WORKFORCEALLIANCE
OF THE NORTH BAY
DRIVING WORKFORCE TALENT

GOVERNING BOARD SPECIAL MEETING AGENDA

Friday, August 14, 2020
1:30 PM

WANB Administrative Office
1546 First Street, Second Floor, Napa
Call-in number: +1 669 900 9128, Meeting ID: 927 0356 4844
Password: 255233

CALL TO ORDER	
I.	A. Welcome, Introductions B. Public Comment C. Chair's Update – Damon Connolly
CONSENT CALENDAR	
These matters typically include routine financial or administrative action items requiring a vote. Any item will be discussed separately at the request of any person. Items are approved with one single motion.	
II.	A. None
REGULAR CALENDAR	
III.	A. Approval of Health Benefits Resolution and Heath Benefits MOU with the Special District Risk Management Authority (SDRMA) (Action) [Board letter III.A] [Attachment III.A] B. Approval of Workforce Alliance of the North Bay Employee Handbook (Action) [Board letter III.B] [Attachment III.B] C. Approval/Ratification of WANB agreements (Action) [Board letter III.C]
INFORMATION / DISCUSSION ITEMS	
IV.	A. Legislative Update on Workforce Development – Executive Director will provide update on legislative priorities in light of Covid – 19 economic recovery.
ADJOURN	
V.	A. Adjourn

WORKFORCEALLIANCE
OF THE NORTH BAY
DRIVING WORKFORCE TALENT

TO: GOVERNING BOARD

FROM: STAFF

SUBJECT: BOARD LETTER III.A – APPROVAL OF HEALTH BENEFITS RESOLUTION AND HEATH BENEFITS MOU WITH THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY (SDRMA)

DATE: AUGUST 14, 2020

CC: FILE

JPA staff solicits Workforce Alliance Governing Board approval to adopt the Special District Risk Management Authority (SDRMA) Health Benefits Memorandum of Understanding (MOU) and Health Benefits Resolution, pending approval of SDRMA underwriting. If adopted by this board, and approved by SDRMA underwriting, Workforce Alliance of the North Bay will be able to utilize SDRMA benefits for staff on the Workforce Alliance of the North Bay payroll.

These benefits include health insurance, dental insurance, vision insurance, long term disability insurance, life insurance, and an employee assistance program. The SDRMA benefits package are superior to the marketplace offerings and are comparable to the benefits negotiated for and provided by Napa County to its staff.

The proposed Health Benefits Resolution, Health Benefits MOU, and the SDRMA administrative guidelines are provided here as Attachment III.A. They are required documents in order to move forward with this benefits provider. If approved by your board today, benefits for staff on WANB payroll will take effect on October 1, 2020.

STAFF RECOMMENDATION

Staff recommends that the Governing Board adopts the Special District Risk Management Authority Health Benefits MOU and Health Benefits Resolution, pending approval of SDRMA underwriting to provide comprehensive and competitive benefits to its employees.

ATTACHMENT III.A

RESOLUTION NO. _____

A RESOLUTION OF THE (GOVERNING BODY) OF Workforce Alliance of the North Bay APPROVING THE FORM OF AND AUTHORIZING THE EXECUTION OF A MEMORANDUM OF UNDERSTANDING AND AUTHORIZING PARTICIPATION IN THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY'S HEALTH BENEFITS PROGRAM

WHEREAS, Workforce Alliance of the North Bay, a public agency duly organized and existing under and by virtue of the laws of the State of California (the "ENTITY"), has determined that it is in the best interest and to the advantage of the ENTITY to participate in the Health Benefits Program offered by Special District Risk Management Authority (the "Authority"); and

WHEREAS, the Authority was formed in 1986 in accordance with the provisions of California Government Code 6500 *et seq.,* for the purpose of providing risk financing, risk management programs and other coverage protection programs; and

WHEREAS, participation in Authority programs requires the ENTITY to execute and enter into a Memorandum of Understanding which states the purpose and participation requirements for the Health Benefits Program; and

WHEREAS, all acts, conditions and things required by the laws of the State of California to exist, to have happened and to have been performed precedent to and in connection with the consummation of the transactions authorized hereby do exist, have happened and have been performed in regular and due time, form and manner as required by law, and the ENTITY is now duly authorized and empowered, pursuant to each and every requirement of law, to consummate such transactions for the purpose, in the manner and upon the terms herein provided.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE ENTITY AS FOLLOWS:

Section 1. Findings. The ENTITY's Governing Body hereby specifically finds and determines that the actions authorized hereby relate to the public affairs of the ENTITY.

Section 2. Memorandum of Understanding. The Memorandum of Understanding, to be executed and entered into by and between the ENTITY and the Authority, in the form presented at this meeting and on file with the ENTITY's Secretary, is hereby approved. The ENTITY's Governing Body and/or Authorized Officers ("The Authorized Officers") are hereby authorized and directed, for and in the name and on behalf of the ENTITY, to execute and deliver to the Authority the Memorandum of Understanding.

Section 3. Program Participation. The ENTITY's Governing Body approves participating in the Special District Risk Management Authority's Health Benefits Program.

Section 4. Other Actions. The Authorized Officers of the ENTITY are each hereby authorized and directed to execute and deliver any and all documents which are necessary in order to

consummate the transactions authorized hereby and all such actions heretofore taken by such officers are hereby ratified, confirmed and approved.

Section 5. Effective Date. This resolution shall take effect immediately upon its passage.

PASSED AND ADOPTED this _____ day of _____, 20_____ by the following vote:

AYES: _____

NOES: _____

ABSENT: _____

_____
Name

_____
Title

_____
ENTITY Secretary

MEMORANDUM OF UNDERSTANDING

THIS MEMORANDUM OF UNDERSTANDING (HEREAFTER "MEMORANDUM") IS ENTERED INTO BY AND BETWEEN THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY (HEREAFTER "SDRMA") AND THE PARTICIPATING PUBLIC ENTITY (HEREAFTER "ENTITY") WHO IS SIGNATORY TO THIS MEMORANDUM.

WHEREAS, on August 1, 2006, SDRMA was appointed administrator for the purpose of enrolling small public entities into the Public Risk Innovation, Solutions and Management (PRISM) Health and/or Employee Benefits Small Group Program (hereinafter "PROGRAM"); and

WHEREAS, the terms and conditions of the PROGRAM as well as benefit coverage, rates, assessments, and premiums are governed by the PRISM Health Committee and/or PRISM Employee Benefits Committee for the PROGRAM (the "COMMITTEE") and not SDRMA; and

WHEREAS, ENTITY desires to enroll and participate in the PROGRAM.

NOW THEREFORE, SDRMA and ENTITY agree as follows:

1. PURPOSE**.** ENTITY is signatory to this MEMORANDUM for the express purpose of enrolling in the PROGRAM.

2. ENTRY INTO PROGRAM**.** ENTITY shall enroll in the PROGRAM by making application through SDRMA which shall be subject to approval by the PROGRAM's Underwriter and governing documents and in accordance with applicable eligibility guidelines.

3. MAINTENANCE OF EFFORT**.** PROGRAM is designed to provide an alternative health benefit solution to all participants of the ENTITY including active employees, retired employees (optional), dependents (optional) and public officials (optional). ENTITY public officials may participate in the PROGRAM only if they are currently being covered and their own ENTITY's enabling act, plans and policies allow it. ENTITY must contribute at least the minimum percentage required by the eligibility requirements

4. PREMIUMS. ENTITY understands that premiums and rates for the PROGRAM are set by the COMMITTEE. ENTITY will remit monthly premiums based upon rates established for each category of participants and the census of covered employees, public officials, dependents and retirees.

   Rates for the ENTITY and each category of participant will be determined by the COMMITTEE designated for the PROGRAM based upon advice from its consultants and/or a consulting Benefits Actuary and insurance carriers. In addition, SDRMA adds an administrative fee to premiums and rates for costs associated with administering the PROGRAM. Rates may vary depending upon factors including, but not limited to,

demographic characteristics, loss experience of all public entities participating in the PROGRAM and differences in benefits provided (plan design), if any.

SDRMA will administrate a billing to ENTITY each month, with payments due by the date specified by SDRMA. Payments received after the specified date will accrue penalties up to and including termination from the PROGRAM. Premiums are based on a full month, and there are no partial months or prorated premiums. Enrollment for mid-year qualifying events and termination of coverage will be made in accordance with the SDRMA Program Administrative Guidelines.

5. BENEFITS. Benefits provided to ENTITY participants shall be as set forth in ENTITY's Plan Summary for the PROGRAM and as agreed upon between the ENTITY and its recognized employee organizations as applicable. Not all plan offerings will be available to ENTITY, and plans requested by ENTITY must be submitted to PROGRAM underwriter for approval.

6. COVERAGE DOCUMENTS. Except as otherwise provided herein, coverage documents from each carrier outlining the coverage provided, including terms and conditions of coverage, are controlling with respect to the coverage of the PROGRAM and will be provided by SDRMA to each ENTITY. SDRMA will provide each ENTITY with additional documentation, defined as the SDRMA Program Administrative Guidelines which provide further details on administration of the PROGRAM.

7. PROGRAM FUNDING. It is the intent of this MEMORANDUM to provide for a fully funded PROGRAM by any or all of the following: pooling risk; purchasing individual stop loss coverage to protect the pool from large claims; and purchasing aggregate stop loss coverage.

8. ASSESSMENTS. Should the PROGRAM not be adequately funded for any reason, pro-rata assessments to the ENTITY may be utilized to ensure the approved funding level for applicable policy periods. Any assessments which are deemed necessary to ensure approved funding levels shall be made upon the determination and approval of the COMMITTEE in accordance with the following:

   a. Assessments/dividends will be used sparingly. Generally, any over/under funding will be factored into renewal rates.

   b. If a dividend/assessment is declared, allocation will be based upon each ENTITY's proportional share of total premiums paid for the preceding 3 years. An ENTITY must be a current participant to receive a dividend, except upon termination of the PROGRAM and distribution of assets.

c. ENTITY will be liable for assessments for 12 months following withdrawal from the PROGRAM.

d. Fund equity will be evaluated on a total PROGRAM-wide basis as opposed to each year standing on its own.

9. WITHDRAWAL. ENTITY may withdraw subject to the following condition: ENTITY shall notify SDRMA and the PROGRAM in writing of its intent to withdraw at least 90 days prior to their requested withdrawal date. ENTITY may rescind its notice of intent to withdraw. Once ENTITY withdraws from the PROGRAM, there is a 3-year waiting period to come back into the PROGRAM, and the ENTITY will be subject to underwriting approval again.

10. LIAISON WITH SDRMA. Each ENTITY shall maintain staff to act as liaison with SDRMA and between the ENTITY and SDRMA's designated PROGRAM representative.

11. GOVERNING LAW. This MEMORANDUM shall be governed in accordance with the laws of the State of California.

12. VENUE. Venue for any dispute or enforcement shall be in Sacramento, California.

13. ATTORNEY FEES. The prevailing party in any dispute shall be entitled to an award of reasonable attorney fees.

14. COMPLETE AGREEMENT. This MEMORANDUM together with the related PROGRAM documents constitutes the full and complete agreement of the ENTITY.

15. SEVERABILITY. Should any provision of this MEMORANDUM be judicially determined to be void or unenforceable, such determination shall not affect any remaining provision.

16. AMENDMENT OF MEMORANDUM. This MEMORANDUM may be amended by the SDRMA Board of Directors and such amendments are subject to approval of ENTITY's designated representative, or alternate, who shall have authority to execute this MEMORANDUM. Any ENTITY who fails or refuses to execute an amendment to this MEMORANDUM shall be deemed to have withdrawn from the PROGRAM on the next annual renewal date.

17. EFFECTIVE DATE. This MEMORANDUM shall become effective on the later of the first date of coverage for the ENTITY or the date of signing of this MEMORANDUM by the Chief Executive Officer or Board President of SDRMA.

18. EXECUTION IN COUNTERPARTS. This MEMORANDUM may be executed in several counterparts, each of which shall be an original, all of which shall constitute but one and the same instrument.

In Witness Whereof, the undersigned have executed the MEMORANDUM as of the date set forth below.

Dated: _____ By: _____

Special District Risk
Management Authority

Dated: _____ By: _____

Workforce Alliance of the North Bay

Special District Risk Management Authority (SDRMA) Health Benefits Administrative Guidelines

We are public employees. Just like you.

Special District Risk Management Authority, referenced as SDRMA in this document, is a public agency formed under California Government Code Section 6500 et seq. and provides a full-service risk management program for California's local governments.

SDRMA was established in 1986 to provide risk financing and risk management services through a financially sound pool to California public agencies, delivered in a timely and responsible cost-efficient manner. Our combined membership totals over 660 individual public agencies throughout California.

In 2006, SDRMA became the administrator for the small group program under the CSAC Excess Insurance Authority (EIA) employee benefits pools. SDRMA's Employee Benefits Small Group Program provides health benefits to agencies that have 2 to 200 full time employees for Medical and 2 to50 full time employees for Ancillary coverages. SDRMA currently has over 140 agencies participating in the employee benefits small group program and offers Medical, Dental, Vision, Basic Life and AD&D, Long Term Disability and Employee Assistance Program.

Contents

Purpose

The purpose of the SDRMA Administrative Guidelines is to provide clear, consistent, and effective guidance to agencies and service providers participating in the Employee Benefits Small Group Program. This guidance seeks to educate agencies on administrative processes as structured by the Program. The intent is to preserve the integrity of the Program and each of its participating agencies benefit plans as well as to protect the rights of covered employees, retirees and their dependents. These guidelines may be amended from time to time to comply with new legislation, updated procedures and applicable regulations.

Any reference to "Agency/Agencies" or "Employer/Employers" in this document is meant to include any publicly funded organization that falls under the category of County, City or Special District and that is a participating agency of the Employee Benefits Small Group Program under SDRMA. It may include any other agency that falls outside of the aforementioned categories if underwriting has approved the employer group to join the Small Group program under SDRMA.

The Employee Benefits Small Group program through SDRMA does not extend coverage to Educational Organizations. Organizations that are not Publicly Funded are not eligible to join the Small Group Program through SDRMA.

Contracts

There is a Memorandum of Understanding (MOU), Resolution, and Program Participation Agreement that must be approved and signed to join the Employee Benefits Small Group Program after the agency has been approved by underwriting. These contracts cannot be amended/customized by the agency. SDRMA must receive originals of the MOU and Resolution from the entity. SDRMA must also receive a copy of the Program Participation Agreement.

As outlined in SDRMA's MOU under Amendment of Memorandum, if SDRMA's MOU is amended by the SDRMA Board of Directors such amendments are subject to approval of agency's designated representative or alternate. SDRMA will send an updated MOU to each participating agency requesting approval of the updated MOU along with an updated Resolution.
Please send the signed original MOU and Resolution to:

Special District Risk Management Authority
Attention: Alana Little – Health Benefits Manager
1112 I Street, Suite 300
Sacramento, California 95814

Program Eligibility

Participating Agencies are responsible for verifying all enrollees are qualified to enroll in the Employee Benefits Small Group Program. This includes verification of qualified dependents. They are also responsible for managing mid-year changes including terminations to ensure changes meet the IRS guidelines.

Below is an outline of who is considered a qualified applicant for the benefits of the program. Each agency may have additional rules that would narrow who is allowed to enroll, but the agency may not extend coverage beyond what is allowed without SDRMA's consent.

- Example 1: If an agency would like to extend coverage to grandchildren, the proposed coverage would need to be reviewed by the CSAC-EIA for consent since grandchildren are not considered as a qualified dependent.
- Example 2: If an agency decided it wants to exclude coverage to spouses, the agency has full right to deny coverage, as the agency's action doesn't exceed what is allowed under the Employee Benefits Small Group Program parameters.

Qualified Subscribers

Qualified subscribers are defined as:

1. Full-time salaried or hourly employees who are actively at work at least 30 hours per week. Employee of the agency must meet the eligibility requirements within the agency's guidelines set for employees.
2. A Part-time employee who is working a minimum of 20 or more hours per week.
3. Agencies with 50 or more Full-time employees that offer medical coverage Variable Hour, Temporary, Seasonal, and others who become eligible based on the Affordable Care Act (ACA) Look-back Measurement/Stability Period.
4. COBRA Participants Eligible to elect coverage through COBRA.
5. A retiree who meets the eligibility requirements set by the agency for retiree benefits (pre and post Medicare) would include the retiree spouse/domestic partner and eligible dependents. To qualify for SDRMA Medicare plans and rates, retiree must be enrolled in Medicare Parts A&B and cannot be actively working.
6. If you are a new agency with SDRMA, retired employees who are currently eligible and participating on the plan will be eligible to continue coverage under the program, if the coverage permits. Retirees who declined coverage may not enroll in any coverage at a subsequent enrollment date.

   Note: if the retiree continues coverage and at open enrollment decides to drop his dependents, the retiree has the same rights as an active employee to add the dependents back on in a future open enrollment or a mid-year life qualifying event that would allow the addition. Adversely, the same does not hold true for the retiree who terminates their coverage: They and their dependents will not have opportunity to re-join the program and

will no longer be a qualified subscriber.

7. A surviving Spouse of an employee or retiree who can continue lifetime coverage as a subscriber.

   Spouse in this circumstance should be enrolled under the Early Retiree or the Medicare plan since they are not an active employee. This definition does not refer to situations where COBRA is offered to surviving spouses – instead, this is extended coverage with no termination date defined.
8. Board Members, Trustees, Council Members, or Other Elected Officials can only elect a plan if they are eligible on the coverage that was offered prior to the agency joining SDRMA and are subject to the same requirements as Active employees. Exceptions can be made with approval from underwriting.

Qualified Dependents (To age 26)

Qualified Dependents are defined as:

1. Natural Child(ren)
2. Adopted Child(ren)
3. Stepchild(ren)
4. Court-Ordered Dependent (Legal Guardian)
5. Child(ren) of a California State Registered Domestic Partner
6. Other Qualified Dependent(s) of a Registered Domestic Partner
7. Spouse
8. Registered Domestic Partner*
9. Disabled Dependents
10. Others not included above that are claimed for tax purposes, must be approved by CSAC-EIA.

Overage-Dependent: When a dependent turns 26, they are considered an over-age dependent. Over-age dependents will be automatically termed off the respective participant plan the first of the month following their birth month.

Disabled Dependents do not have to go through medical review until age 26. Once they are age 26, annual medical review is required. There is no coverage age limit for medically approved disabled dependents.

*Domestic Partners: The Small Group Program will allow coverage under both the **standard version** and **extended version** of the law. The California Family Code **standard version** defines a domestic partnership as: 1) two adults of the same sex who have chosen to share one another's lives in an intimate and committed relationship of mutual caring; or 2) two equally committed adults of the opposite sex **if** one or both partners **are over age 62** and one or both partners meet specified eligibility criteria under the Social Security Act. The **extended version** of the law extends coverage to those individuals who are in a domestic partnership and their qualified dependents and who meet the eligibility criteria under the Social Security act **regardless of age or gender**.

Unless your agency follows the extended version of the California Family Code, Domestic Partners must be California State Registered Domestic Partners, or for opposite sex partners under age 62, a Domestic Partnership Agreement is needed proving partnership. (A Domestic Partnership Agreement is a legal agreement outlining the legal and financial details of the relationship.) If your agency follows the extended version of the California Family code, SDRMA can provide a template of the Domestic Partnership Agreement that must be notarized. Please note that Domestic Partners who enter into a Domestic Partnership Agreement can only enroll in coverage when an employee is newly hired and enrolling in coverage for the first time or during Open Enrollment. Outside of Open Enrollment, if a Domestic Partnership Agreement is no longer in effect and the Domestic Partners have separated, the employee must notify the agency within 31 days of the Domestic Partnership Agreement termination and the agency must notify SDRMA within 31 days of the Agreement termination.

Non-Qualified Dependents fall outside of the definitions above. Common examples of Non-Qualified Dependents are listed below:

1. Grandchild(ren)
2. Parent(s)
3. Grandparent(s)
4. Niece/Nephew
5. Foster child(ren) – Non-Qualified as they are covered by the State Government
6. Legally Separated Spouse/Domestic Partner
7. Divorced Spouse (including those who are required to cover their spouse based on a court order. The liability is not on the agency or the program, the participant must find a plan outside of the group plan to cover the ex-spouse).
8. Financial Dependents that are not court ordered

Documentation to Qualify Dependents:

Dependent Type	Verification Documents
Spouse	– Prior year's Federal Tax Form that shows the couple was married (financial information may be blocked out) – Marriage Certificate for newly married couple where tax return is not available
Domestic Partner	– Certificate of Registered Domestic Partnership issued by State of California – Affidavit of Domestic Partnership Agreement (when applicable)
Children, Stepchildren, and/or Adopted Children up to age 26	– Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) o State Birth Certificates may take 4 to 8 weeks to be received, a Hospital Birth announcement/certificate can be used as proof for enrollment. o Participant may need additional time to provide legal birth certificates due to extenuating circumstances, which is acceptable by SDRMA's Employee Benefits Small Group Program. – Legal Adoption Documentation
Legal Guardianship up to age 18	– Legal Court Documentation establishing Guardianship
Disabled Dependents over age 26 (documentation not needed for children under age 26)	– Legal Birth Certificate or Hospital Birth Certificate (to include full name of child, parent(s) name & child's DOB) - If newly being added to the plan. Prior year's Federal Tax Form that shows child is claimed as an IRS dependent (income information may be blocked out) - If newly being added to the plan. – Completed Disabled Dependent Certification Form completed and submitted to the Medical Carrier for approval to add/continue coverage

Mid-Year Qualifying Events

What is a mid-year election change?

Under the section 125 rules, an employee can make an election change when they experience a "change in status," which includes events such as marriage, birth of a child, change in employment status, dependents aging out of the plan, HIPAA special enrollment events, and residence change. In addition, section 125 allows election changes under a host of other circumstances, including cost and coverage changes, entitlement to Medicare or Medicaid, and change in coverage under another employer plan. The change the employee wants to make must be consistent with the event that occurred that gives rise to the change.

Employers must furnish a notice of special enrollment rights to eligible employees at or before the time they are first offered the opportunity to enroll. The special enrollment notice may be provided by including it in the employer's written application materials that are distributed to eligible employees before enrollment. Even if the employer does not distribute written application materials, the special enrollment notice must be distributed at or before enrollment. SDRMA provides the special enrollment rights with Open Enrollment materials each year and with additional documentation for agencies that are new to SDRMA. The document is provided in PDF format and is titled *Annual Notices.*

What is a Section 125 Cafeteria plan?

A cafeteria plan is a separate written plan maintained by an employer for employees which meets the specific requirements and regulations of section 125 of the Internal Revenue Code.
These IRS requirements provide participants an opportunity to receive certain benefits on a pretax basis. The written plan must specifically describe all benefits and establish rules for eligibility and elections.
When an individual elects pre-tax insurance coverage (also known as Section 125 cafeteria plan benefits), they are afforded one opportunity each plan year to make their election for the coming plan year. This has been most commonly known as Open Enrollment. Outside of this time period, individuals are prohibited from making any alterations to their election, including adding, dropping or changing coverage. However, there may be an opportunity for an individual to make a change if they experience a special enrollment event (or a qualifying event) that would allow the individual to make the mid-year election change. Different qualifying events afford different opportunities for the election change. Alliant, CSAC-EIA's broker for the pool compliance team, has provided a grid that identifies these differences. SDRMA will provide a copy of the most up to date compliance document with Open Enrollment materials.
In order to provide pre-tax benefits to employees, the IRS has established rules by which the benefits are to be offered, which includes election periods and eligibility.
One area of concern is a change within the course of a plan year that do not coincide with a qualified mid-year election change. (Example, dropping coverage for an individual without a coinciding qualified mid-year election change event.) If employers making these changes without a qualified event, they risk taxation issues if audited. By continuing to allow changes without a qualified event, it could jeopardize the pre-tax benefit requiring the coverage to be offered post tax.

Mid-Year Qualifying Events refers to both the addition and termination of employee and dependent coverages.

Under the Employee Benefits Small Group Program through SDRMA, all plan changes resulting from Mid-Year Qualifying Events will be effective on the first of the month following the event. Birth and death are exceptions, and coverage may be added/dropped outside of the first of the month following timeframe.

All Mid-Year Qualifying Events will follow HIPAA guidelines, which allow employees up to 31 days to report the event to their employer. If the change was not reported timely, the agency will be required to wait until the next open enrollment period to make the change. (Exceptions to terminate due to death are made.)

Mid-year qualifying events do require proper documentation to make the change. Please refer to the documentation table from the previous pages for adding a dependent. Below is a short list of what would be needed for the most common mid-year events:

- For Marriage, a marriage certificate
- Divorce, legal separation – court documents
- Loss of other group coverage – loss of coverage notice
- Medicare eligibility – Medicare notice
- For death – a death certificate
- Change in residence impacting plan eligibility – verification of new address
- Judgements or decree by court – Court documents

This list is not exhaustive. For all other qualifying events, please refer to the Mid-Year Election Cheat sheet document that is provided with Open Enrollment materials and with additional documentation for agencies that are new to SDRMA.

Submitting Enrollments/Changes for Health Benefits

For new hire enrollments, retiree enrollments, or mid-year changes such as adding a newborn to coverage, marriage, loss of other group coverage, terminations, or address change, please have the participant complete an SDRMA medical benefits participant enrollment form and/or SDRMA ancillary coverage participant enrollment form (depending on the lines of coverage your agency offers through SDRMA). If the change request requires supporting documentation (please refer to Mid-Year Qualifying Events Section), please send the enrollment form and the supporting documentation to SDRMA via fax at 916.231.4113. SDRMA will contact your agency if there are any questions regarding the request.

Adding individuals Retroactively (other than COBRA):

- An agency may add an individual within 31 days of the effective date of change.

- If the requested add beyond 31 to 90 days from the effective date, the request will require CSAC-EIA staff approval before processing. Requests over 90 days will be reviewed by CSAC-EIA staff.

Retroactivity for COBRA

COBRA Federal guidelines will always be followed without exception. If any group does not have the COBRA guidelines, they may contact SDRMA to receive a soft copy of the manual. The Program makes available COBRA administrative services for all SDRMA Small Group Program agencies.

Rescission

Section 2712 of the Public Health Service Act (the "Act"), as added by the Affordable Care Act ("ACA"), generally prohibits group health plans and health insurance issuers offering group insurance coverage from rescinding coverage. In an effort to improve efficiency and uniform administration, retroactive changes to plan coverage will be permitted only as set forth in this document. The plan's ability to terminate coverage retroactively ("rescind" coverage) is limited by the Affordable Care Act (ACA) and in most cases is not permitted.

Effective 1-1-2020, the plan will not allow retroactive terminations outside of the circumstances outlined in this document.

To support this effort, please be sure to monitor invoices and audit coverage on a monthly basis and submit all changes prior to the 25th of each month.

Rescission Definition

"Rescission" is a cancellation or discontinuance of coverage that has a retroactive effect.

The following circumstances are allowed and not considered rescission if termed retroactively:

1. Termination or cancellation of coverage that is prospective (e.g., happens at a future date).

2. Termination or cancellation of coverage that is effective retroactively because of a failure to timely pay required premiums or contributions (including COBRA premiums) toward the cost of coverage.

3. Termination or cancellation of coverage due to fraud or intentional misrepresentation of material fact, as permitted by the plan and with at least 30 days' advance written notice to each participant who would be affected.

4. The termination or cancellation of coverage is initiated by the individual and the

employer/plan sponsor does not, directly or indirectly, take action to influence the individual's decision or otherwise take any adverse action to retaliate against, interfere with, coerce, intimidate, or threaten the individual. Termination request must still fall within the parameters provided to members to notify employers of qualifying life event.

Example of Permissible Retroactive Terminations:

- Retroactive termination "in the normal course of business" when the employee pays no premiums. This is an accommodation for the common practice of employers/plans reconciling eligibility lists only once per month. Therefore, if a plan only covers active employees (except as required by COBRA) and an employee pays no premiums for coverage after termination of employment, the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative recordkeeping, will not be considered a rescission. Please see Exhibit 2 table for parameters to notify JPA.

Examples of Impermissible Rescissions:

- Retroactive termination that doesn't fall within the above categories: A school teacher is employed on a teaching contract from August 1 to May 31. Coverage through the employer is provided for the entire plan year, August 1 to July 31, and the full premium is paid during that period. A teacher resigns on July 31. The plan may not terminate the teacher's coverage back to May 31 (absent some other reason like fraud) but may terminate coverage prospectively.

- Plan errors: An employer sponsors a plan for full-time employees (30 hours/week). An employee has coverage under the plan as a full-time employee but is reassigned to a part-time role and no longer eligible for coverage. The plan mistakenly continues his coverage, with the employee paying premiums and the plan paying claims. During a routine audit, the plan discovers that the employee no longer works 30 hours a week. The plan cannot rescind coverage to the date the employee changed from full-time to part-time. The plan can terminate coverage prospectively.

Rescission Summary and Recommended Action:

A plan's ability to terminate coverage retroactively is limited by the ACA. To ensure compliance with ACA rules, the plan limits the circumstances when retroactive terminations will be allowed.
To preserve the right to terminate coverage retroactively on the basis of fraud or intentional misrepresentation, the plan must reserve that right in its Summary Plan Description (and other employee communications), and the employer must provide 30 days' advance written notice of its intent to rescind coverage. In general, the employer should be extremely cautious that it has sufficient evidence of fraud before rescinding coverage and should reserve that course of action only when there is clear evidence that the employee's action was intentional and not inadvertent.

The table below has been provided to assist in understanding the timelines to report terminations of coverage to SDRMA. If timelines are not met, either the member will have a future termination date, or may be denied requiring the member to wait until next open enrollment to terminate

coverage. Both instances will require premium payments through the end of coverage.

Exhibit 2 Rescission Table-Employer Driven Termination Requests

Date of Event	Date Term Request Must be Submitted to SDRMA	Benefit Termination Effective Date	Benefit Termination Effective Date
	Last date to submit request	**If submitted prior to the 25th**	***For late submissions (after the 25th)**
January 1-31	February 25	February 1	FOFM from submission
February 1-29	March 25	March 1	FOFM from submission
March 1-31	April 25	April 1	FOFM from submission
April 1-30	May 25	May 1	FOFM from submission
May 1-31	June 25	June 1	FOFM from submission
June 1-30	July 25	July 1	FOFM from submission
July 1-31	August 25	August 1	FOFM from submission
August 1-31	September 25	September 1	FOFM from submission
September 1-30	October 25	October 1	FOFM from submission
October 1-31	November 25	November 1	FOFM from submission
November 1-30	December 25	December 1	FOFM from submission
December 1-31	January 25	January 1	FOFM from submission

(FOFM – First of the Following Month)

*All terminations will be prospective (future date) after the required submission date.

Employee Driven Mid-Year Qualifying Event Termination Requests

Employees timeline to notify employer varies on life event. See mid-year changes guidelines for details	Action allowed	Employer to submit change to SDRMA	Effective date of change
If notification is within 31 days of event	Allow change if event allows	within 10 days of notification from employee	FOFM from qualifying life event
If notification within 60 days of event (if allowed by event type)	Allow change if event allows	within 10 days of notification from employee	FOFM from qualifying life event
Untimely notice by Employee	No Change	within 10 days of notification from employee	Next open enrollment or other qualifying life event
*Untimely notice by Employer	Change prospectively	Immediately	FOFM from notification to SDRMA
Untimely notice but for a dependent who no longer qualifies for the plan	Change prospectively	within 10 days of notification from employee	FOFM from notification to SDRMA

(FOFM – First of the Following Month)
*Handling of premiums needs to be coordinated between employer and employee

Note: All terminations must fall in line with a qualifying event; otherwise, members will need to pay for benefits through the plan year. If a termination request is not in line with a qualifying event, the employee and employer must submit the request for termination at open enrollment to ensure it is processed for the end of the year.

Premiums:

- If claims were submitted during the period that the ineligible member was on the plan and accessing care, the employer may require the employee or retiree to pay either the total amount of claims back to the employer or the added premium cost for the misrepresentation.
- Payments for any services and/or pharmaceutical claims incurred cannot be recouped.
- SDRMA will not return premiums to the employer.

COBRA

Federal Cobra is available to Medical, Dental and Vision plans. SDRMA's third party administrator, Businessolver, administers COBRA coverage. When SDRMA is notified by the employer of a participant and/or dependent termination for Medical, Dental and/or Vision coverage, Businessolver will send a COBRA packet to the termed participant and/or dependent with information on how to enroll in COBRA along with payment information.

For self-funded plans, federal COBRA is all that is offered. Cal COBRA is not available except for fully insured plans such as Medical HMO.

SDRMA provides monthly COBRA reports to agencies via email if they have participants that have been terminated from active medical, dental or vision coverage in the last 31 days and been notified of the COBRA enrollment option, participants that are currently enrolled in COBRA and participants within the last 31 days that have terminated their COBRA enrollment.

Waivers

Eligible employees must show proof of other **group** coverage in order to waive Medical/ Prescription Drug coverage. The Medi-Cal Government Plan may be considered other group coverage due to the financial burden that accepting the employer coverage may put on the participant. Otherwise individual plans, including the California Market Place benefits are not considered other group coverage and would not be a qualified benefit plan to waive employer group coverage.

Retirees may waive coverage without proof of other group coverage; however, as a reminder, they are not permitted to return to the plan once they have waived coverage.

Dependents cannot be added mid-year without a qualifying event. Loss of coverage for a dependent is allowed as a qualifying event if the coverage was group coverage as noted above for the employee. Loss of individual coverage is not considered a qualifying event for a mid-year add. Otherwise dependents can only be added during the annual enrollment period.

Open Enrollment Timeline

SDRMA Open Enrollment is October 1 - October 31 each year. Below is a timeline of Renewal and Open Enrollment

Medical and Ancillary Renewal and Plan Changes timeline	
May	CSAC-EIA Health and Employee Benefits Renewal approved by CSAC-EIA Committee
July	SDRMA receives finalized rates from broker SDRMA sends updated Health Benefits brochure that includes rates via email to participating agencies
August	• Participating Agencies automatically renew, unless agency informs SDRMA with a 90-day withdrawal notice as outlined in SDRMA MOU. If an agency wants to make a plan change the deadline to changes is **August 15th** and must be submitted to SDRMA in writing • Late plan changes received from agencies after August 15th will delay open enrollment for the agency • No plan changes will be accepted after **September 1st** Businessolver and Carriers begin to prepare systems with plan updates and rates
September	Open enrollment materials developed and sent to participating agencies via email
October	– **Open Enrollment for SDRMA participating agencies will be held from October 1-31. Participant enrollments will rollover to the next calendar year unless an Open Enrollment change is submitted by the employer to SDRMA. All changes must be submitted to SDRMA by the end of business day on October 31st**
November	minute 1st-7th SDRMA completes entry of requested Open Enrollment changes in Businessolver platform **8th – 30th** Businessolver creates test file and begins testing files with carriers
December	1st - New plan year files are sent to all carrier**8th-15th** – If applicable based on Open Enrollment change submitted ID cards are triggered and mailed to participants to be received before January 1 1st-8th Discrepancy reports are analyzed by Businessolver and carriers. Enrollment is then finalized 9th-15th ID cards are triggered and produced 20th-31st ID cards are mailed to participants
January	**1st –** SDRMA Plans are active and ready for participants access care

New Group Implementation Timelines:

New agencies joining SDRMA may enter upon the first of any month. The Medical, Dental and Vision program renews on January 1 of each year. Basic Life and AD&D, Long Term Disability and Employee Assistance Program renews on July 1 of each year.

- If an agency joins SDRMA after January 1 for Medical, Dental and Vision, renewal of coverage and rates will occur on the following January 1 in order to become aligned with the SDRMA program cycle.
- If an agency joins SDRMA after July 1 for Basic Life and AD&D, Long Term Disability and Employee Assistance Program, renewal of coverage and rates will occur on the following July 1 in order to become aligned with the SDRMA program cycle.

For SDRMA to setup a new agency under the SDRMA program, SDRMA must receive an executed MOU and Resolution 45 days prior to the agency's requested effective date. Timeframes outside of this may be unfavorable to the outcome.

Below is the preferred timeline for implementations effective January 1st:

SDRMA Small Group Program

Date	***Activity***
August 1 – August 15	Agency sends to SDRMA underwriting documents and SDRMA submits request to underwriting for approval. *Underwriting process takes usually 2 weeks Agency approved by underwriting. SDRMA sends approval email to agency along with enrollment form, MOU and Resolution that needs to be completed/executed by agency. The agency confirms they are joining the SDRMA Program Agency sends via email and hard copy originals executed MOU and Resolution SDRMA informs TPA, Businessolver to setup new group in system SDRMA sends additional documentation to agency pertaining to the plans and coverages they are enrolling in • Businessolver and Carriers prepare systems for open enrollment (45-day timeframe needed prior to Open Enrollment)
October 1 - October 31	**OPEN ENROLLMENT (OE)** Enrollment forms or for agencies with over 20 lives submit excel workbook of new enrollments

November 1 - November 7	SDRMA enters new enrollments in Businessolver system. If agency is over 20 lives SDRMA will request Businessolver to uploaded enrollments to Businessolver system SDRMA sends enrollment report to agency for final agency verification of enrollment within TPA system
November 8 - November 30	Businessolver creates Open Enrollment files and preforms file testing with the Carriers
December 1	**All files are sent to Carriers** (medical and pharmacy)
December 1 - December 8	Discrepancy reports are analyzed by Businessolver and carriers. Enrollment is then finalized
December 9 – December 15	ID Cards are triggered and produced
December 20 - December 31	ID cards are mailed to participants
January 1	Plans are effective – participants can access care

Reporting

Medical:
As with almost all Joint Powers Authority (JPA) Programs, individual or detailed employer claims data is not available.

CSAC-EIA provides SDRMA with a detailed medical utilization report annually. The report is designed to supply SDRMA with useful and actionable data to make informed decisions regarding plan design, cost containment, and wellness efforts. SDRMA reviews the medical utilization report annually and will notify agencies if there have been any plan design changes when rate information is sent in July.

Affordable Care Act (ACA) Employer Reporting

All SDRMA's medical benefits plans follow Affordable Care Act (ACA) guidelines. Throughout the year SDRMA will provide from their broker, Alliant Insurance Services Compliance Alerts pertaining to the ACA. In addition, SDRMA provides to each agency in late January of each year 1095B forms for each participant that was enrolled in a Self-Funded medical plan during the calendar year that is being reported. For Fully Insured plans that include Blue Shield HMO and Kaiser HMO plans, participants enrolled in these plans will receive a 1095B form direct from the carrier, and SDRMA will not send the agency a 1095B form for that participant.

For agencies that have less than 50 Full-Time employees, SDRMA's TPA Businessolver for Self-Funded plans will transmit 1095B and 1094B data to the IRS on behalf of your agency. SDRMA will inform your agency via email if your data was accepted by the IRS or if the IRS rejected any data that was transmitted. SDRMA will reach out to your agency either stating your data was accepted by the IRS or if there was a discrepancy with your agency's data SDRMA will inform your agency of additional information needed.

For agencies that have less than 50 Full-Time employees but offer Fully Insured plan(s) the carrier (Blue Shield or Kaiser) will transmit 1095B data to the IRS on behalf of your agency for each participant enrolled in the Fully Insured plan(s).

For agencies that have more than 50 Full-Time employees SDRMA will not transmit any data to the IRS for the 1095B or 1094B data because as an agency that has 50 or more Full-Time employees you must complete and submit to the IRS 1095C and 1094C data. If your agency would like a vendor for transmitting 1095C and 1094C data to the IRS SDRMA's TPA Businessolver can be contracted with directly. Please contact SDRMA for Businessolver contact information.

Things to know about how the program is set up

Medical:

- If your agency chooses a High Deductible Health Plan, HSA vendors are not automatically chosen and set up for the agency. The agency may use a bank of their choice or may use the Carrier preferred HSA bank. Related service fees will be billed and paid separately by the agency. These fees are not included in the medical rates provided in the SDRMA Health Benefits brochure.

- Federal COBRA is offered through the SDRMA medical plans; however, Cal COBRA is not offered through SDRMA medical plans or by the Carriers (exception for fully insured HMO plans). Participants will need to take an individual plan after Federal COBRA is exhausted.

- Actively working Medicare eligible employees will remain enrolled in the active plan until they retire. The family unit must remain together under the active plan while the Medicare active employee remains working. This would include any dependent that obtains Medicare as well.

- For actively working Medicare Aged employees: The employee should advise Medicare that they are on an active plan and show proof of coverage to avoid any Medicare late enrollment fees into the Part B benefit. Medicare will add the eligible employee on the Part A benefit of Medicare. Medicare will be a secondary payer to the active plan. Employee does not need to pay for Part B while on the active plan and can waive that benefit until they move to the retiree plan.

Out-of-Network Emergency Claims

- For two tiered PPO plans, if a claim is determined to be a non-emergency out-of-network claim, the plan will pay per the out-of-network coverage specified by the agency's applicable plan document. If a non-emergency out-of-network claim occurs under an EPO plan (one tiered PPO plan) with no-out of network coverage, the claim will be denied, and the patient will be responsible for payment.

Pharmacy

- The Pharmacy ID Card is a separate card from the Medical ID card for all plans except High Deductible, Anthem HMO and all Kaiser Plans. PPO, EPO Blue Shield HMO medical cards will display as *No Pharmacy* because pharmacy coverage is carved out to Express Scripts.

- Express Scripts uses Accredo Health Group for their specialty drugs. Specialty drugs are dispensed in 30-day supply or less only. All specialty drugs must go through Accredo to be covered.

- Participants using Mail Order will need to request a new prescription for mail order prescriptions. (*Encouraged to request a 90-day supply with four retail refill allowance).*

- Mail order- if the medication is a new prescription and is a high cost medication, a 90-day supply may not be given initially and will charge participants only 30-day supply.

- There will be separate Pharmacy out of pocket maximum from the Medical plan. The combined total of the separate out of pocket maximums will follow ACA rules. Please refer to the SDRMA Health Benefits brochure for Pharmacy out of pocket maximums.

- Pharmacy Benefits for Medicare Retirees through an Employer Group Waiver Program (EGWP) [also known as; PDP or Medicare Part D] will follow the formulary based on CMS guidelines. SDRMA only has one EGWP plan design. There can be no variation from this plan design. Please request a copy of the SDRMA EGWP plan design if this benefit is being offered.

- Participants cannot decline the pharmacy benefit. Enrollment in the medical plan will trigger an automatic enrollment into the Pharmacy benefit.

- We are unable to accommodate Pharmacy coordination of benefits.

- There are various programs that the CSAC-EIA has purchased that are part of the benefit and savings programs. Some of these programs are: Preferred Generic Program, Smart 90 Incentive and Pharmacy Management programs).

- Pharmacy management programs are put into place to help manage cost for the program ultimately resulting in annual savings on premiums. The following section covers more information about each of these programs.

  Clinical Management Package:
  The purpose of this program is to allow the Pharmacy Benefit Manager (PBM) to monitor and maintain costs based on the Class of Medications rather than by name brands. Classes of medications are identified by the condition the drug is designed to treat. Consequently, monitoring based on the class of the Medication provides the ability to address the changes in pricing and newly developed therapies immediately. This enables the PBM to manage cost continually without being limited by a brand name to manage the program. It also allows the

experts in pharmaceuticals, i.e., the clinicians, to identify that the right drugs are being provided to the right patient, in the right amount for the condition that is being addressed. Programs benefit the patient by protecting them in physical and financial health. The management includes Prior Authorization, Step Therapy, and Quantity Management. SDRMA can provide an FAQ on each of these programs if interested.

Preferred Generic Program:
If a brand medication has come off patent and a generic equivalent has been created the brand is considered a "**Multi-Source Drug**". Under the Preferred Generic program, the generic equivalent will automatically be dispensed at the pharmacy when a multi-source brand drug is scripted. If the multi-source brand is dispensed instead of the generic, the member may have to pay the difference between the brand and the generic plus the generic co-pay. The name "**Generic**" would seemingly presume to be a lesser quality drug, but generic medications are equivalent to brand name medications. Each has the same active ingredient and the same effectiveness. The differences between a brand drug and a generic drug are the price, the name and the inactive ingredients. Most often generics are more reasonably priced which helps mitigate costs.

Smart 90 Incentive:
The Smart 90 Program permits patients to pick up a 90-day supply of their maintenance medication at a local Walgreens or CVS. This does not take away the ability to receive a 90-day supply from the Express Scripts Mail order program. This program is not available for some drugs due to quantity limits. This program is only for maintenance drugs. The Smart 90 Program is designed to increase the access points for patients to receive their maintenance drugs in a 90-day supply. Patients taking a maintenance drug may fill a 30-day supply for the first 3 fills. After the 3rd fill the patient will need to purchase their script at CVS, Walgreens or through Mail order. Otherwise patients will pay the mail order co-pay but only receive the 30-day supply. This program helps bring down the annual cost paid by the member because they are filling their prescriptions less times during the year and at a lower overall cost. SDRMA can provide an FAQ on each of these programs if interested. The following programs are automatically added to every group joining the SDRMA Pharmacy benefit program through Express Scripts: Fraud, Waste and Abuse; Hepatitis C Cure Value; Cholesterol Care Value, and Oncology Care Value.

Retiree Administration

Early Retirees
If your agency offers medical coverage to Early Retirees (under age 65) through SDRMA's medical benefits program and the Early Retiree opts to enroll in coverage, the Early Retiree will be offered the same plan(s) and coverage as your agency's active employees.
Early Retirees also have the same rates as active employees unless they move outside of California. If an Early Retiree moves outside of California, only the plan(s) that your agency offers that are listed under Area V in the SDRMA Health Benefits Brochure will be offered to the Early Retiree.

Early Retirees may waive coverage without proof of other group coverage at Open Enrollment; however, as a reminder, Early Retirees are not permitted to return to the plan once they have

waived coverage.
If your agency has an Early Retiree that will be turning 65, SDRMA will send a Medicare Report to your primary contact for medical benefits and inform the contact to reply if the Early Retiree should be terminated from coverage once they turn 65 or if the Early Retiree will continue as a Medicare Retiree.

Medicare Retirees

If your agency offers coverage to Medicare Retirees and their spouse and/or dependents, the retiree and their spouse and/or dependents must enroll in Medicare Part A and Part B coverage when they turn 65 to be able to continue their coverage under SDRMA. Medicare Retiree participants must have Medicare Parts A and B to be enrolled in the Medicare Medical plans. When a retiree, spouse and/or dependent turns 65 and enrolls in Medicare Part A and Part B, they will be enrolled in SDRMA's coordination of benefits plan as a Medicare participant. Medicare coverage will become primary coverage and SDRMA coverage will become secondary coverage. If EGWP (Part D Pharmacy coverage) is offered, they will be automatically enrolled in Part D Pharmacy coverage when they enroll in the Medicare Medical plan. Kaiser Senior Advantage participants will be auto enrolled in the Part D plan.

If a Retiree does not have Medicare A or B, please contact SDRMA about rates and plans for non-Medicare retirees. Retirees who are eligible for Medicare parts A and B but do not enroll in their Medicare A and B benefit must remain in the higher Non-Medicare rate provided for Early Retirees until they have obtained their Part A and B benefit. Retirees eligible for Medicare should not remain indefinitely in the Non-Medicare rate, so employers and administrators should monitor these participants and ensure they obtain Medicare within 90 days of becoming Medicare eligible. NOTE: Participants who are eligible for Medicare but are still actively working must remain in the active rate along with all their dependents until the participant retires.

Retired participants who obtain Medicare age, but are NOT eligible for Medicare can remain indefinitely in the Non-Medicare Retiree rate.

Retirees who decline coverage may not enroll in any coverage or in any future subsequent enrollment date.
If your agency has an Early Retiree and/or spouse/dependent that will be turning 65, SDRMA will send a Medicare Report to your primary contact for medical benefits and inform the contact to reply if the Early Retiree should be terminated from coverage once they turn 65 or if the Early Retiree will continue as a Medicare Retiree.

SDRMA does offer Medicare split family contracts and rates. This would be provided when the employee has retired and there is one participant on a family contract who is eligible for Medicare and the other family participant is not. The family unit, though the enrollment may be split, must remain on like plans. Example: A retiree cannot be enrolled in a PPO plan while their dependent is enrolled in the HMO plan, nor should they be enrolled in two separate carrier benefits.

SDRMA does not offer a Medicare HMO, Medicare Advantage, HMO Part D or Medical only plans. However, SDRMA does offer a Kaiser Senior Advantage Plan. If you would like to know if your agency is within the service area for Kaiser, please ask SDRMA.

For Kaiser Senior Advantage plans: Participants who are retired and who are Medicare eligible, must assign their Medicare Benefits to Kaiser. If a participant does not assign their Medicare to Kaiser, Kaiser will apply Kaiser Penalty Rates which will be much higher than the Medicare Kaiser rates provided to the employer. It is important that Medicare participants assign their Medicare to Kaiser to avoid these added fees.

Medicare plans under SDRMA follow the Medicare guidelines provided by CMS & Medicare. Specifically you can find the "Medicare & You" annual guide on the www.medicare.gov page under the Tab called "Forms, Help & Resources". There is also a guide CMS created called "Your Guide to Who pays first" which can be found in the link provided or under the Medicare.gov page / Free Medicare Publications. https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf. These resources are created and managed by these entities and are not materials we can alter.

MEDICARE PARTICIPANT ENROLLMENT PROCESS

If your agency's carrier is Blue Shield or Anthem Blue Cross the following is the process for enrolling the participant in the SDRMA Medicare coordination of benefits plan:

When a new retiree or a retiree and/or their spouse/dependent becomes eligible for Medicare an updated medical enrollment form will need to be completed to confirm their medical enrollment portion. In addition to the current medical enrollment form the Express Scripts Medicare (PDP) for CSAC-EIA Medicare Prescription Plan Benefit Election Form must be completed as well to enroll the Medicare participant in Part D Prescription coverage. The Express Scripts Medicare (PDP) for CSAC-EIA Medicare Prescription Plan Benefit Election Form also includes current Medicare Part D prescription coverage details that must be given to the participant enrolling in Medicare.

With the completion of the new Express Scripts Medicare (PDP) for CSAC-EIA Medicare Prescription Plan Benefit Election Form this will help expedite enrollment into the Medicare Part D Prescription coverage. SDRMA will need to receive both the medical and prescription enrollment form within 31 days of the new retiree or a retiree and/or their spouse/dependent becoming eligible for Medicare. We can process the enrollment before the ID card is received from Medicare. Yet, after the Medicare ID card is received, SDRMA will need a copy of the ID card.

The coverage effective date for the Medicare Part D Prescription coverage is contingent on Medicare approving the effective date for the participant. Initially SDRMA will request the effective date of coverage to be the first of the following month after the retirement date or the date that Medicare Part A and Part B is effective. If the effective date needs to be changed to another future date, then the participant will be enrolled in the commercial prescription plan while the Medicare Part D coverage is approved. The date in which the enrollment for Part D prescription coverage is made effective is the effective date that your agency will be billed the Medicare supplemental rate for the retiree and/or spouse/dependent.

The rate will not change to the Medicare Supplemental rate until coverage is effective under the Medicare Part D coverage.

If your agency's carrier is Kaiser, the following is the process for enrolling the participant in the SDRMA coordination of benefits plan:

As an agency that offers coverage to Medicare Retirees and spouses under Kaiser Permanente Senior Advantage (KPSA) plan, there are specific guidelines that need to be followed to ensure timely coverage. According to SDRMA guidelines the retiree and/or spouse must enroll in Part A and Part B coverage when they turn 65 to continue retiree benefits. SDRMA's goal is to inform you of the most up to date process for enrolling a retiree and/or their spouse in the KPSA plan *(**Note:** if your agency offers other carrier plans outside of Kaiser through SDRMA please refer to the process for enrollment into that carrier plan as stated above)*.

The KPSA enrollment process is as follows:

1. At least 60 days prior to the retiree and/or their spouse/dependent turning 65, the employer must reach out to the participant turning 65 and inform the participant of the option of enrolling in the Kaiser Permanente Senior Advantage (KPSA) plan. The KPSA plan also includes prescription coverage. The employer must send to the participant turning 65 the SDRMA medical benefits participant enrollment form, current Kaiser KPSA election form, current Medicare Health Plan Brochure and KPSA Medicare rating document.

2. If the retiree and/or spouse/dependent who is eligible wants to enroll in the KPSA plan they will need to mail to your agency **at least 3 weeks prior to their Medicare Part A and Part B effective date** the following documents:

    a. <u>SDRMA Medical Benefits Participant Enrollment Form-Kaiser Fillable PDF.</u> This enrollment form should include the retiree and/or spouse/dependents that will be enrolled in the KPSA plan and the regular Kaiser plan offered by your agency
    b. <u>Kaiser 2019 KPSA Election Form</u>-This enrollment form should only include the information for the retiree and/or spouse/dependent that is enrolling in the KPSA plan. ***Please ensure to inform the KPSA enrollee that the form must be completed in its entirety and that they should <u>not</u> send the KPSA form to Kaiser directly, but should send it directly to your agency***
    c. <u>Copy of Medicare Part A and Part B ID card</u> listing the effective date of coverage for Part A and Part B

3. As an employer when you receive the *Kaiser 2019 KPSA Election Form* please place an effective date stamp on the form of when as an employer you received the enrollment form. This date stamp will be used by Kaiser Permanente to ensure the correct effective date is issued

4. Once you as an employer receive the following documents:
    - *SDRMA Medical Benefits Participant Enrollment Form-Kaiser Fillable PDF*

- *Kaiser 2019 KPSA Election Form*
- *Copy of Medicare Part A and Part B ID card*

Please send copies of these documents via fax to SDRMA at 916.231.4113. Once SDRMA receives these documents we will enter the enrollment into our third-party administrator's system. Please note that Medicare dictates the effective date of the KPSA plan. Therefore, it is important to sign and return the documents prior to the Medicare eligible effective date to ensure the effective date is close to the participant turning 65.

5. **7 business** days after the documents that are listed under number 4 are sent to SDRMA please send a copy of the *Kaiser 2019 KPSA Election Form* to Kaiser at the following fax or address:
   Fax: 1.858.614.3344
   Mail: Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400

6. After the KPSA enrollment for the participant is processed by Kaiser (processing takes 10 days from the time that Kaiser receives the KPSA enrollment form) Kaiser will send to the KPSA participant a welcome letter along with the additional documents and ID cards. This is confirmation the retiree was enrolled in the KPSA plan and it will include the effective date. If there was an issue with processing the KPSA enrollment Kaiser will send to the KPSA participant a letter requesting further information. This letter is time sensitive and could impact the KPSA enrollment approval

Dental

The CSAC-EIA Dental program is a Self-Funded program with fixed rates.

- The fixed rates are comparable to a fully insured premium rate. Rates will not fluctuate due to claim utilization during the plan year.

SDRMA Dental fixed rates renewals are underwritten and renewed on its own merit under the CSAC-EIA pool.

All Dental groups that have fixed rates under CSAC-EIA are rated together but may receive renewal rate changes different from the pool average based on their own claim experience. Rates renew January 1.

The SDRMA Dental HMO Program is a fully insured program and offers only fully insured premium rates. Rates do not fluctuate due to claim utilization during the plan year.

The SDRMA Dental HMO Program offers three set plan designs with regional rates and renews each year on January 1. The entire Dental HMO Program will renew together as a pool, and SDRMA will

receive the same renewal rate change as the rest of the pool under CSAC-EIA.

Claims Process
After receiving treatment, there are two ways for a participant to submit a claim. If the participant visits a Delta Dental dentist, the dentist will submit the claim(s) and paperwork for the participant. If a participants visit a non-Delta Dental dentist, the member must complete items 1 through 15 on the claim form (claim forms can be obtained on the Delta Dental website, www.dentaldentalins.org). Attach a copy of the dentist's statement of treatment, including the dentist's name and phone number (with area code). Delta Dental will use the dentist's statement to process the claim. It's very important that the statement include a description of each service the dentist performs.

Once completed, the participant should make a copy of the form for their records and mail the original to the address on the form.

Claims are processed within 2 weeks unless additional information is required.

Vision

The SDRMA Vision Program under CSAC-EIA is a fully insured program and offers only fully insured premium rates. Rates do not fluctuate due to claim utilization during the plan year. The SDRMA Vision Program through VSP offers five set plan designs and renews each year on January 1. The entire fully insured program will renew together as a pool, and SDRMA will receive the same renewal rate change as the rest of the pool under CSAC-EIA.

Claims Process for Participating Provider
Once a participant makes an appointment with a VSP provider of their choice, they must notify the provider of their vision coverage in order to receive benefits. The VSP provider will contact VSP to verify eligibility of benefits. The VSP provider will submit the claim form to VSP. The enrollee does not need to submit a claim form when visiting a VSP provider but must identify themselves as having coverage through VSP in order to receive benefits.

Claims Process for Non-Participating Provider
When services and/or materials are obtained from a non-VSP provider, participants should use the following steps to receive the allowed reimbursement:

1. Pay the non-VSP provider the full amount of the bill and request an itemized copy of the bill. The bill should separately detail the charges for the eye exam and materials, including lens type.
2. Include the following information with the bill:
    - The name, address and phone number of the non-VSP provider
    - The covered participant’s ID number
    - The covered participant’s name, address and phone number

- The name of the group
- The patient's name, date of birth, address and phone number
- The patient's relationship to the covered participant (such as self, spouse, child, student, etc.) Participants can simply write the information on the bill or use the printable form available when members sign on to view benefits information at www.vsp.com.

3. Please send a copy of the itemized bill with the above information to VSP to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Please note that claims for reimbursement must be filed within six (6) months of the date of service. Participants will be reimbursed according to the out-of-network reimbursement schedule.

VOYA Basic Life and AD&D, Supplemental Life and Long-Term Disability (LTD)

The SDRMA VOYA self-administered programs are part of the CSAC-EIA pool. The Basic Life and AD&D, Supplemental Life and Long-Term Disability programs have several options available for coverage and renew each year on July 1. The renewal is together as a pool and SDRMA will receive the same renewal rate change as the rest of the pool under CSAC-EIA.

Basic Life and AD&D have value added services for travel assistance, funeral planning and EAP services through ComPsych at no extra cost to participants.

Claims Process
For claims processing please refer to your agency's VOYA administration guide

Employee Assistance Program (EAP)

The carrier for the Employee Assistance Program offered by SDRMA is MHN. MHN provides the following services for Employees: Face to Face and Telephonic Counseling, Legal, Financial Services, etc. MHN provides the following for Employer Services: Brown Bag Seminars, Critical Incident Stress Debriefing, Management Consultations and Management Training.

Employees and Employers can easily access EAP services by referring to the MHN summary provided by SDRMA that lists their employers company code.

Rates renew July 1

Administration

SDRMA is the plan administrator for all programs offered under SDRMA's medical and ancillary benefits. SDRMA does utilize CSAC-EIA contracted vendors. These vendors provide core administrative services to SDRMA's Small Group Program.

Administration	**Carriers**
Medical	Anthem, Blue Shield, Kaiser
Pharmacy	Express Scripts
Dental	Delta Dental
Vision	VSP
Life and Disability	Voya
EAP	MHN
Administration	**Third Party Administrators (TPA)**
Medical/ Pharmacy Billing/Eligibility	Businessolver
Dental Billing/Eligibility	Businessolver/Preferred Benefit Insurance Administrators (PBIA)
Vision (VSP) Billing/Eligibility	Businessolver/Preferred Benefit Insurance Administrators (PBIA)
Life and Disability Billing	Businessolver
EAP Billing	EIA Staff (self-billing) Businessolver

Services provided through Third Party Administrator (TPA)

Medical, Dental, Vision, Basic Life and AD&D, Long Term Disability and Employee Assistance Program:

- Enrollment Eligibility
  - On-line enrollment that SDRMA processes for each agency
  - Mid-year plan changes that SDRMA processes for each agency
  - Open Enrollment managed by SDRMA
- Billing
  - Consolidated billing/invoicing
  - Reconciliation
  - Remittance of payments to carriers and other partners
- COBRA Administration
- Reporting
  - Census, open enrollment reports, etc.
- ACA Employer reporting

Networks Used for Medical and Pharmacy

The following tables identify the networks being used for both Medical and Pharmacy services.

The services for pharmacy coverage are accessed through a separate Express Scripts Pharmacy ID Card. For the Anthem HMO and both Anthem and Blue Shield HDHP plans, the Medical ID card should be used to access the pharmacy benefit.

For the Kaiser plans, participants will receive a Kaiser ID Card for all access.

Each table below has been created based on the Medical Carrier. Be sure to reference the table pertaining to the Medical carrier being accessed.

ANTHEM NETWORK OF PROVIDERS			
Benefit	**ASO Network**	**HMO Network**	**HDHP**
Medical	PPO & EPO Network is the Blue Cross PPO (Prudent Buyer)	Blue Cross HMO (CaliforniaCare)	PPO & EPO Network is the Blue Cross PPO (Prudent Buyer)
Retail Rx	Express Scripts Retail Network	Ingenio Rx	Ingenio Rx
Mail Order Rx	Express Scripts Pharmacy	Ingenio Rx	Ingenio Rx
90 Day Supply	Walgreens and CVS	Blue Cross HMO (CaliforniaCare)	See Mail Order Rx
Specialty RX	Accredo Specialty Health (When a medical claim - CVS Caremark)	Accredo Specialty Health (When a medical claim - CVS Caremark)	Accredo Specialty Health (When a medical claim - CVS Caremark)
Mental Health / Substance Abuse	Prudent Buyer/Anthem's BHN	Providers within the PMG/IPA or Anthem's BHN	Prudent Buyer/Anthem's BHN
Disease Management	Prudent Buyer (DM Program)	Prudent Buyer (DM Program)	Prudent Buyer (DM Program)
Durable Medical Equipment	Blue Cross PPO	Blue Cross HMO	Blue Cross PPO
Chiropractic	Prudent Buyer	Providers within the PMG/IPA or ASH	Prudent Buyer
Acupuncture	Prudent Buyer	Providers within the PMG/IPA or ASH	Prudent Buyer

BLUE SHIELD OF CALIFORNIA NETWORK OF PROVIDERS			
Benefit	**ASO Network**	**HMO Network**	**HDHP**
Medical	Blue Shield PPO Network	Blue Shield HMO Network	Blue Shield PPO Network
Retail Pharmacy	Express Scripts	Express Scripts	CVS Caremark
Mail Order Rx	Express Scripts Pharmacy	Express Scripts Pharmacy	CVS Caremark Mail Service
90 Day Supply	Walgreens and CVS	Walgreens and CVS	See Mail Order Rx
Specialty Pharmacy	Accredo Health Group	Accredo Health Group	CVS Caremark Specialty
Mental Health / Substance Abuse	Blue Shield PPO Network	Magellan	Blue Shield PPO Network
Disease Management	Blue Shield Condition Management Program	Blue Shield Condition Management Program	Blue Shield Condition Management Program
Durable Medical Equipment	PPO – Blue Shield Network providers	HMO – Through Medical group	PPO – Blue Shield Network providers
Chiropractic	Blue Shield PPO Network	ASH	Blue Shield PPO Network
Acupuncture	No true "network" provider must be licensed all paid at in-network level	ASH	No true "network" provider must be licensed all paid at in-network level

KAISER NETWORK PROVIDERS	
Benefit	**HMO Network**
Medical	Kaiser Permanente Network
Retail Rx	Kaiser Permanente Network
Mail Order Rx	Kaiser Permanente Network
Specialty Rx	Kaiser Permanente Network
Mental Health/Substance abuse	Kaiser Permanente Network
Disease Management	Kaiser Permanente Network
Durable Medical Equipment	Kaiser Permanente Network
Chiropractic	ASH
Acupuncture	ASH

Billing and Premiums

Medical:

SDRMA medical premiums are invoiced one month in advance. SDRMA medical invoices are sent automatically via email to invoice contact(s) around the 5th of every month. The invoice due date is around the 22nd of every month. An example for reference is April medical invoice is sent via email on March 5 and payment is due to SDRMA by March 22.

Medical invoices **must be paid in full as billed** by the specified due date listed on the medical invoice. If payment is not received by the due date listed on the invoice interest will accrue at the rate of 1% per month, twelve percent (12%) per annum. Failure to pay premiums can result in your agency being terminated from SDRMA's medical benefits program.

If changes are submitted to SDRMA after the 23rd of each month they will not reflect until the next month's invoice. An example for reference is: Change was received by SDRMA on February 26. The change will reflect on the May invoice. For information on how to submit changes to SDRMA please refer to the Submitting Enrollments/Changes for Health Benefits section.

If your agency would like to receive hardcopy invoices, simply send this request to SDRMA in writing.

Dental, Vision, Basic Life and AD&D, Long Term Disability and Employee Assistance Program:

SDRMA Dental, Vision, Basic Life and AD&D, Long Term Disability and Employee Assistance Program (Ancillary Coverages) premiums are invoiced one month in advance. SDRMA ancillary invoices are sent automatically via email to invoice contact(s) around the 22nd of every month. The invoice due date is around the 10th of the following month. An example for reference is April ancillary invoice is sent via email on March 22 and payment is due to SDRMA by April 10.

Ancillary invoices **must be paid in full as billed** by the specified due date listed on the ancillary invoice. If payment is not received by the due date listed on the invoice interest will accrue at the rate of 1% per month, twelve percent (12%) per annum. Failure to pay premiums can result in your agency being terminated from SDRMA's ancillary benefits program.

If changes are submitted to SDRMA after the 23rd of each month they will not reflect until the next month's invoice. An example for reference is: Change was received by SDRMA on February 26. The change will reflect on the May invoice. For information on how to submit changes to SDRMA please refer to the Submitting Enrollments/Changes for Health Benefits section.

If your agency would like to receive hardcopy invoices simply send this request to SDRMA in writing.

Value Added Programs

CARRUM Health-Additional Surgical Benefit
For active employees, early retirees, COBRA participants and their dependents who are enrolled in PPO, EPO or High Deductible health plans, SDRMA offers an additional surgical benefit through Carrum Health. This allows participants access to an enhanced surgery benefit program with top-quality hospitals and surgeons. Carrum Health is a surgical benefit coordinator that offers fixed cost pricing for specific procedures performed exclusively at Stanford Health Care (Valley Care), Providence Saint John's Health Center, and Scripts. The significant cost reduction has a potential of substantial claims savings, on an average of 30% per procedure! Carrum is a 100% voluntary "add-on" benefit that expands the options for participants. Therefore, there will be no changes or limitations to existing benefits. In addition, there are no medical bills, as co-insurance and deductibles will be waived, and applicable travel expenses will be covered for the patient and one adult companion. ***Please note:** This offering is not available to participants enrolled in an HMO plan or Medicare Retirees and the use of this benefit is optional. This benefit is separate from, and in addition to, the benefits already provided under your current Health Care provider and it is not administered by SDRMA. This benefit must be accessed through Carrum Health and their Care Concierge, who will support you throughout the entire process.

Eligible procedures currently include:

- Knee Replacement
- Hip Replacement
- Coronary Bypass
- Lumbar Spinal Fusion
- Cervical Spinal Fusion
- Bariatric Surgery

**** Additional procedures will become eligible on a regular basis***

For additional information and flyers for Carrum please contact SDRMA

Wellness - SOLERA
Solera is a program for Diabetes Prevention. Employees or eligible retirees enrolled in Blue Shield or Anthem Blue Cross coverage through SDRMA can simply go to the Solera website: solera4me.com/eia and take a test to find out if they are eligible for the Diabetes Prevention Program.

For additional information and flyers for Solera please contact SDRMA

Wellness - Blue Shield Wellvolution
Blue Shield offers to enrolled participants a free Wellness program called Wellvolution. Some of the programs that are available to participants are: Well-Being Assessment, Daily Challenge, Walkadoo Activity Tracking Program and QuitNet. In addition, Blue Shield offers other wellness discounts.

For additional information and flyers for Wellvolution please contact SDRMA

Wellness - Anthem Blue Cross and Kaiser

For Anthem Blue Cross and Kaiser enrolled participants there is a free Wellness program that allows participants to have access to services through Daily Challenge, Walkadoo Activity Tracking Program and QuitNet.

For additional information and flyers for Wellness through Anthem Blue Cross and Kaiser please contact SDRMA

Additional Information and References

Below is a snapshot of who to go to for the various scenarios.

Request	Notes
Provider list	**Anthem** Website: www.anthem.com/ca/EIAHealth/ Customer Service Phone Number: 800.967.3015 **Blue Shield** Website: www.blueshieldca.com/csac Customer Service Phone Number: 855.256.9404 **Kaiser** Website: www.kp.org Customer Service Phone Number: 800.464.4000 **Express Scripts** Website: www.express-scripts.com Customer Service Phone Number: 877.554.3091 **Delta Dental** Website: www.deltadentalins.com Customer Service Phone Number: 800.765.6003 **VSP** Website: www.vsp.com Customer Service Phone Number: 800.877.7195 **VOYA** Website: www.voya.com Basic Life and AD&D Customer Service Phone Number: 888.238.4840 Long Term Disability Customer Service Phone Number: 888.305.0602 **MHN (EAP)** Website: www.members.mhn.com Customer Service Phone Number: 800.242.6220

Open Enrollment packages	SDRMA will provide via email
OE Giveaways/Carrier Representation	If your agency has over 100 employees SDRMA upon written request can ask carriers to send giveaways and/or if carrier can be present at your agency's Open Enrollment fair
Renewal	SDRMA sends updated Health Benefits brochure that includes rates via email to participating agencies. Participating Agencies automatically renew, unless agency informs SDRMA with a 90-day withdrawal notice as outlined in SDRMA MOU.
Enrollment and Retro Requests	Submit enrollments and retro requests to SDRMA. SDRMA will send retro requests to CSAC-EIA for final approval
Escalated Claims Issues	SDRMA
Premium Billing Questions	SDRMA

Contacts

SDRMA Health Benefits Contacts

	Email	***Phone***
Alana Little	alittle@sdrma.org	800.537.7790
Alexandra Santos	asantos@sdrma.org	800.537.7790
SDRMA Health Benefits Email	healthbenefits@sdrma.org	
SDRMA Health Benefits Fax		916.231.4113

Definitions: Pharmacy Program

This section is designed to help agencies navigate and understand complicated Pharmacy Benefit Manager (PBM) terminology.

Express Scripts Pharmacy References: Pharmacy plans that are administered by Express Scripts are as follows and would apply as appropriate below: Blue Shield PPO, EPO and HMO plans. Anthem PPO and EPO plans.

Kaiser HMO, Blue Shield HDHP, Anthem HDHP & HMO pharmacy benefits are administered by the Medical carrier's preferred pharmacy vendor (PBM)

Accredo: An Express Scripts specialty pharmacy.

Accredo clinical days' supply: Accredo has in place clinically based recommended days' supply rules for the various medicines within the specialty offering. These rules are put in place to ensure appropriate drug use and to decrease waste of high-cost drugs.

Acute medication: Drugs taken for a limited time to treat temporary medical conditions or illnesses, such as antibiotics for infections.

Appeal: A review of an initial or first-level appeal denial, along with any additional information provided or available, to determine if the participant's use of the drug meets the Plan's intent for coverage. Appeals are related to coverage denials; they are not related to procedures addressing participant complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations.

Appeals process: A specific process that a participant needs to follow when making an appeal request. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, panel of clinicians, trained prior authorization staff or an independent third-party utilization management company. Participants are notified of the decision and of any rights to appeal an adverse benefit decision.

Benefit exclusion: Also referred to as "not covered," this includes a drug or drug class that is not included in the participant's benefit and means there are no alternatives to try or exceptions to coverage.

Biosimilar: A biopharmaceutical drug designed to have active properties similar to one that has previously been licensed.

Brand: A drug protected by a patent, which prohibits other companies from manufacturing the drug while the patent is in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol®).

In copay and pricing terms, a brand is classified as a non-generic drug that can be multi-source or single- source, as defined below:

- Multi-source brand: Available from multiple sources — generally the brand originator and generic manufacturers
- Single-source brand: Patent-protected and available from only one source

Compound: A medicine that's made of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order.

Controlled Substance: Federal Legend Drug that has potential to cause addiction or abuse.

Copay/coinsurance: The cost of a covered drug paid by the participant at the time the prescription is filled and after the deductible is met (if applicable) per individuals or families.

Copay assistance: For specialty medications filled through Accredo, an Express Scripts specialty pharmacy, the Contact Center and Patient Access teams work with patients to identify and address the need for financial assistance. Express Scripts works with more than 130 copayment programs and continually strives to find more ways to assist participants.

Coverage review: Also known as the initial review or initial determination, this process is followed when a participant requests coverage for a drug, or requests coverage for a drug at a higher benefit. It's the first review of drug coverage based on the Plan's conditions of coverage. The initial review decision is based on the information provided by the prescriber (clinical) or the patient (administrative) and the criteria in place. If the initial review is denied, then the patient/representative may appeal the decision.

Data sharing: The Plan authorizes certain data to be used in data analysis initiatives at Express Scripts. Express Scripts processes more than a billion prescriptions annually for tens of millions of Americans and has extensive experience integrating eligibility and PBM data with medical claims and lab data on behalf of its clients and their medical carriers. This data analysis enables Express Scripts to help identify and make relevant opportunities actionable for participants, caregivers, and providers and to help deliver enhanced participant safety, cost savings and participant service.

Excluded: Drugs that are not covered and will not be reimbursed by the Plan's pharmacy benefit.

Formulary: A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Products are selected on the basis of safety, efficacy and cost. For more information, refer to Formulary.

Formulary exclusions: Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products.

Formulary exclusion exception review: The prescriber may request an exception to the formulary exclusion. Express Scripts contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the formulary exclusion. If the formulary exception is denied, the patient or their representative may appeal the decision.

Generic: A drug that has the same active ingredients in the same dosage form and strength as its brand- name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs. Generic drugs often cost less than brand-name drugs. A generic drug can be produced once the manufacturer of the brand-name drug is required to allow other manufacturers to produce the drug.

Home delivery: A distribution channel in which the participant receives a prescription drug through the mail from the Express Scripts Pharmacy℠.

Maintenance medication: Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression, or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide participants with lower costs and more convenience.

Maximum allowable cost: A Maximum allowable cost or MAC list generally refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for generic drugs and brand name drugs that have generic versions available (multi-source brands). Essentially, no two MAC lists are alike and each PBM picks and chooses products for their MAC lists, using different criteria to derive and apply prices to the list. Some of the factors that PBMs consider to choose products for inclusion on a list are availability of the product in the marketplace, whether the product is obtainable from more than one manufacturer, how the product is rated by the FDA in relation to the innovator drug and price differences between the brand and generic products. However, there is no standardization in the industry as to the criteria for the inclusion of drugs on MAC lists or for the methodology as to how the maximum price is determined, changed or updated.

National Pharmacy & Therapeutics Committee: The National Pharmacy & Therapeutics (P&T) Committee, a fully independent body that makes final formulary determinations, comprises 15 independent physicians and one independent pharmacist who are not employed by Express Scripts. This committee reviews clinical information (formulary evaluation, place in therapy, and competitive product category overviews) for medications newly approved by the FDA. It focuses on clinical considerations.

The P&T Committee meets six times per year. If necessary, mail ballots may be used to seek committee member comments and approval for new clinical designations between meetings—for example, following Food and Drug Administration (FDA) approval of a therapeutic-breakthrough drug.

Network pharmacy: A pharmacy (also called a retail network pharmacy) that participates in the Plan's network. In most cases, participants need to use a network pharmacy to pay the amounts specified by the Plan.

Non-network pharmacy: A pharmacy not associated with the retail network. Benefits will not be covered at the same rate as a network pharmacy and participants will have to pay the full cost of the medication at non-network pharmacies.

Not covered: Also known as "benefit exclusion," this includes a drug or drug class that is not included in the participant's benefit, which means there are no alternatives to try or exceptions to coverage.

Over the counter (OTC): A drug that's available without a prescription from a doctor.

Participating pharmacy: Any licensed retail pharmacy with which Express Scripts (or its affiliates) has executed an agreement to provide covered drugs to participants. This does not include any home delivery or specialty pharmacy affiliated with that participating pharmacy. Participating pharmacies are independent contractors of Express Scripts.

Pharmacy benefit manager (PBM): An information-based, clinically oriented service organization that manages prescription benefits for other organizations. PBM services can include contracting with a network of pharmacies; establishing payment levels for provider pharmacies; negotiating rebate arrangements; developing and managing formularies and preferred drug lists for the Plan's review and selection; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs. Many PBMs also operate home delivery pharmacies. Express Scripts is your Plan's PBM.

Pharmacy network: Groups of chain and independently owned pharmacies that contract with a claims processor or plan administrator to provide medicine and pharmacy services to participants at a preset price.

Plan design: The elements of pharmacy benefits, such as drugs covered, participant costs, limitations and conditions of benefit coverage under the Plan and permitted locations for obtaining covered drugs. Express Scripts manages plan design components as determined by the Plan.

Prescription drug – according to the FDA:

- Prescribed by a doctor
- Bought at a pharmacy
- Prescribed for and intended to be used by one person
- Regulated by FDA through the New Drug Application (NDA) process. This is the formal step a drug sponsor takes to ask that the FDA consider approving a new drug for marketing in the United States. An NDA includes all animal and human data and analyses of the data, as well as information about how the drug behaves in the body and how it is manufactured.

According to Wikipedia: A prescription drug (also prescription medication or prescription medicine) is a pharmaceutical drug that legally requires a medical prescription to be dispensed.

Prescription drug covered expense: Services provided within a given health or pharmacy care plan. Health care and drug benefit services provided or authorized by the payer's Medical Staff or payment for health care services.

Prescription drug plan (PDP): A stand-alone plan, covering only prescription drugs.

Rebate: Money received from certain drug manufacturers as a result of the inclusion of those manufacturers' branded products on the formulary.

Specialist pharmacist: An Express Scripts pharmacist who receives extra training in medicines used to treat specific long-term and complex conditions. These pharmacists use nationally accepted, evidence-based procedures and work with physicians to identify gaps in care across different providers. Specialist pharmacists personally counsel patients to help them understand and follow through on their treatments.

Specialty drug: A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

Split fill: An Accredo program that divides the copay into four breaks, using the standard day breaks of 1-15, 16-30, 31-60 and 61-90 (alternative day breaks are available). The standard for 1-15 days' copay is 1/6 of the standard copay. This is part of the clinical days' supply program.

Therapeutic Resource Center® (TRC): Through personalized care delivered by experienced specialist pharmacists within TRCs, Express Scripts improves patient safety, essential medication adherence and the affordability of drug regimens by closing important gaps in care and optimizing therapies for participants with long-term conditions.

Tiers: The level of coverage for each drug, for example, generic drug tier, brand drug tier or specialty drug tier. The coinsurance or copayment will depend on which tier the drug is in — with lower tier drugs typically costing less than higher tier drugs.

Definitions: Medical

Adjudication: Refers to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

Administrative Services Only (ASO): An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group but does not assume any financial risk for the payment of benefits.

Balance bill: The amount you could be responsible for (in addition to any co-payments, deductibles or coinsurance) if you use an out-of-network provider and the fee for the particular service exceeds the allowable charge. Refers to the leftover sum that a provider bills to the patient after insurance has only partially paid the charge that was initially billed.

Calendar Year Deductible: The dollar amount for covered services that must be paid during the calendar year (January 1 – December 31) by participants before any benefits are paid by the Plan.

Centers of Medical Excellence (CME): Health care providers designated as a selected facility for specified medical services. Providers participating in a CME network have an agreement to accept an agreed upon amount as payment in full for covered services.
Coinsurance: An arrangement under which the participant pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80% of the allowable charge, with the participant responsible for the remaining 20%, which is then referred to as the coinsurance amount.

Condition Care: Helps promote and improve the overall health status and quality of life of participants and helps promote and/or prevent disease progression and avoid and/or prevent the complications associated with the conditions.

Coordination of Benefits: This is the process by which a health insurance company determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health insurance policy.

Co-Payment: A specific charge that a health plan may require a participant to pay for a specific medical service or supply, after which the insurance company pays the remainder of the charge.

Deductible: An amount the covered person must pay before payments for covered services begin. The deductible is usually a fixed amount. For example, an insurance plan might require the insured to pay the first $250 of covered expense during a calendar year.

Dependent: Person, (spouse or child), other than the subscriber who is covered under the subscriber's benefit certificate.

Employee Assistance Program (EAP): A program that is designed to assist in the identification and resolution of productivity problems associated with personal concerns of employees. The program provides employees and their dependents with access to confidential, short-term counseling by qualified practitioners, in person or over the phone.

Explanation of Benefits (EOB): A form sent to the covered person after a claim for payment has been processed by the carrier that explains the action taken on that claim. This explanation might include the amount that will be paid, the benefits available, reasons for denying payment, or the claims appeal process.

Flexible Spending Account: Accounts that let workers set aside pre-tax money from their paycheck toward premiums or costs not covered by their health plan, such as co-payments. All the money must be used within the plan year or it is lost.

Health Assessment: More agencies are asking workers to fill out such assessments, which give health improvement tips. Agencies can give workers financial incentives to do so.

Health Insurance Portability and Accountability Act (HIPAA): A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, restricts pre-existing condition exclusion periods to ensure portability of health-care coverage between plans, group and individual; requires guaranteed issue and renewal of insurance coverage; prohibits plans from charging individuals higher premiums, co-payments, and/or deductibles based on health status.

Health Maintenance Organization (HMO): A plan that offers a wide range of health care services through a network of providers who agree to provide services to participants at a pre-negotiated rate. Participants of an HMO choose a primary care physician who will provide most of the health care and refer participants to HMO specialists as needed.

Health Savings Account: A tax advantaged savings account to be used in conjunction with certain high-deductible (low premium) health insurance plans to pay for qualifying medical expenses, such as deductibles. Contributions may be made to the account on a tax-free basis. Funds remain in the account from year to year and may be invested at the discretion of the individual owning the account. Interest or investment returns accrue tax-free. Penalties may apply when funds are withdrawn to pay for anything other than qualifying medical expenses. Employers can also fund such plans.

ID Card/Identification Card: A card issued by a carrier to a covered person, which allows the individual to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare billing statement.

IBNR: An acronym for "incurred but not reported". This is an accounting estimate used by health plans to accrue for care that was provided "incurred" in one accounting period, but not paid or "reported" until another accounting period.

In-Network: Refers to the use of providers who participate in the carrier's provider network. Many benefit plans encourage covered persons to use participating (in-network) providers to reduce the individual's out of pocket expense.

Medical Tourism: To have medical care outside the United States.

Medigap: Refers to various private health insurance plans sold to supplement Medicare.

Negotiated Rate: The amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Open Enrollment: A time period during which eligible participants can select among the plans offered by their employer as well as make any other dependent changes.

Out-Of-Network: The use of health care providers who have not contracted with the carrier to provide services. Participants are generally not reimbursed if they go out-of-network except in emergency situations.

Out-Of-Pocket: The most a participant would pay for covered medical expenses in a plan year through copays, deductibles and coinsurance
before your insurance plan begins to pay 100 percent of the covered medical expense.

Participating Provider: A physician, hospital, pharmacy, laboratory or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a health benefit plan.

Pre-Authorization: A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non- emergency outpatient services before the services are provided.

Preferred Provider Organization (PPO): A type of managed care organization that has a panel of preferred providers who are paid according to a discounted fee schedule. The enrollees do have the option to go to out-of-network providers at a higher level of cost sharing.

Reasonable and Customary: This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. Also known as Usual, Customary and Reasonable (UCR).

Skilled Nursing Facility: An inpatient healthcare facility with the staff and equipment to provide skilled care, rehabilitation and other related health services to patients who need nursing care, but do not require hospitalization.

Subscriber: The individual in whose name a contract is issued, or the employee/retiree covered under an employer's group health contract.

Transparency: The ability for patients to have easy access to understandable information about the cost and quality of their health care options. They should be able to obtain this information from their health plan and medical providers prior to the time of treatment.

TO: GOVERNING BOARD

FROM: STAFF

SUBJECT: BOARD LETTER III.B – APPROVAL OF WANB EMPLOYEE HANDBOOK

DATE: AUGUST 14, 2020

CC: FILE

JPA staff solicits Workforce Alliance Governing Board approval of the draft Workforce Alliance of the North Bay Employee Handbook.

Paragraph 10 - Powers/ Responsibilities of the Agency exercised by the Governing Board of the JPA, states that the "Agency shall have the power to exercise any power common to all Member Counties authorized by Chapter 5 of Division 7 of Title 1 of the Government Code of the State of California (commencing with section 6500) and is hereby authorized to do all acts necessary for the exercise of these common powers, including…:

(7) To perform all acts necessary or proper to carry out fully the purposes of this Agreement.

Additionally, Paragraph 16 of the JPA agreement, Staffing of the Agency states:

> (1) The Governing Board of the Agency shall appoint an Executive Director who shall be responsible for the administration of the Agency. The Executive Director shall have the ability to hire/or contract other necessary staff in consultation with the WDB and with the approval of the Agency's governing Board. The Director shall be the designated officer who shall file an official bond pursuant to Government Code Section 6505.1.

At its July 16th, 2020 meeting, the Governing Board formally appointed the Executive Director to the Workforce Alliance of the North Bay and directed the new Executive Director to take immediate steps to transition WANB to be the employer of record of future subordinate staff including but not limited to payroll systems, personnel policies, recruitment, hiring, training, and evaluation.

The attached WANB Employee Handbook sets forth the terms and conditions of employment of temporary, full- and part-time employees, and supervisors hired by the Executive Director. It describes the employment expectations and processes including but not limited to payroll, recruitment, hiring, termination, training, evaluation, benefits and more. The Executive Director and WANB legal counsel have worked together over the last month to draft and review the handbook presented. If approved by your board today, the Executive Director will be able to take substantive steps forward to fully staff the WANB with critical human resources necessary to complete the objectives of the organization.

STAFF RECOMMENDATION

Approve employee handbook and direct Executive Director to follow policies laid out in the employee handbook to staff the Workforce Alliance of the North Bay.

WORKFORCEALLIANCE
OF THE NORTH BAY
DRIVING WORKFORCE TALENT

EMPLOYEE HANDBOOK

1546 1st Street
Napa, CA 94559

Established

August 2020

Table of Contents

Introductory Policies

Introductory Statement

Welcome! As an employee of the Workforce Alliance of the North Bay (WANB), you will find your employment to be both rewarding and challenging.

Because the quality of our employees is the key to our success, we carefully select our new employees. In turn, we expect employees to contribute to the success of WANB.

This Employee Handbook sets forth the terms and conditions of employment of all full- and part-time employees, and supervisors. Individual written employment contracts may, at the Executive Director's discretion, supersede some of the provisions of this handbook.

This Handbook contains the policies and practices in effect at this time. All previously issued handbooks and any inconsistent policy or benefit statements or memoranda are superseded.

WANB reserves the right to revise, modify, delete, or add to any and all policies, procedures, work rules, or benefits stated in this handbook or in any other document, except for the policy of at-will employment. Any written changes to this handbook will be distributed to all employees so that employees will be aware of the new policies or procedures.

This handbook sets forth the entire agreement between you and WANB as to the duration of employment and the circumstances under which employment may be terminated. Nothing in this employee handbook or any other personnel document, including benefit plan descriptions, creates or is intended to create a promise or representation of continued employment for any employee.

This Handbook is designed to familiarize you with our major policies. Your supervisor or manager will be happy to answer any questions you may have.

Responsibility

Management has responsibility for administering these written personnel policies. Management includes the Executive Director and his/her appointed management level designate. Such designation shall be made in writing. To handle situations not covered by these policies, Management may take problem solving action. Changes or amendments to personnel policies may be approved by the Executive Director, at any time.

Every employee is expected to be familiar with these policies and shall consult with Management on questions of interpretation before decisions are made or actions are taken. All employees will receive a copy of these policies.

Exceptions to these policies may be made only by Management.

Statement of At-Will Employment Status

Employment at WANB is employment at-will. Employment at-will may be terminated with or without cause and with or without notice at any time by the employee or Management. Nothing in this Handbook or in any document or statement shall limit the right to terminate employment at-will. No manager, supervisor or employee of WANB has any authority to enter into an agreement for employment for any specified period of time or to make an agreement for employment other than at-will. Only the Executive Director of WANB has the authority to make any such agreement and then only in writing.

Integration Clause and the Right to Revise

This employee handbook contains the employment policies and practices of WANB. All previously issued handbooks and any inconsistent policy statements or memoranda are superseded.

Management reserves the right to revise, modify, delete or add to any and all policies, procedures, work rules or benefits stated in this handbook or in any other document, except for the policy of at-will employment. However, any such changes must be in writing.

Any written changes to this handbook will be distributed to all employees so that employees will be aware of the new policies or procedures. No oral statements, or representations can in any way change or alter the provisions of this handbook.

This handbook sets forth the entire agreement between employees and Management as to the duration of employment and the circumstances under which employment may be terminated. Nothing in this employee handbook, or in any other personnel document, including benefit plan descriptions, creates or is intended to create a promise or representation of continued employment for any employee.

Acknowledgment of Receipt

I have received my copy of the WANB employee handbook. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained in the handbook.

I understand that except for employment at-will status, any and all policies or practices can be changed at any time by Management. Management reserves the right to change my hours, wages and working conditions at any time. I understand and agree, that other than the Executive Director of WANB, no manager, supervisor or representative of WANB has authority to enter into any agreement, express or implied, for employment for any specific period of time, or to make any agreement for employment other than at-will; only the Executive Director has the authority to make any such agreement and then only in writing signed by the Executive Director.

I understand and agree that nothing in the employee handbook creates or is intended to create a promise or representation of continued employment and that employment with WANB is employment at-will; employment may be terminated at the will of either WANB or myself. My signature below certifies that I understand that the foregoing agreement on at-will status is the sole and entire agreement between WANB and myself concerning the duration of my employment and the circumstances under which my employment may be terminated. It supersedes all prior agreements, understandings and representations concerning my employment with WANB.

Employee's Signature_____Date _____

Equal Employment Opportunity

WANB is an equal opportunity employer and makes employment decisions on the basis of merit. We want to have the best available persons in every job. WANB policy prohibits discrimination against or preferential treatment based on race, color, creed, gender, religion, marital status, age, national origin or ancestry, physical or mental disability, and medical condition including genetic characteristics, sexual orientation, or any other consideration made unlawful by federal, state, or local laws. It also prohibits unlawful discrimination or preferential treatment based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. All such discrimination is unlawful.

WANB is committed to compliance with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in WANB operations and prohibits unlawful discrimination by any employee of WANB, including supervisors and coworkers.

To comply with applicable laws ensuring equal employment opportunities to qualified individuals with a disability, WANB will make reasonable accommodations for the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or an employee unless undue hardship would result.

Any applicant or employee who requires an accommodation in order to perform the essential functions of the job should contact the Executive Director and request such an accommodation. The individual with the disability should specify what accommodation he or she needs to perform the job. WANB then will conduct an investigation to identify the barriers that interfere with the equal opportunity of the applicant or employee to perform his or her job. WANB will identify possible accommodations, if any, that will help eliminate the limitation. If the accommodation is reasonable and will not impose an undue hardship, WANB will make the accommodation.

If you believe you have been subjected to any form of unlawful discrimination, submit a written complaint to your supervisor or the Executive Director. Your complaint should be specific and should include the names of the individuals involved and the names of any witnesses. If you need assistance with your complaint, or if you prefer to make a complaint in person, contact the Executive Director. WANB will immediately undertake an effective, thorough, and objective investigation and attempt to resolve the situation.

If WANB determines that unlawful discrimination has occurred, effective remedial action will be taken commensurate with the severity of the offense. Appropriate action also will be taken to deter any future discrimination. WANB will not retaliate against you for filing a complaint and will not knowingly permit retaliation by management employees or your coworkers.

Unlawful Harassment

WANB is committed to providing a work environment free of unlawful harassment. WANB policy prohibits sexual harassment and harassment based on pregnancy, childbirth or related medical conditions, race, religious creed, color, gender, national origin or ancestry, physical or mental disability, medical condition, marital status, age, sexual orientation, or any other basis protected by federal, state, or local law or ordinance or regulation. *All such harassment is unlawful.*

WANB's anti-harassment policy applies to all persons involved in the operation of WANB and prohibits unlawful harassment by any employee of WANB, including supervisors, coworkers

and any other persons. It also prohibits unlawful harassment based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics.

Prohibited unlawful harassment includes, but is not limited to, the following behavior:

- Verbal conduct such as epithets, derogatory jokes or comments, slurs or unwanted sexual advances, invitations, or comments;
- Visual displays such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings, or gestures;
- Physical conduct including assault, unwanted touching, intentionally blocking normal movement or interfering with work because of sex, race, or any other protected basis;
- Threats and demands to submit to sexual requests as a condition of continued employment, or to avoid some other loss, and offers of employment benefits in return for sexual favors; and
- Retaliation for reporting or threatening to report harassment.
- Communication via electronic media of any type that includes any harassing conduct that is prohibited by state and/or federal law, or by WANB policy.

If you believe that you have been unlawfully harassed, submit a written complaint to your supervisor as soon as possible after the incident. You will be asked to provide details of the incident or incidents, names of individuals involved, and names of any witnesses. Supervisors will refer all harassment complaints to the Executive Director of WANB. WANB will immediately undertake an effective, thorough, and objective investigation of the harassment allegations.

If WANB determines that unlawful harassment has occurred, effective remedial action will be taken in accordance with the circumstances involved. Any employee determined by WANB to be responsible for unlawful harassment will be subject to appropriate disciplinary action, up to, and including termination. A WANB representative will advise all parties concerned of the results of the investigation. WANB will not retaliate against you for filing a complaint and will not tolerate or permit retaliation by management, employees or co-workers.

WANB encourages all employees to report any incidents of harassment forbidden by this policy *immediately* so that complaints can be quickly and fairly resolved.

Employment Policies and Practices

Exempt Employees

In accordance with the Federal Fair Labor Standards Act (FLSA) and California requirements executive and professional employees are exempt from minimum wage and overtime requirements. Exempt employee's salaries are not subject to reduction because of variations in the quality or quantity of work performed.

Non-Exempt Employees

Non-Exempt employees are paid overtime in accordance with Federal & State laws and regulations.

Work Week and Work Day

The work week begins on Sunday at 12:00 am and ends on Saturday at 11:59 am. All references to "work week" in this policy refer to this time period. The work day (a consecutive 24-hour period) begins at 12:01 a.m. and ends at midnight. All references to "work day" or "day" reference this time period.

Full-Time Employees

Full-time employees are defined by WANB as those who are regularly scheduled to work, and do work, forty (40) hours per work week or more. Following 30 days of regular full- time employment, full-time employees are eligible for most employee benefits described in this handbook. Exceptions are noted in the applicable benefit section.

Regular Employees

Regular employees are those who are hired to work on a regular schedule and are not classified as temporary employees. Regular employees may be classified as full-time or part-time.

Part-Time Employees

Part-time employees are those who normally are scheduled to work and who do work less than 40 hours per work week. Part-time employees may be assigned a work schedule in advance or may work on an as-needed basis. Part-time employees are eligible for some, but not all employee benefits described in this handbook.

Temporary Employees

Temporary employees are those employed for short-term assignments. Short-term assignments will generally be specific assignments of a limited duration. Generally temporary employees are not eligible for employee benefits except where mandated by applicable law. However, the Executive Director may decide to provide some additional benefits depending on the project duration.

Job Duties

An employee's supervisor will explain the employee's job responsibilities and the performance standards expected. An employee should be aware that his/her job responsibilities may change at

any time during his/her employment. From time to time, employees may be asked to work on special projects or to assist with other work necessary or important to the operation of WANB. Employees' cooperation and assistance in performing such additional work is expected.

WANB reserves the right, at any time, with or without notice, to alter or change job responsibilities, reassign or transfer job positions, or assign additional job responsibilities.

Work Schedules

The WANB office is normally open for business between the hours of 8:00 AM and 5:00 PM, Monday through Friday. Management/Supervisors will assign individual work schedules. All employees are expected to be at their desks or work stations at the start of their scheduled shifts, ready to perform their work.

Meal and Rest Periods

Employees are provided with a one (1) hour meal period, to be taken approximately in the middle of the workday. Employees are allowed one ten-minute rest period for every four hours of work or major portion thereof. Management/Supervisors will schedule individual meal and rest periods. Employees are expected to observe assigned working hours and the time allowed for meal and rest periods. During a meal break employees are relieved of all duty and are free to leave the premises.

All employees who are scheduled for a work period of five or more hours shall be provided with an unpaid, off-duty meal period of at least 30 minutes to commence no later than the end of the employee's fifth hour of work. When a work period of no more than six hours will complete the day's work, the employer and employee may waive the meal period by mutual agreement. Non-exempt employees are allowed one paid ten-minute rest period for every four hours of work or major portion thereof. Management or supervisors will schedule individual meal and rest periods. Employees are expected to observe assigned working hours and the time allowed for meal and rest periods. During a meal break, employees are relieved of all duty and are free to leave the premises.

Employees with questions or concerns regarding meal and rest periods should promptly report them to their supervisor.

Timekeeping Requirements

Non-exempt employees are required to record their own time worked on a timesheet at the start and at the end of each work period, including before and after their lunch break. Timesheets must be approved by an employee's supervisor and turned into the fiscal department on the 16th and the first day of the month. If the 16th or the first day of the month fall on a weekend or holiday, employees will turn in their timesheets on the preceding workday.

Any errors on your time card/time sheet should be reported immediately to your supervisor.

Exempt employees are required to record their sick leave, vacation, unpaid leave, and holidays. Timesheets must be turned into the fiscal department on the 1st and 16th day of each month for the preceding half month. If the 16th or the first day of the month fall on a weekend or holiday, employees will turn in their timesheets on the preceding workday.

Payment of Wages for Exempt and Hourly Employees

Exempt Employees

Paydays are the 8th and 22nd of each month, for pay periods ending the last of the previous month and the 15th of the month, respectively. If a payday falls on a weekend or holiday, employees will be paid on the preceding workday.

Paychecks are disbursed via direct deposit. Employees will receive an electronic portal that they can use to access copies of the check and paystub. Employees should review their paychecks each time and report any errors to your supervisor and Fiscal Officer immediately.

Hourly Employees

Paydays are the 8th and 22nd of each month, for pay periods ending the last of the previous month and the 15th of the month, respectively. If a payday falls on a weekend or holiday, employees will be paid on the preceding workday. Employees should review their paychecks each time and report any errors to your supervisor and Fiscal Officer immediately.

Overtime

As necessary, employees may be required to work overtime. For purposes of determining which hours constitute overtime, only actual hours worked in a given work day or workweek will be counted (i.e. holidays, leave, etc. do not count). All overtime work must be previously authorized by a supervisor. WANB provides compensation for all overtime hours worked by non-exempt employees in accordance with state and federal law as follows:

All hours worked in excess of 8 hours in one workday or 40 hours in one workweek will be treated as overtime.

Compensation for hours in excess of 8 hours in one workday or 40 for the workweek or all hours on the seventh consecutive day of work in any one workweek, shall be paid at a rate one and one-half times the employee's regular rate of pay. Compensation for hours in excess of 12 hours in one workday or all hours over 8 hours on the seventh consecutive day of a workweek, shall be paid at a rate of two times the employee's regular rate of pay. Alternatively, overtime hours worked may be banked at one and one-half times for vacation accrual, at the Executive Director's discretion. Exempt employees may have to work hours beyond their normal schedules as work demands require. No overtime compensation will be paid to exempt employees.

Employees with questions or concerns about overtime should promptly report them to their supervisor.

Make-up Time

Employees can work make-up time, and the hours will not count toward overtime hours when all of the following requirements are met, and been approved by the Executive Director:

- The employee is making up work time that is or would be lost as a result of a personal obligation of the employee
- The make-up time occurs within the same seven-day workweek as the time taken off from work.
- The hours worked do not exceed 11 hours in one day or 40 hours in one workweek.
- The employee provides a signed written request for each occasion that he or she makes the request for make-up time and his/her supervisor approves the request.

Advances

WANB does not permit advances against paychecks or against unaccrued vacation or sick leave.

Personnel Records

Employees have a right to inspect certain documents in their personnel files, as provided by law, in the presence of a WANB representative at a mutually convenient time. No copies of documents in the file may be made, with the exception of documents that an employee has previously signed. An employee may add his/her version of any disputed item to the file.

WANB will attempt to restrict disclosure of all personnel files to authorized individuals within WANB. Any request for information from personnel files must be directed to the Executive Director. Only the Executive Director can authorize the release of information about current or former employees. Disclosure of personnel information to outside sources will be limited. However, WANB will cooperate with requests from authorized law enforcement or local, state or federal agencies conducting official investigations and as otherwise legally required.

Names and Addresses

WANB is required by law to keep current all employees' names and addresses. Employees are responsible for notifying WANB in the event of a name or address change.

Employee References

All requests for references and letters of recommendation must be directed to the Executive Director. The Executive Director may authorize other managers, supervisors or employees to release references for current or former employees. WANB's policy as to references for employees who have left the WANB is to disclose only the dates of employment and the title of the last position held. If an employee authorizes disclosure in writing, WANB will also provide a prospective employer with the information on the amount of salary or wage last earned.

Performance Evaluations

Employees will receive periodic performance reviews. The review will be conducted by the employee's supervisor who will discuss it with him/her. The first formal performance evaluation will be after completion of six months of employment. After that review, performance evaluations will be conducted annually, on or about the anniversary date of the employee's employment with WANB. The frequency of performance evaluations may vary depending upon length of service, job position, past performance, changes in job duties or recurring performance problems.

Performance evaluations may review factors such as the quality and quantity of the work performed, knowledge of the job, initiative, work attitude and attitude toward others. The performance evaluations should help employees become aware of their progress, areas for improvement and objectives or goals for future work performance. Positive performance evaluations do not guarantee increases in salary or promotions. Salary increases and promotions are solely within the discretion of the Executive Director and depend upon many factors in addition to performance. After the review employees will be required to sign the evaluation report simply to acknowledge that it has been presented and discussed with them by their supervisor, and that they are aware of its contents.

Open-Door Policy

Suggestions for improving the WANB are always welcome. At some time, you may have a complaint, suggestion, or question about your job, your working conditions, or the treatment you are receiving. Your good-faith complaints, questions, and suggestions also are of concern to WANB. We ask you to first discuss your concerns with your supervisor, following these steps:

- Within a week of the occurrence, bring the situation to the attention of your immediate supervisor, who will then investigate and provide a solution or explanation;
- If the problem persists, you may describe it in writing and present it to the Executive Director, who will investigate and provide a solution or explanation. We encourage you to bring the matter to the Executive Director as soon as possible after you believe that your immediate supervisor has failed to resolve it; and
- If the problem is still not resolved, the issue may be resolved by following the WANB Complaint Resolution Procedure.

This procedure, which we believe is important for both you and the WANB, cannot guarantee that every problem will be resolved to your satisfaction. However, the WANB values your observations and you should feel free to raise issues of concern, in good faith, without the fear of retaliation.

Recruitment

It is the goal of WANB to promote from within whenever possible. WANB will select on the basis of merit the employee best qualified to fill a job vacancy or a new position.

All regular full-time and part-time employees will be given two days written notice of promotional opportunities. Interested employees must submit a resume and application.

Notice of any vacant position not filled internally shall be sent to established community recruitment sources and/or local newspapers, to ensure reaching qualified prospective applicants.

Appointing Authority

The Executive Director will be hired by the WANB Governing Board, who will determine this position's annual salary.

All other positions will be hired by the Executive Director, at an annual salary to be determined by the Executive Director.

Employment of Relatives

The WANB may not hire relatives where actual or potential problems may arise regarding supervision, security, safety or morale, or where potential conflicts of interest exist. "Relatives" are defined to include anyone related by blood, marriage or adoption. Employees who are related may not be in a supervisory/reporting relationship with each other. Employees may also not be part of a hiring committee where a relative is considered for the position.

If two employees marry or become related, causing actual or potential problems such as those described above, only one of the employees will be retained with WANB unless reasonable accommodations can be made to eliminate the actual or potential problems. The employees will have 30 days to decide which relative will stay. If this decision is not made in the time allowed, the Executive Director will make the decision, taking the employment history and job performance of both employees into account.

Reductions in Force

Under some circumstances, WANB may need to restructure or reduce its workforce. If it becomes necessary to restructure our operations or reduce the number of employees, WANB will attempt to provide advance notice, if possible, so as to minimize the impact on those affected. If possible, employees subject to layoff will be informed of the nature of the layoff and the foreseeable duration of the layoff, whether short-term or indefinite.

Voluntary Termination

An employee who voluntarily resigns his/her employment or fails to report to work for three (3) consecutively scheduled workdays without notice to, or approval by his/her supervisor, will voluntarily terminate employment with WANB. All WANB owned property must be returned immediately upon termination of employment.

Termination of Employment

The Executive Director works at the will of the WANB WDB and Governing Board and may be terminated at will at any time without statement of cause being given. Such involuntary termination requires a three-quarter vote of the WDB and a concurring three quarter vote of the Governing Board.

All employees, work at the will of Management and may be terminated at will at any time by Management without statement of cause being given.

In the case of resignation, exempt and non exempt employees are expected to give a minimum of two (2) week's notice.

An employee leaving WANB employment for any reason will receive all earned salary/wages, payment for accrued vacation, and all earned and accrued overtime and compensatory time. Such payment will be made at the end of the pay period or sooner for involuntary termination.

Standards of Conduct

Prohibited Conduct

The following conduct is prohibited and will not be tolerated by WANB. This list of prohibited conduct is illustrative only; other types of conduct covered elsewhere in this manual or against statute or public policy or otherwise injurious to security, personal safety, employee welfare or WANB's interests also may be prohibited.

1. Theft, deliberate or careless damage or destruction of any WANB property or the property of any employee or customer.
2. Falsification of employment records, timesheets, employment information or other WANB records.
3. Unauthorized use of WANB equipment, time, materials, or facilities.
4. Provoking a fight or fighting during working hours or on WANB property.
5. Carrying firearms or any other dangerous weapons on WANB premises at any time.
6. Engaging in criminal conduct whether or not related to job performance.
7. Insubordination, including but not limited to failure or refusal to obey the orders or instructions of a supervisor or member of management, or the use of abusive or threatening language.
8. Failure to notify a supervisor when unable to report to work or the need to leave during working hours.
9. Abuse of sick leave.
10. Failure to observe working schedules, including rest and lunch periods.
11. Working overtime without authorization.
12. Wearing extreme, unprofessional or inappropriate styles of dress or hair while working.

This statement of prohibited conduct does not alter WANB's policy of at-will employment. Employees and WANB remain free to terminate the employment relationship at any time, with or without reason or advance notice.

Conflicts of Interest

The operation of the WANB requires employees to be independent, impartial, and responsible to the people they serve; that decisions and policies be made through the proper channels; that the WANB may not be used for personal gain; and that the public have confidence in its integrity.

Situations of actual or potential conflict of interest are to be avoided by all employees. Business or personal involvements which impair an employee's ability to exercise good judgment on behalf of WANB, create an actual or potential conflict of interest.

Disclosure of confidential information concerning the property, government, or affairs of the WANB, or any agency, employer, or client served by the WANB without proper legal authorization; or, using such information to advance the financial or private interest of the employee or employee's relatives or friends is strictly prohibited.

No employee shall accept a retainer or external compensation for services provided as an employee of WANB.

An employee involved in any of the types of relationships or situations described in this policy should immediately and fully disclose the relevant circumstances to his/her immediate

supervisor, or any other appropriate supervisor, for a determination as to whether a potential or actual conflict exists. If an actual or potential conflict is determined, WANB may take whatever corrective action appears appropriate according to the circumstances. Failure to disclose facts shall constitute grounds for disciplinary action.

Off-Duty Conduct

While WANB does not seek to interfere with the off-duty and personal conduct of its employees, certain types of off-duty conduct may interfere with the WANB's legitimate business interests. For this reason, employees should be aware of the following policies:

Employees are expected to conduct their personal affairs in a manner that does not adversely affect WANB's integrity, reputation or credibility. Illegal or unethical off-duty conduct on the part of an employee that adversely affects WANB's legitimate business interests or the employee's ability to perform his or her job will not be tolerated.

Drug and Alcohol Abuse

WANB is concerned about the use of alcohol, illegal drugs or controlled substances as it affects the workplace. Use of these substances whether on or off the job can adversely affect an employee's work performance, efficiency, safety and health and therefore seriously impair the employee's value to WANB. In addition, the use or possession of these substances on the job constitutes a potential danger to the welfare and safety of other employees and exposes WANB to the risks of property loss or damage, or injury to other persons.

Furthermore, the use of prescription drugs and/or over-the-counter drugs also may affect an employee's job performance and seriously impair the employee's value to WANB.

Use, Sale, or Possession of Drugs or Alcohol

The following rules and standards of conduct apply to all employees either on WANB property or during the workday (including meals and rest periods).

The following are strictly prohibited by WANB:

- Driving a WANB vehicle or operating a WANB asset while under the influence of alcohol.
- Distribution, sale or purchase of an illegal or controlled substance during the workday.
- Possession or use of an illegal or controlled substance, or being under the influence of an illegal or controlled substance during the workday.

Violation of the above rules and standards of conduct will not be tolerated. WANB also may bring the matter to the attention of appropriate law enforcement authorities.

In order to enforce this policy, WANB reserves the right to conduct searches of WANB property or employees and/or their personal property, and to implement other measures necessary to deter and detect abuse of this policy.

Any employee who is using prescription or over-the-counter drugs that may impair the employee's ability to safely perform the job, or affect the safety or well-being of others, must notify a supervisor of such use immediately before starting or resuming work.

Employee Assistance

WANB will encourage and reasonably accommodate employees with chemical dependencies (alcohol or drug) to seek treatment and/or rehabilitation. To this end, employees desiring such assistance should request a treatment or rehabilitation leave. WANB is not obligated, however, to continue to employ any person whose performance of essential job duties is impaired because of drug or alcohol use, nor is WANB obligated to re-employ any person who has participated in treatment and/or rehabilitation if that person's job performance remains impaired as a result of dependency. Additionally, employees who are given the opportunity to seek treatment and/or rehabilitation, but fail to successfully overcome their dependency or problem, will not automatically be given a second opportunity to seek treatment and/or rehabilitation. This policy on treatment and rehabilitation is not intended to affect the WANB's treatment of employees who violate the regulations described above. Rather, rehabilitation is an option for an employee who acknowledges a chemical dependency and voluntarily seeks treatment to end that dependency.

Drug Free Workplace

It is the policy of WANB to maintain a drug free workplace; to ensure all employees are free from the effects of drug use during work hours; and to ensure that drugs are not permitted on the premises. A drug free workplace is essential to maintaining the safety and efficiency of operations, and the health and safety of employees and the public.

All employees are prohibited from the unlawful manufacture, distribution, dispensing, possession or use of any controlled substance during work hours or on the premises of the WANB or any of its training sites. "Controlled substance" means a controlled substance as defined in Schedules I through V of Section 202 of the Controlled Substance Act.

The Executive Director shall be responsible for the implementation of a Drug Free Awareness Program to inform employees of:

- The dangers of abuse in the workplace;
- The organization's policy of maintaining a drug free workplace,
- Any available counseling, rehabilitation and employee assistance programs, and
- Penalties that may be imposed upon employees for drug abuse violations.

Violation of this prohibition policy may result in suspension, removal from employment, or other disciplinary action. Employees may be required to undertake rehabilitation counseling as a condition of employment.

As a condition of employment, any employee convicted of a criminal drug statute violation occurring in the workplace must notify the Executive Director, in writing, within five calendar days of such conviction. Within 20 calendar days of receiving notification of a conviction, the Executive Director will advise the employee, in writing, of the personnel action to be taken.

Punctuality and Attendance

Employees of the WANB are expected to be punctual and regular in attendance. Any tardiness or absence causes problems for fellow employees. When employees are absent, workloads must be performed by others.

Employees are expected to report to work as scheduled, on time and prepared to start work.

Employees also are expected to remain at work for their entire work schedule, except for meal periods or when required to leave on authorized WANB business

If an employee is unable to report for work at the scheduled start time on any particular day, he/she must call his/her supervisor no later than the scheduled start time for that day. In all cases of absence or tardiness, employees must provide their supervisor with an honest reason or explanation. Employees also must inform their supervisor of the expected duration of any absence. Absent extenuating circumstances, employees must call in on any day employees are scheduled to work and will not report to work.

If an employee fails to report for work without any notification to his/her supervisor and his/her absence continues for a period of five days, WANB will consider that the employee has abandoned employment and has voluntarily terminated. On the third day of the employee's absence, the Employer shall make reasonable efforts to notify the employee that employment will terminate upon five days of absence. Employees separated from employment for job abandonment will be reinstated with such charge removed from the employee's record upon presentation of justification for absence such as severe accident, severe illness, false arrest, or mental or physical impairment which prevented notification. Employees have no right to appeal if deemed to have resigned as a result of job abandonment.

Personal Standards

Each employee of WANB is a representative of the WANB in the eyes of the public. Employees assigned to the office are expected to dress in a manner consistent with a professional business office.

Customer Relations

It is the WANB's philosophy to maintain standards of excellence in customer service. Employees are expected to be polite, courteous, prompt and attentive to every client.
When a situation arises where the employee does not feel comfortable or capable of handling a situation, his/her supervisor should be called immediately.

Confidentiality

Each employee is responsible for safeguarding confidential information obtained during employment. An employee may have access to confidential information regarding WANB, its clients, its partners or fellow employees. It is the employee's responsibility to in no way reveal or divulge any such information unless it is necessary for the employee to do so in the performance of his/her duties. Access to confidential information should be on a "need-to-know" basis and must be authorized by the employee's supervisor. Any breach of this policy will not be tolerated and legal action may be taken by WANB.

Media Contacts

Employees may be approached for interviews or comments by the news media. Only contact people designated by the Executive Director may comment on WANB policy or events that have an impact on the WANB.

Restrictions on Political Activities

No political activities may be conducted at the WANB facilities during work hours.

Employer Property

File cabinets, desks, and storage areas are WANB property and must be maintained according to WANB rules and regulations. They must be kept clean and are to be used only for work-related purposes. WANB reserves the right to inspect all WANB property to ensure compliance with its rules and regulations, without notice to the employee and/or in the employee's absence. It may be necessary to assign and/or change "passwords" and personal codes for access. These items are to be used for company business and they remain the property of the company. WANB will keep a record of all passwords/codes used and/or may be able to override any such password system.

Prior authorization must be obtained from the Executive Director before any WANB property may be removed from the premises.

For security reasons, employees should not leave personal belongings of value in the workplace. Personal items may be subject to inspection and search, with or without notice, with or without the employee's prior consent.

Terminated employees should remove any personal items at the time they leave the WANB. Personal items left in the workplace by previous employees are subject to disposal if not claimed at the time of the employee's termination.

Use of Electronic Media

The WANB uses various forms of electronic communication including, but not limited to computers, laptops, e-mail, telephones, voicemail, fax machines, all online services paid for by WANB, Internet, and World Wide Web. All electronic communications, including all software and hardware, remain the sole property of WANB.

Employees who misuse electronic communications and engage in defamation, copyright or trademark infringement, discrimination, harassment or related actions will be subject to immediate termination.

WANB will override all personal passwords if it becomes necessary to do so for any reason. The WANB reserves the right to access and review electronic files, messages, mail, etc., and to monitor the use of electronic communications as is necessary to ensure that there is no misuse or violation of WANB policy or any law.

Employees are not permitted to access the electronic communications of other employees or third parties unless directed to do so by WANB management.

Questions about access to electronic communications or issues relating to security should be addressed to the Executive Director or appointed designee.

Prohibited Use of Company Cell Phone While Driving

In the interest of the safety of our employees and other drivers, WANB employees are prohibited from using cell phones while driving on WANB business.

If your job requires that you keep your cell phone turned on while you are driving, you must use a hands-free device and safely pull off the road before conducting WANB

business. Under no circumstances should employees place phone calls while driving a motor vehicle on WANB business.

Security

The WANB has developed guidelines to help maintain a secure workplace. Be aware of persons loitering for no apparent reason in parking areas, walkways, entrances and exits, and service areas. Report any suspicious persons or activities to security personnel. Secure your desk or office at the end of the day. When called away from your work area for an extended length of time, do not leave valuable and/or personal articles in or around your workstation that may be accessible. The security of facilities as well as the welfare of our employees depends upon the alertness and sensitivity of every individual to potential security risks. You should immediately notify your supervisor when unknown persons are acting in a suspicious manner in or around the facilities, or when keys are missing. No employee is permitted to be alone in a facility which is open to the public.

If an employee suspects that a client, fellow employee or any other person is potentially violent, the employee should not hesitate in alerting a co-worker, and calling 911 immediately.

Health and Safety

Every employee is responsible for the safety of him- or herself as well as others in the workplace. To achieve our goal of maintaining a safe workplace, everyone must be safety conscious at all times.

In compliance with Proposition 65, WANB will inform employees of any known exposure to a chemical known to cause cancer or reproductive toxicity.

Ergonomics

The WANB is subject to Cal/OSHA ergonomics standards for minimizing workplace repetitive motion injuries. WANB will make necessary adjustments to reduce exposure to ergonomic hazards through modifications to equipment and processes and employee training. The WANB encourages safe and proper work procedures and requires all employees to follow safety instructions and guidelines.
WANB believes that reduction of ergonomic risk is instrumental in maintaining an environment of personal safety and well-being, and is essential to our business. We intend to provide appropriate resources to create a risk-free environment.

If you have any questions about ergonomics, please contact your supervisor.

Smoking

Smoking is not permitted in any enclosed area of the facility.

Housekeeping

All employees are expected to keep their work areas clean and organized. People using common areas such as the lunch rooms and restrooms are expected to keep them sanitary. Please clean up after meals and dispose of trash properly.

Employees Who Are Required to Drive

Employees who are required to drive their own vehicle on WANB business will be required to show proof of current, valid licenses and current effective insurance coverage on the first day of employment.

Employees who drive their own vehicles on WANB business will be reimbursed at the rate established by the Executive Director.

TeleWORK Policy

Introduction and Purpose

Teleworking, or allowing an employee to work at home or an alternate location as part of their scheduled hours within a pay period, can both accommodate the needs of the employee and benefit the WANB. The WANB considers teleworking to be a viable work option that, when used appropriately, benefits both the organization and the individual employee. Teleworking is a tool allowing for flexibility in work options for a variety of reasons, including providing services in an innovative manner as well as to provide flexibility during an emergency. This is especially true during declared emergencies that may include the need to physically relocate, or physically distance for the protection of the community and employees.

Teleworking is defined as allowing employees, during their scheduled work hours, to fulfill their job responsibilities at a telework location other than their primary work location.

For purposes of this policy, teleworking is a voluntary work arrangement, not an entitlement. Teleworking does not change salary, job responsibilities, benefits and WANB-sponsored insurance coverages, or other basic terms and conditions of employment with the WANB or alter the employee's assignment to a primary worksite. The decision to permit teleworking is solely at the discretion of the WANB's Executive Director.

Teleworking Guidelines and Principles

- Teleworking is a cooperative arrangement between the supervisor and employee, for reasons that include:
    - the needs of the job, employee, and WANB.
    - the operational needs of the department and the services it provides to the public unless mandated due to an emergency.
    - the employee's current level of performance, up to and including the employee's most recent evaluation.
    - the need to physically relocate or reduce the number of staff at the workplace.
    - the need to create flexibility to provide essential services.

- Jobs suitable for telework are characterized by clearly defined tasks and work products that may be completed at a location other than the worksite. The expectation of work deliverables is the same, regardless of work location.

- Each teleworking arrangement must be a joint agreement between the employee and supervisor, and approved by the Executive Director. Teleworking is voluntary and may be

terminated by the employee, supervisor, or Executive Director and should be communicated in writing describing the reason, within forty-eight (48) hours unless mutually agreed upon between employee and supervisor/manager. Telework may be an alternative if physical distancing restrictions cannot be met as a result of the office configuration.

- The business needs of the WANB onsite office may take precedence over telework days.

- In the event of delay in repair or replacement of equipment or any other circumstances under which it would be impossible for the employee to telework, the WANB may assign the employee to work onsite.

- Depending on the job, equipment needs for teleworkers will vary. Some equipment may be provided at the WANB's availability as set forth in “Equipment Considerations” below. The teleworking employee is responsible for ensuring compliance with electronic security expectations.

Selection Criteria

Criteria to be considered when assessing the feasibility of telework are:

- Job Characteristics
- Clear and definable tasks and work products exist or can be identified, and work activities are measurable, including objectives with identifiable timeframes.
- Alternatives to face-to-face communication such as (telework communication can be handled via telephone, voicemail, e-mail, or video conferencing) where physical presence is not required or is not possible.
- Position already works independently in the handling of information, such as writing, reading, telephoning, planning, etc.

Roles and Responsibilities

Executive Director or Designee:

- Examine department operations and identify job duties where telework will be successful.
- Ensure managers and supervisors are advised of the Telework Policy and the use of the Telework Agreement.
- Provide approval or written explanation of denial on Telework Agreements.
- Follow appropriate protocols and all local, state and/or federal regulatory guidelines during emergencies when considering telework agreements.

Supervisors/Managers:

- Educate prospective and current employees about the Telework Policy and review the Telework Agreement form.
- Obtain approval of the Executive Director or designee for all Telework Agreements.
- Inform teleworkers that failure to comply with established WANB and department policies and procedures, as well as telework requirements, may result in termination of the Teleworker Agreement.

- Provide specific, measurable, and attainable performance expectations for the teleworker, such as specific assignments and corresponding deadlines.
- Communicate at least weekly regarding progress made and any other topics related to teleworking. Supervisors will provide support as needed on an ongoing basis.
- Periodically review telework schedules.
- Maintain copies of all signed Telework Agreements.
- Coordinate with Fiscal-Administrative Officer regarding potential budget impacts (additional ITS equipment, ITS services, etc.)

Teleworkers:

- Agree and sign a Teleworking Agreement.
- Shall have normally scheduled work hours, unless employee pre-arranges with their supervisor and/or Department Head. To maintain service level standards employees must be available and accessible via email and/or telephone during those work hours. Employees agree to respond to inquiries in the same fashion, and within the same timeframes, as if in the office.
- Teleworkers must record and report all of their time accurately on their timesheet. If any employee is not able to telework, the employee must code their timecard using the appropriate time (i.e., if an employee is sick they must use sick leave or other accrued time to cover the hours not worked).
- Teleworker will remain obligated to comply with all WANB rules, policies and procedures and be responsible that service demands are met. This agreement shall be documented using the Telework Agreement form.
- Will take all reasonable precautions to safeguard confidential or privileged information from disclosure and prevent unauthorized access to any WANB system at the telework location.
- Teleworker will have a designated workspace maintained by the employee. The WANB shall not be responsible for any costs related to remodeling and set-up (e.g., furniture, fixtures) of the designated workspace. The WANB, at its discretion, may assist employees with costs for teleworking. Expenses not covered in this policy will be dealt with on a case-by-case basis between the employee and the Executive Director.
- Tax implications related to the home workspace are the responsibility of the employee.
- Teleworker will manage dependent care and personal responsibilities in a manner that allows them to successfully fulfill job responsibilities.
- Communicate at least weekly regarding progress made and any other topics related to teleworking.

Equipment Considerations

The need for teleworking equipment shall be determined on a case-by-case basis by the employee and supervisor. Employee's personal equipment used for teleworking should be compatible with the WANB's remote access technologies, unless the nature of the work assignment does not require it. The Executive Director shall have final determination of the WANB equipment needed for teleworking purposes. If WANB equipment is approved, the repair and maintenance of teleworking equipment is the responsibility of the WANB; the WANB may track the use of borrowed WANB

equipment to ensure it is used solely for business purposes and in meeting the goals of the WANB. WANB will maintain a current inventory of equipment.

The WANB, at its sole discretion, may choose to provide equipment and related supplies for use by the employee while teleworking or may permit the use of employee-owned equipment subject to WANB rules and limitations. The decision as to the type, function, and/or quality of electronic hardware, systems access and voice and data shall rest entirely with the WANB. The employee agrees that the use of equipment, software, data and supplies provided by the WANB for use by the employee is limited to authorized persons.

Telework Objectives and Deliverables

Supervisors and employees will jointly set clear and measurable performance objectives and deliverables, including:

- Identifying the specific tasks and objectives.
- Establishing how to measure the objectives.
- Prioritizing work by identifying those results most crucial and those that can be deferred.
- Analyzing how objectives support work goals.
- Timekeeping/Reporting and Liability

All WANB policies regarding attendance and hours worked including break and lunch period rules and changes to work schedule shall apply to teleworking employees. The teleworker and supervisor shall agree upon a schedule of normally scheduled work hours, to be approved by the Executive Director. The teleworker must be available and accessible during those work hours unless pre-arranged with their supervisor and/or Department Head.

Establishing a telework location does not make the teleworker's regular commute to their primary work location a business trip or subject to compensation.

Overtime

Existing policies and laws are applicable for teleworkers. Overtime work shall be pre-authorized by the supervisor/manager.

Information Security Requirements

Federal and State regulations and contract requirements for information security that apply to on-site employees shall apply to teleworkers. The teleworking employee is responsible for ensuring compliance with the computer use standards, regulations, contracts and security of information at their telework location, including logging off the computer when not in use, and securing all WANB documents and data.

The information provided by the WANB for teleworker use, generated in the course of teleworking, and/or used by the teleworker for approved WANB purposes is owned and an asset of the WANB, and must be protected from unauthorized, incorrect or accidental access, use, modification, destruction or disclosure.

The WANB has an unrestricted right of access to and disclosure of all data and software on any

WANB equipment at the request of the appropriate WANB official(s). Information generated on WANB time, as well as work undertaken on behalf of the WANB during or outside of any WANB worksite and/or work hours shall be made available for review at the request of appropriate WANB officials. Such access and disclosure shall be in accordance with, and subject to any controls or restrictions imposed by applicable statutes or licenses.

Safety and Liability

The employee has the responsibility to maintain their telework space in a safe condition, free from hazards or other dangers. The WANB does not assume any liability for loss, damage, or wear of employee-owned equipment, furniture, or other personal property.

The teleworker remains liable for injuries to third parties and/or members of the employee's family on the teleworker's premises.

Employee Benefits

General

To the extent that resources are available, it is the intention of WANB to provide health, dental, vision and life insurance benefits to its regular full-time employees. The provision of such benefits, along with other forms of compensation will be evaluated on an annual basis and modified as necessary.

Legally Mandated Benefits

FICA Alternative Plan. As a governmental employer, WANB has chosen not to participate in the Federal Social Security portion of the FICA program. Instead, WANB provides its employees with a defined contribution retirement plan as an alternative to Social Security. This plan meets IRS requirements for WANB employees to be exempt from Social Security withholdings.

Under this plan, a minimum of 7.5% employer contribution to an Individual Retirement Account is made on behalf of the employee. The employee may also voluntarily contribute any amount up to the applicable legal limits of the Individual Retirement Account. Any vesting provisions required by IRS tax law or the plan administrator will be followed. These individual accounts are owned and controlled by each individual employee. Employees are encouraged to contribute as much as possible to ensure their retirement income is secure. Because this plan is a defined contribution plan, *the employee is not guaranteed a specific amount of benefits upon retirement.* Instead, the amount of benefits for each employee depends on the contributions made and the investment performance of the investments selected by the employee. Contributions to this account are held in a trust for the benefit of the employee and are income tax deferred. *Workforce Alliance of the North Bay is not liable for any loss which results from the participant's exercise of control over his or her individual retirement account.*

Medicare. The legally mandated Medicare portion of the FICA program is provided for all employees.

Workers Compensation (State of California). Worker's compensation insurance is provided for all employees.

Disability Insurance (State of California). Disability insurance through the State Disability Insurance program is provided for all employees.

Unemployment Insurance (State of California). State of California unemployment insurance is provided for all employees.

Other Benefits Currently Provided by WANB

WANB provides health insurance plans for eligible employees and their eligible family members. This health insurance benefit may include medical, dental, vision and life insurance. This benefit requires that the eligible employee complete and provide insurance enrollment information forms to the Fiscal Officer. It is the employee's responsibility to provide these forms in a timely manner.

Eligibility for Health Benefits

Regular full-time employees are eligible for medical, dental, vision, life insurance, Cafeteria Plan, Deferred Compensation Plan, and the Staff Incentive Compensation Plan, provided they meet the eligibility requirements under the terms of the health insurance policy.

Part-time/Temporary employees are not eligible for medical, dental, vision and life insurance, unless approved by the Executive Director. *Those benefits classified with an asterisk (*) are benefits provided only to regular full-time employees.*

Health Insurance: Healthcare coverage for spouses and dependents may be purchased by the employee at WANB's current cost through the cafeteria plan which is described below. WANB will cover at least 50% of the additional cost for any dependents. The availability of such health insurance coverage and the amount to be paid by the employer, if any, will be determined annually, based on available funds.

Dental Insurance: Dental coverage for spouses and dependents may be added at the employees discretion. 100% of the cost is covered by WANB. The availability of such dental insurance coverage and the amount to be paid by the employer, if any, will be determined annually, based on available funds.

Vision Insurance:. Vision coverage for spouses and dependents may be added by the employee through the cafeteria plan which is described below. The availability of such vision insurance coverage and the amount to be paid by the employer, if any, will be determined annually, based on available funds.

Life Insurance: WANB currently provides life insurance for each individual employee. The availability of such life insurance, the amount of coverage and the amount to be paid by the employer, if any, will be determined annually, based on available funds.

*Cafeteria Plan: WANB currently provides an IRS Section 125 Cafeteria Plan to all full-time employees. Under this plan, a specific amount of money is provided to each employee on an annual basis to pay for elective benefits. The employee may choose from a range of benefits including: spouse and dependent health insurance, spouse and dependent dental insurance, a Medical Expense Flexible Spending Account or a Dependent Care Flexible Spending Account. At the discretion of the Executive Director, any unused benefit funds may be deposited into the employees deferred compensation plan as an employer contribution. The availability of such a cafeteria plan and the amount of coverage to be provided will be determined annually, based on available funds.

*Deferred Compensation Plan: WANB maintains a Public Employer Deferred Compensation Plan which allows employees to voluntarily defer a portion of their income each year to be invested for retirement and employer to contribute at that Executive Director's discretion. Such amounts are income tax deferred and are held in a trust account for the benefit of the employee. The employee can make investment selections based upon the options currently available under the plan.

*Staff Incentive Compensation Plan: WANB staff will have the opportunity to receive an annual incentive compensation payment. This plan is utilized to encourage efficient and effective performance, and is thus contingent upon individual staff performance and contribution to the goals of the WANB as determined by the Executive Director.

A pool of funds for staff incentive payments shall be available to the WANB Executive Director to

award staff incentive bonuses at the end of each program year. The WANB Executive Director has the discretion to determine the amount of each individual employee's bonus amount and whether each individual's performance was satisfactory and contributed to the goals of the Board, in order for each employee to receive a performance bonus.

This incentive compensation plan is not guaranteed and may be terminated at any time by the Executive Director.

Holidays

Eligible WANB employees receive holiday pay for the following holidays:
Compensated Holidays: January 1 (New Year's Day) (ii) The third Monday in January (Martin Luther King Jr.'s Birthday) (iii) The third Monday in February (Washington's Birthday) (iv) March 31 (Cesar Chavez's Birthday) (v) The last Monday in May (Memorial Day) (vi) July 4 (Independence Day) (vii) The first Monday in September (Labor Day) (viii) November 11 (Veterans Day) (ix) The fourth Thursday in November (Thanksgiving Day) (x) The day following Thanksgiving Day (xi) December 24 (Winter Holiday) (xii) December 25 (Winter Holiday)

Holidays Falling on a Saturday or Sunday. If any of the above holidays falls on a Sunday, the holiday will be observed the following Monday, and if any falls on a Saturday, it will be observed the preceding Friday. If December 24 falls on a weekend, it will be observed the preceding Friday. If December 25 falls on a weekend, it will be observed the following Monday

After six months of full-time continuous employment, regular full-time employees are entitled to one personal holiday per calendar year.

Part-Time/Temporary employees are not eligible for holiday pay.

Vacation Leave

Regular Full-Time Employees

WANB encourages employees to take vacation on an annual basis. To encourage utilization of vacation leave, ***Regular Full-Time non exempt*** employees may carry a balance of 400 vacation hours. Exempt employees may carry a balance of 530 vacation hours. Once an employee has reached the maximum accrual, no additional vacation will be accrued until vacation is used by the employee.

Use of vacation leave shall not be allowed until the employee has successfully completed their first three (3) month period of employment. Accumulation of vacation days does not begin until completion of the first three months of employment.

Accrued vacation leave must be exhausted prior to the commencement of an approved unpaid leave of absence.

An approved unpaid leave of absence of five (5) days or less shall not affect the accrual of vacation credit. An unpaid leave of absence in excess of five (5) days will freeze vacation accrual.

An employee whose employment with WANB is terminated for any reason shall be entitled to compensation for all accrued vacation up to the maximum accrual amount permitted. Under no other circumstances may an employee cash out vacation leave.

All vacation leave must be pre-scheduled and approved by Management.

Part-Time Employees

Vacation leave for part-time is earned and accrued as follows:
Paid vacation leave shall accrue at the rate of five (5) days per year (3.333 hours per month), during employment.

WANB encourages employees to take vacation on an annual basis. To encourage utilization of vacation leave, ***Part-Time employees*** may carry a balance of 120 vacation hours. Once an employee has reached the maximum accrual, no additional vacation will be accrued until vacation is used by the employee. This cap of 120 hours applies regardless of the years of service, hours of total service or rate vacation is earned.

Use of vacation leave shall not be allowed until the employee has successfully completed their first three (3) month period of employment. Accumulation of vacation days does not begin until completion of the first three months of employment, at which time the amount of accumulated vacation will be prorated so that one half (1/2) of the annual allowed will be added to the employees total accumulated vacation time. This only applies to the first year of employment. Thereafter, vacation will accrue in the normal manner described below.

Accrued vacation leave must be exhausted prior to the commencement of an approved unpaid leave of absence.

An approved unpaid leave of absence of five (5) days or less shall not affect the accrual of vacation credit.

An employee whose employment with WANB is terminated for any reason shall be entitled to compensation for all accrued vacation. Under no other circumstances may an employee cash out vacation leave.

All vacation leave must be pre-scheduled and approved by Management.

Sick Leave

Regular Full-Time Employees

Sick leave is earned and accrued as follows:
Sick leave is to be used for employee or family member incapacitation due to illness, medical or dental appointments and bereavement purposes only. Abuse or misuse of sick leave privilege will not be tolerated by WANB.

Sick leave with pay shall accrue at a rate of one day (8 hours) per month of employment, beginning upon the start of employment. A regular full-time employee may accrue no more than 1040 hours.

A regular full-time employee who has completed 15 or more years of service is eligible to receive payment for unused sick leave at termination of employment. An employee with less than 15 years of service will not be paid for any unused sick leave. Payment will be made based on the employee's final hourly rate of pay. All eligible employees will be compensated at 50% of their final hourly rate of pay for unused sick leave at time of termination, up to a maximum of 400 hours. Any unused sick leave in excess of 400hours will not be compensated for eligible employees.

Accrued sick leave must be exhausted prior to the commencement of an unpaid leave of absence due to reasons covered by sick leave.

An approved unpaid leave of absence of five (5) days or less shall not affect the accrual of sick leave credit.

No sick leave credit shall accrue during an unpaid leave of absence of more than five days.

Management may require certification of illness or disability condition from the employee's physician or medical practitioner when the employee is absent on sick leave for more than three (3) consecutive working days.

The employee is responsible for notifying the office staff as close to 8:00 a.m. as possible on a day that they will not be present due to an illness.

Part-Time/Temporary Employees

Sick leave is earned and accrued as follows:
Sick leave is to be used for employee or family member incapacitation due to illness, medical or dental appointments and bereavement purposes only. Abuse or misuse of sick leave privilege will not be tolerated by WANB.

WANB will provide eligible employees with three days or 24 hours of paid sick time on their first day of employment with WANB.

Unused paid sick time will not carry over from year to year. However, WANB will place three days or 24 hours of paid sick time into the part-time employee's leave bank each year on your anniversary date. Employees will be able to access all three days or 24 hours of paid sick time at the beginning of each 12-month period.

Sick leave does not vest and is not paid out upon termination of the employment relationship. Sick leave must be exhausted prior to the commencement of an unpaid leave of absence due to reasons covered by sick leave.

Management may require certification of illness or disability condition from the employee's physician or medical practitioner when the employee is absent on sick leave for more than three (3) consecutive working days.

The employee is responsible for notifying the office staff as close to 8:00 a.m. as possible on the day that that they will not be present due to an illness.

Leaves of Absence

Management may grant unpaid leaves of absence to employees in certain circumstances. It is important for an employee to request any leave in writing including the reason for the requested leave, and the length of time requested to the Executive Director as far in advance as possible, to keep in touch with his/her supervisor or the Executive Director during the leave, and to give prompt notice if there is any change in the return date. Upon return from an approved leave of absence, the employee will be credited with the full employment status which existed prior to the start of the leave. If the leave expires and the employee has not contacted his/her supervisor or WANB, it will be assumed that the employee does not plan to return and that he/she has

terminated employment.

Accrued sick leave must be exhausted prior to the commencement of an unpaid leave of absence for medical reasons (or any reasons listed as appropriate for use of sick leave). Accrued vacation leave must be exhausted prior to the commencement of an approved unpaid leave of absence.

During the time the employee is on a leave of absence, no benefits will be earned.

WANB does not continue to pay premiums for health insurance coverage for employees on leaves of absence. However, employees may self-pay the premiums under the provisions of COBRA. The Fiscal Officer can provide additional information on this subject.

Bridging of Time

It is the intention of WANB to provide service credit to persons who were previously Special Employees of WANB through the WANB Employee Loaning Agreement with the County of Napa. Former Special Employees of WANB will receive credit for service calculated from their original service date as with the County of Napa, provided the break in service between Special Employment and employment with WANB does not exceed 365 days. Any break in service between 1 and 365 days will be deducted from the employee's service time. Credit for service will apply to:

- Seniority date
- Vacation accrual
- Sick leave accrual
- Retirement

Pregnancy Disability Leave

Disability due to pregnancy, childbirth, or related medical conditions will be treated like any other disability in accordance with State and federal law.

Any female employee planning to take pregnancy disability leave should advise the personnel department as early as possible. Employees who need to take pregnancy disability must inform the Executive Director when a leave is expected to begin and how long it will likely last. If the need for a leave or transfer is foreseeable, employees must provide notification at least 30 days before the pregnancy disability leave or transfer is to begin. If 30 days' advance notice is not possible, notice must be given as soon as practical.
Upon the request of an employee and recommendation of the employee's physician, the employee's work assignment may be changed if necessary to protect the health and safety of the employee and her child;

- Requests for transfers of job duties will be reasonably accommodated if the job and security rights of others are not breached;
- Temporary transfers due to health considerations will be granted when possible. However, the transferred employee will receive the pay that accompanies the job, as is the case with any other temporary transfer due to temporary health reasons;
- Pregnancy leave usually begins when ordered by the employee's physician. The employee must provide WANB with a certification from a health care provider. The certification

indicating disability should contain:

- The date on which the employee became disabled due to pregnancy; The probable duration of the period or periods of disability; and
- A statement that, due to the disability, the employee is unable to perform one or more of the essential functions of her position without undue risk to herself, the successful completion of her pregnancy, or to other persons.
- Leave returns will be allowed only when the employee's physician signs a release certifying the employee is ;
- An employee will be required to use accrued sick time (if otherwise eligible to take the time) during a pregnancy disability leave. An employee will be allowed to use accrued vacation or personal time (if otherwise eligible to take the time) during a pregnancy disability leave; and
- Duration of the leave will be determined by the advice of the employee's physician, but employees disabled by pregnancy may take up to four months. Part-time employees are entitled to leave on a pro rata basis. The four months of leave includes any period of time for actual disability caused by the employee's pregnancy, childbirth, or related medical condition. This includes leave for severe morning sickness and for prenatal care.

Leave does not need to be taken in one continuous period of time and may be taken intermittently, as needed. Leave may be taken in increments of 1 hour.

Under most circumstances, upon submission of a medical certification that an employee is able to return to work from a pregnancy disability leave, an employee will be reinstated to her same position held at the time the leave began or to an equivalent position, if available. An employee returning from a pregnancy disability leave has no greater right to reinstatement than if the employee had been continuously employed.

Military Leave

Employees who wish to serve in the military and take military leave should contact the Executive Director for information about their rights before and after such leave.
Employees are entitled to reinstatement upon completion of military service provided they return or apply for reinstatement within the time allowed by law.

Jury Duty or Witness Leave

WANB encourages employees to serve on jury duty when called. Non-exempt employees who have completed six months of continuous full-time employment will receive full pay while serving up to 5 days of jury duty. Exempt employees will receive full salary. Employees should notify their supervisors of the need for time off for jury duty as soon as a notice or summons from the court is received. Employees may be requested to provide written verification from the court clerk of having served. If work time remains after any day of jury selection or jury duty employees will be expected to return to work for the remainder of their work schedule.

Any mileage allowance, fee, etc., paid by the court for jury service is to be retained by the employee to the extent permitted by law.

Time Off for Voting

In the event that an employee does not have sufficient time outside of working hours to vote in a statewide election, the employee may take off enough working time to enable him or her to vote. Such time off shall be taken at the beginning or the end of the regular working shift, whichever allows for more free time, and the time taken off shall be combined with the voting time available outside of working hours. Under these circumstances an employee will be allowed a maximum of two hours on the Election Day without loss of pay. Where possible, the employee shall give his or her supervisor at least two days' notice that time off to vote is needed.

External Employee Education

Training costs for training required of the employee by WANB shall be fully paid by WANB.

Worker's Compensation

WANB, in accordance with state law, provides insurance coverage for employees in case of work-related injury. You are insured for any on-the-job injury or work related illnesses by Special District Risk Management Authority (SDRMA.) Worker's Compensation provides the following benefits:

- Medical Care - Payment of all approved medical and hospital bills
- Disability Income - If hospitalized, or unable to work for more than three days as a result of your work injury or illness, you will receive temporary disability payments equal to two-thirds of your average weekly wage, up to the maximum allowable by law, per week. If your injury results in a permanent disability which decreases your ability to work, additional payments will be provided
- Death Benefits - Should a work injury or illness cause death, a benefit will be paid to your dependents.

To ensure that you receive any workers' compensation benefits to which you may be entitled, you will need to:

- Immediately report any work-related injury to your supervisor. This includes minor sprains and injuries that may only require first aid. Failure to report injuries may result in a delay or loss of benefits. Complete the Employee Claim Form (provided by WANB) and return it to your immediate supervisor within 24 hours of receipt.
- Any injury requiring emergency treatment should be treated at the nearest hospital emergency room immediately following the injury. Call 911 for assistance if needed.
- For normal medical treatment, after you file a claim your supervisor will refer you to an approved medical care facility for initial treatment within 3 business days. If you go to any other medical facility without prior authorization from SDRMA, your billings may not be paid and will become your responsibility. This requirement will be waived if, prior to a work injury or illness occurring, you declare in writing to your supervisor your desire to see your personal physician of record in the event of a work injury or illness. The declaration must include your personal physician's name, address and telephone number. If after 30 days you wish to select another physician, you should address your request, in writing, to SDRMA's partner, York Risk Services Group, Inc.
- Should the doctor restrict you from regular duty because of a work injury or illness, you must immediately provide your supervisor with a written notice from the physician outlining your restrictions. We will, whenever possible, attempt to accommodate your restrictions by providing appropriate modified/alternate work for you while you are unable to perform your

normal duties.

- It is illegal to collect Worker's Compensation temporary disability income while working. If you return to work while collecting temporary disability, you must contact SDRMA.
- Worker's Compensation fraud is a felony in California. Any person who files or contributes to the filing of a false Worker's Compensation claim is committing a crime punishable by a prison sentence and/or fine.

In order for this system to work most efficiently, we need your cooperation. Please see your supervisor should you have any questions, or you may contact either the Claims Representative at SDRMA at 800-537-7790 or the Information and Assistance Officer with the Division of Worker's Compensation at 800-736-7401.

WORKFORCEALLIANCE
OF THE NORTH BAY
DRIVING WORKFORCE TALENT

TO: GOVERNING BOARD

FROM: STAFF

SUBJECT: BOARD LETTER III.C – RATIFY APPROVAL OF WORKFORCE ALLIANCE AGREEMENTS

DATE: AUGUST 14, 2020

CC: FILE

JPA staff Governing Board ratification for the following agreements and amendments enacted by the Executive Committee and Workforce Development Board:

CONTRACTOR	NEW/ AMENDMENT	NEW MAXIMUM AMOUNT	COMMENTS
Marin County Health and Human Services	Amendment #2	$778,731	Provision of supportive services for the Underserved COVID-19 impacted Individuals and Employment Recovery National Dislocated Worker Grant funds. Amendment increases total contract maximum by $248,145
Napa County Health and Human Services Agency	Amendment #3	$781,305	Provision of supportive services for the Underserved COVID-19 impacted Individuals and Employment Recovery National Dislocated Worker Grant funds. Amendment increases total contract maximum by $185,856
Mendocino Private Industry Council, Inc.	Amendment #6	$1,759,185	Provision of Prison to Employment program services Mendocino County and provides supportive services for the Underserved COVID-19 impacted Individuals and Employment Recovery National Dislocated Worker Grant funds for both Lake and Mendocino Counties. Amendment increases total contract maximum by $208,599

Paragraph 10 - Powers/ Responsibilities of the Agency exercised by the Governing Board of the JPA, states that the "Agency shall have the power to exercise any power common to all Member Counties authorized by Chapter 5 of Division 7 of Title 1 of the Government Code of the State of California (commencing with section 6500) and is hereby authorized to do all acts necessary for the exercise of these common powers, including…:

(3) Employ agents, employees, consultants, advisors, independent contractors and other staff;
(4) Make and enter into contracts, including contracts with public and private organizations and individuals;"

STAFF RECOMMENDATION

Ratify agreements with the above noted contractors and partners and authorize board chair and/or executive director to sign final negotiated agreements.