1, 2015.

THERE IS A SEPARATE STATEMENT OF COVERAGE FOR THE DISABILITY PROVISIONS OF THIS PLAN.

PARTICIPATION

Who may participate? Certain classified employees of the Employer are eligible for PFL coverage. An individual in a covered class of employment on the effective date of this Plan is immediately eligible for coverage. New employees in a covered class will become eligible on the date of their employment.

PAID FAMILY LEAVE

When am I eligible for PFL? When you are unable to work because you must provide care to a sick or injured Family Member or to bond with a New Child. A leave for the purpose of bonding with a New Child is limited to the first year after the birth, adoption, or foster care placement of the child.

BENEFITS

How much will I receive? If you have a valid PFL claim, you will be paid 55% of your weekly benefit amount up to $1,075. Partial weeks are paid at a daily rate that is 1/7 of your weekly benefit.

When do my benefits begin? For each PFL Benefit Period your benefits begin on the eighth day of your leave.

A PFL Disability Benefit Period is deemed to be continuous (i.e. you do not need to serve another seven-day waiting period) if you (i) must provide care to the same Care Recipient within a Twelve-month Period, or (ii) have a period of disability related to childbirth followed by a period of PFL for bonding associated with the birth of that child.

On what are benefits based? Benefits are based on your annual salary divided the number of days you are scheduled to work annually times five (5).

What is the maximum benefit payable? The maximum benefit payable for PFL during any Twelve-month Period will be six (6) times the weekly benefit amount.

Will I still be eligible for benefits if I receive wages while on a PFL? Yes, provided that the money you earn part-time when combined with your benefits does not exceed your regular weekly earnings (excluding overtime pay). Your benefit will cover the difference between your part-time earnings and your regular earnings.

CERTIFICATION

For the purpose of providing care to a sick or injured Family Member you must submit a certificate from a Physician that establishes medical eligibility of the Serious Health Condition of your Family Member who warrants your care. The information provided must be within the Physician's knowledge and must be based on a physical examination and documented medical history of the Family Member requiring care.

The certificate must contain but is not limited to: (i) the name, social security number (if issued) and date of birth of the Family Member requiring your care, (ii) a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or where no diagnosis has been obtained, a detailed statement of symptoms, (iii) the date, if known, on which the condition

commenced, (iv) an estimate of the amount of time (days and hours per day) that the Physician believes you are needed to care for the Family Member, and (v) a statement that the Serious Health Condition warrants your participation to provide care for your Family Member. "Warrants your participation" includes, but is not limited to, providing psychological comfort, and arranging "third party" care for the Family Member, as well as directly providing, or participating in, medical care.

If any Family Member in good faith adheres to the teachings of a bona fide church, sect, denomination, or organization, and depends for healing entirely upon prayer or spiritual means, the certificate of a duly authorized and accredited practitioner of such bona fide church, sect, denomination or organization, as to the Serious Health Condition of the Family Member that warrants your care, and the estimated duration of the needed care, will be accepted.

You must provide information about yourself and the Care Recipient. This information includes but is not limited to: (i) your authorization for the Company or the Company's authorized claims administrator to disclose your information to the Care Recipient's Physician or practitioner, the Care Recipient, the California Employment Development Department or the California Unemployment Insurance Appeals Board, and (ii) the Care Recipient's or authorized representative's signature authorizing the treating Physician or practitioner to release protected health information to you (the care provider), the Company or the Company's authorized claims administrator, the California Employment Development Department or the California Unemployment Insurance Appeals Board.

For the purpose of bonding with a New Child you must submit a claim and supporting documentation that provides satisfactory evidence of the birth, adoption or foster care placement of the child. The supporting documentation must contain but is not limited to the child's full name, date of birth, gender, if applicable, date of placement or adoption and, if available, social security number.

To verify the birth of a child, the supporting documentation may be any of the following: (i) a photocopy of the child's certified birth certificate, (ii) a photocopy of the completed hospital or birthing center documents attesting to the birth of the child, or (iii) a letter from the birthing center's or hospital's Director of Medical Records or their designate containing the child's full name, date of birth, gender and, if available, social security number plus the full name of the mother, full name of the father, if known, or registered Domestic Partner and a dated signature of the treating Physician or midwife, or Director of Medical Records or their designate as appropriate.

For paternal, non-spouse bonding claims (where you are not named on one of the documents listed above), a photocopy of California Department of Child Support Services form *Declaration of Paternity* (or equivalent proof) must be submitted.

To verify the adoption of a New Child, the supporting documentation may be a photocopy of any of the following: (i) the Department of Social Services form *Notice of Placement*, (ii) the Department of Social Services form *Independent Adoption Placement Agreement*, (iii) a court order for placement for adoption issued within the United States, (iv) the child's passport clearly showing an Immigration and Naturalization Services (INS) stamp, or (v) the child's adoption certificate from the country's competent local authority with a notarized English translation.

To verify the foster care placement of a New Child, the supporting documentation may be any of the following: (i) a photocopy of the Department of Social Services form *Approval of Family Caregiver Home*, or (ii) a statement on letterhead from the County Department of Social Services, or equivalent government entity, stating the child's full name, date of birth, gender and, if available, social security number, resident address where the child is placed, date of foster care placement including the length of time of the placement if duration has been established, full name(s) of the person(s) with whom the foster care placement is made, including such person's residence address, date of birth and, if available, social security account number(s). The

statement must also include a dated signature of the social worker, the social worker's typewritten name and the social worker's direct telephone number.

EXCLUSIONS

1. You will not receive benefits under this Plan for any PFL Disability Benefit Period that does not begin while you are covered under the Plan.
2. You will not receive benefits under this Plan if you are receiving or are entitled to receive unemployment benefits under any unemployment compensation act of the United States or of any state.
3. You will not receive benefits under this Plan if you are incarcerated (in jail or any other facility, public or private) as a result of a criminal conviction.
4. You will not receive benefits under this Plan if you receive (or are eligible to receive) Workers' Compensation temporary disability indemnity, permanent disability benefits (if such benefits are paid due to the same illness or injury) or maintenance allowance. Under some circumstances, if the amount you receive in Workers' Compensation benefits is less than the amount payable under this Plan, this Plan can pay the difference.
5. Except as described under "What if I am covered by more than one plan…?" (above), you will not receive benefits under this Plan if you are receiving or are entitled to receive state disability insurance under the disability benefit act of this state or any other state or any company plan established in lieu of a state plan.
6. If you intentionally make a false statement or representation (or withhold material facts) in order to obtain benefits, you will be ineligible for benefits for at least 7 days (starting on the date we notify you) but not more than 35 days. You will not receive benefits for an additional 56 days if there is a second infraction of this provision.
7. You will not receive benefits under this Plan for any day for which another Family Member is ready, willing, able and available for the same period of time that you are providing the required care.

COVERAGE ENDS

When does my coverage end? On the earliest of the following: (i) when you cease to be eligible; (ii) at midnight of the day your employment ends; or on the 15th day after you begin an unpaid LOA, or at midnight of the 15th day following a layoff without pay; or (iii) the date of termination of the Plan.

If you established a Care Recipient Period while covered by this Plan, all subsequent claims for the same Care Recipient through the end of the Twelve-month Period will remain the liability of this Plan.

CLAIMS

How do I file a claim? Call Keenan & Associates at (800) 444-9995. A claim for benefits must be filed not later than 41 days after you would have been eligible to receive benefits, unless there is good cause for an extension.

Your employer or its authorized administrator has the right to (i) require supplemental forms from the Physician, or those authorized to certify to PFL, as often as deemed necessary, and (ii) have the Care Recipient examined by a Physician while you are claiming benefits under the Plan. This may be done as often as may reasonably be required during the period benefit payments may be due under the Plan.

What if my claim is denied? Represented employees will be provided with the normal and customary grievance process identified in their collective bargaining agreement.

Unrepresented employees' first recourse should be directed to the Director of Human Resources. The final and determinative recourse should be directed to the Vice Chancellor of Finance and Administration.

MISCELLANEOUS If you are entitled to leave under the FMLA and the CFRA you must take your Paid Family Leave concurrently with the leave taken under the FMLA and the CFRA. **Important:** Your right to PFL benefits under this Plan does not provide any form of job protection.