2021

Employee Benefits Overview

Central Contra Costa Sanitary District

Protecting Public Health and the Environment

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Medicare Part D Notice: 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 Annual Notices for more details.

Live Well. Be Happy.

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.

The benefits in this summary are effective:

January 1 – December 31, 2021

What's New?

VOYA SUPPLEMENTAL LIFE SPECIAL OPEN ENROLLMENT

- Employees who did not previously elect voluntary life coverage, or elected an amount under the Guaranteed Issue (GI) will be able to elect or increase up to the GI without medical questions. This is a one-time opportunity for this Open Enrollment!

BCC - NEW FSA VENDOR

- BCC is replacing P&A as our Flexible Spending Account vendor starting January 1st, 2021.
- Those enrolling for 2021 (healthcare, dependent care, or commuter) will be receiving new debit cards prior to January 1, 2021.
- **All claims for plan year 2020 should still be submitted to P&A.**
- Don't forget you do have to take action to enroll.

TALKSPACE – NEW FREE DIGITAL THERAPY RESOURCE

- An online therapy service that is available to all regular employee and dependents 13+ years old.
- This benefit connects you to a dedicated therapist via text, voice or video messages.

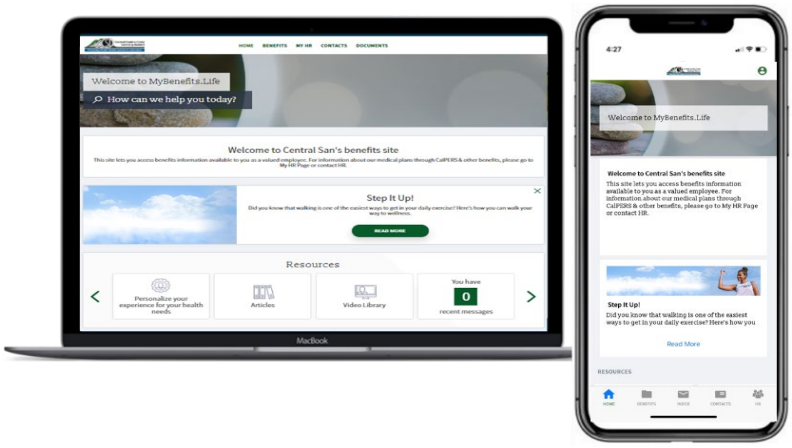
MYBENEFITS.LIFE™

Bye, Ben-IQ, welcome MyBenefits.Life!

- The Ben-IQ app will be transitioning to this new and improved, MyBenefits.Life (MBL). MBL is a web portal AND a mobile app that house all benefits-related information – information where and when you need it.
- Please see next page for more information.

MyBenefits.Life™ (Replacing Ben-IQ)

MyBenefits.Life is a mobile application and web portal (tablet enabled) that gives you24/7 access to all your benefits information. MyBenefits.Life is available for download for Android and iPhone smartphones.



FEATURES

MyBenefits.Life makes getting the information they want uncomplicated. At home or on-the-go, they get immediate access to the following:

- Information on all of your benefit offerings
- Benefit plan details, plan summaries, documents, and more
- Plan contacts and web links • Announcements and enrollment information
- Educational tools (informative articles, videos, glossary, etc.)

GETTING STARTED WITH MYBENEFITS.LIFE

Using your Smartphone or Tablet

1. Download and launch the app.
2. Enter your assigned Employer Key : **centralsan**

Using your Computer

1. Type centralsan.mybenefits.life on your internet browser
2. Enter your assigned Employer Key : **centralsan**

GET IT ON Google Play

Download on the App Store

Who Can You Cover?

WHO IS ELIGIBLE?

Employees working 30 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical and dental, vision and supplemental life plans:

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your registered domestic partner.
- Your children (including your domestic partner's children):
  - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

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.

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, grandchildren, and siblings.
- Employees who work less than 30 hours per week, seasonal employees, contract employees, or employees residing outside the United States.

WHEN CAN I ENROLL?

Coverage for new, full-time employees begins on the **first day of the month after employment commences**.

Open enrollment time at Central San is a once-a-year opportunity for employees and retirees to make changes to their medical plans. The open enrollment period runs September thru October each year for changes effective January 1st of the following year.

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

You have 30 days to make your change.

Benefit Plan Changes

WHERE CAN I GET AN ENROLLMENT FORM?

Contact Human Resources at (925) 228-9500 or e-mail Carrie Shields or in person.

WHAT DO I DO WITH MY COMPLETED ENROLLMENT CHANGE FORMS?

Forward your completed form(s) to Human Resources for processing.

HOW LONG CAN MY DEPENDENT CHILD/CHILDREN REMAIN ON MY BENEFIT PLANS?

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 deferred compensation 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.

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

GET A VIDEO HOUSE CALL

Most medical carriers now have telemedicine options available to their members mainly for the following reasons:

- **Lower costs** – most video visits cost less than an office visit
- **Convenience** – allows access to care in the comfort and privacy of your own home, and
- **Slows the spread of infection** – eliminates the risks of being exposed to infections

Check with your healthcare provider if this option is available to you.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

Medical Plans

SUMMARY OF BENEFITS AND COVERAGE NOTICE (2021)

Choosing your health plan is an important decision. To assist you with this process, each health plan available to you through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). To view the SBCse, visit www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates or any of the health plan websites below. To request a free paper copy of the SBC and glossary, please contact each health plan directly. HR Department may have copies of SBC for distribution.

Anthem Blue Cross HMO

Member Services	(855) 839-4524
Website	www.anthem.com/ca/calpers

Kaiser Permanente

Member Services	(800) 464-4000
Website	www.kp.org/calpers

Blue Shield of California

Member Services	(800) 334-5847
Website	www.blueshieldca.com/calpers

PERS Select, PERS Choice, and PERSCare

Administered by Anthem Blue Cross

Member Services	Actives & Medicare: (877) 737-7776
Website	www.anthem.com/ca/calpers

Health Net of California

Member Services	(888) 926-4921
Website	www.healthnet.com/calpers

Sharp Health Plan

Member Services	(855) 995-5004
Website	www.sharphealthplan.com/calpers

Western Health Advantage

Member Services	(888) 942-7377
Website	www.westernhealth.com/calpers

UnitedHealthcare

Member Services	Actives: (877) 359-3714 Retirees: (888) 867-5581
Website	www.uhc.com/calpers

OptumRX (Pharmacy Benefit Manager)

Member Services	Actives: (855) 505-8110 | Medicare: (855) 505-8106
Website	www.optumrx.com/calpers

PREMIUM RATES

Since health care costs vary throughout California, regional pricing adjusts premiums to reflect the actual cost of care in your specific region. To find your specific health plan premium rates, visit www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates and select your specific region.

Medical Plans

Central San's goal is 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 the CalPERS Medical Program.

UNDERSTANDING HOW CalPERS HEALTH PLANS WORK

FEATURES	HMO	PPO	EPO
Accessing health care providers	Contracts with providers (doctors, medical groups, hospitals, labs, pharmacies, etc.) to provide you services at a fixed price.	Gives you access to a network of health care providers (doctors, hospitals, labs, pharmacies, etc.) known as preferred providers.	Gives you access to the EPO network of health care providers (doctors, hospitals, labs, pharmacies, etc.)
Selecting a primary care physician (PCP)	Most HMOs require you to select a PCP who will work with you to manage your health care needs.	Does not require you to select a PCP.	Does not require you to select a PCP.
Seeing a specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Allows you access to many types of services without receiving a referral or advance approval.	Allows you access to many types of services without receiving a referral or advance approval.
Obtaining care	Generally requires you to obtain care from providers who are a part of the plan network. Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (except for emergency and urgent care services)	Encourages you to seek services from preferred providers to ensure your coinsurance and co-payments are counted toward your calendar year out-of-pocket maximums. Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill.	Requires you to obtain care from providers who are a part of the plan network. Requires you to pay the total cost of services if you obtain care outside the EPO's provider network without a referral from the health plan (except for emergency and urgent care services).
Paying for services	Requires you to make a small co-payment for most services.	Limits the amount preferred providers can charge you for services. Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider.	Requires you to make a small co-payment for most services.

Source: CalPERS' Open Enrollment 2020 Health Benefit Summary

CalPERS DIABETES PREVENTION PROGRAM

All CalPERS health plans offer a diabetes prevention program (DPP) at no cost to eligible members. This is designed to slow and prevent type 2 diabetes among CalPERS members who have prediabetes. For more information visit CalPERS' Diabetes Prevention Program page.

Medical Premium Rates

2021 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 Del Norte	935.84	935.84	-	1,871.68	1,871.68	-	2,433.18	2,433.18	-
Anthem Blue Cross Select	925.60	925.60	-	1,851.20	1,851.20	-	2,406.56	2,406.56	-
Anthem Blue Cross Traditional	1,307.86	1,120.21	**187.65**	2,615.72	2,240.42	**375.30**	3,400.44	2,912.55	**487.89**
Blue Shield Access+	1,170.08	1,120.21	**49.87**	2,340.16	2,240.42	**99.74**	3,042.21	2,912.55	**129.66**
Blue Shield Access+ EPO	1,170.08	1,120.21	**49.87**	2,340.16	2,240.42	**99.74**	3,042.21	2,912.55	**129.66**
Blue Shield TRIO	880.50	880.50	-	1,761.00	1,761.00	-	2,289.30	2,289.30	-
Health Net SmartCare	1,120.21	1,120.21	-	2,240.42	2,240.42	-	2,912.55	2,912.55	-
Kaiser Permanente	813.64	813.64	-	1,627.28	1,627.28	-	2,115.46	2,115.46	-
PERS Choice PPO	935.84	935.84	-	1,871.68	1,871.68	-	2,433.18	2,433.18	-
PERS Select PPO	566.67	566.67	-	1,133.34	1,133.34	-	1,473.34	1,473.34	-
PERS Care PPO	1,294.69	1,120.21	**174.48**	2,589.38	2,240.42	**348.96**	3,366.19	2,912.55	**453.64**
United HealthCare	941.17	941.17	-	1,882.34	1,882.34	-	2,447.04	2,447.04	-
Western Health Advantage	757.02	757.02	-	1,514.04	1,514.04	-	1,968.25	1,968.25	-

Important:

All premiums paid by the employee are paid via a monthly payroll deduction. The payroll deduction is made with pre-tax dollars in accordance with Central San's Health Plan Premium Tax Conversion Program.

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 Plan	
	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	Plan pays 95% after deductible	Plan pays 90% after deductible
Root Canals	Plan pays 95% after deductible	Plan pays 90% after deductible
Periodontics	Plan pays 95% after deductible	Plan pays 90% after deductible
Major Services	Plan pays 90% after deductible	Plan pays 90% after deductible
Orthodontic Services		
Orthodontia	Plan pays 90%	Plan pays 90%
Lifetime Maximum	$3,000	$3,000 (combined with in-network)
Dependent Children	Covered	Covered
Full-time Students	Covered	Covered

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
Examination		
Benefit	$10 copay	Up to $45
Frequency	1 x every 12 months	In-network limitations apply
Materials[1]	$10 copay	See fee schedule below
Eyeglass Lenses		
Single Vision Lens	Plan pays 100% of basic lens	Up to $30
Bifocal Lens	Plan pays 100% of basic lens	Up to $50
Trifocal Lens	Plan pays 100% of basic lens	Up to $65
Frequency	1 x every 24 months	In-network limitations apply
Lens Enhancements		
Standard Progressive	$0	
Premium Progressive	$95 - $105	Up to $50
Custom Progressive	$150 - $175	
Frequency	1 x every 24 months	In-network limitations apply
Frames		
Benefit	$150 allowance for a wide selection of frames Additional $20 for featured frame brands Plus 20% off any costs over the allowance	Up to $70
Frequency	1 x every 24 months	In-network limitations apply
Contacts (Instead of Glasses)[2]		
Exam (with fitting & evaluation)	$60 copay	Up to $105
Benefit	$150 allowance	(exam & contact lens combined)
Frequency	1 x every 24 months	In-network limitations apply

[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.

Vision

A vision exam helps detect the signs of health conditions like high blood pressure, diabetes, and high cholesterol—along with other eye and health issues.

BETTER PROVIDER CHOICE WITH VSP

You can choose your provider from 71,000 access points, including the largest national network of independent doctors and nearly 4,500 participating retail chain locations. For convenience, most VSP participating doctors also offer early morning, evening and weekend appointments, and 24-hour access to emergency care.

If you prefer to use a non-network provider, this option is also available under our plan however, the benefit allowances are lower.
EXCLUSIVE MEMBER DISCOUNTS

EXTRA SAVINGS ON GLASSES & SUNGLASSES

- Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.
- 20% savings 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.

Eyeconic®, an easy-to-use, in-network, online eyewear platform is also available to all members. Eyeconic® offers free shipping and returns, virtual try-on tool, free frame adjustment or contact lens consultation and all-inclusive pricing on glasses and lenses. For more information on Eyeconic®, visit eyeconic.com.

LASER VISION CORRECTION

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

HEARING AID DISCOUNT

VSP® Vision Care members can save up to $2,400 on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.

TruHearing also provides members with:

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

USING YOUR VSP BENEFIT IS EASY

- Create an account at vsp.com to view your benefits.
- Find an eye care provider who is right for you. To find a VSP provider, visit vsp.com or call (800) 877-7195.
- **NO ID CARD NECESSARY.** Just provide your SSN at your provider's office. If you would like to have a card, you can print one by registering on line at VSP.com.

Life and AD&D Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

CENTRAL SAN PAID LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident.

Coverage is provided by Voya Financial.

Coverage for Local One employees

Basic Life Amount	2 times the annual E-Step earnings up to a maximum of $50,000
Basic AD&D Amount	2 times the annual E-Step earnings up to a maximum of $50,000

For Management Support/Confidential Group (MS/CG) employees

Basic Life Amount	1 times the annual E-Step earnings up to a maximum of $75,000
Basic AD&D Amount	1 times the annual E-Step earnings up to a maximum of $75,000

For Management Group employees

Basic Life Amount	2 times the annual earnings up to a maximum of $250,000
Basic AD&D Amount	2 times the annual earnings up to a maximum of $250,000

Coverage for eligible dependents:

Spouses/Domestic Partners	$1,500 life insurance benefit
Child	$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.

Life and AD&D Insurance

Special Enrollment Opportunity

SUPPLEMENTAL LIFE AND AD&D

Supplemental Life & Accidental Death & Dismemberment (AD&D) 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.

SPECIAL OPEN ENROLLMENT FOR 2021!

Voya has granted employees a **one-time, special enrollment opportunity** for the voluntary life plan during this Open Enrollment.

Employees who did not previously elect voluntary life coverage, or elected an amount under the Guaranteed Issue (GI) will be able to elect or increase up to the GI without medical questions.

During your 2021 Open Enrollment Period (9/21 – 10/16) you will not need to provide Evidence of Insurability (EOI) (i.e. answer health questions) to apply for the amounts below:

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

Life and AD&D Insurance

Special Enrollment Opportunity

ENROLLMENT INSTRUCTIONS

- Voya enrollment forms with rates can be can be accessed at centralsan.mybenefits.life (employer key: centralsan) under the Documents tab
- Submit your completed forms to Human Resources.

SUPPLEMENTAL LIFE AND AD&D RATE CALCULATION WORKSHEET

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	$0.086
Age 25-29	$0.061
Age 30-34	$0.067
Age 35-39	$0.094
Age 40-44	$0.143
Age 45-49	$0.237
Age 50-54	$0.380
Age 55-59	$0.555
Age 60-64	$0.726
Age 65-69	$1.044
Age 70-74	$1.768
Age 75+	$4.796

AD&D Rate: $0.035 per $1,000

Dependent Child(ren) Rate:

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

To calculate your monthly premium:

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 on the left: Line 2: _____
3. Multiply line 1 by line 2. This will be your monthly premium. 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

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-term disability is provided through State Disability Insurance (SDI). The monthly premium of 1% of salary is deducted from the employee's paycheck.

Employees covered by 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

Short-term disability insurance and Paid Family Leave provide a benefit after a **seven (7) calendar day** waiting period.

WORKERS' 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

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Voya Financial.

Below is the LTD coverage for General and MS/CG employees' disability insurance and is paid for in full by Central San:

Monthly Benefit Amount	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	$5,000
Benefits Begin After: 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' premium for LTD coverage is deducted from monthly paycheck.

Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	$13,500
Benefits Begin After: Accident/Sickness	 60 days of disability
Maximum Payment Period*	Social Security normal retirement age

Voya Value Added Services

TRAVEL ASSISTANCE

Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependents will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world. Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services:

PRE-TRIP INFORMATION	EMERGENCY PERSONAL SERVICES	EMERGENCY TRANSPORTATION*	MEDICAL ASSISTANCE
These valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including: • Immunization requirements • Visa & passport requirements • Foreign exchange rates • Embassy/consular referral • Travel/tourist advisories • Temperature & weather conditions • Cultural information	In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including: • Urgent message relay • Interpretation/ translation services • Emergency travel arrangements • Recovery of lost or stolen luggage or personal possessions • Legal assistance and/or bail bond	Should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance-designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf. *The services listed above are subject to a maximum total payment of $150,000.	• Medical referrals for local physicians and dentists • Medical case monitoring • Prescription assistance and eyeglass Replacement • Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant)

If you need emergency or pre-trip services...	Voya Travel Assistance
...use the contact information and identify yourself as an eligible participant in the Voya Travel Assistance program. You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described. Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.	Contact Voya Travel Assistance 24 hours a day, 365 days a year for: pre-trip information, emergency personal services, medical assistance services and emergency transportation services. **Group name: CSAC-EIA / Group number: 316407** **In the US, toll-free:** 800.859.2821 **Worldwide, collect**: 202.296.8355 **Email:** ops@europassistance-usa.com **Online portal:** https://eservices.europassistance-usa.com/sites/Voya **Group ID**: N1VOY **Activation code:** 140623

Voya Value Added Services

Voya Financial has partnered with ComPsych® GuidanceResources® to provide no-cost, confidential solutions to life's challenges.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues.

Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 877.533.2363
TTY: 800.697.0353

Group name: CSAC-EIA
Group number: 316407

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: My5848i

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

VOYA FINANCIAL™

Contact Your GuidanceResources® Program

Call: 877.533.2363
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNowSM
Web ID: MY5848i

Voya Value Added Services

FUNERAL PLANNING

Available to employees who are covered for group life insurance through their employer. Funeral planning and concierge services are provided by Everest Funeral Package, LLC. Everest is pleased to provide a value-added service that empowers individuals who are dealing with funeral related issues.

WHO IS EVEREST?

Everest, the first nationwide funeral planning and concierge service, is an independent consumer advocate who works on your behalf. Everest's sole purpose is to provide the information you need to make the most informed decisions about all funeral related issues and then put those wishes into action.

Everest is an impartial consumer advocate, not a funeral home. Everest does not sell funeral goods or services, nor does Everest receive any commissions from funeral homes or other service providers in the funeral industry. With Everest, you are removed from a sales-focused environment, allowing you and your family to make well-informed and confident decisions during a stressful time.

SERVICES INCLUDE:

PRE-PLANNING SERVICES

24/7 ADVISOR ASSISTANCE

- To discuss funeral planning issues

PRICEFINDER℠ RESEARCH REPORTS

- The only nationwide database of funeral home prices
- Detailed, local funeral home price comparisons

ONLINE PLANNING TOOLS INCLUDE:

- Personal profile
- "10 key decisions" planner
- "my wishes" planning guide
- Reference guide
- Information stored and maintained in a secure data warehouse

AT-NEED SERVICES

AT-NEED FAMILY SUPPORT

- Family assistance and plan implementation
- Communicate the personal funeral plan to the funeral home, removing the family from a sales-focused environment
- Provide 24-hour assistance throughout the
- Funeral process

NEGOTIATION ASSISTANCE

- Gather pricing information and present it to the family in an easy-to-read format
- Negotiate funeral service pricing with local
- Funeral homes
- Help the family compare prices of caskets and other products

GETTING STARTED

GROUP NAME: CSAC-EIA | GROUP NUMBER: 316407

Create an online profile and use Everest's planning tools visit everestfuneral.com/voya

- Enter your email address and your employer's name
- Create a password and complete your online profile
- Access "planning tools"

If you do not have access to a computer, Everest advisors are available 24/7 by calling 1-800-913-8318.

Flexible Spending Accounts

New Vendor!

mySMARTCARE Powered by BCC

BCC IS CENTRAL SAN'S FSA VENDOR STARTING JANUARY 1, 2021.

The Flexible Spending Accounts (FSA) are a great way to pay for medical, dental, or vision expenses as well as dependent care expenses on a tax free basis. You may enroll in either or both the **Healthcare Spending Account** or the **Dependent Care Spending Account**.

These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to social security tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

At enrollment, you determine the amount of money to contribute to one or both of these accounts for Central San's plan year. The contributions are deducted pre-tax per pay period from your paycheck and deposited into the FSA account(s). You request reimbursement of qualified expenses as you incur the expenses from your FSA account(s).

PLEASE ESTIMATE YOUR ANNUAL CONTRIBUTIONS CAREFULLY!

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.

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.

Both the Health Care Spending Account and the Dependent Care Spending Account are annual benefit plans that you must enroll in each year you wish to participate.

Flexible Spending Accounts

HEALTHCARE SPENDING ACCOUNT

This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your healthcare plan. Medical-related expenses include out-of-pocket money for copays or deductibles for medical, dental and vision services.

The maximum amount you may contribute to the Healthcare Spending Account for Plan Year 2021 is $2,750 per person, per plan. There is no household maximum as with the Dependent Care Spending Account. Therefore, if your spouse's employer also offers an FSA, he/she could also enroll up to the maximum amount.

DEPENDENT CARE SPENDING ACCOUNT

The maximum amount you may contribute to the Dependent Care Spending Account is $5,000 each calendar year, or $2,500 each calendar year if you are married but file separate tax returns. This account will reimburse you with pre-tax dollars for daycare expenses for your child(ren) and other qualifying dependents. These include expenses for child care or dependent adult care for a member of your household.

Eligible Dependents Include:

- Children under the age of 13 who qualify as dependents on your Federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your Federal tax return.

COMMUTER BENEFIT PROGRAM

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.

TRANSACTIONS AND SUBMITTING A CLAIM

BCC will issue you a Benefits Card that works likes a debit card. When you incur an eligible expense, present your Benefits Card to the provider of the goods or services you are purchasing. Swipe your card at the point-of-service and the expense will automatically be deducted from your Flexible Spending Account balance. Or, you may submit your claim electronically or by mail.

Flexible Spending Accounts

HOW TO USE YOUR PLAN

There are various ways to access your pre-tax money:

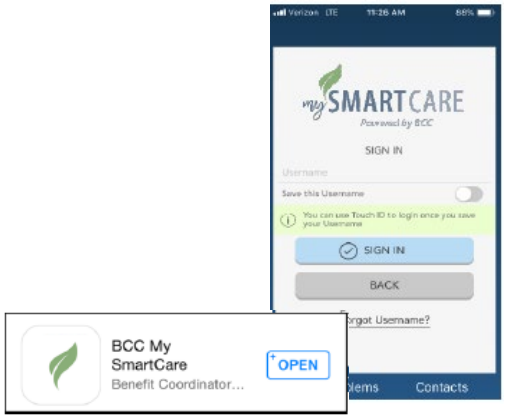
DEBIT CARD

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:

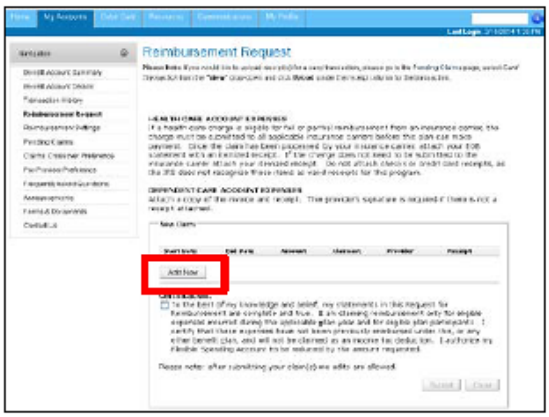
My SmartCare Mobile provides you with a secure, single access point to manage your accounts from your mobile device. Use your existing username and password to access your accounts from anywhere at any time.

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 https://www.mywealthcareonline.com/bccsmartcare/
- 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.



Flexible Spending Accounts

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!

MY SMARTCARE ONLINE PORTAL

1) Go To: https://www.mywealthcareonline.com/bccsmartcare/

2) Click 'REGISTER' at the top right corner of the screen to begin

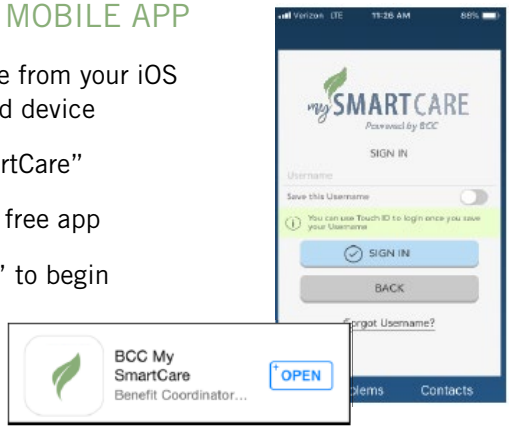
MY SMARTCARE MOBILE APP

1) Open the app store from your iOS or Android powered device

2) Search "BCC SmartCare"

3) Install & open the free app

4) Click "REGISTER" to begin



- 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.
- 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

Retirement Programs

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	$ 0.00
Earliest Age of Retirement	50
Final Average Compensation Period	Highest 12 months

New Members:

Formula	2% at 62
Pensionable Compensation Limit	$149,016 in 2019
Earliest Age of Retirement	52
Final Average Compensation Period	36 months

401(A) MONEY PURCHASE PLAN

Central San does not participate in the Social Security System except for a mandatory Medicare contribution from both the employee and employer.

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. Employees have a choice of savings and investment options.

MEDICARE

Employees hired after April 1, 1986 have 1.45% of their salary deducted for Medicare.

DEFERRED COMPENSATION

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

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.

Wellness Resources

Additional Resource

There are times when everyone needs a little help or advice. The services below are available to Central San employees, dependents, and household family members at no additional cost.

NEW FREE DIGITAL THERAPY RESOURCE

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.

To get started, register at talkspace.com/Alliant. In order to be validated for use, when prompted enter the Organization Name, enter **centralsan**.

This benefit is in additional to our MHN EAP benefit.

EMPLOYEE ASSISTANCE PROGRAM

The confidential Employee Assistance Program (EAP) through MHN Inc. can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free.

PROBLEM-SOLVING SUPPORT

Call for help with life's ups and downs. MHN is here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events, and more

WORK AND LIFE SERVICES

Experts can help you balance your work with your life! Call MHN for:

- Childcare and eldercare assistance
- Financial Services
- Legal Services
- Identity Theft Services
- Daily Living Services

You are entitled to **six (6) sessions per incident per fiscal year** - either face-to-face, telephonic or web-video consultations.

NEED HELP?

Call toll-free, 24/7: 1-800-242-6220 | TTY users call 711. Or visit members.mhn.com; register with the company code: **cccsd**

Additional Benefits and Information

WELLNESS PROGRAM

Central san has contracted with John Muir Medical Center to provide a wellness program for regular employees. Participation is optional.

As part of the program, Central San maintains fitness centers for all regular employees and sponsors wellness related activities.

LONGEVITY COMPENSATION

Employees who have ten or more years of continuous service will receive a 2.5% salary increase. Employees who have twenty or more years of continuous service will receive an additional 2.5% salary increase.

SAFETY SHOES

$230 allowance for employees is provided for safety shoes.

BILINGUAL PAY

Employees whose bilingual skills provide the district a benefit in providing district services shall be designated to receive a bilingual allowance. An employee designated for a bilingual allowance shall receive an additional $75 per pay period.

EDUCATION INCENTIVE/REIMBURSEMENT

Central San will allow up to $2,000 per year for tuition reimbursement for job-related classes.

REGISTRATION DIFFERENTIAL

Central San grants a five percent salary increase to employees who achieve registration or licensing as professional engineer, land surveyor, certified management accountant, or certified public accountant in a position not requiring such registration or license if it benefits Central San.

PUBLIC EMPLOYEES' UNION, LOCAL ONE

Local one represents the general employees group. Monthly dues (1.55%) are based on salary to a maximum of $150/month plus a $10/month unit fund fee.

MANAGEMENT SUPPORT/CONFIDENTIAL GROUP

Monthly dues are $20.

PAY PERIODS

The pay period is from the 18th of the month to the 17th of the following month. Payday is the last work day of the month.

Holidays and Leaves

HOLIDAYS

There Are 13 Paid Holidays Per Year:

- New Year's Day (January 1)
- Martin Luther King Jr.'S Birthday (Third Monday In January)
- Lincoln's Birthday (February 12)
- Washington's Birthday (Third Monday In February)
- Memorial Day (Last Monday In May)
- Independence Day (July 4)
- Labor Day (First Monday In September)
- Veterans Day (November 10)
- Thanksgiving Day (Fourth Thursday In November)
- Day After Thanksgiving
- Christmas Eve (December 24)
- Christmas Day (December 25)
- New Year's Eve (December 31)

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 hired after May 1, 1985 receive 12 days per year. There is no maximum accrual.

Holidays and Leaves

SICK LEAVE INCENTIVE BENEFIT PROGRAM

FOR EMPLOYEES HIRED AFTER MAY 1, 1985, 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, you may convert your unused sick leave to 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 month 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

For Assistance

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

Plan Type	Group No./ID	Provider	Phone Number	Website
CalPERS Medical		CalPERS	Please refer to page 7	www.calpers.ca.gov
Vision	12137687	Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
Dental	0234	Delta Dental	(800) 765-6003	www.deltadentalins.com
Life and AD&D Long Term Disability	Group#: 316407 Acct#: 194	Voya Financial	(800) 955-7736	www.voya.com
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	CCCSD	MHN	(800) 227-1060	www.members.mhn.com
	MY5848i	ComPsych®	(877) 533-2363	guidanceresources.com
	centralsan	Talkspace[NEW!]	N/A	talkspace.com/Alliant
Travel Assistance	N1VOY	EuropAssistance	(800) 859-2821	https://eservices.europassistance-usa.com/sites/Voya
Defined Benefit Pension		Contra Costa County Public Employees' Retirement Association	(925) 521-3960	www.cccera.org
Flexible Spending Account		BCC – My SmartCare	(800) 685-6100	https://www.mywealthcareonline.com/bccsmartcare/
Deferred Compensation	109623 401(a) 303896 (457)	ICMA-RC	(800) 669-7400	www.icmarc.org

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Key Terms, continued

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

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

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in a Central Contra Costa Sanitary District health plan for 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 a Central Contra Costa Sanitary District 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 Central Contra Costa Sanitary District's health plan if your dependent becomes 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 rights, you may add the dependent to your current coverage or change to another health plan.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under our plans. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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.

Important Plan Notices and Documents

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by Central Contra Costa Sanitary District represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Central Contra Costa Sanitary District offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Central Contra Costa Sanitary District are available on the District's intranet site or by contacting Human Resources.

NOTICE OF CHOICE OF PROVIDERS

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

MEDICARE PART D NOTICE

Important Notice from Central Contra Costa Sanitary District 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 Contra Costa Sanitary District 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 Contra Costa Sanitary District has determined that the prescription drug coverage offered by our plans are, 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 Contra Costa Sanitary District coverage will 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 Central Contra Costa Sanitary District 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 Contra Costa Sanitary District prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Contra Costa Sanitary District 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 office 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 Central Contra Costa Sanitary District 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 or (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 **www.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, 2021

Name of Entity: Central Contra Costa Sanitary District

Contact: Human Resources

Address: 5019 Imhoff Place, Martinez CA 94553

Phone: 925.228.9500

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

	Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852- 3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2020, 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 1/31/2023)

ACA DISCLAIMER

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.83% of your modified adjusted household income.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83% of your household income for the year 2021, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your 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.

[1] An employer-sponsored 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.

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: 946 000 257 CA: 925 02 939
5. Employer address		6. Employer phone number
5019 Imhoff Place		(925) 228-9500
7. City	8. State	9. ZIP Code
Martinez	CA	94553
10. Who can we contact about employee health coverage at this job?		
Carrie Shields		
11. Phone number (if different from above)		12. Email address
(925) 229-7323		CShields@centralsan.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax

credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard?

☐ Yes (go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets minimum value standard offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't received any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets minimum value standard. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Central Contra Costa Sanitary District

Protecting Public Health and the Environment

Rev. 9.11.2020