Leave of Absence Without Pay

Please Read Carefully

Employees on a leave of absence without pay for one full pay period or longer must notify Risk Management of the County Personnel Department to make arrangements for continuation and payment of insurances in advance of the leave of absence.

- If the employee is staying in a paid status by using their accruals, then the medical contributions will continue to be deducted from the employees' paycheck in advance for the next month's medical coverage.

- The employee may elect to cancel their health benefits coverage or continue coverage by paying a premium directly to their health plan (CalPERS Direct Payment Policy). **Either choice requires the employee to complete appropriate paperwork.**

County Contributions

- The County shall make the same contributions for employee insurances for eligible employees on an approved FMLA/CFRA/PDL, or Workers' Compensation Leave of Absence Without Pay as if the employee were actively working or on paid leave.
- Should the period of Unpaid Leave extend beyond the duration of the approved FMLA/CFRA/PDL for which the employee is entitled, or if the employee is not entitled to FMLA/CFRA/PDL Leave, the County paid medical contribution will continue towards Employee Only. It will continue during the period of the employee's Medical Leave of Absence. **The County does not pay medical contribution for dependent (s) coverage when the employee is no longer entitled to FMLA/CFRA Leave.**
- Employees on a Personal Leave of Absence are not eligible to receive a County contribution towards any insurance benefits for themselves or their dependent(s).

Time Bank

The employee on unpaid leave of absence who qualifies for, and receives time bank donations will not have their medical contributions amounts deducted from the dollar amount of the time bank donation. Time bank does not coordinate/integrate with the Direct Payment Authorization process.

Procedure for Continuation of Health Insurance during Leave of Absence without Pay
(Direct Pay)

STEP 1- Enrollment

Complete the **"Direct Payment Authorization"** Form HBD-21:

- Complete only section numbers: 1, 2, 3, 4, 6d, 6e
- All other sections will be completed by the Benefits Staff.
- Send the form to the Benefits Unit via email at benefits.questions@santacruzcounty.us or by mail to 701 Ocean St. Rm.510, Santa Cruz, CA 95060.

Upon receipt of Form HBD-21, the Benefits Unit will enroll you in Direct Pay.

STEP 2 – Paying Your Medical Premium

Your health plan will invoice you directly with the premium amount due.

- Attached is the applicable rate sheet outlining your premium.
- If paying by check make it payable to your health plan.
- Attached is a list of health plan addresses for your convenience.

STEP 3 - Reimbursement

After your form of payment has been processed by your financial institution, complete the attached **"Employee Request for Reimbursement of County Medical Contribution"**:

- Employee Name
- Address *(write your full address to ensure proper delivery)*
- Employee Number
- Last Actual Day Worked
- Check the box for your type of Leave
- Sign and Date the form
- Send the form with proof of the processed payment to the Benefits Unit via email at benefits.questions@santacruzcounty.us or by mail to 701 Ocean St. Rm.510, Santa Cruz, CA 95060.

Make Note

- The County will mail your reimbursement check and a reimbursement form to complete and return with your next proof of payment.
- Requests for reimbursement must be submitted to the Benefits Unit within 90 days from the date the payment was processed from.

PERS USE ONLY – DOCUMENT REFERENCE NUMBER

C

PUBLIC EMPLOYEES' RETIREMENT SYSTEM
Health Benefits Branch
P.O. Box 942714
Sacramento, CA 94229-2714
(888) CalPERS (225-7377)
TDD - (916) 795-3240 FAX (916) 795-1277

DIRECT PAYMENT AUTHORIZATION

PERS-HBD-21 (Rev 4/88)

PART A • EMPLOYEE INFORMATION •

1. SOCIAL SECURITY NUMBER	2. NAME (FIRST) (MIDDLE) (LAST)
3. HOME PHONE NUMBER ( )	4. HOME ADDRESS (STREET) (CITY) (STATE) (ZIP)

PART B • CARRIER PREMIUM •

5A. DIRECT PAYMENT TO: (CARRIER NAME AND ADDRESS)	5b. PLAN CODE 6a. GROSS PREMIUM $.
THE ABOVE PREMIUM IS PAYABLE TO CARRIER INDICATED, BEGINNING WITH PREMIUM MONTH OF:	6b. MONTH (alpha) / 6c. YEAR (numerical)

I agree to pay the total premium direct to the health plan carrier listed above before the tenth of each month which precedes the premium month. (For example, the June premium would be due by May 10th; the July premium would be due by June 10th.)
Note: I understand that failure to pay premiums will result in the suspension of my coverage. I also understand that the carrier will not bill me for premium and no employer contribution is available for direct payment.

6d. EMPLOYEE SIGNATURE (See reverse for important information and disclosure statement.) ▶	6e. DATE

PART C • REASON FOR DIRECT PAY •

7. ☐ LEAVE OF ABSENCE	8. ☐ APPEAL FOR DISMISSAL	9. ☐ SUSPENSION
10. ☐ ON WORKER'S COMP (ELECTED NOT TO SUPPLEMENT) OR CLAIM PENDING	11. ☐ PERMANENT INTERMITTENT (OFF-PAY)	12. ☐ ROLL CODE 9
13. ☐ APPLIED FOR DISABILITY RETIREMENT	14. ☐ OTHER (INSUFFICIENT EARNINGS, PENDING NDI)	PLEASE EXPLAIN

PART D • AGENCY INFORMATION •

15A. NAME OF EMPLOYING AGENCY **County of Santa Cruz**	15b. EMPLOYEE POSITION INFORMATION AGENCY / UNIT / CLASS / SERIAL / BARG. UNIT
16. DATES OF ABSENCE (numerical) FROM: MONTH / DAY / YEAR — TO: MONTH / DAY / YEAR	17. LAST PREMIUM DEDUCTION PAY PERIOD MONTH (alpha) / YEAR (numerical)
18. SIGNATURE OF HEALTH BENEFITS OFFICER	19. DATE / 20. TELEPHONE NUMBER **(831) 454- 2600**

Note Fill out highlighted portions only.**
Return by email at benefits.questions@santacruzcounty.us or by mail at 701 Ocean St. Room 510, Santa Cruz, CA 95060

Bay Area Rates

COUNTY OF SANTA CRUZ

PERSONNEL DEPARTMENT
MICHAEL J. MCDOUGALL, DIRECTOR
AJITA PATEL, DEPUTY DIRECTOR
701 OCEAN STREET, SUITE 510, SANTA CRUZ, CA 95060-4073
(831) 454-2600 FAX: (831) 454-2411 TDD: 711

EMPLOYEE REQUEST FOR REIMBURSEMENT OF COUNTY MEDICAL CONTRIBUTION

Employee Name: _____ Employee Number: _____
(*Print*)

Address: _____
(*Street, City, State, Zip Code*)

I am/or will be on a leave of absence and am electing to continue health coverage for myself (and my dependent(s), if currently enrolled) through the CalPERS Direct Pay Authorization Policy. My type of Leave of Absence is/will be:

☐ FMLA/CFRA/PDL ☐ Workers' Comp ☐ Other Medical

Proof of Direct Pay to the health plan must accompany this request form in order for the reimbursement to be processed. Proof of payment is defined as a copy of a cancelled check, a copy of a bank or credit card statement which indicates the date of payment, amount of payment, and the payee.

For FMLA/CFRA/PDL, or Workers' Comp Leaves, the County will reimburse the employee for the same contribution amount as if the employee were actively working or on paid leave.

If the employee is not entitled to FMLA/CFRA/PDL, or Workers' Comp Leave or the leave has extended beyond the duration of the approved FMLA/CFRA/PDL or Workers' Comp Leave, the County contribution towards **employee-only** medical will be reimbursed (there is no reimbursement for the dependent(s) coverage)

Requests for reimbursement of County medical contribution should be made each month and will not be considered eligible for reimbursement after 90 days have lapsed from the date the payment was processed. Please mail this form to: Benefits Unit 701 Ocean St., Room 510, Santa Cruz, CA 95060. Allow 2 weeks for processing of the reimbursement request.

_____
Employee Signature Date

For Benefits Division Use Only:

Health Plan: _____ # of dependents: _____ Keying Group: _____ Benefit Status: _____

Month / Year Paid: _____ Amount Paid: _____ Amount Reimbursed: _____

Index #: _____ Analyst Approval: _____ Date: _____

Direct Pay Health Plan Payment Address

Blue Shield Access

Blue Shield of CA
P.O. Box 629019
El Dorado Hills, CA 95762-9019

Anthem Select / Anthem Traditional

Anthem Blue Cross
File 29698
Los Angeles, CA 90074-9698

United HealthCare

UHC Benefits Services
P.O. Box 221709
Louisville, KY 40252
1-866-747-0048 (DP issues)

Kaiser

Kaiser Permanente
P.O. Box 7141
Pasadena, CA 91109-7141

PORAC

Anthem Blue Cross PORAC Unit
File 29698
Los Angeles, CA 90074-9698

Anthem PPO plans

PersCare/Pers Choice/Pers Select Membership Department
Blue Cross of California
P.O. Box 629
Woodland Hills, CA 91365-4387

HealthNet Smartcare

11971 Foundation Place
Attn: COBRA
Rancho Cordova, CA 95670

Revised: 1/2017