2025 BENEFITS

Employee Benefit Guide

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

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GETTING STARTED

2025 BENEFITS
January 1, 2025
through
December 31, 2025

IMPORTANT NOTE:
This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

At Central Contra Costa Sanitary District (Central San), we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason Central San offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit summaries, Summary of Benefits & Coverage (SBC) or Evidence of Coverage (EOC). The plan benefit booklets determine how all benefits are paid.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

Full-time, regular employees are eligible for benefits.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible Dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who Is Not Eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than 30 hours per week, temporary employees not on Central San's payroll, contract employees, or employees residing outside the United States.

When You Can Enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in September every year until October.

CALPERS DEPENDENT ELIGIBILITY VERIFICATION

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form Required	Marriage Certificate Required	State of California Domestic Partner (DP) Registration	Birth Certificate /Certificate of Adoption Required	Social Security Number
Employee only	●				●
Employee & Spouse	●	●			●
Employee & Domestic Partner (DP)	●		●		●
Employee & Children	●			●	●
Employee, Spouse/DP & Children	●	●	●	●	●

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2018, yet you did not report it until 2021, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On page 6, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 60 days from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 30 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Temporary Full-Time Employees

If you are hired as a temporary full-time employee (working on average 130 or more hours a month), you are eligible for medical plan coverage for you and your eligible dependents on the first day of the month after employment commences. You may choose any plan but will be responsible for 100% of the premiums.

Seasonal Employees

If you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), pursuant to the Affordable Care Act (ACA), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee by ACA definition. Your 12- month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12-month period, you will be defined as full-time and, if otherwise eligible for benefits, you will be offered coverage by the first of the second month after your IMP ends.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

ENROLLING FOR BENEFITS

Oracle

Employee Self-Service, in Oracle, is an online system that enables you to make all your benefit decisions in one place.

Before You Enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

How Long Can My Dependent Child(ren) Remain On My Benefits Plan?

Up to age 26.

When Must I Delete Ineligible Dependents?

Notification of ineligible dependents must be submitted to Human Resources within **30 days** of the following events:

- Divorce
- Reaching maximum dependent age of 26
- Death

Note: *If Human Resources is not notified within 30 days of the disqualifying event, the employee will be liable for the cost of all premiums paid by Central San for the ineligible dependent.*

What If I Have Medical Coverage?

Regular employees eligible for District paid health coverage may receive an additional $400 per month with the entire amount contributed to the 401(a) deferred compensation plan if they have medical coverage elsewhere. Employees who waive health plan coverage also waive chiropractic and hearing aid coverages.

Employees are required to provide evidence of coverage and sign a waiver of coverage form in order to receive the waiver allowance in lieu of health coverage.

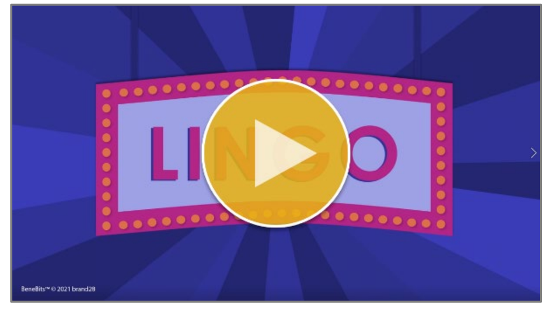
Note: *If employee loses coverage under another health plan, he/she does not have to wait for Open Enrollment Period and may enroll in Central San Coverage at the time of the loss. Coverage commences first of the month following loss of coverage.*

MEDICAL

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

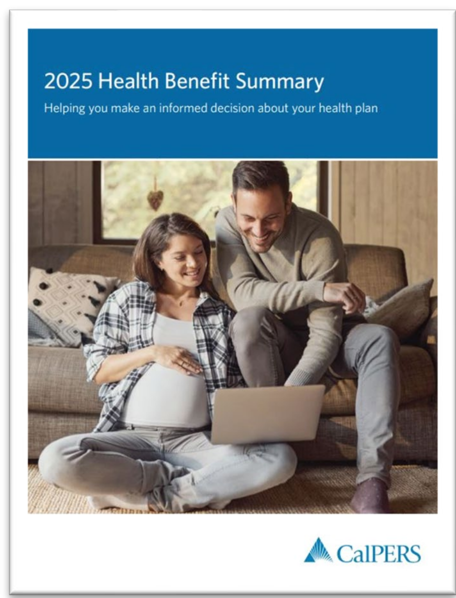


- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

CALPERS MEDICAL BENEFITS

It is Central San's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. Central San offers a choice of medical plans through CalPERS Medical.

For a summary of the different plans, and additional information please review the CalPERS Open Enrollment site: calpers.ca.gov/page/active-members/health-benefits/open-enrollment. On this site you will find the Health Benefits Summary, Health Program Guide, additional resources and information regarding your CalPERS Health Plan options.



2025 HEALTH BENEFIT SUMMARY

Click the image above to view the 2025 CalPERS Health Benefit Summary.

Why Would I Choose A PPO Plan?

- You have a doctor you like, and you would like to keep this doctor.
- You want to see specialists and other providers without having to first get a referral and/or pre- approval.
- You want the freedom to see providers who are not in the network.
- You are confident that you can manage your own care.
- You do not want a primary care doctor.

Why Would I Choose An HMO Plan?

- You don't want the extra responsibility of managing your own care.
- You do not want to pay the higher costs of a PPO.
- You do not want to get bills from providers.

Explore Your Benefits With MyCalPERS

Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at my.calpers.ca.gov.

To find CalPERS health plans available in your area, search by zip code at calpers.ca.gov.

CHANGES TO CALPERS MEDICAL BENEFITS

What's Changing In 2025?

- HMO Plans
  - Several HMO plans are expanding into new regions
    - Impacts to Contra Costa County, Shasta County, Imperial County, Monterey County and Solano County.
- PPO Plans
  - Blue Shield of California will be the new administrator for all PPO plans
    - For members in a Basic plan, Blue Shield is partnering with Included Health to provide member services, including answering inquiries, guiding members to the most appropriate in-network and high-quality providers, and providing care coordination services for members, particularly those with complex health conditions
    - Included Health will also expand access to care through their supplemental virtual primary care and behavioral health care services
    - There are no changes to copays, coinsurance, or deductibles with this transition to Blue Shield
- All Plans
  - Doula Benefit for all Pregnant and Postpartum members on the Basic plans
  - Travel Benefit for Medically Necessary Care

Click here for more information on ALL upcoming plan changes.

MEDICAL PREMIUM RATES

2025 CalPERS Health Plan Rates – Region 1

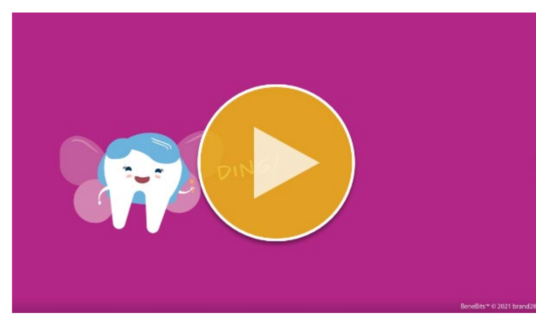
Health Plans	EMPLOYEE ONLY			EMPLOYEE & 1 DEPENDENT			EMPLOYEE & 2+ DEPENDENTS		
	Total Premium	Central San Pays	Employee Pays	Total Premium	Central San Pays	Employee Pays	Total Premium	Central San Pays	Employee Pays
Anthem Blue Cross Select	$1,256.65	$1,256.65	-	$2,513.30	$2,513.30	-	$3,267.29	$3,267.29	-
Anthem Blue Cross Traditional	$1,500.40	$1,500.40	-	$3,000.80	$3,000.80	-	$3,901.04	$3,901.04	-
Blue Shield Access+	$1,170.17	$1,170.17	-	$2,340.34	$2,340.34	-	$3,042.44	$3,042.44	-
Blue Shield TRIO	$1,134.79	$1,134.79	-	$2,269.58	$2,269.58	-	$2,950.45	$2,950.45	-
Kaiser Permanente	$1,112.90	$1,112.90	-	$2,225.80	$2,225.80	-	$2,893.54	$2,893.54	-
PERS Gold	$1,013.70	$1,013.70	-	$2,027.40	$2,027.40	-	$2,635.62	$2,635.62	-
PERS Platinum	$1,476.10	$1,476.10	-	$2,952.20	$2,952.20	-	$3,837.86	$3,837.86	-
United HealthCare Signature Alliance	$1,184.58	$1,184.58	-	$2,369.16	$2,369.16	-	$3,079.91	$3,079.91	-
United HealthCare Signature Harmony	$1,005.02	$1,005.02	-	$2,010.04	$2,010.04	-	$2,613.05	$2,613.05	-
Western Health Advantage	$914.27	$914.27	-	$1,828.54	$1,828.54	-	$2,377.10	$2,377.10	-

DENTAL

OUR PLAN

Delta Dental PPO

Click to play video



Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DELTA DENTAL

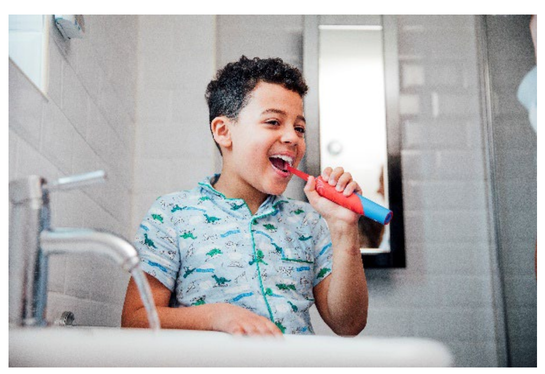
Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Central San provides you with a 100% fully-paid comprehensive coverage through Delta Dental Insurance Company. This plan includes orthodontia (maximum $3,000 lifetime benefit) and TMJ riders (maximum $1,500 lifetime benefit).

Employees and dependents are responsible for treatment copays and deductibles.

	Delta Dental PPO	
	In-Network	**Premier & Out-of-Network**
Calendar Year Deductible	$25 (individual) $75 (family)	$25 (combined with in-network) $75 (combined with in-network)
Annual Plan Maximum	$2,100	$2,000 (combined with in-network)
Waiting Period	None	None
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%
Basic Services Fillings Root Canals Periodontics	 Plan pays 95% after deductible Plan pays 95% after deductible Plan pays 95% after deductible	 Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible
Major Services	Plan pays 95% after deductible	Plan pays 90% after deductible
Orthodontic Services Orthodontia Lifetime Maximums Dependent Children Full-Time Students	Plan pays 90% $3,000 Covered Covered	Plan pays 90% $3,000 (combined with in-network) Covered Covered

DELTA DENTAL RESOURCES



LifePerks

As a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life. Register and learn more about LifePerks at discountmember.lifecare.com.

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. Opt in by visiting www.deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Toothpic

Toothpic is a photo-based tele-dentistry app for PPO & premier plan members. Although Toothpic is not available for dental emergencies, members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist that is part of the PPO & Premier Network, can highlight issues from the photos, such as cavities, gum disease, oral hygiene, or other dental concerns. The dentist can then assist with next steps or possible treatments or a home care regimen.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Members can compare procedure costs at nearby dentists should members need to plan in terms of costs. Members can also receive a detailed explanation of their costs based on upcoming treatment.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

VISION

OUR PLAN

VSP Vision

Click to play video

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VSP VISION

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. Central San pays for the full cost of the vision premiums for you and your eligible dependents.

	VSP Choice Network	
	In-Network	**Out-of-Network**
Exams Benefit Frequency	$10 copay Once every 12 months	Up to $45 Once every 12 months
Materials	$10 copay	See fee schedule below
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Plan pays 100% for basic lens Plan pays 100% for basic lens Plan pays 100% for basic lens Once every 24 months	Up to $30 Up to $30 Up to $30 Once every 24 months
Lens Enhancements Standard Progressive Premium Progressive Custom Progressive Frequency	$0 $95-$105 $150-$175 Once every 24 months	Up to $50 Once every 24 months
Frames Benefit Frequency	$150 allowance for a wide selection of frames Additional $20 for featured frame brands Plus 20% off any costs over the allowance Once every 24 months	Up to $70 Once every 24 months
Contacts (Elective) Exam Benefit Frequency	$60 copay $150 allowance Once every 24 months	Up to $105 (exam & contact lens combined) Once every 24 months

[1]Materials copay: When purchasing eyewear, an additional $10 copay will be required.

[2]When you choose contacts instead of glasses, your $150 allowance applies to the cost of your contacts. There is an additional copay for the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

You may receive benefits when using non-VSP providers by submitting your claims directly to VSP. Reimbursements will be made as indicated in the non-network schedule above. Find VSP network doctors at www.vsp.com or by calling (800) 877-7195.

VSP SAVINGS AND RESOURCES

ACCESS TO OVER $3,000 IN EXCLUSIVE MEMBER SAVINGS

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.

Extra Savings on Glasses and Sunglasses

Get an extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

You won't pay more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

TruHearing® Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too. TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

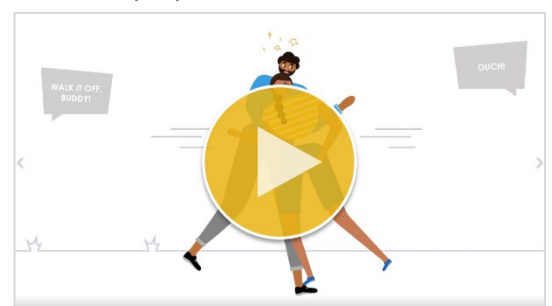
VSP Diabetic Eyecare Plus Program

This program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best.

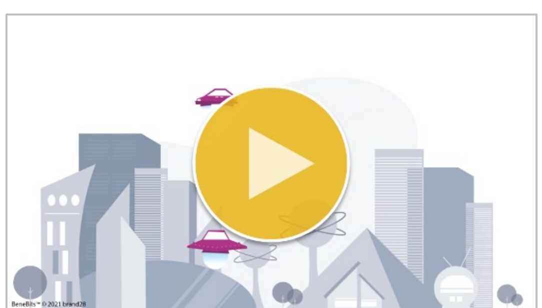
The program also provides supplemental coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema. Members can self-refer, visit their VSP Provider as often as needed, and pay only a copay for services.

ENGAGE

Click to play videos



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

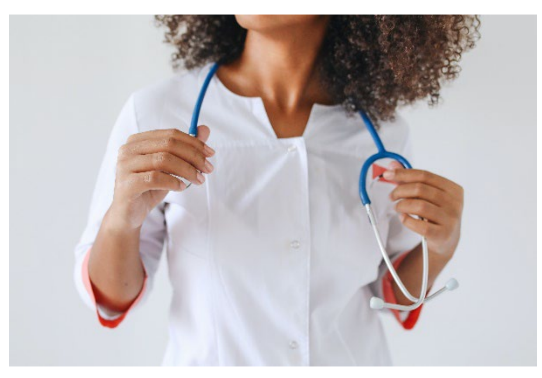
- Finding the right care at the right cost
- Understanding preventive care benefits

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or ▪ stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

CONCERN – EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
800-344-4222

Website
Login.concernhealth.com

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 6 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care
- Parent Coaching

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

WELLNESS RESOURCES

Free Digital Therapy Resources

Talkspace is an online therapy platform that makes it easy and convenient for you to connect with a licensed behavioral therapist from anywhere, at any time.

You can send unlimited text, video, and audio messages to your dedicated therapist via secure, HIPAA-compliant web browser or the Talkspace mobile app. No commutes, appointments, or scheduling hassles.

All consultations are confidential and secure.
This benefit is in addition to our Concern EAP benefit.

GET STARTED TODAY

Log on to our wellness portal for resources to help you reach your full health and wellbeing potential.

Organization Name: centralsan

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

CENTRAL SAN-PROVIDED LIFE AND AD&D INSURANCE

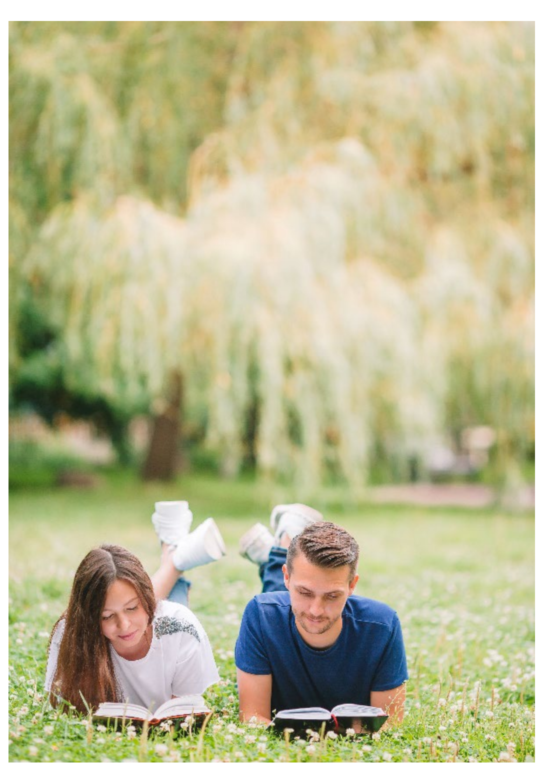
Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Voya Financial, and premiums are paid in full by Central San.

	Basic Life Amount	Basic AD&D Amount
Coverage for Local One Employees	2 times the annual E-Step earnings up to a maximum of $50,000	2 times the annual E-Step earnings up to a maximum of $50,000
Management Support/ Confidential Group (MS/CG) Employees	1 times the annual E-Step earnings up to a maximum of $75,000	1 times the annual E-Step earnings up to a maximum of $75,000
Management Group Employees	2 times the annual earnings up to a maximum of $250,000	2 times the annual earnings up to a maximum of $250,000
Eligible Dependents	$1,500 life insurance benefit	$1,000 life insurance benefit

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

SUPPLEMENTAL LIFE AND AD&D INSURANCE



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting Those You Leave Behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya Financial.

If you enroll during your initial enrollment period or are newly eligible and elect an amount that exceeds the guaranteed issue amounts as outlined below, you will need to provide an Evidence of Insurability before the excess amount will be effective.

If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant. Late entrants may need to show evidence of insurability should they elect coverage during Open Enrollment.

Covered	Employee	Spouse	Child(ren)
Minimum Coverage Amount	$10,000	$5,000	$10,000 per child. No medical information required.
Increments	$10,000	$5,000	
Maximum Coverage Amount	Up to $250,000 (not to exceed plan pays 50% of employee benefit)	Up to $500,000 (not to exceed 5 x annual earning)	
Guaranteed Issue Amount	$100,000	$50,000	$10,000

Add-Ons

Your Central San paid and supplemental life policies come with the following options:

- **Living Benefits Option**. If you are diagnosed as terminally ill with a 12 month or less life expectancy, you may be eligible to receive payment of a portion of your life insurance. The remaining amount of your life insurance coverage will be paid out to your beneficiary when you die.
- **Life Conversion and Portability**. You can continue your life insurance coverage even after your employment with Central San ends.
    - Conversion: Option to convert your term policy to a whole life policy that accumulates cash value and will be computed at individual insurance rate. **Premiums for the converted policy will be substantially higher compared to the Central San sponsored term plan.**
    - Portability: Allows you to continue your life insurance coverage even if you are no longer employed with Central San.

If you need more information on these options, please reach out Human Resources.

SUPPLEMENTAL LIFE AND AD&D INSURANCE – RATE CALCULATION

Employee and Spouse Rates

- Employees may elect up to $500,000 of life insurance, in increments of $10,000. You are guaranteed coverage for $100,000 during initial enrollment.
- Spouses may elect up to $250,000 of life insurance, in increments of $5,000. Guaranteed issue coverage is $50,000 during initial enrollment.
- Dependent child(ren) are eligible for coverage of $10,000 each. Guaranteed issue amount is the same during initial enrollment.
- Any amount you elect above the guaranteed issue (GI) will be subject to medical underwriting. If you elect additional life insurance, your monthly premium rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Age	Rate per $1,000
Under Age 25	$0.06
Age 25-29	$0.06
Age 30-34	$0.075
Age 35-39	$0.098
Age 40-44	$0.143
Age 45-49	$0.21
Age 50-54	$0.36
Age 55-59	$0.60
Age 60-64	$0.915
Age 65-69	$1.763
Age 70 and over	$2.865
AD&D Rates	$0.035 per $1,000

Life Insurance Rate Chart

1. Amount Elected: Write the amount of units you want. (1 unit = $1,000) Line 1:___
2. Write your age-based rate from the table to the left. Line 2:___
3. Multiple Line 1 by Line 2. This is your monthly premium amount. Line 3:___

Example:

A 45-year-old employee requesting for $250,000 life & AD&D coverage.

1. Amount elected & # of units : $250,000/$1,000 = 250
2. Rates:
   Life Insurance: $0.237
   AD&D Insurance: $0.035
3. Life: 250 x $0.237 = $59.25
   AD&D: 250 x $0.035 = $8.75
   $68.00 per month

Dependent Child(ren) Rates

- **Life**: $0.94 per $10,000
- **AD&D:** $0.35 per $10,000

STATE DISABILITY INSURANCE (SDI) & WORKERS COMPENSATION

State Disability Insurance

Employees covered by State Disability Insurance (SDI) are also covered by Paid Family Leave (PFL) insurance. PFL benefits are available to persons who take time off from work to:

- Care for a seriously ill child, spouse, parent, grandparent, grandchild, sibling, parent-in-law or domestic partner, or
- Bond with a with a new minor child

State Disability Insurance and Paid Family Leave provide a benefit after a **seven (7) calendar day** waiting period.

Worker's Compensation Insurance

All Central San employees, including temporary employees are covered by Workers' Compensation Insurance.

Central San's Workers' Compensation Program is administered by the Risk Management Division.

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Coverage is provided by Voya Financial.

General and MS/CG Employees' LTD Plan

Paid in full by Central San

Monthly benefit amount	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefits	$5,000
Benefits begin For General Employees For MS/CG Employees	 180 days of disability 90 days of disability
Maximum payment period*	Social Security normal retirement age

*The age at which the disability begins may affect the duration of the benefits.

Management Employees' LTD Plan

Deducted from employees' monthly paycheck

Monthly benefit amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefits	$13,500
Benefits begin Accident/Sickness	 60 days of disability
Maximum payment period*	Social Security normal retirement age

VOYA VALUE ADDED SERVICES

GET STARTED TODAY

To access these value-added services, visit guidanceresources.com or download our mobile app "GuidanceNow" from your favorite app store.

Web ID: My5848i

ComPsych®

Telephonic clinical and work/life support, referrals for community services, free 30-minute financial and legal consultations, educational resources and webinars.

Estate Planning

EstateGuidance® makes it easy with online tools that walk you through the process in minutes. Just access the site using the directions provided and supply the information. Your will can be completed online and downloaded to your computer or printed and shipped to you.

Financial Resources

Just call your GuidanceResources toll-free number. You'll be connected to a GuidanceConsultant who will talk with you about your specific situation and schedule a phone appointment for you with one of our financial experts.

Funeral Planning

Funeral planning and concierge services are provided by Empathy, which offers both pre-planning and at-need services at or near the time of need. At-need services include price negotiation assistance and communicating the family's wishes to the funeral home.

Travel Assistance

A comprehensive worldwide travel assistance program that includes pre-trip planning and emergency assistance to covered persons while traveling 100 miles or more from home.

Legal Guidance

You'll be connected to a GuidanceConsultant who will talk with you about your situation and schedule a phone appointment for you with one of our staff attorneys. If you need more immediate help, you can be connected to an attorney directly.

FINANCIAL WELLNESS

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future.

RETIREMENT PROGRAMS

Medicare

Employees have 1.45% of their salary deducted for Medicare.

Deferred Compensation

Central San offers an optional Deferred Compensation Plan (457). Mission Square is the plan provider, and employees can select from a variety of savings and investment options.

Defined Benefit Pension

Central San contracts with the Contra Costa Public Employees' Retirement Association (CCCERA) to provide a defined benefit pension. In compliance with the legal requirements of the California Public Employees' Pension Reform Act of 2012 (PEPRA), Central San shall maintain two defined benefit plans.

Plan one is for "classic members", defined by PEPRA as a Central San employee who was active as of December 31, 2012, all former Central San employees, and new hires who were members of a reciprocal public pension plan as of December 31, 2012, and who were employed within the last six months by a public agency covered by a reciprocal plan prior to Central San employment.

Plan two is for "new members", defined by PEPRA as either an individual who was not a member of a reciprocal public pension plan on or before December 31, 2012, or an individual who had a break in service of more than six months prior to Central San employment.

Classic Members:

Formula	2% at 55
Pensionable Compensation Limit	$345,000 for 2025
Earliest Age of Retirement	50
Final Average Compensation Period	Highest 12 months

PEPRA Members:

Formula	2% at 62
Pensionable Compensation Limit	$181,734 for 2025
Earliest Age of Retirement	52
Final Average Compensation Period	36 months

RETIREMENT PROGRAMS, CONTINUED

Health Reimbursement Account (HRA)

For all regular employees hired on or after June 30, 2009, Central San contributes 1.5% of base salary to a Health Reimbursement Account (HRA) to be utilized by employees to pay for eligible medical expenses post-employment. Employees have a choice of savings and investment options.

Unrepresented employees make a mandatory 7% of base salary pre-tax contribution each pay period.

Management employees hired after June 30, 2009 who are not PEPRA and all Management employees hired after June 30, 2019, make a mandatory 1.5% of base salary pre-tax contribution each pay period.

401 (A) Money Plan

Central San does not participate in the Social Security System except for a mandatory Medicare contribution from both the employee and employer. In lieu of Social Security, Central San contributes to a 401(a) plan in an amount equivalent to the employer portion of the Social Security contribution which is currently 6.20% of salary up to $168,600 for 2025. Employees have a choice of savings and investment options.

Upon the first day of employment, employees can make a one-time, irrevocable election to make voluntary pre-tax contributions to the 401(A) plan. This election must be made on the first day of employment and cannot be changed or revoked during employment with Central San. This voluntary contribution is in addition to the Central San contribution.

Unrepresented employees make a mandatory pre-tax contribution to the 401(A) plan in addition to the Central San contribution. The contribution is percentage based, from 2% - 12.5% of base pay, per pay period and the percentage is based on annual salary.

Retiree Benefits

New employees will be covered by medical and dental plans when they retire from Central San employment provided, they meet the “Rule of 70”.

Under the “Rule of 70”, an employee’s age plus years of service with Central San at the time of retirement must total 70, with a minimum requirement that the employee must be at least 55 and have at least ten years of continuous service with Central San at the time of retirement.

Eligible qualified dependents other than the employee’s spouse who were covered as dependents at the time of retirement also shall be covered by medical and dental plans with the exception that the employee shall pay the full cost of coverage for those dependents.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Set Aside Healthcare Dollars For The Coming Year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through BCC.

How The BCC FSA Works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,200, the 2025 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- There is a "Use it or Lose it" rule if you do not claim expenses incurred. **Claims for expenses incurred by March 15th of the following plan year must be submitted by March 31st** or you will lose the unexpended portion of your contributions.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

Cafeteria Plan

At the beginning of every calendar year, Central San contributes varying amounts per Bargaining Unit towards full-time regular employees' healthcare and/or dependent care spending accounts. Employees may opt to combine their own dollars for maximum contribution to the healthcare and/or dependent care spending accounts.

Central San provides $100/month for General Employees, $220/month for Management Support/ Confidential Group employees, and $425/month for Management employees. The Central San contribution may also be taken as cash.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE
The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up To $5,000 Per Year Tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by BCC.

Here's How The BCC Dependent Care FSA Works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

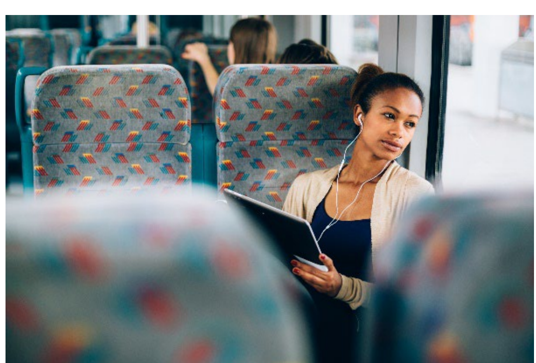
Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

SAVE ON COMMUTE EXPENSES

Transportation Savings Account—up To $315 Per Month Tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by BCC.

Central San participates in the Bay Area Commuter Benefits Program which offers incentives and tax-free benefits for employees who use alternative commute methods. Details of this program can be obtained by visiting Central San's intranet or by contacting Human Resources.



HOW TO USE YOUR BCC ACCOUNT

Debit Card

BCC offers employees the option to use a debit card for your healthcare expenses. The money you set aside in your FSA account(s) for medical expenses is available on your card. When you pay for these expenses, you do not need to pay out-of-pocket and wait for reimbursement from BCC – expenses are automatically deducted from your account on the card. Typically, when you pay with your debit card at a pharmacy or doctor's office, receipts will not be required by BCC, but you must still obtain and keep a receipt for the purchase.

Mobile App

My SmartCare Mobile provides you with a secure, single access point to manage your accounts from your mobile device. Use your existing username and password to access your accounts from anywhere at any time.

With the app, get instant access to your account balances, plan details, recent transactions and communications from BCC. Claims and substantiation materials can also be submitted through the app. Download it for free from Google Play or App Store.

Online Portal

- Log on to www.benefitcc.wealthcareportal.com/Page/Home
- Sign in using your existing MySmartCare log in and password OR click "Register" if you are a new user.
- You have the option to save your User ID to your mobile device by choosing 'ON' next to "Save this Online ID". This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial login.
- Once logged in to My SmartCare Portal, click on 'Reimbursement Request' in the left Navigation menu.

MY SMARTCARE REGISTRATION GUIDE

BCC's My SmartCare online portal and mobile app allow you to freely and securely access your BCC reimbursement accounts 24/7/365. Register from either platform!

When registering as a new user, My SmartCare will walk you through a series of registration questions followed by a secure authentication process to validate you as a user.

- Use your Social Security Number as your Employee ID.
- Your employer ID is: **BCCCCCSD**
- Use your Benefits Debit Card number or your Employer ID as your Registration ID.
- By registering with My SmartCare, you will have the option to receive important push notifications (account balance, grace period, year-end reminders; notice of debit card mailed, etc.) via e-mail or text message. You can manage these notifications in your My SmartCare communication settings.
- You have the option to save your User ID to your mobile device by choosing 'ON' next to "Save this Online ID". This will allow you to bypass the secure sign in process each time you log in after you verify your identity during the initial log in.

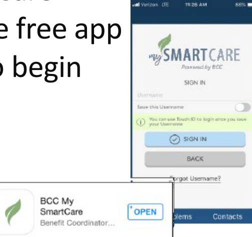
CUSTOMER SERVICE
800-685-6100
customersupport@benxcel.com

My SMARTCARE Online Portal

Go to www.benefitcc.wealthcareportal.com/page/home Click "REGISTER" at the top right corner of the screen to begin

My SMARTCARE Mobile

1. Open the app store from your iOS or Android powered device
2. Search "BCC SmartCare"
3. Install and open the free app
4. Click "REGISTER" to begin



NEW! PET INSURANCE THROUGH SPOT

Pets are family. Protect them like family.

Spot helps pet parents achieve peace of mind, and knows that every pet is unique, with one-of-a-kind needs. That's why Central San partnered with Spot to offer you and your family affordable and comprehensive plan options that you can customize to your budget and specific needs.

How does Spot plans work?

- Visit any licensed vet in the U.S. or Canada
- Submit your claim via our easy-to-use app
- Get quick cash back on covered vet bills

What do Spot plans cover?

- Emergency visits
- Lab fees
- Behavioral problems
- X-rays & other tests
- Surgeries
- Cancer
- And much more!

You can get a quote for a Spot plan by visiting www.spotpet.link/centralsan, or by calling (800) 905-1595 and mention that you are with Central Contra Costa Sanitary District (Priority code: EB_CCCSD). Member Service agents are available to help with questions from 8am – 8pm EST, Monday through Friday.

TIME AWAY FROM WORK

Paid time off policies

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can take some "me time" to relax, recover from illness, and take care of personal and family business. Our time off benefits include:

- **Holiday Compensation**
  Employees who are required to work on Thanksgiving Day, Christmas Day, and New Year’s Day receive triple time.
- **Birthday Leave**
  Employees represented by public employees’ union, local one receive eight hours per year of birthday leave. Leave must be taken within the month of, or the calendar month after, their birthday or it is lost for that calendar year. Supervisor’s prior approval is required.
- **Administrative Leave**
  Employees represented by the management support/confidential group receive three administrative leave days per year. Management employees receive five administrative leave days per year.
- **Sick Leave**
  Employees receive 12 days per year. There is no maximum accrual.

Refer to your employee handbook for information on eligibility and specific leave policies.

2025 PAID HOLIDAYS

2025 Paid Holidays

Central San provides 14 paid holidays per year. Additional holidays may be designated at the company's discretion.

Holiday	Date
New Year's Day	January 1st
MLK's Birthday	Third Monday of January
Lincoln's Birthday	February 12th
Washington's Birthday	Third Monday in February
Memorial Day	Last Monday in May
Juneteenth	June 19th
Independence Day	July 4th
Labor Day	First Monday in September
Veterans' Day	November 11th
Thanksgiving Day and the Day After	Fourth Thursday and Friday in November
Christmas Eve	December 24th
Christmas Day	December 25th
New Year's Eve	December 31st

SICK AND VACATION LEAVE

Sick Leave Incentive Benefit Program

The following schedule applies:

Years of Service	Pay-Off at Termination	Pay-Off at Retirement
0-4 Years	0%	0%
5-9 Years	25%	25%
10-24 Years	25%	35%
25 & over	25%	40%

Note: If you retire directly from active employment with Central San, your unused sick leave balance less incentive payout will be reported to CCCERA as retirement service credit. The conversion is made on an hour-for-hour basis.

Vacation Leave

All employees, with the exception of temporary status employees, earn paid vacation time from the first week of employment.

		Days Max Accrual*
10 days/year	0-3 years of service	20
15 days/year	3-5 years of service	30
16 days/year	5-10 years of service	32
17 days/year	10-15 years of service	34
20 days/year	15-20 years of service	40
25 days/year	20-25 years of service	50
30 days/year	25+ years of service	60

*At anniversary date

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether You Retire Or Continue To Work, Choosing The Right Healthcare Option Is An Important Decision When You Reach Age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

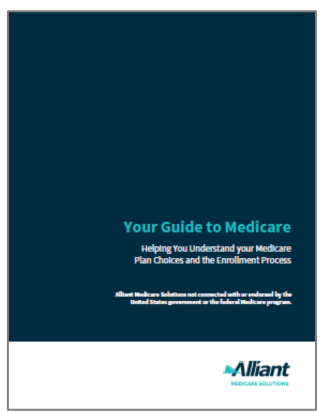
Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

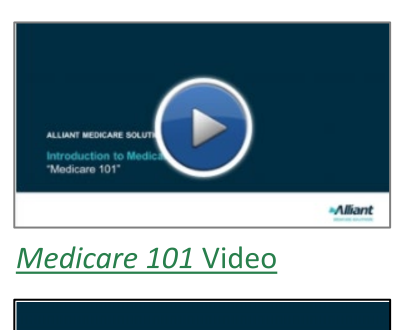
How Does It Work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More



Your Guide to Medicare



Medicare 101 Video

Social Security Planning Video

POTENTIAL INSURANCE COST SAVINGS

With AIHS, affordable health insurance is within reach.
Schedule an appointment at alliantindividualhealthsolutions.com or call (877) 328-1195 to speak with a licensed insurance agent.

Your extended family and friends can also use AIHS at no charge!

Could your family get health insurance subsidies?

As part of our commitment to providing benefit options that meet your specific needs, we have partnered with Alliant Individual Health Solutions (AIHS). AIHS does not replace the company-sponsored group health insurance plans—rather, it expands options available to you and your dependents, with the opportunity for significant savings.

New rules make insurance more affordable for many

Changes in recent legislation could mean your dependents may now qualify for subsidies in the Affordable Care Act Marketplace (also called the Exchange), possibly lowering your family's healthcare premiums. The federal government has changed who may be eligible for Marketplace subsidies. If your family members previously were ineligible for Marketplace subsidies, they may now qualify.

How does it work?

The AIHS team can help you:

- Explore whether your dependents are eligible for subsidies.
- Learn whether an individual health plan could be a more affordable option than the company-sponsored group plans.
- Secure health coverage if you or your dependents are leaving a company plan.

AIHS may be able to help you find affordable coverage if:

- Your dependent child is turning 26 (making them no longer eligible for coverage under a company plan).
- You are retiring early (before Medicare benefits start at 65).
- Your spouse is younger than 65 (and not eligible for Medicare yet).
- You're leaving the company and want to explore options that may be more affordable than COBRA.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually, and where to find them

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan type	Provider	Phone number	Website	Policy #
CalPERS Medical	CalPERS	Please refer to page 10	www.calpers.ca.gov	
Vision	Vision Service Plan (VSP)	800-877-7195	www.vsp.com	30105867
Dental	Delta Dental	800-765-6003	www.deltadentalins.com	0234
Life and AD&D Long-Term Disability	Voya Financial	800-955-7736	www.voya.com	316407 Acct #194
Short-Term Disability	State Disability Insurance (SDI)	800-480-3287	www.edd.ca.gov	
Workers' Compensation Insurance	Safety and Risk Management Division	925-229-7320		
EAP	Concern ComPsych Talkspace	800-344-4222 877-533-2363 N/A	www.login.concernhealth.com www.guidanceresources.com www.talkspace.com/alliant	CCCSD MY5848i Centralsan
Travel Assistance	IMG Global	317-659-5841	www.imglobal.com	N1VOY
Defined Benefit Pension	Contra Costa County Public Employees' Retirement Association	925-521-3960	www.cccera.org	
Flexible Spending Account (FSA) **Parking/Transit**	BCC – My SmartCare	800-685-6100	www.mywealthcareonline.com/bccsmartcare	
Deferred Compensation	ICMA-RC	800-669-7400	www.icmarc.org	401(a): 109623 457: 303896

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

- **Marketplace Coverage Options and Your Health Coverage**
- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

______________________________.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)	
Central Contra Costa Sanitary District		**Federal: 94-6000257** **CA: 925-03-939**	
5. Employer address **5019 Imhoff Place**		6. Employer phone number **925-228-9500**	
7. City **Martinez**		8. State **CA**	9. ZIP code **94553**
10. Who can we contact at this job? **Cindy Granzella**			
11. Phone number (if different from above): **925-229-7222**	12. Email address **cgranzella@centralsan.org**		

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

MEDICARE PART D NOTICE

Important Notice from Central San About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Central San** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Central San** has determined that the prescription drug coverage offered by the OptumRx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your **Central San** coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under OptumRx is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your **Central San** prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **Central San** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the **Central San** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

> Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	**Central Contra Costa Sanitary District**
Contact-Position/Office:	Cindy Granzella
Address:	5019 Imhoff Place Martinez, CA. 94553
Phone Number:	925-229-7222

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in **Central San**'s health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the **Central San**'s health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the **Central San**'s health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

CalPERS maintains the HIPAA Notice of Privacy Practices describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by clicking here.

Notice of Choice of Providers

The HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan directly. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2024**. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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