CROCKETT COMMUNITY SERVICES DISTRICT

Personnel Committee Meeting
Agenda for Tuesday, September 24, 2019

TIME: 3:00 PM
PLACE: 850 Pomona Street, Crockett

CALL TO ORDER AND CONSIDER CHANGES TO THE AGENDA:

PUBLIC COMMENTS:

OPEN SESSION:

1. Consider Health Benefits Program for full-time employees, form recommendation to the District Board.

2. No Tip Policy, form recommendation to the District Board.

CLOSED SESSION:

3. Public Employee Performance Evaluation: General Manager, Pursuant to Government Code Section 54957.

OPEN SESSION:

4. Announcement of actions taken during closed session.

5. General discussion of employment issues such as but not limited to employment policies and procedures, future agenda items, policy suggestions, benefit alternatives and performance awards.

ADJOURNMENT:

In compliance with the Americans with Disabilities Act of 1990, if you need special assistance to participate in a District meeting, or if you need a copy of the agenda, or the agenda packet, in an appropriate alternative format, please contact the General Manager at (510) 787-2992. Notification of at least 48 hours prior to the meeting or time when services are needed will assist District staff in assuring that reasonable arrangements can be made to provide accessibility to the meeting or service.

CROCKETT COMMUNITY SERVICES DISTRICT

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TO: Personnel Committee / Board of Directors

FROM: General Manager

SUBJECT: Health Benefit Program

DATE: September 17, 2019

The Crockett Community Services District used to offer health benefits through CalPERS but elected to terminate participation in the Public Employees' Medical and Hospital Care Act in 2009. In July 2017, the Personnel Committee began discussions on offering health benefits to its employees. When reviewing previous benefits studies and in conversations with other similar agencies in Contra Costa staff was unable to find any agency that did not offer health insurance benefits of some sort to its employees.

Various benefit programs including re-enrollment in CalPERS Health, enrollment in Special District Risk Management Authority's (SDRMA) Medical Benefits Program, pursuing group medical insurance in the individual insurance market through Alliant and Cal Choice, and researching Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) were looked at.

SDRMA Medical Benefits Program

Special District Risk Management Authority's (SDRMA) Health Benefits Program came out as the top choice for our District. SDRMA has been providing public agencies risk management solutions and coverage protection for over 30 years. Their *2020 Health Benefits Program Overview and Medical Benefits Summary* is included with this memo for review. SDRMA also offers Ancillary Coverages including dental, vision, life, long term disability and an employee assistance program however they are not included in the proposed health benefits package being considered.

PROS	CONS
Small group pool, historically low rate increases	Must have two active employees to enroll
Lower monthly premiums compared to CalPERS	Must have 75% eligible employees enroll *(initially)*
SDRMA Administration and account management	Limited plan choices; 2 plans + 1 Kaiser
Ancillary coverages available *(if desired later)*	Subject to underwriting approval
Can offer coverage to retirees but not required	

After approval by the underwriter, to join, the District Board will need to approve a Resolution and MOU. The District may join the program at any time; however, SDRMA must receive the MOU and Resolution 45 days before the requested effective date. It will take approximately 45 days to process enrollment forms, issue benefit packets and insurance cards from the time that the enrollment forms are received.

It is in the Resolution that the District will state the rules for eligibility and define that health benefits are only offered to full-time employees. Part-time employees not eligible for health benefits through the District would still be able to obtain health insurance through Covered California individually and can still apply for subsidies based on their income.

For the purposes of the medical benefits program, an "active" full time employee is an employee who works a minimum of 34 hours per week. Coverage would be available as long as the group maintains at

minimum 2 eligible employees, which means the District must have at least 2 full time employees (whether or not enrolled) in order to continue offering the SDRMA Health Benefits program.

Funding

Funding for a Health Benefits Program was included in the FY 19/20 budget. Changes were made to the Property Tax allocation formulas which helped provide funding for all full-time employees regardless of which department they work for. Property tax revenue has been increasing year-over-year between 5% and 9% annually and looks to be a steady source of revenue, growing faster than health benefit premiums over the same period. A total of $18,480 as been allocated for health benefits for the six months between January 1, 2020 and June 30, 2020.

STAFF RECOMMENDATION:

Staff supports enrolling in the SDRMA Medial Benefits Program and recommends setting the employee and District rates based on a percentage of the Kaiser HMO premium.

As part of the review staff was asked to consider the following:

- Find Funding – *identified increasing funding source and allocated funds in budget.*
- Employee Costs - *keep employee share near or below their current contributions.*
- Succession Planning – *develop health program that is comprable to nearby Districts.*
- Cash-in-lieu of Medical Benefits – *low priority, optional exclusion pay not pursued.*

Based on above staff recommends offering Blue Shield PPO (Gold and Silver) and Kaiser HMO 20 plans. Rates are based on employee paying 90% of the premium for Kaiser Self, 80% on Self plus One, and 70% on Self plus family with PPO plans adjusted accordingly for parity of benefits received.

Crockett Community Services District Proposed Medical Benefits Rates 2020		
	Monthly	
	District Share	Employee Share
Blue Shield Gold PPO Self Only	$736.24	$156.26
Blue Shield Gold PPO Self plus One	$1,292.54	$490.42
Blue Shield Gold PPO Self and Family	$1,466.56	$852.92
Blue Shield Silver PPO Self Only	$639.54	$0.00
Blue Shield Silver PPO Self plus One	$1,282.14	$0.00
Blue Shield Silver PPO Self and Family	$1,466.56	$198.08
Kaiser HMO 20 Self Only	$736.24	$81.80
Kaiser HMO 20 Self plus One	$1,292.54	$323.14
Kaiser HMO 20 Self plus Family	$1,466.56	$628.52

ACTION:

The Personnel Committee should discuss and formulate opinions and recommendations to the Board including defining the employer contribution amount percentages (90/80/70 or other).

The District Board should consider the recommendations from the Personnel Committee and direct staff accordingly, including but not limited drafting of Resolution and Memorandum-of-Understanding with details of Health Benefits Program.

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SDRMA

SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY

Special District Risk Management Authority is a public agency formed under California Government Code Section 6500 et seq. to provide a full-service risk management program for California's local governments including property, liability and workers' compensation coverages. In addition, we offer a Health Benefits Program in conjunction with the California State Association of Counties Excess Insurance Authority (CSAC-EIA Health).

The Health Benefits Program consists of Medical Benefits and Ancillary Coverages. Medical Benefits include health plans by Blue Shield, Anthem-Blue Cross and Kaiser. Blue Shield and Anthem-Blue Cross plans have prescription drug programs provided by Express Scripts. Ancillary Coverages include Delta Dental, VSP Vision, VOYA FINANCIAL Life and Long Term Disability and MHN Employee Assistance Program. Public agencies can select which programs they would like to join subject to underwriting approval.

We realize selecting a health plan for your agency and your employees is just one of the key decisions you are faced with on an on-going basis. This important decision involves not only the cost of various providers and plans, but also access to doctors and hospitals, prescription drug services, and other additional programs and services. The combination of health plans and providers that is right for your agency depends on a variety of factors, such as your preference for a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and the need for access to specific doctors and hospitals.

We understand that comparing health plan benefits, features and costs can be complicated. This brochure provides information that will help simplify your decision making process. Our enrollment process is easy and only requires a few simple steps.

For more information, please contact us at **800.537.7790**. We are ready to serve you!

IMPORTANT TERMS TO KNOW

You may see and hear some unfamiliar terms as you begin to use your health plan. It's important that you understand these terms so you can get the most out of your coverage.

Premium • This is the amount you pay every month to SDRMA to maintain your health insurance coverage.

Copay • This is a fixed amount you pay for certain covered services, like doctor's visits.

Calendar Year Deductible • This is the fixed amount some plans require you to pay before the plan begins to pay its share for covered benefits.

Coinsurance • Once you have paid your full deductible this is the percentage owed by you to pay for accessed services. This can fluctuate based on the cost the provider is charging and/or what has been agreed to between the Medical carrier and the Provider. Coinsurance is unlike Copay which is always a flat dollar amount.

Maximum Medical Out of Pocket • This is the maximum you'll pay per year for medical services before your health plan begins to pay for 100% of services, protecting you and your family from catastrophic medical expenses. Most of your copayments, deductibles and coinsurance payments will be counted toward this limit.

Medical Benefits Summary

PLAN SUMMARY – BLUE SHIELD *See page 27, note 14 for Plan Selections and Combination Guidelines

DEDUCTIBLES/CO-INSURANCE	Gold PPO		Platinum PPO	
Calendar Year Deductible(s) (Individual/Family)	$500 / $1,000		$300 / $600	
Maximum Medical Out of Pocket (Individual/Family)	$2,000 / $4,000		$1,300 / $3,600	
Medicare Medical Maximum Out of Pocket	$1,500 / $3,000		$1,000 / $3,000	
Services/Coverages	Participating Providers (You Pay)	Non-Participating Providers (You Pay)	Participating Providers (You Pay)	Non-Participating Providers (You Pay)
Inpatient Hospital Room, Board & Support Services (prior authorization required)	20%	50% up to $600 per day	10%	50% up to $600 per day
Ambulatory Surgery Center	Deductible Waived; 10% Coinsurance	50% up to $350 per day	Deductible Waived; No Charge	50% up to $350 per day
Emergency Room				
Visit Results in Admission as Inpatient	20%		10%	
Visit Does Not Result in Admission	20%, $100 co-pay		10%, $100 co-pay	
Physician Benefits (office visits)	$20 co-pay	50%	$20 co-pay	50%
Preventative Care	No Charge	Not Covered	No Charge	Not Covered
Rehabilitation Service (in an office location)	20%	50% up to $350 per day	10%	50% up to $350 per day
Acupuncture (26 visits per calendar year/combined with Chiropractic)	20%		10%	
Durable Medical Equipment	20%	Not Covered	10%	Not Covered
Hospice	20%	Not Covered without prior authorization	10%	Not Covered without prior authorization
Ambulance	20%		10%	
Home Health Care 100 visits/year (prior authorization required)	20%	Not Covered without prior authorization	10%	Not Covered without prior authorization
Chiropractic Services (26 visits per calendar year/combined with Acupuncture)	20% up to $50 per visit	50% up to $25 per visit	10% up to $50 per visit	50% up to $25 per visit
Prescription Drugs *Active/Early Retiree Plans Only*	Express Scripts*		Express Scripts*	
Prescription Maximum Out of Pocket	$4,600 / $9,200		$5,300 / $9,600	
(At Participating Pharmacies only)	Generic / Brand / Non-Formulary / Specialty		Generic / Brand / Non-Formulary / Specialty	
Retail - 30 day supply	$5 / $30 / $45 / 30% (max co-pay $150)		$5 / $30 / $45 / 30% (max co-pay $150)	
Mail Order - 90 day supply	$10 / $75 / $112.50 / 30% (max co-pay $300)		$10 / $75 / $112.50 / 30% (max co-pay $300)	
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	None		None	

THIS SUMMARY IS INTENDED TO COMPARE COVERAGE BENEFITS ONLY. THE ACTUAL PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

NON-PARTICIPATING PROVIDER MEMBER COST MAY NOT APPLY TO MAXIMUM OUT OF POCKET COSTS.
*See Rx benefits for Medicare on page 13 under the "EGWP" pharmacy co-pay structure.

SDRMA

MEDICAL BENEFIT RATES FOR 2020 – GUARANTEED UNTIL JANUARY 1, 2021

AREA I - Northern CA: Bay Area

Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, Yolo, Yuba

PLAN	Employee	Employee + 1	Employee + 2 or More
Gold PPO	$892.50	$1,782.96	$2,319.48
Platinum PPO	$975.12	$1,949.22	$2,535.72
Silver PPO	$639.54	$1,282.14	$1,664.64
EPO	$1,072.02	$2,144.04	$2,786.64
HDHP 10%	$732.36	$1,464.72	$1,903.32
HDHP 20%	$631.38	$1,261.74	$1,640.16
Access+ HMO 15	$994.50	$1,989.00	$2,586.72
Access+ HMO 20	$924.12	$1,849.26	$2,403.12
Kaiser HMO 15	$848.64	$1,676.88	$2,173.62
Kaiser HMO 20	$818.04	$1,615.68	$2,095.08

AREA II - Northern CA: Other Counties

Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, Tuolumne

PLAN	Employee	Employee + 1	Employee + 2 or More
Gold PPO	$867.00	$1,736.04	$2,254.20
Platinum PPO	$929.22	$1,857.42	$2,414.34
Silver PPO	$622.20	$1,244.40	$1,616.70
EPO	$1,037.34	$2,077.74	$2,703.00
HDHP 10%	$722.16	$1,448.40	$1,881.90
HDHP 20%	$596.70	$1,191.36	$1,551.42
Access+ HMO 15	$1,004.70	$2,007.36	$2,610.18
Access+ HMO 20	$935.34	$1,870.68	$2,428.62
Kaiser HMO 15	$848.64	$1,676.88	$2,173.62
Kaiser HMO 20	$818.04	$1,615.68	$2,095.08

AREA III - Southern CA: Los Angeles Area

Los Angeles, San Bernardino, Ventura

PLAN	Employee	Employee + 1	Employee + 2 or More
Gold PPO	$737.46	$1,469.82	$1,911.48
Platinum PPO	$805.80	$1,608.54	$2,089.98
Silver PPO	$532.44	$1,056.72	$1,372.92
EPO	$861.90	$1,718.70	$2,232.78
HDHP 10%	$645.66	$1,292.34	$1,678.92
HDHP 20%	$533.46	$1,064.88	$1,384.14
Access+ HMO 15	$774.18	$1,548.36	$2,010.42
Access+ HMO 20	$722.16	$1,439.22	$1,870.68
Kaiser HMO 15	$701.76	$1,384.14	$1,794.18
Kaiser HMO 20	$672.18	$1,326.00	$1,717.68

Rates shown are for active and retired employees, and public officials.

PLAN SUMMARY – BLUE SHIELD *See page 27, note 14 for Plan Selections and Combination Guidelines

Silver PPO		EPO	HDHP 10% and (20%)	
$2,000 / $4,000		$300 / $600	$1,400 / $2,800 ($3,000 / $6,000)	
$5,000 / $10,000		$1,300 / $2,600	$5,000 / $10,000 ($5,950 / $11,900)	
$3,000 / $6,000		$1,000 / $2,000	Non-Applicable	
Participating Providers (You Pay)	Non-Participating Providers (You Pay)	Participating Providers (You Pay)	Participating Providers (You Pay)	Non-Participating Providers (You Pay)
20%	50% up to $600 per day	No Charge	10% (20%)	50% up to $600 per day
Deductible Waived; 10% Coinsurance	50% up to $350 per day	Deductible Waived; No Charge	(10%) No Charge	50% up to $350 per day
20%		No Charge	10% (20%)	
20%, $100 co-pay		$100 co-pay	10% (20%), $100 co-pay	
$30 co-pay	50%	$30 co-pay	10% (20%)	50%
No Charge	Not Covered	No Charge	No Charge	Not Covered
20%	50% up to $350 per day	$30 co-pay	10% (20%)	50% up to $350 per day
20%		$30 co-pay	10% (20%) up $30 per visit	
20%	Not Covered	20%	10% (20%)	Not Covered
20%	Not Covered without prior authorization	No Charge	10% (20%)	Not Covered without prior authorization
20%		$50 Per Transport	10% (20%)	
20%	Not Covered without prior authorization	$30 co-pay (100 visits/year)	10% (20%)	Not Covered without prior authorization
20% up to $50 per visit	50% up to $25 per visit	$30 co-pay	10% (20%) up $25 per visit	50% up $25 per visit
Express Scripts*		Express Scripts*	Blue Shield	
$1,600 / $3,200		$5,300 / $10,600	Combined with Medical	
Generic / Brand / Non-Formulary / Specialty		Generic / Brand / Non-Formulary / Specialty	Generic / Brand / Specialty	Generic / Brand
$10 / $20 / $45 / 30% (max co-pay $150)		$10 / $20 / $45 / 30% (max co-pay $150)	$7 / $25 / Not Covered	$7 / $25
$20 / $40 / $90 / 30% (max co-pay $300)		$15 / $50 / $112.50 / 30% (max co-pay $150)	$14 / $60 / 30% (max co-pay $150)	Not Covered
$200 / $500		$200	Subject to Deductible	

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NON-PARTICIPATING PROVIDER MEMBER COST MAY NOT APPLY TO MAXIMUM OUT OF POCKET COSTS.

*See Rx benefits for Medicare on page 13 under the "EGWP" pharmacy co-pay structure.

SDRMA

PLAN SUMMARY – BLUE SHIELD *See page 27, note 14 for Plan Selections and Combination Guidelines

DEDUCTIBLES/CO-INSURANCE		Access+ HMO 15	Access+ HMO 20
Calendar Year Deductible(s) (Individual/Family)		None	None
Maximum Medical Out of Pocket (Individual/Family)		$1,500 / $3,000	$1,500 / $3,000
Medicare Medical Maximum Out of Pocket		Non-Applicable	Non-Applicable
Services/Coverages		**Participating Providers (You Pay)**	**Participating Providers (You Pay)**
Inpatient Hospital Room, Board & Support Services (prior authorization required)		No Charge	$250 / Admission
Non Emergency Outpatient Services: Ambulatory Surgery Center Hospital Facility Outpatient Treatment		 No Charge $100 / Surgery No Charge	 $50 / Surgery $150 / Surgery No Charge
Emergency Room			
Visit Results in Admission as Inpatient		No Charge	No Charge
Visit Does Not Result in Admission		$50 co-pay	$100 co-pay
Preventative Care		No Charge	No Charge
Office Visits	Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.	$15 co-pay	$20 co-pay
Rehabilitation Service (in a office location)		$15 co-pay	$20 co-pay
Durable Medical Equipment		20%	20%
Hospice		No Charge	Routine Home Care and Inpatient Respite Care - No Charge 24 Hour Continuous Home Care and General Inpatient Care - $150 / day
Ambulance		$50 co-pay	$100 co-pay
Home Health Care (prior authorization required)		$15 co-pay (100 per year)	$20 co-pay (100 per year)
Chiropractic Services (combined with Acupuncture)		$10 co-pay (30 visits per year)	$10 co-pay (30 visits per year)
Acupuncture (combined with Chiropractic)		$10 co-pay (30 visits per year)	$10 co-pay (30 visits per year)
Prescription Drugs *Active/Early Retiree Plans Only*		**Express Scripts**	**Express Scripts**
Prescription Maximum Out of Pocket		$5,100 / $10,200	$5,100 / $10,200
(At Participating Pharmacies only)		Generic / Brand / Non-Formulary / Specialty	Generic / Brand / Non-Formulary / Specialty
Retail - 30 day supply		$5 / $10 / $25 / 20% (max co-pay $100)	$10 / $25 / Not Covered / 20% (max co-pay $100)
Mail Order - 90 day supply		$10 / $20 / $50 / 20% (max co-pay $100)	$20 / $50 / Not Covered / 20% (max co-pay $100)
Brand Deductible (Individual / Family)		None	None

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PLAN SUMMARY – KAISER *See page 27, note 14 for Plan Selections and Combination Guidelines

DEDUCTIBLES/CO-INSURANCE/MAXIMUM	HMO 15	HMO 20
Calendar Year Deductible(s) (Individual/Family)	None	None
Maximum Medical Out of Pocket (Individual/Family)	$1,500 / $3,000	$1,500 / $3,000
Medicare Medical Maximum Out of Pocket	Non-Applicable	Non-Applicable
Services/Coverages	**Participating Providers (You Pay)**	**Participating Providers (You Pay)**
Inpatient Hospital Room, Board & Support Services (prior authorization required)	No Charge	$250 / Admission
Non Emergency Outpatient Services: Ambulatory Surgery Center Hospital Facility Outpatient Treatment	 $15 / Surgery No Charge $15 / Surgery	 $20 / Surgery No Charge $20 / Surgery
Emergency Room		
Visit Results in Admission as Inpatient	See Inpatient hospital	See Inpatient hospital
Visit Does Not Result in Admission	$50 co-pay	$100 co-pay
Preventative Care	No Charge	No Charge
Office Visits	$15 co-pay	$20 co-pay
Rehabilitation Service (Outpatient)	$15 co-pay	$20 co-pay
Durable Medical Equipment	No Charge	20%
Hospice	No Charge	No Charge
Ambulance	No Charge	$50 co-pay
Home Health Care (prior authorization, up to 100 visits)	No Charge	No Charge
Chiropractic Services (combined with Acupuncture)	$10 / up to 30 visits	$10 / up to 30 visits
Acupuncture (combined with Chiropractic)	$10 / up to 30 visits	$10 / up to 30 visits
Prescription Drugs *Active/Early Retiree Plans Only*	**Kaiser**	**Kaiser**
(At Participating Pharmacies only)	Generic / Brand / Specialty	Generic / Brand / Specialty
Retail - 30 day supply	$5 / $20 / $20	$10 / $25 / 20% (max co-pay $150)
Mail Order - 100 day supply	$10 / $40	$20 / $50
Brand Deductible (Individual / Family)	None	None

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Kaiser HMO Member Services 800-464-4000

SDRMA

PLAN SUMMARY – KAISER – MEDICARE

DEDUCTIBLES/CO-INSURANCE/MAXIMUM	Kaiser Permanente Senior Advantage (KPSA) HMO with Part D
Calendar Year Deductible(s) (Individual/Family)	None
Maximum Medical Out of Pocket (Individual/Family)	$1,500 / $3,000
Medicare Medical Maximum Out of Pocket	Non-Applicable
Services/Coverages	**Participating Providers (You Pay)**
Inpatient Hospital Room, Board & Support Services (prior authorization required)	No Charge
Non Emergency Outpatient Services: Ambulatory Surgery Center Hospital Facility Outpatient Treatment	 $10 / Surgery See Outpatient specific service co-pay $10 / Surgery
Emergency Room	
Visit Results in Admission as Inpatient	See Inpatient hospital
Visit Does Not Result in Admission	$50 co-pay
Preventative Care	No Charge
Office Visits	$10 co-pay
Rehabilitation Service (Outpatient)	$10 co-pay
Durable Medical Equipment	No Charge
Ambulance	No Charge
Home Health Care (prior authorization required)	No Charge
Chiropractic Services (combined with Acupuncture)	$10 / up to 30 visits
Acupuncture (combined with Chiropractic)	$10 / up to 30 visits
Prescription Drugs	**Kaiser**
(At Participating Pharmacies only)	Generic / Brand
30 day supply	$5 / $20
31 – 60 day supply	$10 / $40
61 - 100 day supply	$15 / $60
(Mail Order Refills only)	Generic / Brand
30 day supply	$5 / $20
31 – 100 day supply	$10 / $40

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Kaiser HMO Member Services 800-464-4000

CARRUM HEALTH (CARRUM) – SURGERY BENEFIT PROGRAM

Carrum Health is a special surgery benefit that provides exclusive access to "Centers of Excellence." These hospitals and doctors provide for an improved patient experience and top-quality, more affordable care. The Carrum Health Surgery Benefit is provided at no additional cost and is an option outside of your surgery benefit provided by your medical carrier. Please note HMO plans are not eligible to participant in the Carrum Surgery Benefit.

EMPLOYEE SERVICES

Personalized "Care Concierge" support – Helps guide patient through the process
Recovery – Personalized support through total care coordination
Access to top-Quality Surgeons – perform hundreds of surgeries
All medical expenses – covered for the patient**
Travel Expenses – covered for patient and companion*
Voluntary participation – Employee Initiates the service by phone or online

*IRS Rules a portion of the covered travel will be reported as taxable income to employee.
**IRS regulations on HSA plans the deductible applies but coinsurance is waived.

Eligible procedures include:

- Hip Replacement
- Knee replacement
- Cervical Spinal fusion
- Lumbar Spinal Fusion
- Coronary Bypass Surgery
- Bariatric (Weight Loss)
- Shoulder Repair
- Elbow Repair
- Wrist/Hand Repair
- Ankle/Foot Repair
- Pain Management

Additional procedures will become eligible on a regular basis.

GOTZOOM-STUDENT LOAN REPAYMENT PROGRAM

What's GotZoom?

- A company with a singular focus on DOE student loan repayment programs
- Seven-year performance record

Why We're Better?

Large student debt reduction achieved with federal repayment or forgiveness programs:

- Provides employee immediate relief
- Costs employer significantly less

Employer Benefits

- Retention: equates to a 5% - 20% raise
- Recruitment: 83% of millennials prefer organizations with a student loan benefit
- Value: 3-year ROI 140%

Employee Benefit

- Average student debt reduction of 65%
- Upfront visibility of savings (free loan status analysis and benefit summary)

SDRMA

HEALTH BENEFITS PROGRAM ELIGIBILITY REQUIREMENTS

1. Entity must be a public agency formed under California law.

2. Entity must have a minimum of two full-time active employees to join. An active full-time employee is an employee who is eligible for enrollment in employee sponsored benefits paid for by the Entity. Part-time employees may be considered active employees only if they are currently part of the benefit eligible population and work a minimum of twenty hours weekly.

3. Active Employees:
   Medical Benefits - Entity must contribute a minimum of 75% of the cost for active employees.
   Ancillary Coverages - Entity must contribute a minimum of 75% of the cost for active employees.

4. Dependents:
   Medical Benefits - If the Entity offers coverage to dependents, it is recommended the Entity contribute a minimum of 50% of the cost for dependents.
   Ancillary Coverages - If the Entity offers coverage to dependents, it is recommended the Entity contribute a minimum of 50% of the cost for dependents.

5. Retirees:
   Medical Benefits - Entity may offer coverage to retirees.
   Ancillary Coverages - Entity may offer coverage to retirees. Retirees are only eligible for Dental and Vision.

6. Public Officials:
   Entity may offer coverage to public officials (board members, etc.) only if they are currently being covered and Entity's enabling act, plans and policies allow it. Entity is required to cover 75% of the cost for public officials when covering their medical benefits/ ancillary coverages. Participation for public officials is limited to their term of office.

7. Entity must have at least 75% of eligible employees (and public officials if they are offered coverage by the Entity) enrolled in order to participate. Public Officials, retirees and dependents may not be covered unless active employees are covered.

8. Premiums are based on a full month. There are no partial months or prorated premiums and member changes will be effective first of the month following the qualifying event. The waiting period for medical benefits/ancillary coverages is effective 1st of the following the date of hire of an employee.

9. The maximum dependent child age is 26. Disabled dependent children are not subject to the dependent age restrictions; however, a verification form will be required certifying the disability.

10. Each prospective new Entity must complete and submit the SDRMA Interest Forms including a large claimant disclosure form (Medical Benefits only) detailing any knowledge of and information pertaining to large and/or ongoing claims. Each Entity is subject to underwriting review and may or may not be accepted for coverage. The underwriting process may take up to two weeks for completion.

11. Entity's governing body must approve a resolution authorizing participation in SDRMA's health benefits program and execute the Memorandum of Understanding (MOU).

12. Once an Entity is approved by underwriting they must submit the Resolution and MOU to SDRMA 45 days before the requested effective date of coverage.

13. *Medical Benefits* - Not all Plans will be offered and available to Entities joining the medical benefits program. The Access+ HMO 15, HMO 20 and Kaiser Plans are not available in all areas. Please check with SDRMA at the time you are submitting your request for underwriting approval to see if the HMO plans are available in your area. Entities selecting one of the medical benefits program HDHP High Deductible Plans (HSA Compatible) are responsible for adhering to IRS rules and regulations and maintenance of the HSA account. SDRMA does not provide this service but can provide contact information for a financial institution that currently offers this type of service.

14. Plan Selections and Combination Guidelines:

    Medical Plan Selection
    Subject to underwriting review and approval:
    - 2-100 enrolled lives: 2 plans + 1 Kaiser plan
    - 101-200 enrolled lives: 3 plans + 1 Kaiser plan

    Medical Plan Combinations
    - Only 1 HMO or HDHP plan may be offered to an employee group
    - Future plan changes are subject to review and approval by underwriting

    Ancillary Coverages - Entity will choose the particular dental and/ or vision plan option to offer its employees. The employees are only allowed to enroll in that particular plan.

    Ancillary Plan Selections
    Subject to underwriting review and approval:
    - 2-50 enrolled lives: 1 Dental PPO plan and 1 *Dental HMO plan may be offered to an employee group. 1 Vision plan may be offered to an employee group.
    - Future plan changes are subject to review and approval by underwriting

    * *Dental HMO is not available in all areas. Please check with SDRMA at the time you are submitting your request for underwriting approval to see if the Dental HMO plan is available in your area*

CROCKETT COMMUNITY SERVICES DISTRICT

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TO: Personnel Committee / Board of Directors

FROM: General Manager

SUBJECT: No Tip Policy

DATE: September 17, 2019

On November 1, 2017 the Personnel Committee directed staff to research and develop a Tip / No-Tip Policy and bring it back to the committee for discussion. Staff has completed its research and concluded that it is in the best interest of the public to implement a No Tip Policy.

The Law

Both the federal Fair Labor Standards Act ("FLSA") and California's Labor Code (specifically Codes 350 through 356) regulate tips and gratuities. When deciding workplace-related issues and conflicts, California's courts will always use the law most protective of the employee.

The FLSA permits employers to pay certain employees tipped wages, a lower federal minimum than regular minimum wage. A "*tipped employee*," as defined by the FLSA, is an employee" *engaged in an occupation in which he customarily and regularly receives more than $30 a month in tips.*" FLSA law comes into play if an employer wishes to take a "*tip credit*" to offset the amount an employee is paid per hour. Tipped workers are primarily in the food-and-beverage industry, hospitality and tourism industry or in a service occupation, such as limousine and taxi drivers, sky caps and similar jobs. The FLSA refers to employees who "*customarily and regularly receive tips*" as being subject to the federal guidelines.

The only District employees who may fall under the FLSA guidelines are the Event Supervisors who, on occasion, receive tips from event rentals that may be considered "*customarily and regularly received*". The District has no interest to take a tip credit or implement tip policy due to the administrative burden required by FLSA.

Public Sector Employees

It might be against federal, state or municipal government's ethics policies for salaried or hourly public sector employee to receive gratuities.

The Personnel Policy & Procedures Manual generally describes the employment relationship between the District and its employees. Conflict of Interest is covered under Section V.B. and states in part that employees should "*avoid situations that create an actual or potential conflict between the employee's personal interests and the interests of the District.*"

Government Code Section 8314 prohibits personal use of public property which is not authorized by law. "*Personal purpose*" means those activities the purpose of which is for personal enjoyment, private gain or advantage, or an outside endeavor not related to state business. An argument could be made that as employee's wages are already set and any gratuity money coming from the customer as a result of the use of the public property is an additional payment for that use which is not authorized and therefore prohibited.

In addition, our District's Conflict of Interest Code, which covers the designated positions of Directors, Commissioners, District Secretary, General Manager, Board Legal Counsel, Engineering Consultant, and Department Managers (but not our hourly employees), requires reporting of any gratuities received. The power to influence decisions concerning laws and business opportunities is what is prohibited not the actual giving of the gratuity. Gratuities or gifts should not be taken from people trying to exert influence.

STAFF OPINION

Because of the above arguments, staff recommends implementing a "No tips or gratuities allowed" policy to the list of Personnel Polices Workplace Conduct the District deems to be inappropriate.

ACTION:

The Personnel Committee should discuss, formulate opinions, and send recommendations to the Board.

The District Board should consider the recommendations from the Personnel Committee, determine whether to implement a No Tip Policy, and by motion direct staff accordingly.

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