

County of Santa Clara



Employee Benefit Programs

2015

BASIC BENEFIT PACKAGE

Health Plan

Dental Plan

Vision Care

Basic Life

ADDITIONAL BENEFIT PROGRAMS

Supplemental Life Insurance

Accidental Death & Dismemberment Coverage

Long-Term Disability

State Disability Insurance
(Depending On Your Bargaining Unit)

Deferred Compensation Plan

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Health Care Bonus Waiver Program

Eco Pass (Commuter) Program

The information contained in this packet is not inclusive of all plan provisions and exclusions, nor does this information contain full disclosure. Please see plan brochures and exclusions of each plan, or contact the customer service representatives for each plan.

All County policies and practices are subject to change. All Benefit Programs are subject to collective bargaining. All rates/costs quoted in this document are subject to change.

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Health Plan Types & Selection

The County of Santa Clara offers three types of health plans: a Health Maintenance Organization (HMO), a Point of Service Plan (POS) and a Preferred Provider Organization (PPO).

The **POS** plan offers three levels of coverage known as “tiers”:

- **Tier One – HMO:** You select a Primary Care Physician who provides all of your basic care and refers you to specialists as needed. Under tier one, you pay a \$15.00 office visit co-payment and covered services are paid by the plan at 100%.
- **Tier Two – PPO:** This tier allows you the flexibility of self-referral to any Preferred Provider Physician within the plan’s network, including specialists. You are not required to go through your Primary Care Physician for a referral to a PPO physician. Under tier two, you pay a \$20.00 office visit co-payment and covered services are paid by the plan at 90% of contracted rates. The member is responsible for the remaining 10%.
- **Tier Three – Out of Network:** This tier allows you the flexibility of self-referral to any physician outside the plan’s network of physicians. You are not required to go through your Primary Care Physician when seeking the services of a physician outside of the plan’s network. Under tier three, the plan pays 70% of usual and customary rates. The member is responsible for the remaining 30% and is subject to annual deductibles. Some services covered under tiers one and two are not covered under tier three.

For employees and their dependents who live outside the Health Net service area, the POS plan will allow you and your family members to utilize the HMO level of benefits by selecting a Primary Care Physician (PCP) within a 30-mile radius of your work area. Should you have questions, contact your Employee Service Center for more information.

The **HMO** plan offers services from designated doctors and hospitals within a restricted service area. Most services are covered at 100% with minimal or no office visit co-payments. Out of network services are not covered except under life threatening emergency conditions. The plan determines what qualifies as a life-threatening emergency.

A brief summary of each plan’s features is provided below. For additional information, covered services, limitations and exclusions, you should consult each plan’s summary of benefits or disclosure document.

	HMO	POS & PPO
Service area restricted?	Yes, must live or Work in Santa Clara County – must be within 30 miles of work address	Yes for tier one, No for tiers two and three
Co-payments?	Yes	Yes
Deductibles?	No	Yes for tier three only
Designated Doctors & Hospitals?	Yes	Yes for tier one & two. No for tier three. Payment of benefits is dependent on which tier is accessed
Preexisting Condition Clause?	No	No
Prescription Drug Program?	Yes – Valley Health - \$0.00, Kaiser – Ranges from \$5.00 to \$30.00	Yes – Generic: \$10.00, Brand: \$20.00 Non-Formulary: \$30.00
Claim forms?	No	Yes, depending on Provider
Emergency Room Coverage?	Yes – Valley Health - \$0.00 Kaiser - \$35.00 per visit	Yes – Tier one (HMO) - %0 Tier two (PPO) - \$75.00 Tier three (OON) – 30%
Hospitalization Services?	Yes Valley Health - \$0.00 Kaiser - \$100.00	Yes - \$0.00

Health Plans Offered By The County Of Santa Clara

<u>HMO</u>	<u>POS</u>	<u>PPO</u>
Kaiser Foundation Health Plan Valley Health Plan	HealthNet Select Choice	HealthNet Preferred Provider Organization

Dental Plan Types & Selection

The County of Santa Clara offers two types of dental plans to employees. One type is known as a Fee-For-Service plan and the other is known as a Dental Maintenance Organization.

- A **Fee-For-Service** plan allows a choice of any dentist who is a member of the California Dental Association. The covered services are based on a percentage with an annual dollar limit, depending on the contract an employer has with this type of plan. A portion of the fees is paid for by the participant. Some providers require the member to complete a claim form, although most dentists will file the claim electronically for you. Delta Dental Plan is the fee-for-service plan the County offers to employees. There are three ways you can access services: choosing a Delta PPO dentist, a Delta Premier dentist or a non-network dentist. Your out-of-pocket expenses vary based on the provider you choose and the contracted fee or the program allowance for out-of-network dentists. Your costs are usually lower when you choose a Delta PPO dentist.
- A **Dental Maintenance Organization** is similar to an HMO in that there are specific service areas and dentists a participant must use to receive the full benefits of the plan. There are some minimal co-payments for specific services, however there are usually no annual limits and no claim forms. Liberty Dental is the DMO plan the County offers to employees.

A brief summary of each plan's features is provided below. For additional information, covered services, limitations and exclusions, you should consult each plan's summary of benefits or disclosure document.

Services	Delta Dental Plan	Liberty Dental
Diagnostic/Preventive	Plan pays 75%, member pays 25%	Plan pays 100%
Restorative	Plan pays 75%, member pays 25%	Plan pays 100%
Crowns & Bridges	Plan pays 75%, member pays 25%	Plan pays all but \$75.00
Prosthodontics (dentures)	Plan pays 75% every 5 years, member pays 25%	Plan pays all but \$100.00 each for upper and lower set
Annual Limits	\$2,000.00 per calendar year per member	None
Orthodontic	Plan pays 60% up to \$2,000.00 lifetime, member pays 40%	Plan pays all but \$1,150.00
Provider Access	Approximately 90% of all Dentists in California accept Delta Dental	Must select a Dentist from plan's contracted providers.

Vision Services Plan

How Does the Plan Work?

You may select a provider from a VSP list of optometrists, make an appointment and inform the provider's office that you are a VSP member. The provider's office will contact VSP for you and verify eligibility. You may obtain a list of approved VSP providers from your Departmental Employee Service Center. VSP also has an 800 customer service number and a web site (www.vsp.com) where you can obtain additional information.

What Does the Vision Plan Cover?

Exam & Lenses every 12 months
Frames every 24 months

\$20.00 deductible
\$20.00 deductible

The plan also covers contact lenses up to \$120.00 every 12 months, including the exam. The plan does not cover scratch resistant coating, tinting, tinted contacts or designer frames. Some providers will offer you discounts on these items or discounts on a second pair glasses.

What Is My Biweekly Cost?

The County pays the full cost of the premium for full-time employees. Part-time employees have a prorated cost for this plan based on the number of hours worked in each pay-period. Premium contributions are made on a pre-tax basis.

Health, Dental & Vision Plans Eligibility

Which Employees Are Eligible to Enroll in a Health Plan?

You may enroll in one of the three health plans if you are in a full-time or part-time coded position. Seasonal or temporary (extra help) employees and contractors are not eligible for health and dental plan enrollment and are limited to health plan enrollment based on bargaining unit.

Which Members of My Family Are Eligible to Enroll in My Health Plan?

You may enroll the following eligible members on your health plan:

- a) Your current spouse;
- b) Your children, step children, or adopted children who are under age 26;
- c) Any other children under the age of 26 for whom you have legal guardianship (if legal guardianship was established prior to age 18);
- d) Your children, step children, adopted children or any child you have legal guardianship for who is under the age of 26 and are incapable of self-support because of a physical or mental disability which existed continuously prior to the age of 26 and continue to be certified as disabled on a bi-annual basis.
- e) Your registered domestic partner;
- f) Your registered domestic partner's children if the children meet the same criteria of a child as described above.

Adding and Removing Dependents

You are responsible for contacting your Departmental Employee Service Center to update your dependent status during the plan year (marriage, birth, death, divorce, dissolution of domestic partnership, ineligibility of dependent child due to age, etc.). Notification must be made within 30 days that the status change occurs. Failure to submit notification in a timely manner may impact dependent eligibility for health care continuation under COBRA, and may result in you incurring liability for medical expenses for non-eligible dependents. For Dental and Vision coverage only, Proof of full-time student status is required for children ages 19-23 (or 24 for Liberty Dental).

Which Employees Are Eligible to Enroll in the Dental and/or Vision Plan?

All regular hourly and salaried employees in coded positions, working one-half time or more in a week are eligible for these plans. **Seasonal or temporary (extra help) employees and contractors are not eligible for health, dental, and vision plan enrollment.** Eligible dependents must meet the criteria for enrollment as required by the dental and vision plans. Children between the age of 19 and 23 (or 24 for Liberty Dental) must be full-time students.

Which Members of My Family Are Eligible to Enroll in the Dental and/or Vision Plan?

You may enroll the following eligible members on your dental and/or vision plan:

- a) Your spouse;
- b) Your unmarried children, step children, adopted children who are under age 19;
- c) Any other unmarried children under the age of 19 entirely supported by you and for whom you have

- legal guardianship;
- d) Your unmarried children, step children, adopted children or any child you have legal guardianship for who is over the age of 19 and are incapable of self-support because of a physical or mental disability which existed continuously prior to the age of 19 and continue to be certified as disabled on a bi-annual basis;
 - e) Your registered domestic partner;
 - f) Your registered domestic partner's children if the children meet the same criteria of a dependent child as described above.

Can My Dependent Children Age 19 or Over Remain on My Dental and Vision Plans?

Any dependent who reaches the age of 19 will require verification of full-time student status. It is the responsibility of the employee to provide proof of full-time student status when a dependent turns 19 by filing proof of eligibility with your Departmental Employee Service Center initially and each year thereafter on the birth date. If you fail to provide the proof of eligibility, the County will remove the dependent from your coverage. Additionally, if your dependent no longer meets the criteria for eligibility as an over-age dependent, it is your responsibility to notify the Departmental Employee Service Center in order to complete the necessary paperwork to remove the ineligible dependent from your dental and vision coverage.

The dental and vision plans require that your over-age dependent is a full-time student.

Dependents who turn 23 and enrolled in Delta Dental and VSP vision will be automatically removed from coverage without notice at the end of their birth month. Dependents with Liberty Dental will be removed at age 24.

When May I Enroll Myself or My Eligible Members?

You have 30 days from your date of hire to enroll yourself and your eligible members in the basic benefit package. Part-time employees may enroll in a health plan only, waive the dental and vision plan or enroll in the complete package.

You also have 30 days from the date of an I.R.S qualifying event to enroll yourself and/or your eligible family members on your health, dental and vision plan. A qualifying event is described as marriage, birth, adoption, foster placement, establishment of a registered domestic partnership or when you have lost other health, dental and vision coverage you may have either through another employer or through a family member's employer.

What Should I Do If I Wait Longer than 30 Days to Enroll?

If you wait longer than 30 days from your date of hire to enroll or if you waive enrollment in your benefits, you must wait to enroll until the annual open enrollment period held each year usually during the month of September.

There are exceptions to this rule: Part-time employees who previously waived coverage and then have a change in their coded standard hours may enroll in their benefit package (depending on bargaining unit). Another exception would be if you meet the criteria under California State Assembly Bill 1672. This provision allows for an employee to enroll him/herself or dependents in the basic benefit package due to a loss of other coverage. Contact your Departmental Employee Service Center within 30 days should you find yourself in this situation.

What If I Am Married to Another County Employee or In a Registered Domestic Partnership Where We Both Work For The County? Can We Both Have Health Plan Coverage?

No. If you and your spouse or partner are both County employees, *only one employee is allowed to carry health plan coverage*. One employee may choose to enroll in family coverage and the other employee must waive their health plan coverage and be enrolled as a dependent. This limitation applies to health plan coverage only. You and all eligible dependents may enroll in or remain enrolled in dental and vision coverage. This enrollment limitation does not apply to Court employees. If you are a Court employee, contact your Departmental Employee Service Center to determine your options for enrollment.

Health, Dental & Vision Plan Cost

Health Plan Rates:

The County has a four-tiered rate system for Kaiser and Valley Health coverage and a two-tiered rate system for Health Net. For most full-time coded employees, the County pays the cost of the single rate for all health plans and the majority of the cost of the family rates, regardless of the family structure. Contribution structures are based on bargaining unit agreements. Premium contributions are made on a pre-tax basis. For full-time employees who are married or in a registered domestic partnership and both are working for the County, 100% of the family rate is paid regardless of the health plan. Rates are subject to change each fiscal year.

Dental & Vision Plan Rates:

The County has one rate for the Dental and Vision plans regardless of the family structure. The County pays the full cost of the dental and vision plans for full-time coded employees, whether the coverage is for single employee coverage or includes family coverage.

Part-Time Employees:

Part-time employees share the cost of health, dental, vision and basic life plans. These rates are prorated based on the number of regular hours an employee works each pay-period, but not less than the standard coded hours. Premium contributions are made on a pre-tax basis. For more information on prorated costs, contact your Departmental Employee Service Center.

Payroll Deductions:

Employees are responsible for making sure that the appropriate deduction is being taken from their paychecks. It is important that employees keep track of their paychecks and do not wait more than three pay-periods if you believe there is an error in amount charged. If you experience a problem with your payroll deductions, contact your Departmental Employee Service Center.

Basic Life Insurance Plan

Eligibility:

All active hourly and salaried employees holding regular coded positions and working one-half time or more per week are eligible for coverage. No health clearance is required.

Amount of Insurance and Cost of the Plan:

The amount of the benefit for most employees is \$25,000. For CEMA, Confidential Administrative and Confidential Clerical employees the amount of the benefit is \$50,000. The County pays 100% of the cost for full-time coded employees. Part-time employees pay a prorated amount of the rate based on the number regular hours worked in each pay-period. The benefit amount is payable in the event of the employee's death by any cause except an act of war. You may designate any beneficiary. (Note: California is a community property State, and your spouse may claim a community property interest in your benefits which may affect the rights to benefits of the beneficiary(ies) you have designated. You should consult with an attorney if you wish legal advice regarding community property laws in effect and how they apply to the distribution of your benefits).

Supplemental Life Insurance

Eligibility:

All active hourly and salaried employees holding regular coded positions and working one-half time or more per week are eligible to purchase additional life insurance coverage. This voluntary plan is fully paid for by the employee. A health clearance may be required. You may designate any beneficiary. (Note: California is a community property State, and your spouse may claim a community property interest in your benefits which may affect the rights to benefits of the beneficiary(ies) you have designated. You should consult with an attorney if you wish legal advice regarding community property laws in effect and how they apply to the distribution of your benefits).

Advantage of Enrolling Promptly:

If you enroll within 30 days of your date of hire, no health statement is required. If you decline to enroll during this 30 day period and elect to apply for this insurance at a later date, satisfactory evidence of insurability will be required. A release of your medical records and a physical examination at your own expense may be required. Upon completing a Supplemental Life Evidence of Insurability form, it may take up to three months for an approval or denial of coverage from the insurance company.

Schedule of Benefits:

Please see the plan brochure for the schedule of benefits and costs. This is a voluntary plan fully paid for by the employee and the costs are determined by the employee's base salary. All coverage amounts and cost will be updated automatically as your base salary changes as a result of pay increases. You may also choose an option for a fixed benefit amount and cost which remains stable and does not change when your salary changes. The biweekly costs are the same whether an employee is full-time or part-time.

Accidental Death & Dismemberment Insurance

Eligibility:

All active hourly and salaried employees holding regular coded positions and working one-half time or more per week are eligible for coverage. This is a voluntary plan fully paid for by the employee. You may enroll at any time without restriction.

Schedule of Benefits:

See the plan brochure for the schedule of benefits and costs to the employee. Costs depend on the option you choose. You may choose to cover yourself only or you may cover yourself, your spouse or registered domestic partner and children. A percentage of the value of the benefit amount you elect is paid to you in the event of the death of your spouse and/or children under the family plans. Costs are the same whether the employee is full-time or part-time.

The full amount of coverage is paid to your designated beneficiary if your death occurs within 365 days of an accident. In the case of loss of hand, foot, or eye, the plan pays 50% of the benefit amount. In the case of loss of more than one hand, foot, or eye, the plan pays 100% of the benefit amount. (Note: California is a community property State, and your spouse may claim a community property interest in your benefits which may affect the rights to benefits of the beneficiary(ies) you have designated. You should consult with an attorney if you wish legal advice regarding community property laws in effect and how they apply to the distribution of your benefits).

Long-Term Disability Plan

Eligibility:

Most active hourly and salaried employees holding regular coded positions and working one-half time or more per week are eligible for coverage. This is a voluntary plan fully paid for by the employee. A health clearance may be required.

Advantage of Enrolling Promptly:

If you enroll within 30 days of your date of hire, no health statement is required. If you decline to enroll during this 30 day period and elect to apply for this insurance at a later date, satisfactory evidence of insurability will be required. A release of your medical records and a physical examination at your own expense may be required. Upon completing a Long-Term Disability Evidence of Insurability form, it may take up to three months for an approval or denial of coverage from the insurance company.

Cost of the Plan:

If an employee is covered under the State Disability Insurance Program (SDI), the cost is \$0.81 per \$100.00 of the biweekly base salary. If the employee is not covered by SDI, the cost is \$1.04 per \$100.00 of the biweekly base salary. As your base salary increases, your biweekly premium automatically increases. You may also select a fixed benefit plan and the biweekly premium will remain the same regardless of salary increases.

Base Plan: pays two-thirds of your base salary with no maximum benefit amount and no salary cap.

Fixed Benefit Option: you select a benefit amount that is lower than what your base salary provides. This is a fixed benefit amount and a fixed premium. Should your salary increase your benefit amount and premium will not change.

All plans pay a minimum benefit amount of \$100 biweekly.

Length of Time Benefits Are Payable:

This plan pays benefits for up to two years for illness and up to five years for accident. However, the County has purchased an insurance policy, which provides an enhancement for a catastrophic illness or injury. There is no additional cost to the employee for this enhancement. In addition, this catastrophic plan covers illness or injuries upon expiration of the two or five year self-funded benefits described above. This insured plan will pay benefits up to age 65 if the employee is disabled and unable to perform any occupations.

Other Disability Benefits:

The benefit amount you are eligible to receive under LTD may be affected by any other benefits you receive from other disability plans such as State Disability Insurance, or Workers' Compensation. Please see the plan brochure for a further explanation and exclusions.

State Disability Insurance

Eligibility:

Employees represented by certain bargaining units have an automatic deduction from their biweekly pay. This tax will appear on your paycheck as CA SDI FTDI. Employees covered by SDI may collect benefits up to 52 weeks for a non-industrial illness or injury.

SDI Cost and Benefit Amounts:

The biweekly cost is 1.00% of your salary up to a maximum of \$100,880.00 annually. The amount of the benefits provided to you is based on wages paid to an employee for the highest quarter during a 12-month base period. The maximum weekly benefit amount is \$1,104.00 as of 01/01/2015.

Paid Family Leave Insurance Program

Eligibility:

Employees represented by certain bargaining units have an automatic deduction from their biweekly pay. This tax will appear on your paycheck as CA SDI FTDI. Employees covered by Paid Family Leave may collect benefits up to 6 weeks of benefits in a twelve month period to care for parents, children, spouses, siblings, grandparents and registered domestic partners or to bond with a new minor child.

Paid Family Leave Insurance Cost and Benefit Amounts:

The biweekly cost is 1.0% of your salary up to a maximum of \$100,880.00 annually. The amount of the benefits provided to you is based on wages paid to an employee for the past quarter. The maximum weekly benefit amount is \$ 1,104.00 as of 01/01/2015.

Integration with SDI/Paid Family Leave

Integration of State Disability Insurance (SDI) with Employee's Sick/Vacation Leave:

Within one week of being disabled from work an employee or designee must notify the Departmental Employee Service Center that he/she wants to integrate banked leave time hours with SDI/PFL. The

advantage of integration is to receive an amount as close or equal to your regular net pay while you are disabled. Please note that there is no guarantee of full salary being paid between sick/vacation leave and your SDI/PFL benefits. The amount you will receive is dependent on various factors such as other mandatory deductions normally taken from your regular salary. An additional advantage to integration is that your basic benefit package remains intact while you are receiving paid hours from the County. SDI/PFL has a waiting period of seven calendar days. You will need to use sick leave and/or vacation if you wish to be paid for the first seven calendar days of your disability. Contact your department Service Center for details.

Integration is not automatic. You or your designee must notify the appropriate authority in your department that you wish to integrate. If you do not elect integration, you will be put on an unpaid leave of absence and receive only SDI benefits. This may affect your medical, dental, vision and life insurance. You may elect to integrate at a later date while on an unpaid leave, however, the integration will be from the point you make that election and not retroactive to the beginning of your leave.

Claim Forms:

Obtain claim forms for both programs from your Departmental Employee Service Center, from your doctor or from your hospital. Complete the employee portion of the form, secure your doctor's statement and mail to the address provided on the claim form. Some doctors or hospitals will assist you in completing the form and may even mail it for you. If you complete the claim form in advance, you may start receiving SDI/PFL benefits in as little as two weeks after your disability begins.

Dependent Care Assistance Program

What Is the Dependent Care Assistance Program?

DCAP is an innovative way for you to save tax dollars while converting part of your salary into tax-free benefits. The advantage is tax savings. Since this program uses pre-tax dollars for reimbursement of dependent care expenses, you reduce your income taxes by reducing your taxable salary.

What Expenses Qualify for DCAP?

- Expenses paid for the care of a dependent under age 13
- Expenses paid for the care of a dependent who is physically or mentally incapable of caring for him/herself; including elderly day care

How Does the Plan Work?

Before the start of each plan year (01/01 – 12/31), during open enrollment you will be able to elect to have some of your upcoming wages paid to the plan. These amounts will be placed in a special account called a "reimbursement account", which must be set up in order to pay for the benefit you elected. The portion of your pay that is deducted is not subject to Federal, State, FICA or SDI taxes. However, if you participate in this plan, you may not be able to claim a Federal Income Tax Child-Care Expense Credit on your tax return.

When Do I Make an Election for This Plan?

You must elect to participate in this plan within 30 days of your date of hire, within 30 days of the birth or adoption of a child or during the annual open enrollment period, normally during the month of November. **IRS regulations require that employees participating in this plan must re-elect each calendar year. If you do not re-elect during the normal open enrollment period each year, you will be required to wait until the next open enrollment period to participate in this program. Election of this program is for the entire calendar year, however you may elect to have the entire amount you claim deducted from payroll in fewer than 26 pay periods.**

May I Change My Elections During the Plan Year?

Generally, you cannot change your election once the plan year has begun, except where IRS regulations allow. If you have a family status change, you may be able to change your election provided you meet the IRS criteria.

Is There a Fee for This plan?

The employee is required to pay an after-tax fee of \$3.00 per pay-period. This fee is subject to change

each plan year. When submitting an application for DCAP please specify the number of pay periods for deductions.

What Happens If I Don't Spend All My Plan Contributions?

Any monies left in your reimbursement account at the end of the plan year will be forfeited. Qualifying expenses that you incur late in the plan year will be paid before any amount is forfeited. However, you must make your request for reimbursement no later than 90 days after the end of the plan year. Because you could forfeit amounts in your account, it is very important that you decide CAREFULLY AND CONSERVATIVELY how much to contribute for the plan year.

Contact United Administrative Services at (408) 288-4400 or the Employee Benefits Division for more information on qualifying family status changes or for forms and brochures.

Health Care Flexible Spending Account Program

What Is the Health Care Flexible Spending Account Program?

This program allows an employee to elect a payroll deduction up to a maximum of \$2,500 per calendar year, which is not subject to Federal and State taxes. The advantage is tax savings since this program uses pre-tax dollars for reimbursement of medically necessary expenses not covered by insurance. You reduce your income taxes by reducing your taxable salary.

How Does the Plan Work?

Before the start of each plan year (01/01 – 12/31), during open enrollment you will be able to elect to have some of your upcoming wages paid to the plan. These amounts will be placed in a special account called a "reimbursement account", which must be set up in order to pay for the benefit you elected. The portion of your pay that is deducted is not subject to Federal, State, and SDI taxes.

What Expenses Qualify for This Program?

Any medical, dental or vision expense not covered or reimbursed by your insurance plans. Some examples of allowable expenses are:

- Any expense not covered by your insurance plan
- Dental expenses which exceed covered benefits or are outside of plan coverage
- Co-payments for doctor visits or prescription drugs, or deductibles required by your plan
- Some medically necessary over-the-counter drugs and supplies, if a prescription is provided by your doctor

IRS regulations prohibit participants to pay for any type or portion of insurance premiums with Flexible Spending Account pre-tax dollars.

When Do I Make an Election for This Plan?

You must elect to participate in this plan within 30 days of your date of hire, within 30 days of a qualifying event or during the annual open enrollment period, normally during the month of November. **IRS regulations require that employees participating in this plan must re-elect each calendar year. If you do not re-elect during the normal open enrollment period each year, you will be required to wait until the next open enrollment period to participate in this program. Election of this program is for the entire calendar year.**

May I Change My Elections During the Plan Year?

Generally, you cannot change your election once the plan year has begun, except where IRS regulations allow. IRS regulations allow for changes in election during the plan year under certain qualifying events.

Is There a Fee for This Plan?

The employee is required to pay an after-tax fee of \$3.00 per pay-period. This fee is subject to change each plan year.

What Happens If I Don't Spend All of My Plan Contributions?

Any monies left in your reimbursement account at the end of the plan year will be forfeited. Qualifying expenses that you incur late in the plan year will be paid before any amount is forfeited. However, you

must make your request for reimbursement no later than 90 days after the end of the plan year. Because you could forfeit amounts in your account, it is very important that you decide CAREFULLY AND CONSERVATIVELY how much to contribute for the plan year. The County's plan includes a grace period of 45 days from January 1st- March 15th that allows for incurred expenses to be used towards the remaining balance in the prior plan year.

Health Care Bonus Waiver Program

What Is the Health Care Bonus Waiver Program?

This program allows an employee to receive a taxable increase in gross wages for waiving medical coverage through the County. An employee may elect to continue with dental, vision and basic life insurance coverage or waive all benefits. The amount received by the employee is the same whether medical only is waived or the all benefits are waived.

How Does This Program Work?

A full-time employee elects to waive medical only or all benefits and then receives \$74 per pay-period in taxable wages (effective 06/19/06). Part-time employees who participate in this program will receive an amount based on prorated formulas as determined by coded standard hours.

An employee who elects to participate in this program must complete the necessary paperwork and provide written documentation showing proof of medical coverage with an insurance program outside of the County. Written documentation may include a letter from the insurance company, a letter from the spouse or registered domestic partner's employer, or an annual benefits statement from another employer or insurance company all of which must show current coverage for the plan year. **Your health plan card is not sufficient proof of coverage.**

When Do I Make an Election for This Plan?

You must elect to participate in this plan within 30 days of your date of hire, within 30 days of a qualifying event or during the annual open enrollment period, normally during the month of November. **IRS regulations require that employees participating in this plan must re-elect each calendar year. Should you fail to make an election of either this program or for enrollment in a medical plan, the County will automatically enroll you in the Valley Health Plan and you will be required to wait until the next open enrollment period in November to re-enroll in this program. Election of this program is for the entire calendar year.**

What Happens If I Experience a Loss in Other Medical Coverage?

Within 30 days of experiencing a loss of other coverage, you may enroll in a County sponsored medical plan. You must provide written documentation that states the date of loss of other medical coverage. Once you re-enroll in a County sponsored medical plan, your biweekly compensation will cease.

What If I Retire While Participating in This Program?

An employee who participates in this program and retires during the plan year, will not be eligible to enroll in a County sponsored medical plan until the next annual open enrollment period for medical plans, usually during the month of September. **Exception: An employee who participates in this program, who retires and moves out of state, may elect to enroll in the Payment-in-Lieu program as long as the retiree provides written documentation of medical coverage on an annual basis.**

Can I Participate in This Program If I Am Married to Another County Employee or Are a Registered Domestic Partner of Another County Employee?

An employee who is married to or is a registered domestic partner of another County employee and where both employees have one medical plan between them are not allowed to participate in the Health Care Bonus Waiver Program.

This provision does not apply to Court employees who are married to or who is a registered domestic partner of a County employee.

Deferred Compensation Plan

What Is a Deferred Compensation Plan?

The Deferred Compensation Plan is a tax deferred savings plan allowing employees to defer federal and state taxes based on the biweekly payroll deduction selected by the employee. An employee may elect up to 70% of their biweekly pay up the annual maximum limit as determined by IRS regulations. This contribution is deducted from gross wages prior to paying federal and state taxes. There are special circumstances where you may be able to contribute more than the regular annual limit. Contact the provider for more information. Gross taxable earnings reported to the IRS will not include your Deferred Compensation contribution.

What Are the Investment Options?

The County has a contract with I.C.M.A. Retirement Corporation (ICMA-RC), which offers a variety of mutual funds and other types of investment vehicles. Contact Ray Ortiz, ICMA-RC representative, at 1-(888) 883-8571, or Rick Luerra at (866) 837-9803 for information on the investment options available to you. You may obtain forms and brochures from your Departmental Employee Service Center or ESA – Deferred Compensation Program at (408) 299-5866. You may also access the ICMA-RC website for county employees at www.icmarc.org/santa-clara.html to utilize forms, access to plan statistics, educational tools and more.

The County of Santa Clara does not endorse any particular investment vehicle, nor is the County responsible for the volatility of the stock market. It is the responsibility of the employee to direct their payroll contributions to the investment vehicle of their choice through the appropriate paperwork and/or by working ICMA-RC directly on investment options. You may start or stop your payroll contributions at any time.

Do I Have Access to My Funds Like a Regular Savings Account?

Generally, you do not have access to your funds while you are employed by the County of Santa Clara. Legally, these funds are held in Trust until you separate from service or retire; at which time you have various options for payout. This program is not a savings account from which you can withdraw or deposit at random.

The plan allows participants to take loans from their accounts, subject to provisions detailed in the Plan Document. For additional information on the County's Deferred Compensation loan program, please contact ICMA-RC Investor Services directly at (800) 669-7400.

Another provision under which you may access funds from your account while still employed is an Emergency Withdrawal. This provision is governed by very stringent IRS regulations. Should an employee experience a catastrophic financial event, he/she may apply for an "Emergency Withdrawal" through the ICMA-RC Benefits Administration Office. Specific information is required to apply for this type of withdrawal and a committee consisting of County employees from management and labor will either approve or deny your application. Any monies withdrawn under this provision will be subject to federal and state taxes. If a loan is available to a participant, then an Emergency Withdrawal request will not be granted.

The Deferred Compensation Plan is pursuant to Section 53212 through 53214 of the State of California Government Code and Section 457 of the U.S. Internal Revenue Code and is part of a compensation program for which administration of such plan is based on IRS rules and regulations.

Medical Coverage After Retirement

Do I Have Medical Coverage when I Retire?

The County provides access to group health plan coverage to eligible retirees. Employees hired on or after 08/12/96 are eligible for retiree medical coverage at age 50 with a minimum of 2,088 days (8 years) of accrued County service. Employees hired on or after 06/19/06 are eligible for retiree medical coverage

at age 50 with a minimum of 2,610 days (10 years) of accrued County service. Employees hired on or after 01/01/13 are eligible for retiree medical coverage with 3,915 days of County service (15 years) at 52 years of age at retirement based on the Public Employees' Pension Reform Act. Review your union memorandum of understanding for details.

How Do I Apply for Retiree Medical Coverage?

First you must decide on your retirement date and complete a CalPERS application for retirement. Approximately 60 days prior to your planned retirement date, you should contact the Employee Benefits Department at (408) 299-5880 or (800) 541-7741 to set up an appointment for an Exit Interview in order to enroll in retiree medical coverage. Coverage is not automatic upon retirement; you must complete the necessary paperwork to maintain medical coverage after you retire.

What Is the Cost for Retiree Medical Coverage?

For most retirees, the County pays for single coverage up to the lowest costing health plan, currently the Kaiser Health Plan. Retirees who elect a more expensive medical plan, such as Health Net or Valley Health Plan, or who elect to cover an eligible dependent, need to reimburse the County for the difference in the cost of the monthly premium.

May I Change Plans While I am Retired?

Retirees may change their medical plan coverage during Open Enrollment, which usually takes place in the month of September. Any changes will be effective November 1st following the open enrollment period which usually takes place in September.

What If I Don't Want Coverage at the Time of Retirement?

You may waive your coverage at the time of retirement. Should you wish coverage at a later date, you may enroll during the annual open enrollment period in September or within 30 days of a qualifying event for enrollment. A qualifying event includes loss of other coverage. For more information on qualifying events, contact the Employee Benefits Department.

What If I Move Out of the Service Area of My Medical Plan?

You should contact Employee Benefits when you are planning on any move to see how it will affect your Medical Plan. There are options available to you should you move out of the service area of a particular plan. If you move out of the service area of your plan, you should contact Employee Benefits Department within 30 days to determine which option is best for your situation.

What Happens When I Turn 65 and Become Eligible for Medicare?

The County and all medical plans require that, if eligible, you enroll in Medicare Part A & B. You should contact the Employee Benefits Department once you have received your Medicare card so that you can be enrolled in a Medicare plan. In most cases, the premium payment that the retiree pays for him/herself or dependents will be reduced. For some medical plans, the retiree may be eligible for reimbursement of the Medicare Part B premium deducted from your Social Security benefits. Covered retirees and dependents **should not** enroll in Medicare Part D. Prescription drug coverage is already provided in the medical plans offered to retirees.

Public Employees' Retirement System

What is CalPERS?

CalPERS offers a defined benefits plan, which provides a lifetime pension benefit based on a formula. To be eligible for a service retirement, you must be at least age 50 and have a minimum of five years of CalPERS-credited service.

What Does the County Contribute?

For CalPERS "classic" employees, for most bargaining units, the County pays the majority of the employee's and the employer's share. The remainder is paid by employees on a pre-tax basis and the amount varies and is determined by bargaining unit agreement. For CalPERS "non-classic" employees, the employee must pay at least half of the normal cost. For most bargaining units, the County pays and reports the majority of the value of the member's share as special compensation for the purpose of retirement benefit calculations (also known as EPMC – Employer-Paid Member Contributions). Review your union memorandum of understanding for details.

What Does the Employee Contribute?

The employee pays a small portion of both the employee and employer share, as determined by bargaining unit agreements.

What Are the CalPERS Benefits?

On January 1, 2013 the California Public Employees' Pension Reform Act (PEPRA) went into effect. The pension reform bill made changes to the pension benefits that may be offered to employees hired on or after January 1, 2013. Employees hired on or after January 1, 2013 would be considered as a new member for the purposes of PEPRA. Employees hired into the CalPERS system before January 1, 2013 who have not had a break in service of more than six months are considered CalPERS "classic" employees.

Employee Type	Benefit Formula
Miscellaneous "Classic" Member	2.5% at age 55
Safety "Classic" Member	3% at age 50
Miscellaneous "PEPRA" Member <i>(hired into the CalPERS system on or after 1/1/2013)</i>	2% at age 62, with a minimum age at retirement of 52 years
Safety CalPERS "PEPRA" Member <i>(hired into the CalPERS system on or after 1/1/2013)</i>	2.7% at age 57

CalPERS considers your age, your service years, your benefit level and average hourly pay rate over a 12 month period in determining your monthly retirement benefit. For PEPRA employees, CalPERS considers your age, your service years, your benefit level and average hourly pay rate over a 36 month period in determining your monthly retirement benefit (PEPRA employees are those new to PERS as of January 1, 2013).

Contact CalPERS or the Employee Benefits Department for brochures and forms to apply for retirement. You should apply for retirement through PERS no more than 90 days in advance of your retirement date. You may also access the PERS website at www.calpers.ca.gov to utilize a retirement calculator to obtain an estimate of your monthly retirement allowance.

Leaves Of Absence and Your Benefits

What the County Pays:

The County will pay the single cost of the basic benefit package for full-time employees while on an unpaid leave of absence for medical, maternity and workers' compensation types of leaves for a maximum of 13 payperiods. Employees in Local 521 (Legacy 715), Local 1587, Confidential Clerical or Engineers & Architects (Local 21) will have their single cost of the basic benefit package paid by the County for the entire duration of a workers' compensation leave.

What the Employee Pays:

Employees are responsible for the payment of the difference between the single and family cost of the medical plan in order to maintain coverage for dependents while on leave. These payments must be made on a biweekly basis. Part-time employees are responsible for the prorated portion of their basic benefit package while on leave.

Failure to pay the biweekly costs for family coverage or the prorated portion will result in termination of coverage for yourself and/or your dependents. Upon return from leave, you will be automatically enrolled in the same benefits you had prior to the beginning of your leave. Due to processing timelines, re-enrollment may take up to 30 days. Employees are responsible for payment of any voluntary insurance plans such as Supplemental Life.

The Employee Benefits Department will notify you in writing what your costs will be while on an unpaid leave. It is very important that you keep your immediate Supervisor and your Departmental Employee

Service Center informed about your leave so that the appropriate paperwork is processed through the Personnel/Payroll system. Without appropriate processing, the Employee Benefits Department will not be able to send you important information and your benefits may be inadvertently cancelled.

Leaves Beyond 13 Pay-periods, Personal Leave or Suspension:

The employee will be responsible for payment of the full cost of the basic benefit package for either single or family coverage. You will be notified of your payment responsibilities prior to end of the 13 payperiods or when your Department processes the necessary paperwork for your personal leave. Employees on suspension for one or more pay-periods must contact the Employee Benefits Department to arrange for payment of benefits.

Family Leave Act Policy:

The County has a policy that conforms to the State and Federal Family Leave Acts. In some cases an employee may be eligible to take a family leave up to 12 weeks in a 12-month period with paid benefits for both single and family coverage during this 12-week period. Payment of benefit premiums will be the same as if you are at work. If you have a prorated deduction or pay a premium for family coverage while you are at work, you will be expected to continue those payments while on this type of leave in order maintain your coverage. The County will designate qualifying leaves of absence (paid or unpaid) as Family Leave. An employee may use family leave for their own illness or the illness of a qualified family member or for the birth or adoption of a child.

Eco Pass (Commuter) Program

What Is the Eco Pass (Commuter) Program?

The Eco Pass is a loaded "Clipper Card." The Eco Pass Clipper Card can be used for unlimited rides on the VTA bus or light rail systems; just remember to tag your card before boarding. All eligible County, Court and Housing Authority employees are provided with a Clipper Card. For questions or replacement cards, please email Aurora Rozo at ecopassprogram@esa.sccgov.org.

Eco Pass Clipper Cards are specifically assigned to each employee and allow unlimited rides on the VTA bus and light rail system as long as you are employed with the County of Santa Clara. Employees will no longer need to receive a new card on an annual basis. The same card will be used as long as you are part of the program. The County will not receive any specific information regarding employee utilization or travel. At the point you retire or leave employment with the County, your card will be deactivated but you can continue to use the card by loading personal funds to ride public transit. There is no need to return the card to the County.

The Eco Pass Clipper Card is not valid for free travel or discounts on any other transit system. However, additional fares from other agencies may be loaded on the same Clipper Card. The Clipper Card is an all-in-one transit card and is also accepted on AC Transit, BART, CalTrain, Muni and SamTrans. To use any of these transit agencies you can load personal funds in a number of ways. It is highly recommended that Clipper Cards with additional fare be registered at www.clippercard.com. In the event a registered Clipper Card is lost or stolen, the value of the additional fare loaded on the card will be replaced. If you have questions about coordinating your Eco Pass Clipper Card with other transit services, you can contact Clipper customer service by email at custserv@clippercard.com or by phone at (877) 878-8883 for more information.

How to Use the Eco Pass Clipper Card?

1. Locate the Clipper Card reader either at the front of the bus or on the light rail platform near the ticket vending machine.
2. Tag your card by touching the Clipper logo on the reader, making sure to hold the card flat long enough until a single beep is heard and a green light is displayed by the card reader. Forgetting to tag your card prior to boarding light rail could result in a fine.
3. After tagging your card please have it available to show a VTA fare inspector when asked. You must also carry your County identification when using the Clipper Card and present it if asked. Failure to not

carry your County identification when using your Clipper Card could result in a fine.

What Happens If My Eco Pass Clipper Card Is Lost or Stolen?

Lost or stolen Clipper Cards will be replaced for a \$25.00 first-time replacement fee (\$5.00 if stolen and a police report is provided) or \$50.00 for a second replacement. The Clipper Card will not be replaced if it is lost a third time. To receive a replacement, complete the Eco Pass Replacement Form and send it along with payment to Employee Benefits Department. If you lose your Clipper Card and do not want a replacement, you should still report any lost or stolen Clipper Cards to ecopassprogram@esa.sccgov.org to have the Eco Pass Clipper Card deactivated and prohibit unauthorized use.

What Is the Emergency Ride Home Program and How Does It Work?

Employees may obtain a voucher for a free taxi ride home should an illness, personal emergency or unplanned overtime event (approved by a supervisor) arise and the employee needs transportation home. The employee must have taken a VTA bus or Light Rail to work the same day the voucher is obtained. During normal business hours, contact your Departmental Employee Service Center to obtain a voucher (employees located at Berger Drive can pick up a voucher at the Information Services Department Reception Desk located on the 2nd floor of Building 2 at 1555 Berger Drive). After normal business hours, you may obtain a voucher from the Department of Corrections Main Jail information desk, 150 W. Hedding, (408) 299-8720 or from the Valley Medical Center Security Office, 751 S. Bascom Avenue, (408) 885-5567. After obtaining the voucher, the employee should call the Yellow Checker Cab Company at (408) 293-1234 for taxi service home, sign the voucher and leave it with the taxi driver

I Don't Plan to Use My Eco Pass Clipper Card. Can I Give It or Sell It to Someone Else?

The Eco Pass Clipper Card is non-transferable. Each pass has a unique number which is assigned and tracked to each employee. The Eco Pass Clipper Card can only be used by the employee to whom the card is issued. Anyone who alters, defaces, transfers or duplicates the Eco Pass Clipper Card with the intent to evade the payment of a fare is in violation of California Penal Code 640 and may be punishable by a fine of up to the maximum allowable by law, and may also be subject to disciplinary action. In addition, VTA may confiscate the Eco Pass and pursue claims and demands against, or seek prosecution of, anyone who duplicates, alters, or commits unauthorized use of the Eco Pass Clipper Card.

CUSTOMER SERVICE TELEPHONE NUMBERS

Delta Dental Plan – Group 1766 (www.deltadentalins.com/index.html)	(888) 335-8227
HealthNet Select Choice (www.healthnet.com/portal/home.do)	(800) 522-0088
I.C.M.A. (Deferred Compensation Plan) (www.icmarc.org/santa-clara.html)	
Local Representative – Rick Luerra	(800) 735-7202, ext. 4910
Local Representative – Ray Ortiz	(888) 883-8571
Kaiser Health Plan – Group 890 (www.kaiserpermanente.org)	(800) 464-4000
Liberty Dental Plan – Group 70001 (www.libertydentalplan/scc.com)	(888) 359-1088
Public Employees’ Retirement System (www.calpers.ca.gov)	(888) 225-7377
State Disability Insurance (www.edd.ca.gov)	(800) 480-3287
United Administrative Services	(408) 288-4400
Valley Health Plan – Group C, Policy A (www.valleyhealthplan.org)	(408) 885-4760
Vision Services Plan – Group 106067 (www.vsp.com)	(800) 877-7195
Clipper Customer Service Center (Clipper Card) ecopassprogram@esa.sccgov.org custserv@clippercard.com	(877) 878-8883

For questions regarding eligibility, enrollment or to obtain plan brochures, contact your Departmental Employee Service Center.

DEPARTMENTAL EMPLOYEE SERVICE CENTERS

<u>Department</u>	<u>Budget Unit</u>	<u>Phone Number</u>
Courts	220	(408) 882-2700
Dept. of Child Support Services	200	(408) 503-5318
District Attorney	202, 203	(408) 792-2686
ESA Employee Service Center	101, 102, 103, 104, 105, 106, 107, 110, 112, 114, 115, 117, 118, 120, 130, 132, 135, 140, 145, 148, 168, 190, 204, 210, 260, 261, 262, 263, 411, 9104, 9300	(408) 299-5880
Health & Hospital System	410, 412, 414, 417, 418, 725, 921	(408) 885-5450
Library	610	(408) 293-2326
Parks & Recreation	710	(408) 355-2214
Probation	246	(408) 468-1650
Roads & Airports	603, 608	(408) 573-2406
Sheriff and Custody Bureau	230, 235, 240, 293	(408) 808-4610
Social Services	501, 509	(408) 755-7130