



2012 Employee Benefits Program



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The Sierra Club provides comprehensive employee benefits as part of our total compensation program. Options in cost and plan design are intended to provide you with the opportunity to customize your benefit plan to meet your lifestyle and personal choices, while offering protection, flexibility and security to you and your family.

The decisions you make regarding your enrollment in benefits deserves your careful consideration. Your choices will be in effect for the plan year. You will be able to make changes during the plan year only in the event of an IRS qualified Family Status Change. Be sure to review the plan's covered and non-covered services and any restrictions on your choice of providers. There are many resources available to assist you in making your benefit choices and remember that there are no right or wrong selections; your primary consideration in this decision is what works best for you.

Keep in mind that this summary provides only a general overview of the benefits available to you. It does not include details of all covered expenses or exclusions and limitations. Please refer to each plan's Evidence of Coverage (EOC) booklet for the terms and conditions of coverage. Further, the Sierra Club reserves the right to change, amend or terminate any or all of the benefits shown in the summary, as necessary.



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When Benefits Begin

Regular and limited duration employees working 20 or more hours per week are eligible for coverage under the following benefit programs upon date of hire:

Sick Leave	Employee Assistance Program
Holidays	Sierra Club Membership Discounts *
Vacation Accrual	Credit Union *

* requires separate enrollment forms for participation

Regular and limited duration employees working 20 or more hours per week may enroll in and are eligible for coverage under the following benefit programs on the first day of the month following date of hire:

Medical Plans	Voluntary Term Life Insurance
Dental Plans	Voluntary Accidental Death/Dismemberment Insurance
Vision Care Plan	Flexible Reimbursement Account(s)
Basic Life Insurance	Commuter Transit Program

Long Term Disability coverage is effective on the first day of the month following three months of employment.

Participation in the Retirement Plan (pension) is effective on the first day of the month following two years of employment.

You may elect to participate in the 401(k) Plan. Please refer to your Summary Plan Description for participation and eligibility dates.

Enrollment

Employees must enroll online at **iVantage** and return their benefits enrollment paperwork to the Human Resources Department within 30 days of their date of hire or date of eligibility for benefits. Failure to do so will result in forfeiture of coverage. iVantage will reflect the cost of coverage for your benefit choices including any employee contribution requirements. The Sierra Club's contribution towards the cost of coverage for part-time positions is pro-rated in accordance with the position's full-time equivalency.

The Sierra Club provides employees the opportunity to renew or change their benefit elections once a year, during the Open Enrollment period. Open Enrollment is usually conducted in the fourth quarter of the calendar year. Benefit choices made during Open Enrollment, including renewals and changes, are effective January 1st of the following calendar year. Benefit elections must be made at the beginning of every plan year and cannot be changed during the Plan Year unless the employee has a "Qualified Status Change" as defined by the IRS. Please refer to the Sierra Club Summary Plan Description for details.

Employee Benefit Help Desk and Benefits Website

The Benefit Help Desk is staffed with Benefit Specialists available to assist you with your questions, claims resolution, forms and eligibility regarding your benefit programs. Call 1-800-925-4802 or send an email to: helpdesk@jenkinsgroup.com. Also available is the Benefits Website where you may review the benefit programs offered through the Sierra Club. Go to sierraclub.myjenkinshr.com. The login is **sierraclub**. The password is **benefits**. Within our website, you may review and compare all of the benefit plans offered, link to the provider directories, learn about eligibility, download forms, access the benefits plan rules, and ask questions and receive answers directly from the Human Resources department.



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Benefits Plan Contacts

Plan	Group Number Plan	Customer Service	Web Site
Aetna Medical Plans:	—	—	—
POS Managed Choice Member Services	720391	1-877-204-9064	www.aetn navigator.com
Traditional Choice Member Service	720391	1-877-204-9064	www.aetn navigator.com
HMO Member Services	090110	1-877-402-8742	www.aetn navigator.com
Aetna Commuter Benefits (ACB)	ID: 837043010000	1-877-392-3862	www.aetnacommuterhub.com
Kaiser	07569	1-800-464-4000	www.kaiserpermanente.org
Magellan Employee Assistance Program	3665	1-800-356-7089	www.MagellanHealth.com/member
Merrill Lynch 401(k) Plan	—	1-800-229-9040	www.benefits.ml.com
NBS—FSA	—	1-800-274-0503	www.nbsbenefits.com
Patelco Credit Union	—	415-442-6200 / 1-800-358-8228	www.patelco.org
Principal Dental Plan	1004880-10001	1-800-247-4695	www.principal.com
Principal Life Insurance	H41528	1-800-245-1522	www.principal.com
Provident Credit Union	—	1-800-632-4600	www.providentcu.org
Prudential Long Term Disability	08783	1-800-842-1718	www.prudential.com
Vision Service Plan (VSP)	12000583	1-800-877-7195	www.vsp.com

Medical Plans

The benefits program includes 4 medical plans:

- Aetna POS Managed Choice
- Aetna Traditional Choice
- Aetna HMO
- Kaiser HMO

Each plan provides comprehensive, high-quality healthcare. The plans differ in the way they manage your care and structure out-of-pocket expenses. Medical plan offerings vary according to the employee’s location.

Aetna Point of Service (POS)

When you enroll in a POS plan, you are required to choose a primary care physician to monitor your health care. This primary care physician must be chosen from within the health care network, and becomes your “point of service”. The primary POS physician may then make referrals outside the network, but then only some compensation will be offered by your health insurance company.

For medical visits within the health care network, paperwork is completed for you. If you choose to go outside the network, it is your responsibility to fill out the forms, send bills in for payment, and keep an accurate account of health care receipts.”



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Aetna Traditional Choice

The Aetna Traditional Choice Plan is an indemnity medical plan. You may visit any licensed doctor or hospital. There's no need to worry about networks, referrals or primary care doctors. When you visit your doctor you pay for the cost of care; then submit a claim form for covered expenses. A deductible and coinsurance apply. The amount reimbursed is dependent on the level of benefits outlined by your plan. You are liable for charges above the reasonable and customary charges for covered services. You may need approval from Aetna before you receive certain kinds of care. This plan is available only in locations not serviced by Aetna Managed Choice (POS) or other HMO plan options.

Pre-Existing Condition (applicable to Non-HMO medical plans)

Non-HMO medical plans contain a Pre-existing condition limitation clause. Pre-Existing condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your coverage under this plan. If an individual has a pre-existing condition no payment will be made for services or supplies for the treatment of a pre-existing condition. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption. This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through which you had this coverage) ended the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. To reduce the six-month exclusion period, please provide a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. There are no pre-existing condition limitations for dependents under age 19.

Aetna Health Maintenance Organization Plans (HMO)

If you enroll in the Aetna HMO plan, you select a Primary Care Physician, or PCP, to coordinate your medical care. Your PCP provides routine services and refers you to other providers in the Aetna HMO network when you need to see a specialist or be hospitalized. You must receive care from providers in the Aetna HMO network; Aetna won't pay for non-emergency services you receive from a non-network provider or without a referral from your PCP.

Kaiser Permanente Health Maintenance Organization (HMO)

If you enroll in the Kaiser HMO, you have the convenience of having all of your healthcare needs under one roof. General providers give routine services and refer you to other providers within the Kaiser network when you need to see a specialist or be hospitalized. You must receive care from providers within Kaiser's network. Kaiser won't pay for non-emergency services you receive from a non-Kaiser provider or without a referral.

Selecting a Primary Care Physician (HMO)

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

You have the right to designate any primary care provider who participates in the Kaiser or Aetna networks and who is available to accept you or your family members. Until you make this designation Kaiser HMO or Aetna HMO will designate one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact customer service at Kaiser Permanente or Aetna.



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Medical Plan Options

AETNA MANAGED CHOICE POS PLAN

Medical Plan Features	In-Network	Out-of-Network
Group Policy Number	720391	
Member Services	1-877-204-9064 / www.aetnavigators.com	
Plan Description	Under the POS Plan, you select a Primary Care Physician (PCP) to coordinate your healthcare services. When you obtain services from In-network providers, you receive a greater level of benefits without a deductible.	
Service Area	Most Sierra Club Locations	
Calendar Year Deductible	No Deductible	\$300 per individual / \$600 per family
Calendar Year Co-insurance Maximum	None	\$1000 per individual / \$2000 per family
Lifetime Maximum Benefits	Unlimited, except where otherwise noted	
Medical Benefits	In-Network	Out-of-Network
Physician Office Visits	Covered at 100% after \$20 copay	Covered at 70%
Routine Physical Examinations	Covered at 100% after \$20 copay One exam every 24 months age 18 to 65 One exam ever 12 months age 65 or older Well Child exam frequency varies by age	Covered at 70% the same age requirements as In-network applies
Preventive Care ¹	100%	70%
Prescriptions	Formulary Generic Drugs: Covered at 100% after \$10 copay Formulary Brand Name Drugs: Covered at 100% after \$20 copay Non-Formulary Drugs: Covered at 100% after \$35 copay at participating pharmacies, 30-day supply	Covered at 70% - deductible waived, subject to In-network copays
Mail Order for Maintenance Drugs	90-day supply for two copays from Aetna Rx home delivery	Not covered
Chiropractic Care	Covered at 100% Limited to 20 visits per calendar year; subject to medical necessity and Aetna review	Covered at 70% - limited to 20 visits per calendar year
Short-term Rehabilitation Physical, Occupational and Speech	Covered at 100% limited to 60 visits per calendar year; subject to medical necessity and Aetna review	Covered at 70% - limited to 60 visits per calendar year
Diagnostic X-Ray and Lab	Covered at 100%	Covered at 70%
Hospital Benefits	In-Network	Out-of-Network
Room and Board	Covered at 100% - pre-certification required	Covered at 70% - subject to a separate \$250 deductible per confinement, pre-certification required

1. Note on preventive care: If additional services other than preventive care, as outlined by the US Preventive Services Task Force Recommendation, are obtained during the visit, a copay, coinsurance, and/or deductible will apply.



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Medical Plan Options (Continued)

AETNA MANAGED CHOICE POS PLAN* (CONT'D)

Hospital Benefits (cont'd)	In-Network	Out-of-Network
Surgeon's Fees	Covered at 100%	Covered at 70%
Maternity - Delivery	Covered at 100%	Covered at 70% - subject to a separate \$250 deductible per confinement
Emergency Care	Covered at 100% after a \$50 copay per admission (waived if admitted)	
Mental Health and Substance Abuse Benefits	In-Network	Out-of-Network
Outpatient Services	Covered at 100% after a \$20 copay per visit	Mental Health: covered at 70% Substance Abuse: covered at 70%;
Inpatient Services	Covered at 100%	Covered at 70% - subject to separate \$250 deductible per confinement - pre-certification required

*Co-Insurance Benefits for Oregon, Massachusetts and Utah locations: 100% In-Network, 80% Out-of-Network

**Subject to the deductible and paid at Usual, Customary and Reasonable rates.

+ No day or visit limits for Severe Mental Health Illness diagnoses.

AETNA TRADITIONAL CHOICE PLAN *

Medical Plan Features

Group Policy Number	720391
Member Services	1-877-204-9064 www.aetnavigators.com
Plan Description	You may choose any provider you wish for your health care services
Service Area	Available only in locations not serviced by Aetna Managed Choice (POS) or other HMO plan options
Calendar Year Deductible	\$300 per individual / \$600 per family
Calendar Year Co-Insurance Maximum	\$2000 per individual / \$4000 per family
Lifetime Maximum Benefits	Unlimited - except where otherwise noted
Physician Office Visits	Covered at 80%
Routine Physical Examinations	Covered at 100%, One exam every 24 months ages 18 to 65; One exam every 12 months age 65+; Well Child exam frequency varies by age
Preventive Care	100% - If additional services other than preventive care, as outlined by the US Preventive Services Task Force Recommendation, are obtained during the visit, a copay, coinsurance, and / or deductible will apply.
Prescriptions	Formulary Generic Drugs: Covered at 100% after \$10 copay Formulary Brand Name Drugs: Covered at 100% after \$20 copay Non-Formulary Drugs: Covered at 100% after \$35 copay at participating pharmacies, 30-day supply
Mail Order for Maintenance Drugs	90-day supply for two copays from Aetna Rx home delivery
Chiropractic Care	Covered at 80% - Limited to 20 visits per calendar year; subject to medical necessity and Aetna review



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Medical Plan Options (Continued)

AETNA TRADITIONAL CHOICE PLAN (CONT'D) *

Medical Benefits

Physical Therapy	Covered at 80%
Diagnostic X-Ray and Lab	Covered at 80%

Hospital Benefits

Room and Board	Covered at 80%; pre-certification required
Surgeon's Fees	Covered at 80%
Maternity - Delivery	Covered at 80%
Emergency Care	Covered at 80%

Mental Health and Substance Abuse Benefits

Outpatient Services	Covered at 80% Substance Abuse: Covered at 80%
Inpatient Services	Covered at 80%

*Subject to the deductible and paid at Usual, Customary and Reasonable rates.

+ No day or visit limits for Severe Mental Health Illness diagnoses.

AETNA AND KAISER HMO PLANS

Medical Plan Features	Aetna HMO Plan	Kaiser HMO Plan (available in California only)
Group Policy Number	090110	07569
Member Services	1-877-402-8742 www.aetnavigators.com	1-800-464-4000 www.kaiserpermanente.com
Plan Description	Under the Aetna HMO plan, you and your dependents receive all of your medical care through HMO networks. When you join, you must select a Primary Care Physician (PCP) to coordinate all of your health care needs. Services obtained from non-HMO providers are not covered.	All services must be obtained from or authorized by Kaiser providers or facilities.
Service Area	Most California locations and locations in Arizona, Colorado, Florida, Georgia, Illinois, Maryland, Massachusetts, New York, New Jersey, Ohio, Texas, Virginia and Washington D.C.	Most California locations
Calendar Year Deductible	No Deductible	No Deductible
Calendar Year Co-insurance Maximum	Maximum out-of-pocket expenses for copays are \$1,500 per individual and \$3,000 per family, excluding mental health care expenses	There is no coinsurance for this plan. Maximum out-of-pocket expenses for copays are \$1,500 per individual and \$3,000 per family
Lifetime Maximum Benefits	Unlimited	Unlimited
Physician Office Visits	Covered at 100% after \$20 copay	Covered at 100% after \$15 copay



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Medical Plan Options (Continued)

AETNA AND KAISER HMO PLANS		
Medical Plan Features	Aetna HMO Plan	Kaiser HMO Plan (available in California only)
Routine Physical Examinations and Preventive Care	Covered at 100%	Covered at 100% Well baby and prenatal care: covered at 100%
Preventive Care	100% ¹	100%
Prescriptions	Formulary Generic Drugs: Covered at 100% after \$10 copay Formulary Brand Name Drugs: Covered at 100% after \$15 copay Non-Formulary Drugs: Covered at 100% after \$30 copay at participating pharmacies.30-day supply	\$10 per prescription for up to a 100-day supply of Generic or medically necessary Brand Name Drugs in accordance with Health Plan guidelines when ob- tained at Plan pharmacies
Mail Order for Maintenance Drugs	90-day supply for two copays from Aetna Rx home delivery	Same as when purchased at pharmacy
Chiropractic Care	Not covered	Not covered
Short-term Rehabilitation Physical, Occupational, Speech	Covered at 100% after \$20 copay for 60 consecutive days per incident	Covered at 100% after \$15 copay
Diagnostic X-Ray and Lab	Covered at 100% after \$20 copay	Covered at 100%
Hospital Benefits	Aetna HMO Plan	Kaiser HMO Plan (available in California only)
Room and Board	Covered at 100% pre-certification required	Covered at 100%
Surgeon's Fees	Covered at 100% - PCP referral required	Covered at 100%
Maternity - Delivery	Covered at 100%	Delivery is covered 100%.Pre-natal and first post-natal visit(s) covered at 100% after \$5 copay
Emergency Care	Covered at 100% after \$35 copay (waived if admitted as an in-patient)	Covered at 100% after \$50 copay (waived if admitted as an in-patient)
Mental Health and Substance Abuse Benefits	Aetna HMO Plan	Kaiser HMO Plan (available in California only)
Outpatient Services	Mental Health: covered at 100% after \$20 copay per visit Substance Abuse: covered at 100% after \$20 copay per visit	Covered at 100% after \$15 copay per visit; \$7 copay per group visit Substance Abuse: covered at 100% after \$15 copay per visit; \$5 copay per group visit
Inpatient Services	Mental Health: covered at 100% Substance Abuse: covered at 100%	Mental Health: Covered at 100% Substance Abuse (Detox. only): covered at 100%

1. Note on preventive care: If additional services other than preventive care, as outlined by the US Preventive Services Task Force Recommendation, are obtained during the visit, a copay, coinsurance, and/or deductible will apply.



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Dental Plans

Dental Plan Features	EPO Providers (available in California only)	PPO Providers	Out of Network Providers
Group Policy Number	1004880-10001		
Member Services	1-800-247-4695 / www.principal.com		
Plan Description	Under the Principal POS Dental Plan, you may select any licensed dentist you wish for your dental care. When you obtain services within the EPO Network Tier (where available), there are no deductibles, richer coinsurance and higher maximums. When you obtain services from In-network PPO providers (where available), your benefits are also greater than if you visit an Out-of Network Provider.		
Calendar Year Deductible	None	\$50 per individual for Basic and Major Services, to a maximum of \$150 per family	

Vision Plan

Currently you share the cost of vision care with the Sierra Club for yourself and your eligible family members. You may receive care from any provider; however, VSP pays for eligible expenses at a higher level when you visit a network provider.

When you visit a non-network provider, your copay still applies and you will typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit your itemized receipt within 6 months to VSP for reimbursement up to the plan allowance.

Vision Plan Features	VSP Providers	Non-VSP Providers
Group Policy Number	12000583	
Member Services	1-800-877-7195 / www.vsp.com	
Plan Description	You may choose any provider you wish for your vision care, but you receive the highest level of coverage when you choose participating VSP providers for your services.	
Copay	\$25	\$25
Vision Examination	Covered at 100%* once every 12 months	Covered at 100%* to a maximum of \$45 once every 12 months
Frames	Covered at 100%* up to the retail allowance of \$120 once every 12 months	Covered at 100%* to a maximum of \$47 once every 12 months
Lenses	Covered at 100%*	Covered at 100%* once every 12 months to the following maximum amounts: Single Vision: up to \$45; Bifocal: up to \$65; Trifocal: up to \$85; Lenticular: up to \$125
Medically Necessary Contact Lenses	Covered at 100%*	Covered at 100%* to a maximum of \$210
Elective Contact Lenses	Covered at 100%* to a maximum of \$120 in lieu of frames and lenses	Covered at 100%* to a maximum of \$105 in lieu of frames and lenses

* Subject to applicable copay.



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Life Insurance

Group Life Insurance

Sierra Club provides eligible employees with Group Life Insurance at no cost to you. If you should die while you are covered under this plan, your beneficiary will receive a benefit equal to your annual base salary,* rounded to the next highest \$1,000. The maximum benefit amount is \$350,000.

In the event of a terminal illness, this plan will pay you an advance benefit equal to the lesser of 75% of your benefit or \$250,000. The remainder of your Group Life Insurance benefit, if applicable, will be paid to your beneficiary upon your death.

**Certain employee groups receive a higher level of Life Insurance and Accidental Death & Dismemberment benefits. Refer to your Summary Plan Description.
Note: The premium cost for this benefit is taxable when a portion of the life insurance benefit exceeds \$50,000.*

Voluntary Term Life Insurance

The Voluntary Term Life (VTL) Insurance Plan gives you the opportunity to supplement your Group Life Insurance, and to insure your family members with annual renewable term life insurance. Participation in this benefit is voluntary and you pay the full cost of the plan on an after-tax basis. Cost depends on age and amount of coverage selected.

Coverage amounts available:

Employees: You may enroll for individual policy amounts ranging from \$10,000 to \$500,000, in increments of \$10,000.

Spouse: You may insure your spouse for a benefit amount equal to 50% of your total benefit coverage (Group Life Insurance and Voluntary Term Life combined) to a maximum of \$250,000.

Child(ren): You may insure your child(ren) for a benefit amount equal to 50% of your benefit coverage, in increments of \$2,000, to a maximum of \$10,000.

Note: Evidence of insurability is not required if coverage is purchased upon initial employment and coverage does not exceed \$140,000 for an employee and \$25,000 for a spouse.

Voluntary Accidental Death & Dismemberment Insurance

The Voluntary Accidental Death & Dismemberment (AD&D) Insurance Plan provides you with the opportunity to provide additional benefits to your survivors in the event of your accidental death. Partial benefits are payable if you lose your eyesight or limb(s) as a result of an accident. Benefit amounts range from \$25,000 to \$300,000. Participation in this benefit is voluntary and you pay the full cost of the plan on an after-tax basis. You may also insure your spouse and children.

Income Protection

Long Term Disability

The Long Term Disability (LTD) Plan provides you with income in the event of a long term illness or injury. Sierra Club pays the full cost of this plan.

You are eligible for LTD benefits after you have been totally disabled for 90-days. The plan pays 66 2/3% of your base salary to a maximum monthly benefit of \$13,000.

Paid Sick Leave

Sick leave pay replaces your income when you are unable to work because of an illness or injury. It may also be used for doctor appointments, to care for an ill member of your family, or for a newborn or newly adopted child.

Regular full-time and limited duration employees are eligible for paid sick leave benefits. Sick leave accrues from date of hire at a rate of one day per month. Regular, part-time employees accrue sick leave on a pro-rated basis. Unused sick leave may be carried over from year to year, however, there is no cash-out upon separation of employment.



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Flexible Reimbursement Accounts (FSA)

Flexible Reimbursement Accounts allow you to pay for certain qualifying expenses with pre-tax dollars under the Employee Benefit Plan. Deductions for these expenses are subtracted from your gross pay, before taxes are figured, thereby reducing your taxable income and providing you with the advantage of using the funds to pay for qualifying out-of-pocket medical, dental, vision and dependent care expenses.

Pre-Tax Contributions

Any required employee premium contributions for your health care plan coverage are deducted from your pay on a pre-tax basis unless you request otherwise.

Health Care Reimbursement

Funds set aside for this account may be used to pay for qualifying out-of-pocket medical, dental, and vision care expenses for you and your family. This includes, but is not limited to, deductibles, co-insurance payments, and copays, as well as prescription and other medical items. Over the counter medications are covered with a prescription.

For a complete list of eligible expenses, please refer to IRS Publication 502: "Medical and Dental Expenses." You can order this publication by calling the IRS at **800-829-3676** or review it on-line at <http://www.irs.gov/pub/irs-pdf/p502.pdf>.

You may elect to contribute, through pre-tax payroll deduction, up to \$3,500 per plan year into your Health Care Reimbursement Account.

Dependent Care Reimbursement

Funds set aside for this account are used to pay for eligible dependent care expenses, up to a maximum of \$5,000 per calendar year if you are single or married and filing a joint tax return. If you are married and filing separate tax returns, you may contribute up to \$2,500 per calendar year. This includes child care, elder care or other eligible dependent care for one or more dependents.

For a complete list of eligible expenses, please refer to IRS Publication 503: "Child and Dependent Care Expenses." You can order this publication by calling the IRS at **800-829-3676** or review it on-line at <http://www.irs.gov/pub/irs-pdf/p503.pdf>.

Flexible Reimbursement Account Rules

Flexible Reimbursement Accounts are regulated under Section 125 of the Internal Revenue Code. There are certain federal regulations to consider before enrolling:

- You must designate how much money you wish to contribute annually to each account at the beginning of each plan year (which coincides with a calendar year for Sierra Club). Money set aside for one reimbursement account may not be moved or used to pay expenses in another reimbursement account.
- You may change your annual contributions only if you experience a qualifying "change of family status", such as marriage, divorce, addition or loss of a dependent, or a change in your spouse's employment.
- It is important to carefully review your estimated expenses, as any unspent funds remaining in your account(s) at the end of the plan year are forfeited — referred to as the "Use It or Lose It" rule.* All claims for services incurred on or before the end of the plan year, December 31, must be received by NBS no later than March 31 of the following plan year.

The Flexible Reimbursement Account is administered through NBS. You may contact NBS at **1-800-274-0503**.

**Note: Eligible Flexible Reimbursement Account expenses are determined by the IRS and are subject to change. The Sierra Club does not provide legal or tax advice. A list of eligible expenses may also be accessed on NBS's website (www.NBSBenefits.com) or toll-free at 1-800-274-0503.*



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Retirement

401(k) Plan

The Sierra Club 401(k) Plan is available to regular and limited duration employees who work at least 20 hours per week and meet eligibility requirements. Through this tax-deferred savings program, employees may invest a portion of their income in a wide range of professionally managed diversified investment funds. Refer to your Summary Plan Description for details regarding the participation waiting period and employer contribution.

The 401(k) Plan is administered through Merrill Lynch at **1-800-229-9040**.

Retirement Plan (Pension)

The Sierra Club provides retirement benefits to eligible employees. You are a plan participant and automatically enrolled in the plan on the first day of the month following your two-year anniversary date if you have worked at least 1,000 hours per year. You will receive an annual statement summarizing your vested pension benefits. Refer to the Summary Plan Description for details regarding plan benefits.

If your employment ends prior to retirement, you will be advised of your benefits. Please call Human Resources at **415-977-5629** or refer to the Pension Plan booklet on Staffnet for further information.

Other Benefits

Employee Assistance Program (EAP)

Sierra Club's Employee Assistance Program (EAP), administered by Magellan Health, provides highly confidential, experienced, professional, source assistance to manage life challenges that may interfere with personal and/or professional life. All full or part-time and limited duration employees, and their eligible dependents, may use the EAP services. The EAP also provides referral services.

You and your dependents are eligible for up to 5 counseling sessions per issue per year. Magellan Health is available to assist you 24-hours a day, seven days per week. You may contact Magellan at **1-800-356-7089** or on-line at **www.magellanhealth.com/member**

Commuter Transit Benefits — Aetna Commuter Benefits

Sierra Club works with Aetna Commuter Benefits (ACB) to allow employees to pay for certain work-related transportation expenses on a pre-tax basis as permitted by the IRS. Eligible expenses include passes or vouchers for mass transit, such as: local subway, train, and bus. Employees pay less in taxes, because this money is deducted from paychecks before federal income or Social Security taxes are withheld. This benefit is offered nationally. Eligible employees may register for the site on or after their benefits effective date. Please visit the ACB website, www.aetnacommuterhub.com, to view your local participating transit options. To register you'll need your company ID which is: 837043010000.

Paid Parental Leave

Sierra Club provides six weeks of paid leave benefits to either parent of a newborn or newly adopted child. This is in addition to paid leave benefits that are drawn from accrued sick or vacation hours. In order to be eligible for the paid parental leave benefit, the employee must have worked for the Club for at least 12 continuous months as of the date that the child is born, or the adopted child is placed under the employee's care.



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Other Benefits (cont'd)

Vacation & Holidays

Vacation accrues at a monthly rate based on years of service, and vests on a semi-monthly basis. Part-time employees accrue vacation on a pro-rated basis. Vacation leave will not be accrued beyond an unused balance of six (6) weeks. When the balance falls below six weeks, the accrual will resume.

The following schedule shows the amount of vacation time earned for full-time employees during a period of continuous service:

LENGTH OF EMPLOYMENT	ANNUAL ACCRUAL
0-24 Months	2 Weeks
25-60 Months	3 Weeks
61-120 Months	4 Weeks
121+ Months	5 Weeks

Upon separation of employment, employees are entitled to a cash-out of up to 225 hours of accrued vacation (pro-rated for part-time employees). In addition, Sierra Club provides paid holidays. A schedule is available at the beginning of each calendar year.

Credit Union

Provident Central and Patelco are available to all Sierra Club employees. They both offer a full range of banking services such as checking, savings, low interest loans and no-fee credit cards. You may join by paying a one-time (non-refundable) minimal fee. All family members are eligible for membership.

Sierra Club Membership

If you work a minimum of 20 hours per week, you are eligible for complimentary membership in the Sierra Club for yourself and your partner. This membership offers all the same privileges of a regular membership, including the SIERRA magazine and the local chapter newsletter. You must complete and submit an application form to Human Resources to become a member.

Discounts on Sierra Club Outings and Publications

Full-time regular and limited duration employees who have been employed one year are eligible for discounts on Sierra Club national outings. All benefit-eligible employees are also eligible for a discount off the list price of materials published by Sierra Club books.

Equal Opportunity Employer

Employment at the Sierra Club is based upon qualifications and competency. The Sierra Club does not discriminate against anyone in the treatment, hiring, training, assignment, compensation, promotional opportunities, employee benefits, recall from layoff, discharge and discipline, or any other term and condition of employment on the basis of race, religion, sex, age, national origin or ancestry, color, sexual orientation, gender identity, marital status, parental status, veteran's status, union activity, political affiliation, physical or mental disability unrelated to an individual's ability to perform the job with or without reasonable accommodation, or any other basis prohibited by law.

Sierra Club will reasonably accommodate an individual's physical or mental disability in accordance with legal obligations. Further information related to reasonable accommodation is available from the Human Resources Department. If you believe that you require an accommodation because of a disability, please speak with your supervisor or with Human Resources.



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Change In Status

The following events shall constitute a Change in Status

- **Special Open Enrollment Rights.** The exercise of enrollment rights provided for in IRC Section 9801 (f) and corresponding regulations.
- **Legal Marital Status.** Events that change employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation and annulment.
- **Number of Dependents.** Events that change the number of employee's dependents, including following birth, death, adoption and placement for adoption.
- **Employment Status.** Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite, and a change in employment status with consequence that the individual becomes (or ceases to be) eligible under the plan.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements.** Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- **Residence.** A change in the place of residence of the employee, spouse or dependent that impacts your access to health care.
- **Judgment, Decree or Order.** Compliance with a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change of custody including a qualified medical child support order.
- **Entitlement to Medicare or Medicaid.** Upon becoming entitled to Medicare or Medicaid or loss of such entitlement.
- **Change in Coverage of Spouse or Dependent Under Other Employer's Plan.** A change under the plan of the spouse's former, spouse's or dependent's employer if:
 - A cafeteria plan or qualified benefit plan of the spouse's, former spouse's, or dependent's employer permits its participants to make an election change that would be permitted under these Change in Status rules; or,
 - The cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan or qualified benefits plan of the spouse's, former spouse's, or dependent's employer.
- **Dependent Care.** In the case of dependent care assistance plan only, if there is a cost change imposed by a Dependent Care Service Provider who is not a relative of the employee.

Lifetime Limits

Sierra Club's health plans do not contain any lifetime limits on the dollar value of benefits.



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HIPAA Privacy

HIPAA requires that the privacy of your personal health information be protected. The Plan's Notice of Privacy Practices, distributed to all Plan Participants, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. If you have misplaced your copy of the Plan's Notice of Privacy Practices, please contact Human Resources to request a replacement.

Please note, employees taking time off work to care for a covered child, spouse, parent or domestic partner with a serious health condition or to bond with a new child are not guaranteed job reinstatement unless they qualify for Family Medical Leave. Please see the Family Medical Leave policy for the eligibility requirements for that leave.

If you need to take time off work to care for a covered child, spouse, parent or domestic partner with a serious health condition or to bond with a new child, please advise Human Resources. Employees can also contact their local Employment Development Department for further information.

Grandfathered Status

Aetna and Kaiser Permanente believe the HMO, POS and Traditional Plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **415-977-5611**. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

The Women's Health and Cancer Rights Act of 1998

The Federal "Women's Health and Cancer Rights Act of 1998" requires coverage of treatment related to mastectomy. If you or your dependent are eligible for mastectomy benefits under this coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under your plan.



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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a one of these States, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

You should contact your State for further information on eligibility.

To verify if your State has a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565