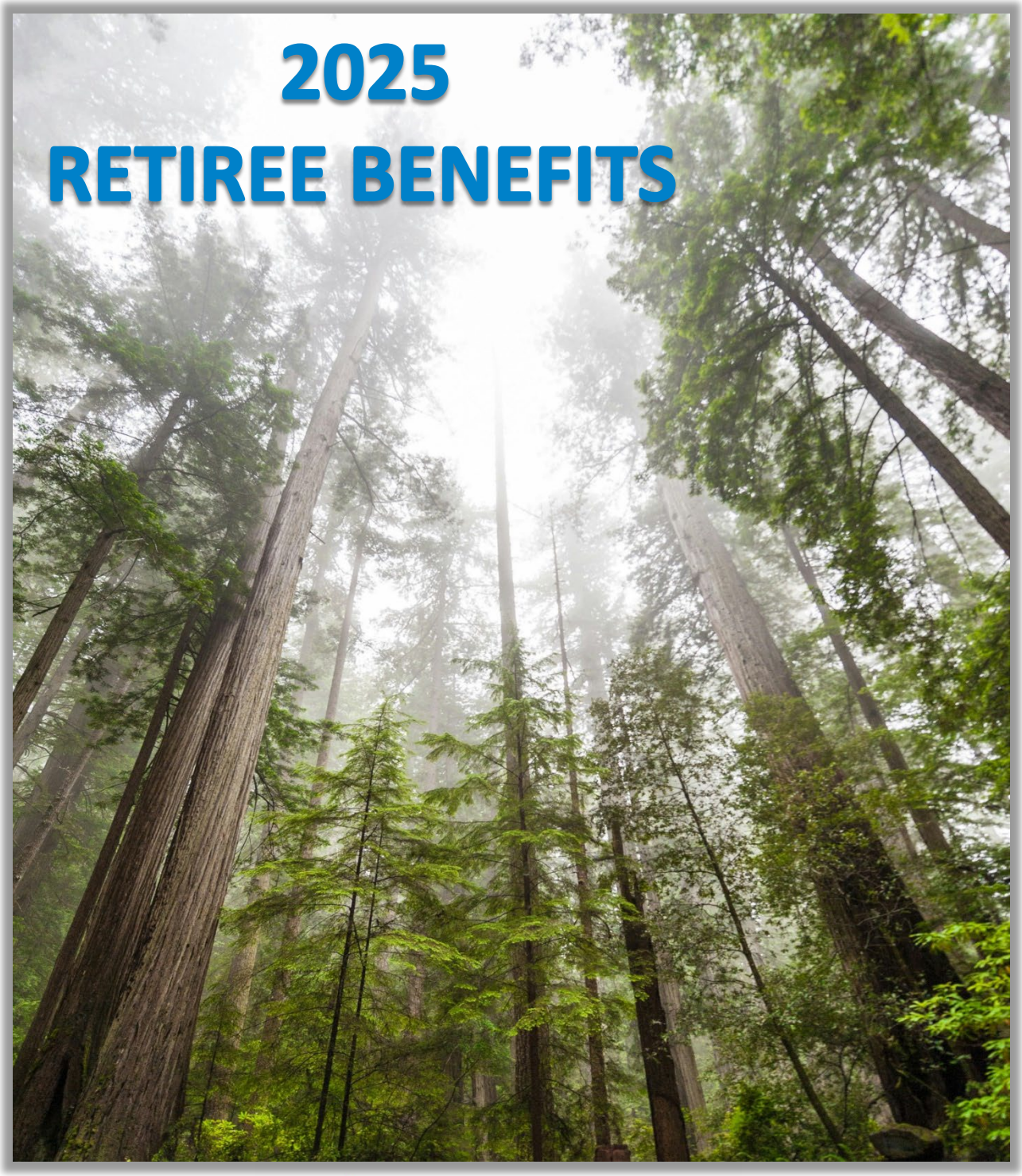
2025
RETIREE BENEFITS



Valley Water

April 1, 2025 through December 31, 2025

Better Together

TABLE OF CONTENTS

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 Important Plan Information section for more details.

GETTING STARTED

2025 BENEFITS

April 1, 2025
through
December 31, 2025

As we begin our annual Open Enrollment, please take this opportunity to evaluate your healthcare elections and make any changes. This year's Open Enrollment period is **February 17, 2025 through March 7, 2025**. The choices you make during this period will cover you and your eligible dependents effective April 1, 2025, and may only be changed if you experience an IRS qualifying event.

Retirees may enroll eligible dependents such as current legal spouses, domestic and natural/step/adopted/legally eligible children in Valley Water plans. If you divorce or if a dependent is no longer eligible for benefits, you must notify the Benefits & Wellness Program within 30 days. Your ineligible dependent will then be offered COBRA coverage for up to 36 months. If, however, you do not notify the Benefits & Wellness Program immediately, your ineligible dependent may not be eligible for COBRA benefits.

As you read through the guide, keep in mind that it is a summary of your retiree benefits and not a complete detailed description of every policy, procedure, or benefit plan. If there is ever a discrepancy between the information presented here and the official plan documents or agreements involved, the official insurance provider's Evidence of Coverage (EOC), Summary Plan Description (SPD), the policy certificate, or contract that applies to each specific benefit will govern how your benefits are determined and administered.

All forms must be returned to the Benefits & Wellness Program no later than Friday, March 7, 2025.

MEDICAL

OUR PLANS UNDER AGE 65

Blue Shield PPO

Blue Shield Access+ HMO

Blue Shield Trio HMO

Kaiser HMO

OUR PLANS AGE 65+

Blue Shield PPO

Anthem Medicare Preferred PPO (NEW)!

Kaiser Senior Advantage HMO

Important Notes

- Blue Shield HMO Plans are only available to retirees and their dependents who are under age 65.
- Kaiser Senior Advantage Plan, Blue Shield PPO Plan, and Anthem Medicare Preferred PPO Plan are for retirees and their dependents who are enrolled in Medicare.
- Once the retiree elections are made, they are locked in until the next Open Enrollment period**. With the move to a calendar year plan in 2026, there will be another opportunity to enroll in Fall 2025.**

FITNESS PROGRAMS FOR SENIOR ADVANTAGE MEMBERS

SilverSneakers (Anthem Medicare Preferred PPO Members ONLY)

Stay active with SilverSneakers Fitness Program. Members have access to no cost gym memberships with amenities including pool, spa, specialized fitness classes, walking groups and social events.

For participating fitness locations, call (866) 584-7389 or visit silversneakers.com.

What is SilverSneakers?

SilverSneakers is a fitness and wellness program that is offered at no additional cost to Medicare members 65+ who are enrolled in the Anthem Medicare Preferred PPO plan.

This program is designed for all levels and abilities and provides access to online and in-person classes, over 15,000 fitness locations, and health & wellness discounts.

What's Included With a SilverSneakers Membership?

- Specially designed exercise classes for all fitness levels online and in-person
- Community classes offered in-person and online
- Access to everything the applicable fitness location offers (the member should contact each location to see what's available)
    - Hot tubs
    - Tennis courts
    - And much more!
- Online resources with nutrition and fitness tips

OnePass (Kaiser Senior Advantage Members ONLY)

OnePass can help you stay active and healthy with flexible options to support any healthy aging journey. You can exercise at a fitness center, join classes and events from home, and access personalized resources to enhance your well-being. This plan is offered at no additional cost to Medicare members 65+ who are enrolled in the Kaiser Senior Advantage plan.

Once you're a Kaiser Permanente Medicare health plan member, follow these steps:

1.Visit youronepass.com.

2.Click "Get Started" to register. Enter in your First Name, Last Name, Date of Birth, and Health Plan Member ID.

3.Once you're registered, you'll receive a Member Code. Be sure to write down your code and keep it handy. You will need to enter it each time you register for a new fitness location or other One Pass service.

4.Start searching for gyms by clicking on the "Find a gym" page.

What is OnePass Program?

- Choose from the largest nationwide network of gyms and fitness locations. Visit any place in the network and create a routine just for you.
- Work out at home with live, digital fitness classes or on-demand workouts.
- Get complete brain workout, including an initial cognitive test and an ongoing brain training program featuring a collection of games and activities to keep you engaged.
- Join a group class or find local clubs and social events that match you to connect with others who share your passions.

HOW TO USE YOUR PLAN

Kaiser HMO Plan

The Kaiser HMO plan uses exclusive doctors and Kaiser facilities located throughout California. All services and supplies must be provided, prescribed, authorized, or directed by a Kaiser Health Plan physician except in the case of an emergency.

Blue Shield HMO Plan

The Blue Shield HMO plan requires each member of your family to choose a Primary Care Physician (PCP) within a medical group. For all but a few select services, your PCP will coordinate and direct your care within your assigned medical group. Employees can self-refer to a specialist within your assigned medical group for an initial consultation without a referral. Retirees should carefully consider the medical group and network of specialists within the medical group when selecting a PCP. Except in an emergency, you must receive a referral by your PCP prior to receiving care. You may find a Blue Shield PCP by going to: www.blueshieldca.com.

Blue Shield PPO Plan

In a PPO plan, the member is responsible for ensuring that the required prior authorization is complete before receiving certain services. In addition, PPO members should be certain to receive services from Blue Shield's network of contracted providers to reduce out-of-pocket expenses. You can search for in-network providers at: www.blueshieldca.com.

MEDICAL PLANS – RETIREES 65+

	Blue Shield PPO[1]	Anthem Medicare Advantage PPO
	In-Network	In-Network
Calendar Year Deductible[2] Individual Family	 $250 $500	 None
Calendar Year Out-of-Pocket Maximum[2] Individual Family	 $2,000 $4,000	 $1,000 per member
Office Visit Primary Care Specialist	 20% after deductible 20% after deductible	 $10 $30
Preventive Services	No charge	No charge
Chiropractic	20% after deductible (up to 20 visits/year)	$10 (up to 30 combined visits/year)
Acupuncture	20% after deductible (up to 40 visits/year)	$10 (up to 30 combined visits/year)
Lab and X-ray	20% after deductible	No Charge
Urgent Care	20% after deductible	$10 (copay waived if admitted within 72 hours)
Emergency Room	$100 (copay waived if admitted)	$100 (copay waived if admitted within 72 hours)
Inpatient Hospitalization	20% after deductible	No charge
Outpatient Surgery	20% after deductible	No charge
PRESCRIPTION DRUGS		
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	 $10 $15 $30 30% up to $200	($2,000/member Copay Out of Pocket Maximum) $10 $15 $30 20% up to $200
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	 $20 $30 $60 30% up to $400	 $20 $30 $60 Limited to a one-month supply

[1]Blue Shield PPO information is based upon in-network services. For services out-of-network, the member is responsible for the co-payment in addition to any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count towards the calendar year deductible or co-payment maximum.

[2]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 2025 through December 2025.

ANTHEM MEDICARE ADVANTAGE PPO (NEW!)

Anthem Medicare Preferred PPO PPO Plan Highlights:

- Access to the same network of doctors and other health care providers you use today that are either part of the Anthem network of doctors or accept Medicare.
  - You can find the most recent list of the Anthem Medicare network providers here: anthem.com/find-care.
  - Or you can locate a Medicare participating provider here: medicare.gov/physiciancompare.
- Defined copayments for doctor and specialist visits, just like an HMO plan, but with PPO flexibility and freedom.
- Access to out-of-network providers that accept Medicare nationwide.
- Similar drug copays and coinsurance and a rich formulary.
- Plan offers routine Chiropractic and Acupuncture services.
- Single Customer Care phone number for both your medical and pharmacy benefits.
- A new single Anthem ID card that can be used whenever you get services covered by the plan and for prescription drugs you get at network pharmacies (You no longer need to carry multiple ID cards).

MEDICAL PLANS - RETIREES UNDER 65

	Blue Shield Access+ HMO	Blue Shield Trio HMO
	In-Network	In-Network
Calendar Year Deductible[1] Individual Family	None	None
Calendar Year Out-of-Pocket Maximum[1] Individual Family	$2,000 $4,000	$2,000 $4,000
Office Visit Primary Care Specialist	$10 Access+ (self-referral): $30 Other (referred by PCP): $10	$10 Trio+ (self-referral): $30 Other (referred by PCP): $10
Preventive Services	No charge	No charge
Chiropractic & Acupuncture	$10 (up to 30 combined visits/year)	$10 (up to 30 combined visits/year)
Lab and X-ray	No Charge	No Charge
Urgent Care	$10	$10
Emergency Room	$100 (copay waived if admitted)	$100 (copay waived if admitted)
Inpatient Hospitalization	No charge	No charge
Outpatient Surgery	No charge	No charge
PRESCRIPTION DRUGS		
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	$10 $15 $30 20% up to $200	$10 $15 $30 20% up to $200
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	$20 $30 $60 20% up to $400	$20 $30 $60 20% up to $400

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 2025 through December 2025.

BLUE SHIELD TRIO HMO

Trio HMO is powered by a specially selected network of local doctors, specialists, and hospitals committed to working more closely together. This ensures all aspects of your care are more connected and efficient – keeping your premiums as low as possible in the process. Like other HMO plans, with Trio, you have a primary care physician (PCP). Your PCP can coordinate your care, treat common illnesses and injuries, and provide a referral if you need to see a specialist.

You can check if your current PCP or other doctors are in the Trio network by visiting: valleywater.org/valley-water-retirees-information.If you don't see them, don't worry – Blue Shield can help you find new healthcare providers from within the quality Trio network.

Enhanced customer service with Shield Concierge

Trio HMO gives you access to Shield Concierge – a personalized, coordinated customer care assistant. One simple phone call connects you to a team of health experts who are ready to answer your health-related questions. Shield Concierge can help you with the following:

- Transfer medical records and prescriptions
- Find a new doctor or specialist
- Continue receiving care without interruption when switching plans
- Understand your new benefits

To find a provider

You can check if your current PCP or other doctors are in the Trio network by visiting the website below.
www.blueshieldca.com/fad/home

BLUE SHIELD RESOURCES

QUESTIONS?

Visit the website below for plan information and additional resources.
https://www.bscaplan.com/xs5n8x

Bluecard – Stay covered while traveling

When you're outside of California or out of the country, you and your family can get urgent and emergency care through the BlueCard® and Blue Shield Global Core programs. These programs offer access to doctors and hospitals almost everywhere in the U.S. and in 170 countries and territories around the world.

To find a provider in the U.S. visit blueshieldca.com/find-a-doctor or call (800) 810-2583. To find a provider outside the U.S. visit the website above or call (804) 673-1177 collect from outside the U.S.

Away From Home (HMO Plan Only)

Blue Shield HMO members and their covered dependents qualify for Away From Home Care if they meet one of the following circumstances and will be on an extended stay: long-term traveler, families living apart, student.

Blue Plans participating in the Away From Home Care program will honor temporary enrollment in their HMOs, so you can consider Blue plan physicians in other cities as your extended healthcare network. Note: Away From Home Care is not available in all states. For more information, please call (800) 622-9402.

BLUE SHIELD WELLNESS

Make real improvements to your health with Wellvolution

Wellvolution is a digital platform for health and well-being. It offers over 50 tested apps and programs to help you achieve your health goals – at no extra cost. Areas of focus include disease prevention and reversal, nutrition, sleep, stress, smoking and more! Learn more at wellvolution.com.

Save on fitness club memberships & more

Get help saving money and living healthier with a wide range of wellness discount programs including discounts on fitness centers, acupuncture and chiropractic services; therapeutic massage; and eye exams, frames, contact lenses, and LASIK surgery. Learn more at blueshieldca.com/wellnessdiscounts.

Teladoc

You have access to Teladoc's national network of U.S. board-certified physicians. Whenever you need care, Teladoc medical doctors are available 24/7/365 by phone or video. You can also speak to licensed therapists, psychiatrists, and mental health professionals who can help you manage addiction, depression, stress or anxiety, domestic abuse, grief, and more. Mental health appointments are available from 7 a.m. to 9 p.m. local time, seven days a week. You can visit blueshieldca.com/teladoc or call (800) 835-2362 for more information.

Headspace

As the world's most science-backed meditation app, Headspace can help you reduce stress, increase resilience, and get a better night's rest. By dedicating just a few minutes a day you can join 70 million Headspace members worldwide using meditation to improve mental well-being. Visit wellvolution.com/mentalhealth to get started.

Maven

The Maven Maternity Program, to support you every baby step of the way. With Maven, you and your partner can get access to virtual care for pregnancy, postpartum, and returning to work after parental leave. Plus, you'll enjoy 24/7 access to Care Advocates, specialists, and coaches – as well as content tailored to your experience. To learn more, go to blueshieldca.com/maven.

MEDICAL PLANS

	Kaiser HMO	Kaiser Senior Advantage HMO
	In-Network	In-Network
Calendar Year Deductible[1] Individual Family	None	None
Calendar Year Out-of-Pocket Maximum[1] Individual Family	$2,000 $4,000	$1,000 per member
Office Visit Primary Care Specialist	$10 $10	$10 $10
Preventive Services	No charge	No charge
Chiropractic & Acupuncture	$10 (up to 30 combined visits/year)	$10 (up to 30 combined visits/year)
Lab and X-ray	No Charge	No Charge
Urgent Care	$10	$10
Emergency Room	$100 (copay waived if admitted)	$100 (copay waived if admitted)
Inpatient Hospitalization	No charge	No charge
Outpatient Surgery	No charge	No charge
Vision Exam	No charges (once every 12 months)	No charge (once every 12 months)
Eyeglass Lenses, Frames and Contacts	$175 allowance (once every 12 months)	$175 allowance (once every 12 months)
PRESCRIPTION DRUGS		
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	$10 $15 N/A $30	$10 $15 N/A $30
Mail Order- 100 Day Supply Tier 1 Tier 2 Tier 3 Tier 4	$20 $30 N/A N/A	$20 $30 N/A N/A

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 2025 through December 2025.

KAISER RESOURCES

Telehealth

Get quality care when you need it. Schedule a phone or video visit, talk with a Kaiser clinician anytime day or night for advice available 24/7, email your doctors, get prescriptions sent straight to your door, and more. Call (866) 454-8855 or visit kp.org/getcare.

Kaiser Away From

Kaiser Members are covered for emergency and urgent care anywhere in the world. Whether you're traveling in the United States or a foreign country, Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

myStrength

myStrength is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can get myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

Calm

Try the Calm app for self-care and better sleep. Calm is an app that uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

Headspace Care

The Headspace Care app provides 1-on-1 emotional support coaching and self-care activities to help with many common challenges. Coaches are available by text 24/7. Adult members can get Headspace Care at kp.org/selfcareapps.

ClassPass

Kaiser has teamed up with fitness industry leader ClassPass to make it easier for you to exercise from the comfort of your home or local gym/studio. Kaiser members can get on-demand video workouts at no cost and reduced rates on live stream and in-person fitness classes. To get started, visit kp.org/exercise.

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

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

alliantmedicaresolutions.com

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.

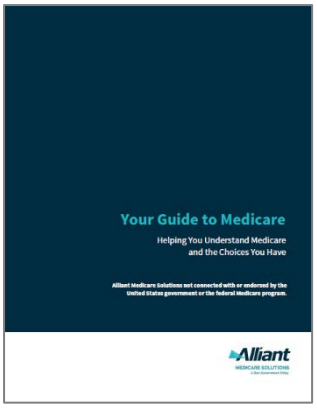
Introducing Alliant Medicare Solutions

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?

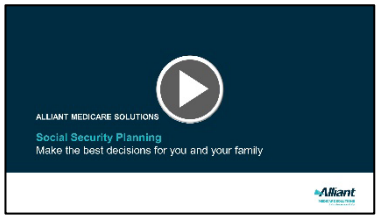
1. Call Alliant Medicare Solutions at (877) 888-0165 to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work 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

RETIREEFIRST – ANTHEM MAPD ADVOCATES

Whether facing a serious health problem or dealing with a confusing bill, it is easy for retirees to become confused and frustrated by the complicated healthcare system. RetireeFirst will guide you through the healthcare maze by providing the personalized support you deserve.

Valley Water has a dedicated Advocacy Team who will help you understand your healthcare benefits, options, and available resources while working on your behalf to resolve any issues. On every call, you will talk to a live person—no chatbots or call menus. The Advocates are trained Medicare experts who ensure a simple and stress-free retirement healthcare experience.

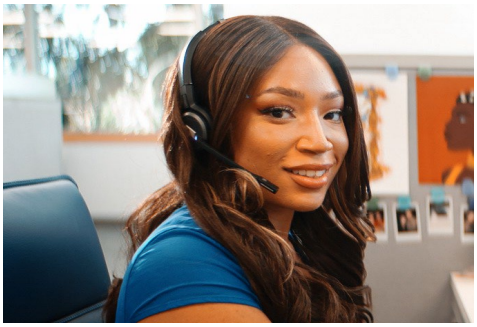
How the Advocates Can Assist You

- Personal information changes
- Card replacements
- Claims, billing, and payment support
- Provider network questions
- Lower-Cost generic availability, prior authorizations, and mail-order services
- High-Cost prescription copay assistance
- Education and assistance with additional plan benefits
- Formulary, tier, and copay assistance
- Three-Way calls to Medicare, vendors, healthcare providers, pharmacies, and Social Security

The Retiree Advocates Are:

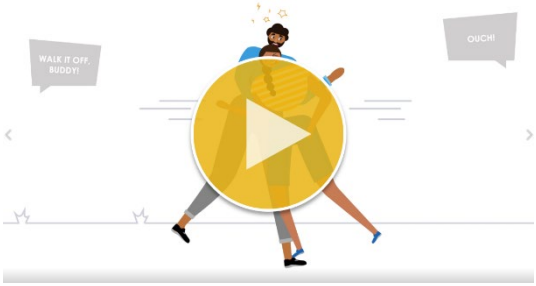
- Trained Medicare experts
- All based in the United States
- HIPAA compliant and dedicated to protecting personal information
- Compassionate and focused on improving your health and wellbeing

Those members enrolled (or considering enrolling) on the Anthem MAPD plan are eligible for this service.



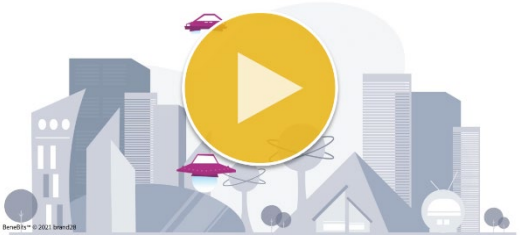
RetireeFirst is available Monday–Friday, 5AM–2PM PT (408) 868-8964 or toll free (855) 301-8203

ENGAGE



Urgent Care vs ER

Scan the QR code to watch the video.



Virtual Healthcare

Scan the QR code to watch the video.

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
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

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	**$$$$$**

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

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/ 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.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Scan the QR code to watch the video.

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

IMPORTANT PLAN INFORMATION

INFORMATION INCLUDES

Plan Contacts

Annual Notices

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

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Valley Water if your domestic partner is your tax dependent.

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website	Group No.
Medical	Blue Shield	(855) 599-2650	www.blueshieldca.com	W0051426
Teladoc	Blue Shield Teladoc	(800) 835-2362	www.teladoc.com/bsc	W0051426
Nurse Line	Blue Shield NurseHelp 24/7	(877) 304-0504		W0051426
Medical	Anthem	(855) 301-8203	www.retireefirst.com/valleywater	
Medical	Kaiser	(800) 464-4000	www.kp.org	7189
Nurse Line	Kaiser Advice Nurse 24/7	(866) 454-8855		7189
Retiree Advocacy MAPD Only	RetireeFirst	(855) 301-8203	www.retireefirst.com/valleywater	
Benefits Hotline	Valley Water	(408) 630-3030	employeeservices@valleywater.org	

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices in this guide:

- **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
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **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
- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

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 medical plan deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call the carriers.

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).

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Valley Water'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 Valley Water'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 Valley Water'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

We maintain the HIPAA Notice of Privacy Practices for Valley Water describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Benefits team.

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

Michelle's Law

The available plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify the benefits team in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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 9.12% in 2023 of your modified adjusted household income.

Notice of Choice of Providers

The Blue Shield HMO plans generally require 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. Until you make this designation, Blue Shield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield Customer Service. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact Blue Shield Customer Service.

Medicare Part D Notice

Important Notice from Valley Water 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 Valley Water 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. Valley Water has determined that the prescription drug coverage offered by the Blue Shield and Kaiser plans 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 Valley Water coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under the Blue Shield and Kaiser plans 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 Valley Water 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 Valley Water 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 benefits hotline at X3030 for more 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 Valley Water 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:	04/01/2025
Name of Entity/Sender:	Santa Clara Valley Water District
Contact-Position/Office:	Benefits Team
Address:	5750 Almaden Expy, San Jose, CA 95118
Phone Number:	Benefits Hotline X3030

NOTES


Valley Water