ARTICLE VI

Compensation

A. **SALARIES:**

1. **Salary Schedules and Regulations:** The regular rate of pay for each employee in the bargaining unit shall be in accordance with the Salary Schedules available at each work site of the Child Development Centers and Head Start Program offices and on the District web site. The Provisions for Administration of Salary Schedules are incorporated in Appendix B of this Agreement.

2. **Biweekly Salary Advance:** Upon submission of a timely request, an employee may be advanced not more than one-half of his/her net pay after deductions every two (2) weeks.

3. **Payroll Errors:** Proper salary class and step placement is a joint responsibility of the employee and the District. All employees are encouraged to review their salary placement annually and should they believe that they are improperly placed on the salary schedule, they should immediately bring this information to the attention of the District. In the event that an incorrect salary placement results in an underpayment, the District will issue a warrant for approximately ninety (90) percent of the net underpayment from the revolving fund within ten (10) working days from the day the error has been verified and Payroll receives written notification. Full adjustment will be reflected in the employee's next regular pay warrant. Should the incorrect salary placement result in an overpayment, the employee will reimburse the District the full amount of such overpayment on a repayment schedule developed by the District and the employee. In the event of an error favoring the employee or the District, the error shall be corrected retroactively for a period of up to three (3) years dating from the discovery of the error. "Discovery of the error" is defined as the date the District or the employee first receives written notification.

   a. When an employee requests an audit of payroll records beyond the immediately preceding thirty-six (36) months, the employee will be charged for this service at the rate of $20 per hour. The service fee will be waived if the audit reveals an actual error. The employee may request an estimate of the time involved in the audit prior to authorizing Payroll to proceed.

   b. Within two years of receipt of the annual service credit statement from the State Teachers Retirement System (STRS)/Public Employees Retirement System (PERS), as applicable, employees may request review of a perceived discrepancy in annual service as reported in that statement.

4. **Pay Warrant Adjustments.** (Education Code, Section 45051) Contract employees hired after the beginning of the contract year shall be notified at the time

of employment that they will receive a pay adjustment in their first warrant. Contract employees who resign, retire, go on unpaid leave, or are terminated prior to the end of their work year may have their last pay warrant adjusted.

5. **Mileage.** Employees who are authorized by the Board of Education to receive reimbursement for mileage will be reimbursed at the rate per mile established by the Internal Revenue Service for business mileage.

6. **Head Teachers (Head Start).** Head teachers shall receive two (2) increments in addition to their regular step and column placements described in the current salary schedule.

7. **403(b) Plan.** Unit members may participate in the District approved tax sheltered annuity plans, including the 403(b) plan, through voluntary payroll deduction. The District shall pay the fees, if any, of a third party administrator who will be responsible for plan administration and compliance. The District shall consult with TALB when considering a change in the 403(b) third party administrator.

B. **HEALTH AND WELFARE BENEFITS:**

1. **Employee Eligibility.** All bargaining unit employees working fifty (50) percent or more of a full-time assignment as defined in Article V (Days and Hours of Employment), Sections A. and J., are eligible for health, dental, vision, and life insurance benefits as provided in this Article. Effective 2010-11, the employer contribution shall be pro-rated for less-than-full time unit members.

   a. All coverage is effective the first day of paid service or first paid day upon return from unpaid leave of absence.

   b. Any employee in unpaid leave status for a period in excess of thirty (30) calendar days may continue health and welfare benefit coverage as provided in this Article by personally paying the premiums. The percent of the annual premiums to be paid shall be the same as the percent of the contract year during which the employee is in unpaid leave status. (For example, a one hundred seventy-eight [178] day employee on unpaid leave for one [1] semester, i.e., eighty-nine [89] days, is responsible for fifty (50) percent of the annual benefit premiums.)

   c. Effective 9/1/06, an employee who fails to enroll during open enrollment or within thirty (30) days of initial eligibility will be automatically enrolled in Blue Shield PPO, Delta Premier, Vision, and Life.

   d. Dependents of employees who, pursuant to paragraph c. above, are defaulted into the designated District group medical plans are not eligible to be enrolled except as follows:

(1) During the next open enrollment period; and/or

(2) Within thirty (30) days of becoming eligible by virtue of such qualifying events as birth, adoption, marriage or registering of a California Domestic Partnership.

2. The 2013 District annual maximum contribution toward individual unit member insurance premiums for District medical plans for full time employees, employee plus one and family coverage shall be based on the 2013 District PPO rates as adjusted by the cost containment changes. The District's annual maximum contribution excludes District dental and vision insurance.

Beginning the 2014 insurance year (January 1, 2014), and each year thereafter, the District shall increase the prior year's District annual maximum contribution toward individual unit member insurance premiums for District medical plans for full-time employees, employee plus one and family coverage by 3.5%. In the event the elected coverage in a District insurance program exceeds the above stated District maximum annual contribution, the cost difference shall be paid by the unit member through payroll deduction. The Health Benefits committee shall actively work to limit increases greater than 3.5%, through plan design modifications, vendor selection, wellness programs, and member education. In the event that the combination of the annual PPO rate increase and/or cost containment results in premiums below the District maximum annual contribution described above, that difference will mitigate future rate increases.

Effective January 1, 2016, change the health and welfare plan year from the current calendar year (January 1 to December 31) to match the District's fiscal year (July 1 to June 30). The change shall be managed in the following manner:

a. Effective July 1, 2016 the new plan year shall be based on the fiscal year (12 months). Open enrollment shall take place in May of each year with all plan changes being effective on July 1.

b. Flexible Spending Accounts will remain on the calendar year and will continue to have their open enrollment in November.

c. In the initial transition year, the deductibles and out-of-pocket maximums that have accrued during the "short" plan year shall carry over for the first plan year based on the fiscal calendar. The accrued deductible and out-of-pocket maximum then shall reset back to zero on July 1, 2017.

d. The District Annual Maximum (DAM) shall be converted to the fiscal year by taking the arithmetic average of the DAM for 2016 and 2017 calendar years.
   Example:
   2016-2017 DAM = [(2016 DAM) + (2017 DAM)]/2
   Effective July 1, 2017 the DAM will increase each July 1 by 3.5%.

3. The lowest cost District HMO medical plan offered unit members in any given insurance year shall not be subject to the District annual maximum contribution described in Section 2 above. In the event that the District anticipates that the premiums for the lowest cost District medical HMO plan may exceed the District annual maximum contribution as described in Section 2 above in the succeeding year, negotiations will automatically be initiated to address the excess cost during the next round of negotiations.

4. All eligible unit members retiring from the District after August 31, 2013 shall receive the same District annual maximum contribution for District medical plans provided to active unit members. Eligible unit members who retire on or before the above date shall not be subject to the District's annual maximum contributions as described in Section 2 above.

5. The District shall apply any health benefit cost containment changes, including plan design changes, implemented for active employees to retirees.

6. **Health Insurance.** Employees may choose coverage for themselves and their eligible dependents or same gender domestic partners for whom a Declaration of Domestic Partnership is currently on file in the office of the Secretary of State for the State of California. A choice shall be made from any one of the approved plans described below during the enrollment period announced by the Risk Management Branch. The District will pay no dollar amount greater than the maximum premium equivalent paid to fund the comprehensive plan carrier (Blue Shield). The employee must pay any additional premium cost. This arrangement is consistent with federal regulations concerning health maintenance organizations (HMO).

   a. Kaiser Foundation Health Plan.
   Brief description of coverage: Unlimited lifetime maximum.
   Continuation of existing plan without modification of benefits, except as noted.

   Annual out of pocket maximums are $1,500 Individual and $3,000 Family

   Physician Visit: $10 co-pay, effective 7/1/2017.

   Emergency Room Visit: $100 co-pay, effective 3/1/2013. The fee is waived if the person is admitted to the hospital.

   Chiropractic Care: $5 co-pay and 30 visits per year, effective 1/1/07.

   Prescription Plan: (100 Day Supply): Retail Generic and Non-Formulary co-pays are $5; Retail Brand co-pay is $10 effective 7/1/17.

b. **HMO Plan**.

Brief description of coverage: Effective March 1, 2013, this plan will be referred as the HMO TALB plan. The ability to move between the HMO and Comprehensive Major Medical is no longer available. Continuation of existing plan without modification of benefits, except as noted.

HMO. Office visits, $10; no deductible; hospitalization 100% covered. Unlimited lifetime maximum. Continuation of existing plan without modification of benefits, except as noted effective 7/1/17.

Emergency Room Visit: $100 co-pay, effective 3/1/2013. The fee is waived if the person is admitted to the hospital.

Chiropractic Care (HMO): $5 co-pay, up to 30 visits per year, effective 1/1/07.

Prescription Plan: Effective 7/1/18, the HMO prescription plan will revert to a three (3) system by the provider. Retail co-pay per thirty (30) day prescription: $10 formulary; and $35 non-formulary. Mail order co-pay for up to ninety (90) day prescription supply: $5 generic; $5 generic, $10 formulary; and $35 non formulary.

c. **PPO. COMPREHENSIVE MAJOR MEDICAL**. Continuation of existing plan without modification of benefits, except as noted.

(a) Effective January 1, 2016, $300/$600 deductible; 20% co-insurance; $1,000 individual/$2,000 family per year out-of- pocket limit (in addition to deductible).

(b) Effective January 1, 2016, $500/$1,000 deductible; 40% co-insurance; $5,000 individual/$10,000 family per year out-of-pocket limit (in addition to deductible).

Emergency Room Visit: (In-Network/Out of Network) $100 co-pay, effective 7/1/2017. The fee is waived if the person is admitted to the hospital; subject to plan specifications.

Prescription Plan: Effective 7/1/2017 the PPO plan will include a comprehensive prescription program with the following co-pay structure:

National Formulary: The District shall participate in the National Formulary to the extent offered by the district PPO Plan's Pharmacy Benefit Manager effective July 1, 2016.

Retail Pharmacy (30 Day Supply): $5 co-pay for generic; $20 co-pay for formulary; and $50 co-pay for non-formulary.

Mail Order (90 Day Supply): $0 co-pay for generic; $20 co-pay for formulary; and $50 co-pay for non-formulary.

Effective 7/1/2017, all diabetes medications shall be filled in a 90 day supply through Mail Order or 90 day supply through Walgreens (no other drugs outside the diabetes category in a 90 day supply at Walgreens).

d. Hearing Aids. Any active employee who is insured under any one of the District sponsored medical plans may request reimbursement for the costs of hearing aids. The maximum amount of reimbursement shall not exceed one thousand dollars ($1,000) within any three (3) year period. The cost of hardware, fitting tests, and other tests related to the hearing aids purchased shall be included for reimbursement purposes.

7. **Dental Insurance.** The District agrees to provide eligible employees with District payment of premium costs. Employees may choose between approved plans described below:

a. Delta Dental, PPO Plus Premier. This is a continuation of the present plan and the District shall continue to pay premium costs under this plan for the employee only. The employee may choose to pay premium costs for eligible dependents. Maximum amount paid by plan per person per calendar year:

In-Network PPO Dentists: $2,200.
Premier and Out-of-Network Dentists: $2,000.

b. Delta Care (PMI) Dental Health Plan. This is a continuation of the present plan. Coverage for both the employee and his/her eligible dependents is provided for by this plan.

8. **Life Insurance.** Employees whose regular annual salary exceeds fifteen thousand dollars ($15,000) shall be insured for the amount of the annual salary but not to exceed fifty thousand dollars ($50,000); employees whose regular annual salary is fifteen thousand dollars ($15,000) or less shall be insured for fifteen thousand dollars ($15,000). The amount of coverage shall be based upon the salary rate on the last day of actual service to the District by the employee.

9. **Vision Care Insurance.** The District agrees to provide vision care insurance for eligible employees. The Medical Eye Services plan provides one (1) comprehensive examination every twelve (12) consecutive months; two (2) pairs of lenses in any twenty-four (24) consecutive months. Employee is responsible for paying a ten dollar ($10) deductible per calendar year. Prior enrollment in the plan is required.

10. **Mental Health Care Service.** Employees and eligible dependents shall be provided outpatient mental health care service through the same Health provider in which the unit member is enrolled through the District (i.e. If medical is provided by the PPO, the mental health care is provided through the PPO.)

11. **125 Plan – Flexible Spending Accounts.** Upon securing the appropriate government approval, the District will provide employees the opportunity to participate in a 125 Plan at no administrative cost to the employee. Attendance at informational meetings shall be voluntary.

C. **DURATION OF BENEFITS:**

1. **Retiring Employees After Seventeen Years of Service.** Employees shall be eligible for District-paid premiums for health insurance provided that (a) the employee is age fifty-five (55) or older upon retirement and has seventeen (17) or more service years in the District or (b) the employee has at least thirty (30) years of service credit with STRS or PERS and seventeen (17) or more service years with the District. This benefit shall end when the retiree reaches age sixty-seven (67) on the condition that the retiree, if eligible, applies for coverage under Medicare Part A and B coverage at age sixty-five (65). Eligible employees who fail to apply for such coverage will not receive District-paid premiums for health insurance from age sixty-five (65) to age sixty-seven (67). (Article VI, C, 1, Lines 13-16) The retiree, or unremarried spouse of deceased retiree, may remain in the District plan by paying personally the insurance premiums without any limit on age.

   Medicare coverage will be primary for those employees who are eligible; the District's plan will provide secondary or umbrella coverage over Medicare payments. Additional information is available from the Risk Management Branch. (For health insurance benefits, unit member employees compensated for fifty [50] percent or more of a full-time assignment will receive one [1] year of credit toward the required seventeen [17] years of service.)

2. **Resigning/Retiring Employees.** Employees who do not qualify under Section 1. above and who resign as of the last day of the school year and after having served a complete contract year immediately prior thereto shall be eligible for District-paid health, dental, vision, and life insurance benefits through September 30 following the school year of service.

   Retirees age fifty-five (55) or older may remain in a District plan by paying personally the insurance premiums beginning the first of the month after the employee's retirement date. There is no limit on age. Medicare coverage will be primary for those employees who are eligible; the District's plan will provide secondary or umbrella coverage over Medicare payments. Additional information is available from the Risk Management Branch.

3. **Temporary Contract Employees.** Persons with temporary contracts who receive a letter of assurance for future employment shall have continuous health, dental, vision, and life insurance benefits through the months of July, August, and September following receipt of the letter of assurance.

4. **Employees on STRS/PERS Disability.** Employees who otherwise qualify and who are disabled and begin drawing STRS/PERS disability payments after June 1, 1979, shall be eligible for District-paid health insurance for the term of the disability but not more than thirty-nine (39) months from the dates of approval of the disability allowance.

5. **Health Insurance Extension.** For employees who do not qualify for benefits as described in Sections C.1. or C.2. or C.3. above, District-paid health, dental, vision, and life insurance coverage shall be extended to the end of the calendar month in which employment is terminated.

6. **Dental Insurance Extension.** Employees who retire from the District may remain in a District plan by paying personally the insurance premiums as provided for in Education Code, Section 7000. Employees who terminate employment with the District may extend their dental insurance at employee expense as provided in the Consolidated Omnibus Budget Reconciliation Act (COBRA). Information should be requested from the Risk Management Branch.

D. **TUBERCULOSIS EXAMINATION.** Required examinations for tuberculosis shall be provided by the District at no cost to employees only if District-designated service providers are utilized. The TB testing procedures has added a TB risk assessment questionnaire and, if risk factors are identified, the District shall require TB testing and examination to determine the unit member is free of infectious tuberculosis. The examination shall consist of an approved intradermal tuberculin test (Mantoux), which, if positive, shall be followed by an x-ray of the lungs.

E. **CONSULTATION MEETINGS.** The Association shall be invited on an annual basis to consultation meetings with the District and other employee groups for the purpose of exchanging information on the implementation of health, dental, and vision plans. The District also shall provide the Association the following documents without cost: provider service agreements, financial reports, cost containment reports, and claims information summaries.

F. **HEALTH AND WELFARE BENEFITS COMMITTEE.** The Association and District agree to form a joint committee to meet on an as needed basis to address the current and projected increases in health care costs. All recommendations will be submitted for consideration to the respective collective bargaining teams for negotiating. The specific duties of the subcommittee shall include:

a. Actively considering health and benefit cost containment measures relating to District PPO, HMO, vision and dental insurance plans for recommendation to the parties. The

includes, but is not limited to, co-payments and plan design modifications, active rate bidding by health care vendors/providers and alternative plans. It is the intent that the subcommittee shall use every reasonable effort to maintain the premiums for the lowest cost District HMO medical plan below the District annual maximum contribution described in Section B.2 above.

b. Membership education intended to fully maximize health benefits in a manner that encourages cost containment and quality health care (e.g., use of emergency room for non-emergency matters, use of generics, etc.).

c. Ongoing data sharing regarding comparable costs and health plans with similar districts.

d. Timelines for meetings consistent with making necessary recommendations for ongoing negotiations and health benefit renewal dates.

e. Identifying an additional $800,000 in cost containment and plan changes for TALB unit members for implementation no later than January 1, 2014. These cost containment changes will reduce the premiums for the affected plans beginning January 1, 2014 and are intended to mitigate individual unit member premium contributions as described in Section B.2.

Committee representation shall be limited to a maximum of four representatives from each party. The parties shall utilize consultants and/or facilitators as mutually agreeable. Team members shall agree to joint training on labor-management facilitation, health benefit design and how to assess benefit plans and look for cost savings while maintaining quality health care.

Subject to state or federal regulations, the parties agree that all data and communications regarding health and welfare benefit programs shall be shared openly between the parties, including discussions regarding bidding and renewals.