Health Program Guide

An informational guide to your CalPERS health benefits

Information as of August 2024

CalPERS

About CalPERS

The CalPERS Health Benefits Program is a nationally recognized leader in the health care industry. We put our expertise and influence to work to help us deliver quality, equitable, and affordable health care for our members and employers.

CalPERS is the largest purchaser of public employee health benefits in California, and the second largest public purchaser in the nation after the federal government. Our program is governed by the Public Employees' Medical and Hospital Care Act (PEMHCA) and provides benefits to approximately 1.5 million public employees, retirees, and their families.

Depending on where you reside or work, CalPERS offers active employees and retirees health plans, which may include:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)

The CalPERS Board of Administration annually determines health plan availability, covered benefits, health premiums, and copayments. Whether you are working or retired, your employer or former employer makes monthly contributions toward your health premiums.

About This Publication

The ***Health Program Guide*** describes CalPERS Basic health plan eligibility, enrollment, and choices. It provides an overview of CalPERS health plan types and tells you how and when you can make changes to your plan (including what forms and documentation you will need). It also describes how life changes or changes in your employment status can affect your benefits and eligibility.

This publication is one resource CalPERS offers to help you choose and use your health plan. Others include:

- ***Health Benefit Summary:*** Provides valuable information to help you make an informed choice about your health plan; compares benefits, covered services, and copayment information for all CalPERS health plans
- ***Medicare Enrollment Guide:*** Provides information on how Medicare works with your CalPERS health benefits

If there are any inconsistencies between the Health Program Guide and the provisions of the Public Employees' Medical Hospital Care Act (PEMHCA), the provisions of PEMHCA will apply.

You can obtain the above publications, required forms, and other information about your CalPERS health benefits through the CalPERS website at **www.calpers.ca.gov** or by calling CalPERS at **888 CalPERS** (or **888**-225-7377).

Where to Get Help With Your Health Benefits Enrollment

If you are an active employee, contact your health benefits officer to make all health benefit enrollment changes. Your health benefits officer is usually located in your personnel office or human resources department. With your health benefits officer's approval, you may also make changes online through myCalPERS at **my.calpers.ca.gov**.

Once you retire, CalPERS becomes your health benefits officer. As a retiree, you may make changes to your health plan in any of the following ways:

- Online through myCalPERS at **my.calpers.ca.gov**
- By calling us toll free at **888 CalPERS** (or **888**-225-7377)
- By faxing or writing to us at:
  CalPERS
  Health Account Management Division
  P.O. Box 942715
  Sacramento, CA 94229-2715
  Fax: (800) 959-6545

The chart on pages 16–17 indicates the forms and supporting documentation needed for most changes.

Contents

Eligibility Requirements

Who Is Eligible

Employees and annuitants of the State of California (State), California State University (CSU), and contracting agencies are eligible to enroll in the CalPERS Health Program. In most cases, your enrollment status does not affect your eligibility and you don't need to be enrolled in the past, present, or future to maintain eligibility.

For example:

- If you are eligible for health at the time of retirement but decline enrollment, you are eligible to enroll at a later time with a qualifying life event or during the Open Enrollment period.
- If you are eligible for health as a dependent but decline enrollment upon a member's death, then you remain eligible for health coverage and can enroll later.

Annuitants are eligible retirees or survivors. Although both are annuitants, their eligibility requirements are different. Annuitant and survivor are defined in Government Code 22760 and referenced on page 38 in Definition of Terms.

The following individuals can enroll in CalPERS health benefits if they meet eligibility requirements.

Employees

Eligibility is based on tenure and time base of your qualifying appointment. You must work at least half-time and have a permanent appointment or a "limited term" appointment with a duration of more than six months.

If you are a temporary or variable-hour employee, you may be eligible for health coverage due to provisions in PEMHCA that help large contracting agency employers meet the Affordable Care Act (ACA) requirements. To check if you meet the expanded eligibility criteria, contact your employer.

State Permanent Intermittent (PI) Employees

If you are a PI employee, you may enroll if you have credit for a minimum of 480 paid hours at the end of a "control period." A control period is six months from January 1 to June 30 or July 1 to December 31. You cannot become eligible in the middle of a control period even if the minimum hours are met. To continue to qualify for coverage, you must be credited with at least 480 paid hours at the end of each control period or at least 960 hours in two consecutive periods. Checkpoints to determine whether the hours have been met are June 30 and December 31.

Retirees

You are eligible to enroll in a CalPERS health plan if you meet all of the following criteria:

- Your retirement date is within 120 days of separation from employment
- You were eligible for health benefits upon separation
- You receive a monthly retirement allowance
- You retire from the State, California State University (CSU), or an agency that currently contracts with CalPERS for health benefits for your specific employee group

Family Members

The terms "family member" and "dependent" are used interchangeably. Eligible family members include:

- Spouse
- Registered domestic partner
- Children (natural, adopted, domestic partner's, or step) up to age 26
- Children, up to age 26, if the employee or annuitant has assumed a parent-child relationship and is considered the primary care parent — see page 13 for more details
- Certified disabled dependent children age 26 and older — see page 13 for more details

Survivor

Survivors are eligible for health benefits if they:

- Qualify for a monthly survivor check,
- Were eligible dependents when the annuitant died, and
- Still qualify as eligible family members.

Who Is Not Eligible

Certain State or contracting agency employees and family members are not eligible for CalPERS health benefits.

Ineligible Employees

- Those working less than half time* (except for certain California State University and contracting agency employees whose contracts provide health benefits for less than half time work)
- Those whose appointment lasts less than six months*
- Those whose job classification is "Limited-Term Intermittent"* (seasonal or temporary)
- Those classified as "Permanent Intermittent" who do not meet the hour requirements within the control period
- Those whose employer does not have a contract or has terminated its contract with CalPERS

** The Affordable Care Act has provisions which expand eligibility criteria for certain variable-hour employees. For additional information, please contact your employer. CalPERS cannot advise on the timekeeping and documentation requirements of variable-hour employees under the Affordable Care Act.*

Do Not Enroll Ineligible Family Members

PEMHCA prohibits you from enrolling ineligible family members. If you do so, CalPERS will retroactively cancel the enrollment and you must pay all costs incurred by the ineligible person from the date the coverage began.

Ineligible Family Members

The following family members are not eligible for coverage:

- Former spouses/former registered domestic partners
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or who were deleted from coverage (see "Disabled Children Not Eligible for Coverage" on page 13 for more information)
- Children of a former spouse/former registered domestic partner (unless the former stepchild is certified as a parent-child relationship dependent)
- Foster children
- Grandparents
- Parents

Medicare Eligibility

If you are currently enrolled in a CalPERS Basic plan, you and/or your dependents are eligible to enroll in a CalPERS Medicare plan under any of the following circumstances:

- You are age 65 or older, retired, and eligible for premium-free Medicare Part A in your own right or through the work history of a current, former, or deceased spouse (you must enroll and maintain payment of Medicare Part B).
- You and/or your dependents are any age, have End-Stage Renal Disease (ESRD) and have completed any applicable coordination periods with the Social Security Administration (SSA).
- You are retired and you and/or your dependents have a Social Security-qualified disability.
- You are retired from a California State Teachers' Retirement System (CalSTRS) employer and are eligible for the CalSTRS Medicare Premium Payment Program. For more details, see the ***Medicare Enrollment Guide***, visit **www.calstrs.com**, or call CalSTRS toll free at (800) 228-5453.

If you have questions regarding your Medicare eligibility, contact the Social Security Administration at (800) 772-1213 or TTY (800) 325-0778, or visit **www.ssa.gov**.

Health Plan Options

Choosing a Health Plan

CalPERS offers a variety of health plans with high-quality health care provider networks. When exploring plans, you will want to consider factors such as:

- Lower-cost options
- The available doctors and hospitals in your area
- The location of care facilities
- And how the plan works with other health plans like Medicare.

When you choose a plan, be sure to review the plan's covered and non-covered services and the restrictions on your choice of providers. The right plan for you will depend on your specific situation. You can use ***Your Guide to Choosing a Health Plan*** as a checklist of tools and resources to guide you as you shop plans so you can make the best decision for you and your family.

If you need help selecting a plan, visit **www.calpers.ca.gov** or log into your myCalPERS account at **my.calpers.ca.gov** to access the following tools and resources:

- The **Search Health Plans** tool lets you find and compare plans in your area; see monthly premiums and member satisfaction ratings; view side-by-side plan, benefit, and copay comparisons; and search for primary care doctors and specialists.
- The ***Health Benefit Summary*** provides a side-by-side comparison of plans and benefits, covered services, and copayment information to help you make an informed choice.

Health Plan Availability

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP Code. You cannot use a P.O. Box to establish eligibility, but may use it for mailing purposes. To enroll in a Medicare plan, you must use your residential address.

If you are a retired CalPERS member, you may select any plan in your residential ZIP Code area. If you are a working retiree, you may use the ZIP Code of your current employer for plan eligibility.

If you use your residential ZIP Code, all enrolled dependents must reside in the plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the plan's service area, even if they do not reside in that service area.

To determine if the plan you are considering provides service where you reside or work, contact the plan before you enroll. You may also use the **Health Plan Search by ZIP Code** tool, available at **www.calpers.ca.gov** and on myCalPERS at **my.calpers.ca.gov**.

CalPERS Basic Health Plans

Depending on where you reside or work, one or more of the following Basic health plan types may be available to you. You can use the **Health Plan Search by ZIP Code** tool on our website for the plans available in your area. (For a full listing of health plans, refer to the ***Health Benefit Summary***.)

Health Maintenance Organization (HMO) Plans

HMOs offer members a range of health benefits, including preventive care. The HMO will give you a list of doctors from which you select a primary care provider (PCP). Your PCP coordinates your care, including referrals to specialists. Other than applicable copays, you pay no additional costs when you receive pre-authorized services from the HMO's contracted providers. Except for emergency and urgent care, if you obtain care outside the HMO's provider network without a referral from the health plan, you will be responsible for the total cost of services.

Preferred Provider Organization (PPO) Plans

Unlike an HMO, where a primary care provider directs all your care, a PPO allows you to select a primary care provider and specialists without referral. A PPO is similar to a traditional "fee-for-service" health plan, but you must use doctors in the PPO network or pay higher coinsurance (percentage of charges). In a PPO plan, you must meet an annual deductible before some benefits apply. You are responsible for a certain coinsurance amount, and the plan pays the balance up to the allowable amount.

When you use a non-participating provider, you are responsible for any charges above the amount allowed.

Exclusive Provider Organization (EPO) Health Plans

The EPOs serve certain California counties. EPO plans offer the same covered services as an HMO plan, but you must seek services from the plan's network of preferred providers. You are also able to access physicians and specialists that participate in the network without a referral. You pay copayments, for some services, but you have no deductible, no claim forms, and a geographically restricted service area.

CalPERS Medicare Health Plans

There are Medicare Advantage Plans (Managed Care Plans) and Supplement to Medicare Plans. Depending on where you reside or work, one or more of the following Medicare plan types may be available to you. (For a full listing of plan options, refer to the ***Health Benefit Summary***.)

> For more information about how the CalPERS Health Program works with Medicare, please refer to the ***Medicare Enrollment Guide***.

Medicare Advantage HMO Plans

With a Medicare Advantage HMO plan, you work closely with your Primary Care Physician (PCP) to get the care you need. You pay no additional costs, other than applicable copayments, when you receive services from the plan's network of providers. If you go to out-of-network doctors or hospitals, you will have to pay for all services (except for emergency or out-of-area urgent care services).

Medicare Advantage PPO Plans

With a Medicare Advantage PPO Plan, you do not need to select a PCP or obtain referrals to see specialists. Members have access to a network of health care providers known as preferred providers. This type of plan allows you the option of seeing non-preferred providers but may require you to pay a higher percentage of the health care bill. These plans are available only to individuals who live in the plans service areas. To remain a member of a plan, you must continue to reside in the plan service area.

PPO Supplement to Medicare Plans

With a PPO Supplement to Medicare plan, you do not need to select a PCP or obtain referrals to see specialists. Members have access to a network of health care providers known as preferred providers. If your providers participate in Medicare, your health plan will pay most bills for Medicare-approved services. If any of your providers do not accept Medicare payments, you will have to pay a larger portion of your health care bills. You can find out if you will have to pay more by asking your providers.

Combination Plans

CalPERS requires all family members to have the same health carrier. A combination plan means at least one family member is enrolled in a Medicare plan and at least one family member is enrolled in a Basic plan through the same health carrier.

Your current CalPERS Basic plan may not offer a CalPERS-sponsored Medicare plan; therefore, a health plan change would be required. Consider your family's needs when determining which Medicare plan is right for you. If you or your family member become eligible for Medicare and enroll in a CalPERS Medicare plan, all members of your family will be impacted by the Medicare member's change in health plans.

Important Reminder

Once you or your family members enroll in a CalPERS Medicare health plan, you may not change back to a CalPERS Basic plan. This rule does not apply if the Social Security Administration cancels your Medicare benefits for a reason such as a permanent move outside the United States, or you return to work and are eligible for employer group health coverage. If your Medicare benefits are canceled due to non-payment of your Medicare Part B premiums or by your request, you may not change back to a CalPERS Basic plan.

Costs & Paying

How to Calculate Your Cost

Your cost depends on the plan you choose and your employer or former employer's contribution toward that plan's premium.

Health Plan Premium – **Employer Contribution** = **Your Cost**

For more information about health plan costs, please refer to the **Health Plans & Rates** page on the CalPERS website at **www.calpers.ca.gov**.

Health Premium Contributions

The employer contribution is the amount your employer or former employer will contribute toward your health plan premium. The amount of this contribution varies.

State and CSU Contributions

When you retire from the State of California or the California State University (CSU), you may receive a percentage of the State's contribution toward your health plan premium in retirement. Employer contributions are subject to vesting requirements and can be found on the **Retiree Plans & Rates** webpage on the CalPERS website at **www.calpers.ca.gov**.

Public Agency and School Contributions

If you're retiring from a public agency or school, your employer's monthly contribution is established by contract. Your employer has the authority to make changes to the contribution amount or cancel the contract.

Health Vesting

State Health Vesting Requirements

For State employees, "vesting" refers to the amount of time you must be employed by the State to be eligible to receive employer contributions toward the cost of the monthly health premium during retirement. Bargaining unit negotiations may affect the State's vesting requirements.

Exempt employees are also subject to health vesting based on their State hire date. For additional information, please refer to the ***Understanding Health into Retirement for Specialized Categories of State Employees*** guide on our website.

State vesting requirements do not apply to employees of the Legislature, contracting agency retirees, or those on disability retirement. The amount the State contributes toward your health coverage depends on whether you are vested. The contribution amount is determined by a formula set by law and the date you were first hired by the State. A State contribution of 100% may not cover the entire cost of the health plan premiums (you will be responsible for the remaining balance).

The following applies to all State employees, exempt employees, Legislators, Judges, LRS and JRS members based on their first state hire date as indicated below.

- **First hired by the State prior to January 1, 1985:** You are eligible to receive 100% of the State's contribution toward your health premium upon your retirement.
- **First hired by the State between January 1, 1985 and January 1, 1989:** You are subject to vesting requirements, as follows:
  - 10 years of credited State service: You are fully vested and qualify for 100% of the State's contribution toward your health premium.
  - Less than 10 years of credited State service: You are eligible for health coverage; however, the State's contribution will be reduced by 10% for each year of service under 10 years. You will be responsible for the difference.

The following State bargaining units, exempt employees, and excluded employees have a 20-year health vesting schedule based on their first State hire date as indicated below. The percentage of the State's contribution is based on your completed years of State service.

- Bargaining Units 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, and 21 — after January 1, 1989
- Bargaining Units 1, 9, and 17 — after June 1, 1989
- Excluded and exempt employees — after January 1, 1990

Years of Credited State Service	State Contribution
Fewer than 10	0%
10	50%
10–19	50%, plus 5% added for each year after the 10th year
20 or more	100%

The following applies to all Judges, State, and excluded employees. These bargaining units have a 25-year vesting schedule for those who are first hired on or after certain dates. These bargaining units and hire dates are as follows:

- Bargaining Unit 12 and related employees — On or after January 1, 2011
- Bargaining Units 9, 10, and related employees — On or after January 1, 2016
- Bargaining Units 1, 2, 3, 4, 6, 7, 8, 11, 13, 14, 15, 17, 18, 19, 20, 21, related employees, and the Judicial Branch — On or after January 1, 2017
- Bargaining Unit 16 and related employees — On or after April 1, 2017
- Bargaining Unit 5 and related employees — On or after January 1, 2020

Note: *Employees of the Judicial Branch hired prior to January 1, 2017 are subject to the 10 years' vesting requirement.*

If you were hired as a State employee in one of these bargaining units or its related employees on or after the date indicated, and you've earned 25 years of state service, you are fully vested and qualify for 100% of the state's contribution toward your health premium. This table shows the percentage of the state's contribution you will receive based on your years of service credit.

Years of Credited State Agency Service	State Contribution
Fewer than 15	0%
15	50%
15–24	50%, plus 5% for each year after the 15th year
25 or more	100%

CSU Health Vesting Requirements

Some CSU bargaining units hired on or after certain dates are subject to a 10-year health vesting schedule. Once you reach 10 years of service credit, you are fully vested and qualify for 100% of the State's contribution toward your health premium. The bargaining units and hire dates are as follows:

- Bargaining Unit 3 — On or after July 1, 2017
- Non-represented employees — On or after July 1, 2018
- Bargaining Units 1, 2, 4, 5, 6, 7, 9, and 10 — On or after July 1, 2018
- Bargaining Unit 11 — On or after July 1, 2019

Contracting Agency Health Vesting Requirements

Contracting agency employees may be subject to vesting requirements. Some contracting agencies elect to establish vesting requirements for their employees upon retirement. Vesting schedules apply only to employees hired on or after the effective date of the contract or memorandum of understanding that establish vesting requirements.

Enrolling in a Health Plan

Enrollment Events & Effective Dates

This section provides information about enrollment time frames and effective dates for enrolling yourself and family members. If your initial time frame expires, you may enroll during the next Open Enrollment period, or during a special or late enrollment opportunity. (See section "Additional Enrollment Opportunities" on page 14 for more information.) The chart on pages 16–17 identifies the forms and supporting documentation required to enroll eligible family members.

There are two types of qualifying health enrollment events, permissive and mandatory.

Permissive: Health changes related to these events are voluntary. If you choose to make a change, you must submit your request within 60 days of the qualifying event. Changes are effective the first of the month following the received date.

Examples of permissive events:

- New CalPERS covered employment
- Marriage or registered domestic partnership
- Change of address

Open Enrollment

The Open Enrollment period takes place each fall. Changes made during Open Enrollment are effective the following January 1. During this time, you can:

- Enroll in a health plan
- Change health plans
- Add or remove eligible dependents
- Cancel coverage

Mandatory: Mandatory qualifying events require that you make a change to your enrollment. The effective date is the first of the month following the event.

Examples of mandatory events include:

- Divorce or termination of a domestic partnership
- Death of a dependent family member
- Death of a subscriber

Enrollment Event Type	Effective Date
Open Enrollment	January 1st of the following year
Permissive Event*	1st of the following month after the request is received. Request must be within 60 days of the event date.
Mandatory Event	1st of the following month after the event date

** Enrollment requests made outside of 60 days of the event date will result in a HIPAA late enrollment. See page 14 for additional enrollment opportunities.*

If you aren't currently enrolled, the following life events allow for a new enrollment in a health plan.

Life Event	Permissive or Mandatory
Adoption/Placement for Adoption	Mandatory
Birth	Mandatory
Court-Ordered Coverage	Permissive
Loss of Other Coverage	Permissive
Marriage	Permissive
Retirement	Permissive

Where to Get Help With Your Health Benefits Enrollment

If you are an active employee, contact your health benefits officer to make all health benefit enrollment changes. Your health benefits officer is usually located in your personnel office or human resources department. With your health benefits officer's approval, you may also make changes online through myCalPERS at **my.calpers.ca.gov**.

Once you retire, CalPERS becomes your health benefits officer. As a retiree, you may make changes to your health plan in any of the following ways:

- Online through myCalPERS at **my.calpers.ca.gov**
- By calling us toll free at **888 CalPERS** (or **888**-225-7377)
- By faxing or writing to us at:
  CalPERS
  Health Account Management Division
  P.O. Box 942715
  Sacramento, CA 94229-2715
  Fax: (800) 959-6545

The chart on pages 16–17 indicates the forms and supporting documentation needed for most changes.

Employees

You have 60 days from the date of your initial appointment to enroll or decline to enroll in a health plan. You can choose to enroll yourself, or yourself and all eligible family members. (Permanent Intermittent employees have 60 days from the end of the qualifying control period to enroll.) The effective date is the first day of the month following the date your health benefits officer receives the ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12).

When you enroll, you must enroll yourself or yourself and all eligible family members unless the family member is:

- Covered under another health plan
- A spouse not living in your household
- A child aged 18 to 26
- A member of the armed forces

You must complete the ***Health Benefits Plan Enrollment for Active Employees*** (HBD-12) coverage form during your initial eligibility period, whether you elect to enroll or decline health coverage.

If you or your eligible family members decline to enroll during the initial enrollment period, enrollment can occur at a later date. (See "Split Enrollments" on page 13 and "Additional Enrollment Opportunities" on page 14.)

Retirees

As an eligible retiree, you may enroll yourself or yourself and all eligible family members in a health plan within 60 days of your retirement date. The effective date is the first day of the month following the date CalPERS receives the ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30). You may also enroll during any future Open Enrollment period or due to other life events. (See section "Additional Enrollment Opportunities" on page 14).

If you are enrolled in a CalPERS health plan when you separate from employment and want to continue your enrollment into retirement, your coverage will automatically continue as long as your separation and retirement dates are within 30 days of each other. (See the section "When You Are Retiring" beginning on page 24 for more details.) If you do not wish to continue your CalPERS health coverage, contact your health benefits officer (CalPERS, if already retired) to cancel your coverage.

Note: *As you transition from active employment to retirement, be sure to inform CalPERS if you or your dependents are eligible for or enrolled in Medicare.*

Survivors

You may enroll in a health plan as a survivor if you were eligible for enrollment as a dependent on the date of death of a CalPERS retiree and you receive a monthly survivor check. If you meet eligibility requirements, you may enroll in a health plan within 60 days of the employee or annuitant's death. You may also enroll during any future Open Enrollment period or due to other qualifying events (see page 18). If your survivor benefits are pending approval, you may elect to enroll in

Consolidated Omnibus Budget Reconciliation Act (COBRA). The effective date of enrollment is the first day of the month following the date CalPERS receives your ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30). Exceptions may apply for certain contracting agency survivors who do not receive a monthly survivor check. Contact your spouse's former employer for additional information.

If you are enrolled in a CalPERS health plan as a dependent on the date of death of the retiree, we will automatically enroll you as a survivor once your first monthly survivor check is issued. A survivor can only enroll dependents who were eligible for CalPERS health benefits at the time of the retiree's death.

For more information regarding health coverage options for survivors, see the section "Death of Employee or Retiree" on page 20.

Enrolling Family Members

Spouse

You may add your spouse to your health plan within 60 days of your marriage. You are required to provide a copy of the government issued marriage certificate and your spouse's Social Security number and Medicare card (if applicable). Your spouse's coverage is effective the first day of the month following the receipt of the ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) or ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30).

Note: *If your spouse does not have a Social Security number, they can still be enrolled in CalPERS health benefits.*

Registered Domestic Partner

You may add your registered domestic partner to your health plan within 60 days of registration of the domestic partnership. The coverage is effective the first day of the month following the receipt of the ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) or ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30).

To add a domestic partner to your health plan, you must register your domestic partnership through the California Secretary of State's Office or equivalent office from another state. Upon registration, that office will provide you with a Declaration of Domestic Partnership. CalPERS requires that you submit a copy of the approved Declaration of Domestic Partnership, your domestic partner's Social Security number, and a copy of their Medicare card (if applicable). For more information about domestic partnership registration, visit the Secretary of State's website at **www.sos.ca.gov**.

Note: *If your registered domestic partner does not have a Social Security number, they can still be enrolled in CalPERS health benefits.*

Children

Natural-born, adopted, stepchildren, and domestic partner's children who are under age 26 may be enrolled in your health plan, as outlined below:

- Newborn children may be added within 60 days of birth. For up to 30 days of the newborn's life, they will be covered under the policy of the parent. Coverage as a dependent begins the first day of the month following the date of birth.
- Newly adopted children may be added within 60 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 60 days after the date of your marriage or registration of your domestic partnership.

With the exception of newborn children and newly adopted children, the coverage is effective the first day of the month following the receipt of the ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) or ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30).

Disabled Children Over Age 26

A child aged 26 and over who is incapable of self-support because of a mental or physical condition may be eligible to enroll. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician specializing in the dependent's disability. You are required to complete section A of the ***Disabled Dependent Member Questionnaire and Medical Report*** form (HBD-34) and the ***Authorization to Disclose Protected Health Information*** (PERS-BSD-35) and submit

the documents to the dependent's physician. The physician must complete section B and C of the ***Member Questionnaire and Medical Report*** form (HBD-34) and send the document directly to CalPERS for review. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 90 days before and 60 days after the child's 26th birthday
- Within 60 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

Note: *Retirement is not a qualifying event to add a disabled dependent.*

Upon certification of eligibility, the dependent's CalPERS health and dental coverage must be continuous and without lapse. Certification periods are determined by the dependent's treating physician and cannot be longer than seven years. When the certification expires, you are required to submit an updated ***Disabled Dependent Member Questionnaire and Medical Report*** (HBD-34) and ***Authorization to Disclose Protected Health Information*** (PERS-BSD-35) forms for recertification. We must receive these documents no earlier than 90 days prior to the expiration date, and not later than the expiration date.

Note: *If the disabled child has a Social Security Disability (SSD), provide CalPERS with a completed Certification of Medicare Status and a copy of the Medicare card showing the Medicare Benefit Identifier (MBI) and effective dates for Medicare Parts A&B.*

Disabled Children Not Eligible for Coverage

The following disabled children are not eligible for coverage:

- Dependent children whose disability occurred after age 26
- Dependents who initially continued CalPERS Health coverage as disabled dependents beyond age 26 and who were later deleted from the enrollment
- Dependent children whose disability occurred prior to age 26, who were not certified as disabled dependents at age 26
- Dependents who are capable of self-support
- Disabled dependents who were not recertified prior to the expiration date

Dependents in a Parent-Child Relationship

A child other than an adopted, step, or natural-born child, up to age 26, may be added to your health plan if you assume parental status or duties. This relationship must be certified at the time of enrollment of the child and then annually on your birth month. Recertification is also required when you enroll as a retiree. Foster children are not eligible to enroll in a parent-child relationship. If you obtain legal guardianship of a foster child, please contact your health benefits officer.

You have 60 days from the date you assume parental status of the child to enroll them in your health plan. To enroll a dependent who is in a parent-child relationship, you must complete and submit an ***Affidavit of Parent-Child Relationship***. You must provide supporting documentation as indicated on the ***Affidavit of Parent-Child Relationship*** (HBD-40). Coverage is effective the first day of the month following the receipt of the ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) or ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30) and all necessary supporting documentation.

For dependents age 18 and under, the annual recertification requires a copy of the first page of your previous year's income tax return listing the child as a tax dependent.

If you can't provide a tax return, then you must do one of the following:

- During the child's initial enrollment in a parent-child relationship, you must submit three documents that substantiate the child's financial dependence as indicated on the ***Affidavit of Parent-Child Relationship*** (HBD-40). This exception is limited to one tax filing year.
- If you do not file taxes, you must submit:
  - A confirmation from the Internal Revenue Service, Franchise Tax Board, certified public accountant, tax preparer, or other tax professional indicating a tax return is not required, **and**
  - Three or more supporting documents as indicated on the ***Affidavit of Parent-Child Relationship*** (HBD-40).

For dependents aged 19 up to age 26, the annual recertification requires:

- A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent, or
- Supporting documents that substantiate that the child is financially dependent, provided that the child either:
  - Lives with you rent free for more than 50% of the time (submit two supporting documents), or
  - Lives with you and pays rent or is a full-time student and doesn't live with you (submit three supporting documents).

The ***Affidavit of Parent-Child Relationship*** provides a list of acceptable supporting documents. All supporting documents must have the child's name printed on them by the issuer. All supporting documents may not be older than 60 calendar days from the date of signature of the ***Affidavit of Parent-Child Relationship*** (legal judgments, court documents, driver's licenses, state identification, vehicle registrations, and rental/lease agreements may be older than 60 days).

Unlawful Enrollments

Split Enrollments

When two active or retired CalPERS members are married to each other or in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. Parents cannot split enrollment of dependents. We retroactively cancel split enrollments. You will be responsible for all costs incurred from the date the split enrollment began.

Enrolling in Two CalPERS Health Plans

Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a subscriber and a dependent or as a dependent on two enrollments. This duplication of coverage is not permitted by PEMHCA. When dual CalPERS coverage is identified, the enrollment that caused the dual coverage is retroactively canceled. You will be responsible for all costs incurred from the date the dual coverage began.

Members may enroll in both a CalPERS health plan and a health plan provided through a non-CalPERS employer. For example, your spouse may enroll as a dependent in your CalPERS plan and in a plan from their non-CalPERS contracting employer. In this case, the two plans may coordinate benefits.

Additional Enrollment Opportunities

The Health Insurance Portability and Accountability Act (HIPAA) offers two provisions for employees, retirees, and family members to enroll in CalPERS health plans outside of the initial enrollment period and the Open Enrollment period.

Special Enrollment

Special Enrollment refers to certain enrollment opportunities that occur after your initial enrollment but outside of the annual Open Enrollment period. You may need Special Enrollment under the following circumstances:

You lose other health coverage: If you initially declined or canceled enrollment for yourself or your dependents because you had other health coverage, you may be able to enroll in a CalPERS health plan if the other coverage ends. To qualify, you will need to request enrollment within 60 days of the other coverage ending and provide proof that the other coverage has ended.

Court order: Enroll an eligible family member into your health benefits as required by court order. The effective date is the first of the month following the court order date, unless the court order specifies a specific effective date of coverage.

Note: *This does not apply to former spouses.*

You have new family members: When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, or placement of adoption, you may enroll yourself and all eligible dependents within 60 days of that event.

The effective date for a Special Enrollment is the first day of the month following the receipt of the ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) or ***Health Benefits Plan Enrollment for Retirees and Survivors*** form (HBD-30) and all the required documentation.

Late Enrollment

If you decline or cancel enrollment for yourself or your dependents and the Special Enrollment opportunities do not apply, your right to enroll or add dependents outside of Open Enrollment is limited. The earliest effective date of enrollment is the first of the month following a 90-day waiting period.

Once You Are Enrolled

Check Your Health Deductions

When you enroll for the first time, change plans, or add/delete dependents, carefully review the itemized deductions listed on your paycheck or retirement check. Verify that the amount of your share of the plan premium is correct. More information on plan premiums can be found on the **Plans and Rates** page of our website.

If you change plans during Open Enrollment but your January paycheck or retirement check does not reflect your new plan's premium payment, do not continue to use your previous plan's services after the first of the year. The premium payment will be adjusted during the subsequent pay period. If your Open Enrollment plan change is not reflected on your next paycheck or retirement check, contact your employer or CalPERS if retired.

A $0.00 health premium deduction on your paycheck or retirement check indicates that your employer (or former employer) is paying the entire premium on your behalf. If you change plans, you should check to make sure the new plan name is listed on your paycheck or retirement check.

Health Plan Identification Cards

You will need your health plan identification card when you seek medical care. Identification cards are issued by each plan when you enroll, not by CalPERS. Contact your plan directly if:

- You do not receive your card by the effective date of your initial enrollment
- You need care before your card arrives
- You need additional or replacement cards

You can often access an electronic identification card by registering for an online account with your health plan.

Enrollment Forms and Required Documents

Getting the Information You Need

You may view and download health benefits forms and publications on our website at **www.calpers.ca.gov**.

The chart on the following pages can assist you in determining the forms and supporting documentation we need to make various types of enrollment changes.

See page 11 for how to submit your documents.

Enrollment type	Copies of Supporting Documents *	CalPERS Forms **
Active employee (new enrollment)	• N/A	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active)
Adding a registered domestic partner	• Declaration of Domestic Partnership from the California Secretary of State's Office • Social Security card* • Medicare card (if applicable)	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Adding a spouse	• Government-issued marriage certificate • Social Security card* • Medicare card (if applicable)	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Adding a dependent who is in a parent-child relationship (PCR)	• Required supporting documentation as indicated on the ***Affidavit of Parent-Child Relationship***	• ***Affidavit of Parent-Child Relationship*** (HBD-40) • ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Adding/deleting a dependent child	• Medicare card (if applicable) • Reason for add/delete • Birth certificate • Social Security card*	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Changing plans due to address change	• Include both old and new addresses	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Medicare certification (to validate eligibility, ineligibility, or deferment)	• Medicare card (reflecting Parts A & B enrollment) or SSA Notice of Award • Supporting documentation from the SSA of Medicare ineligibility or supporting documentation showing enrollment in the other Employer Group Health Plan	• ***Certification of Medicare Status*** form • ***Ineligibility of Medicare Certification*** form
Death of employee, retiree, or family member	• Death certificate	• N/A

Enrollment type	Copies of Supporting Documents *	CalPERS Forms **
Deleting a registered domestic partner (due to termination of partnership)	• Termination of Domestic Partnership submitted to the California Secretary of State's Office	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Deleting a spouse due to divorce	• Divorce judgment	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Disabled child over age 26 (certification)	• N/A	• ***Disabled Dependent Member Questionnaire and Medical Report*** form (HBD-34) • ***Authorization to Disclose Protected Health Information*** (PERS-BSD-35)
Enrolling self or dependents due to loss of other health coverage	• Certificate of Creditable Coverage, or other proof of loss of coverage • Medicare card (if applicable) • Birth certificate (child) • Government-issued marriage certificate (spouse) • Declaration of Domestic Partnership (domestic partner) • Social Security card*	• ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active) • ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Retiree (new enrollment)	• Medicare card (if applicable) • Government-issued marriage certificate (if applicable)	• ***Health Benefits Plan Enrollment for Retirees*** form (HBD-30)
Off-Pay Status (continue coverage)	• N/A	• ***Direct Payment Authorization*** form (HBD-21) • ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active)
Off-Pay Status (cancel coverage)	• N/A	• ***Direct Payment Authorization*** form (HBD-21) • ***Health Benefits Plan Enrollment for Active Employees*** form (HBD-12) (active)

** Do not submit original documents, since they are not returned. If your eligible dependent does not have a Social Security number, they can still be enrolled in CalPERS health benefits.*

*** With your health benefits officer's approval, you may also make changes online through myCalPERS at **my.calpers.ca.gov**. If you do, the HBD-12 and HBD-30 forms are not required, and all supporting documents may be submitted electronically.*

Life Events That Can Impact Your Enrollment

Family Changes

You are responsible for ensuring the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you will be liable for the health premiums or health care services incurred during the entire ineligibility period. Health plan premium reimbursements are limited to a six-month period for certain life events.

You must report the following life events to make the appropriate change to your health coverage.

Marital Status or Registered Domestic Partnership

Changes in family status because of marriage, divorce, or death may affect your health plan enrollment. Establishing or terminating a registered domestic partnership may also result in changes.

When you divorce or terminate a registered domestic partnership, your former spouse or registered domestic partner and former stepchildren or domestic partner's children are no longer eligible to receive CalPERS health benefits under your coverage unless you assume parental status or duties. (see Dependents in a Parent-Child Relationship on page 13). The coverage terminates on the first day of the month following the divorce or termination of registered domestic partnership date. A copy of the final divorce judgment or Termination of Domestic Partnership is required when you delete a former spouse or registered domestic partner from your health plan.

For example, if your divorce or dissolution occurred in 2020, yet you did not report it until 2023, your former spouse or registered domestic partner will be retroactively deleted from coverage effective the first of the month following the divorce or dissolution. The health premiums will be adjusted for a period of no more than six months from the date your health benefits officer receives copies of supporting documentation.

Note: *Although a member's divorce judgment or settlement may stipulate that they must provide health benefits for the former spouse, the former spouse cannot remain enrolled in CalPERS health benefits, as they are no longer an eligible family member. The member would need to obtain other health coverage for the former spouse.*

Disenroll Ineligible Family Members Immediately

PEMHCA prohibits the continued enrollment of ineligible family members. If you do not disenroll them, you must pay all costs incurred by the ineligible person during the ineligibility period.

Employment Changes

As your employment status changes, so can your eligibility for CalPERS health benefits. Following are examples of some of those changes and information on how you can maintain your health coverage eligibility.

Off-Pay Status/Temporary Leave

You may continue your coverage during off-pay status or while on temporary leave by paying the entire monthly health premium directly to your health plan. You are eligible for direct payment if you:

- Take a leave of absence without pay
- Take temporary disability leave (not covered by FMLA) and do not use sick leave or vacation credits
- Are waiting for approval of disability retirement or "regular" service retirement
- Are waiting for approval of Non-Industrial Disability Insurance benefits
- Are suspended from your job
- Institute legal proceedings appealing a dismissal from your job
- Are a State Permanent Intermittent employee eligible for health benefits but are on non-pay status. (Direct payment may only be elected through the end of the qualifying control period.)

To initiate direct payment, complete the ***Direct Payment Authorization*** form (HBD-21). You must submit requests for the direct payment option to your employer prior to the beginning of your leave, but no later than the last day of the month of coverage. If you do not elect the direct payment option during off-pay status, your health coverage will be canceled. You can re-enroll when you return to pay status with your CalPERS-covered employer if your earnings are sufficient to cover your share of the monthly premium.

While enrolled in direct payment you can:

- Add newly acquired dependents
- Delete dependents
- Change plans (due to a move or during Open Enrollment)
- Cancel your coverage

See page 16 for the required forms and supporting documents.

Military Duty

When you take a leave of absence for military duty, you may continue coverage by paying the monthly health premium directly to your health plan. With direct payment, there are no administrative costs, and your employer does not contribute to your health premium. Your CalPERS health coverage will resume the day you return to pay status. To initiate direct payment, contact your health benefits officer for a ***Direct Payment Authorization*** form (HBD-21). You also have the option to cancel coverage, and may re-enroll upon returning from military duty.

Leaving Your Job

If you leave your job for reasons other than retirement, you are covered until the first day of the second month following the last date you were employed. You must have sufficient earnings to cover your share of the health premium.

If you elect to cancel your coverage before you leave your job, your benefits will not continue, and you will not be eligible for COBRA Continuation Coverage.

Death

Notify CalPERS upon the death of any member, retiree, survivor, or anyone receiving a CalPERS benefit. Employees and annuitants must report the death of a spouse, registered domestic partner, or dependent as soon as possible.

Death of an Employee

If the employee was eligible to retire on the date of death, the surviving family members are eligible for continuation of health benefits provided they were eligible at the time of death and qualify for a monthly survivor check.

After the death of an active State employee, State employers are required to pay contributions for the health coverage of all enrolled eligible dependents for up to 120 days after the death.

Family members who do not meet these qualifications may be eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage. (See the following section "Losing Your CalPERS Coverage" for more information about COBRA.)

Death of a Retiree

Surviving family members are eligible for continued health benefit coverage provided they qualify for a monthly survivor check, were eligible dependents at the time of the retiree's death, and continue to qualify as eligible family members.

Surviving family members who do not meet these qualifications may be eligible for COBRA Continuation Coverage.

Losing Your CalPERS Coverage

If you lose your CalPERS health coverage, you have two options to continue your health benefits: COBRA Continuation Coverage or an Individual Conversion Policy.

COBRA Continuation Coverage

COBRA allows you and your dependents to continue health coverage for a limited time under certain circumstances such as job loss (for reasons other than gross misconduct), reduction in hours worked, death, divorce, and other life events. Your cost under COBRA may include an additional fee, but your total generally will not exceed 102% of the monthly group premium rate.

If you or your dependents are eligible for COBRA, you will be notified by your employer or by CalPERS if retired. You must complete and return a ***Group Continuation Coverage*** form (HBD-85 for active employees and HBD-85R for retirees) within 60 days of notification. Coverage must be continuous from the date your CalPERS coverage ends. You must make your premium payments directly to the health plan.

Guidelines for COBRA Continuation Coverage are as follows:

Active Employees

You may continue COBRA coverage for 18 months if either of the following applies:

- You separate from employment for reasons other than dismissal due to gross misconduct, or
- You have a reduction in work hours to less than half-time (or less than 480 hours in a control period for State Permanent Intermittent employees)

Coverage for either of these reasons applies to you and any enrolled dependents.

Disabled Employees

If you qualify for Social Security Disability or the Supplemental Security Income program, you may continue coverage for up to 29 months. The cost to you cannot exceed 102% of the monthly group premium for the first 18 months, and 150% of the monthly group premium for months 19 to 29. This COBRA coverage applies to you and any enrolled dependents.

Dependents

Dependents may enroll in COBRA for up to 36 months as a result of any of the following:

- Death of the member under which they were dependents. Eligibility applies whether the member was working or retired at the time of death (dependent must have been enrolled in the health plan at the time of member's death).
- Divorce, termination of registered domestic partnership, or legal separation.
- Enrolled child reaches age 26.

Cancellation of COBRA Coverage

COBRA coverage for you or your dependents remains in effect until one of the following events occurs:

- You fail to pay the premium
- You receive coverage through another group health plan
- You become entitled to Medicare
- Your coverage time limit ends
- You request cancellation

Extension of COBRA Coverage

Under certain conditions, California law permits an extension of COBRA benefits. This extension does not apply to out-of-state COBRA enrollees.

If you exhaust your federal COBRA benefit and have had less than 36 months of COBRA coverage, Cal-COBRA may extend the benefit up to a total of 36 months. This Cal-COBRA extension premium cannot exceed 150% of the current group rate. Contact your health carrier to enroll in Cal-COBRA.

Individual Conversion Policy

An Individual Conversion Policy is an alternative to COBRA or can follow COBRA coverage. If you lose your CalPERS health benefits or COBRA coverage, you can request an Individual Conversion Policy through your prior health plan. You must request this new policy within 30 days of losing coverage. All CalPERS health plans offer this Individual Conversion Policy option, but your cost and benefits will differ from your previous coverage.

When You Can Change Your Health Plan

You may change your health plan at the following times:

If you move

You must change plans if you move out of your health plan's service area. Until you make the change, your health plan may limit coverage to emergency or urgent care only. When you move, change employment, or your dependent moves out of the service area, you may submit a health plan change up to 60 days after the move. The effective date of the change is the first of the month following the receipt of your request.

When you retire

You may change health plans within 60 days of your retirement date. You may select any health plan available in your residential ZIP Code area. If you are a working retiree, you can use the ZIP Code of a current employer for eligibility purposes. The effective date of the change is the first of the month following the receipt of your request.

If you are a working retiree enrolled in a Medicare plan, you must use your residential address for eligibility. You cannot use your work address or a P.O. Box to enroll.

When you qualify for Medicare

As a retiree, when you first become eligible for Medicare, you must change from a CalPERS Basic health plan to a CalPERS Medicare health plan. You may also change health plans within 60 days from the effective date of your Medicare enrollment. The effective date of the change is the first of the month following the receipt of your request.

During the CalPERS Open Enrollment period

Open Enrollment is held each fall, and changes become effective the following January 1. You may change your health plan during the Open Enrollment period.

Maintaining Your Enrollment

Dependent Eligibility Verification (State and CSU only)

To ensure only eligible family members are enrolled in health and/or dental benefits under the CalPERS Health Benefits Program, all state employees and annuitants must verify their dependents' continued eligibility.

Dependent verification is required every three years for the following dependents:

- Spouses
- Registered domestic partners
- Stepchildren
- Children of registered domestic partners

Natural-born and adopted children only need to be verified once while you are an active employee and once during your re-verification as a retiree.

Required Documentation

Spouse or Domestic Partner

You must submit a copy of your government-issued marriage certificate or domestic partnership registration filed with the California Secretary of State or a comparable agency in another jurisdiction, and one of the following financial documents:

- A copy of the first page of your federal or state income tax return from the previous tax year, listing you and your spouse or domestic partner, or
- A copy of a document dated within the last 60 days showing current relationship status, such as a recurring household bill or joint statement of account. The document must list your name, the name of your spouse, and same address. In the situation of spouses who keep their finances separate, you may provide separate household bills or account statements if the documents show the same address and are not older than 60 calendar days.

You do not need to submit financial documents if your spouse or registered domestic partner is a CalPERS, JRS, JRSII, or LRS retiree who receives their own retirement check and has the same address as you.

If we determine that you are unable to produce a government issued marriage certificate due to extenuating circumstances, you may complete and submit a notarized ***CalPERS Affidavit of Marriage/Domestic Partnership***.

If the marriage certificate was registered prior to January 1, 1980, the marriage certificate does not need to indicate government issued.

Natural-born and Adopted Children

- A copy of the birth certificate naming you as the parent

Stepchildren

- A copy of the birth certificate naming your current spouse as the parent
- For a stepchild, you must also provide documentation of your current relationship to your spouse

Domestic Partner Children

- A copy of the birth certificate naming your current registered domestic partner as the parent
- For a domestic partner child, you must also provide documentation of your current relationship to your domestic partner

Verification Schedule

The verification cycle is based on your birth month. This three-year cycle repeats. If you enroll family members within six months of your birth month, their eligibility will be verified during your next cycle. Please visit our website to view a schedule of the verification process at **www.calpers.ca.gov/dev**.

Verifying Family Members

Ninety calendar days before your birth month, you will receive a letter with the verification due date, a list of enrolled family members you must verify, and the acceptable verification documents. Instructions on how and where to send verification documents are included.

If you don't respond or provide the required documents during your verification cycle, your dependents will be removed from your health and/or dental benefits. If you provide verification documents for disenrolled eligible dependents after the verification due date, those dependents are re-enrolled the first day of the month following the date the documents are received for health and/or dental benefits. This will result in a gap in benefit coverage.

Note: *The Dependent Eligibility Verification process is separate from the process to recertify a parent-child relationship dependent and a disabled dependent.*

Personal Information Changes

If your name or contact information changes for any reason, including marriage or divorce, update your employer and CalPERS records. This ensures that you receive all your benefit information in a timely manner.

Name Change

If you are an active employee, you must change your or your dependent's name through your employer. If you are a retiree or survivor, you need to provide CalPERS a copy of your corrected Social Security card to change your or your dependent's name. In lieu of the Social Security card, we'll also accept:

- A copy of a letter from a Social Security Office confirming the name change
- A receipt from a Social Security Office confirming that a new card was ordered due to the name change
- A copy of a Medicare Part B card that reflects the corrected Social Security name

Once your or your dependent's name is corrected on CalPERS records, contact your health plan directly to request new health plan identification cards. (See "Health Plan Identification Cards" on page 15.)

Gender Change

If you are an active employee, you must change your or your dependent's gender through your employer. If you are a retiree or survivor, you must provide CalPERS a copy of one of the following documents:

- Driver's license or identification card
- Birth certificate
- Court order to change gender
- U.S. passport or U.S. passport card

Residence or Work Address Change

When you move or change employers, you must update your address so that the correct ZIP Code is used to establish your health plan eligibility. Since you must choose a CalPERS health plan that provides coverage in your work or home ZIP code, a change in your address could mean you have to change plans. You can use the **Health Plan Search by ZIP Code** tool on our website to determine if you are out of your service area and see what plans are available in your new ZIP code. You cannot use a P.O. Box to establish eligibility for health plan enrollment. If you use a P.O. Box as your mailing address, you must also provide your residential address.

If you are an active employee, contact your employer to update your address and determine availability of health plans in your residential or work service area.

If you are a retiree, change your address using one of the following options:

- Online by logging in to myCalPERS
- Contact us by phone at **888 CalPERS** (or **888**-225-7377)
- Download, complete, and return an ***Address Change Authorization*** form by mailing or faxing it to the number shown on the form
- Send us your new address in writing to:
  Benefit Services Division
  P.O. Box 942716
  Sacramento, CA 94229-2716

See "When You Can Change Your Health Plan" on page 21 for more information on changing your health plan due to a move.

When You Are Retiring

If you are nearing retirement, this section provides information about how retirement will affect your health benefits.

Your Separation Date and Your Retirement Date

As retirement approaches, two dates are particularly important: your separation date (last day of employment) and your retirement date. If you are not sure when these dates occur, talk to your employer.

If you anticipate a delay in processing your retirement, you can avoid having your coverage suspended between your last day of work and your retirement date by paying the full monthly premium directly to your health plan. Contact your former employer and ask for a ***Direct Payment Authorization*** form (HBD-21).

For more information on retiree eligibility, see page 2.

The following table explains how your separation date and your retirement date affect your health plan enrollment.

If your separation and retirement date are...	and...	then your health coverage...	Note
within 30 days of each other	you are enrolled in a CalPERS health plan at the time of separation	will continue into retirement without a break.	If you do not want your health benefits to continue, contact your health benefits officer (if still working) or decline coverage on your ***CalPERS Retirement Election Application***.
between 31 and 120 days of each other	you are enrolled in a CalPERS health plan at the time of separation	will not automatically continue. You may re-enroll within 60 days of your retirement date or during Open Enrollment.	When your health coverage lapses, you may be eligible for COBRA.
within 120 days of each other	you are eligible for — but not enrolled in — a CalPERS health plan at the time of separation	eligibility remains valid.	You may enroll within 60 days of your retirement date or during Open Enrollment.
more than 120 days apart	regardless of whether you are enrolled in a CalPERS health plan at the time of separation	cannot be reinstated. You are no longer eligible for CalPERS health benefits.	There are some exceptions. For additional information refer to the ***Understanding Health into Retirement for Specialized Categories of State Employees*** guide available on our website.

Where to Get Help Once You Are Retired

As a retiree, CalPERS is your health benefits officer. You can make most changes to your health enrollment when you log into myCalPERS at **my.calpers.ca.gov**. You may change plans, add or delete dependents during Open Enrollment, recertify parent-child relationships, add a newly acquired dependent, or delete a dependent for certain life events online. You may also request changes by fax at (800) 959-6545, by calling **888 CalPERS** (or **888**-225-7377), or by requesting a change in writing and mailing the request to:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715

Enrollment After Reinstatement

Retirees who reinstated to active employment and then retired again after January 1, 2014 may be eligible to receive health benefits through their first employer. Your eligibility depends on whether you were eligible for retirement health coverage with the first employer, and then separated and retired from the second employer within 120 days. To enroll through your first employer, you must meet the following criteria:

- You were eligible for retiree health coverage prior to reinstatement from retirement and you then retire a second time within 120 days of separation
- The post-retirement employer contribution of your first employer is higher than your second employer
- You request health benefits eligibility through your first employer
- You meet all statutory requirements for both your previous employer and subsequent employer

Getting Help with Your Benefits

If you have questions about your CalPERS health benefits and you are an active member, contact your employer's health benefits officer. If you are a retiree, contact CalPERS.

Contacting CalPERS

Online

For more information on health benefits and programs, visit the CalPERS website at **www.calpers.ca.gov**. To view your current health plan information, go to myCalPERS at **my.calpers.ca.gov**.

By Phone

Call CalPERS toll free at **888 CalPERS**
(or **888**-225-7377)
Monday through Friday, 8:00 a.m. to 5:00 p.m.
TTY (877) 249-7442
(for speech and hearing impaired)

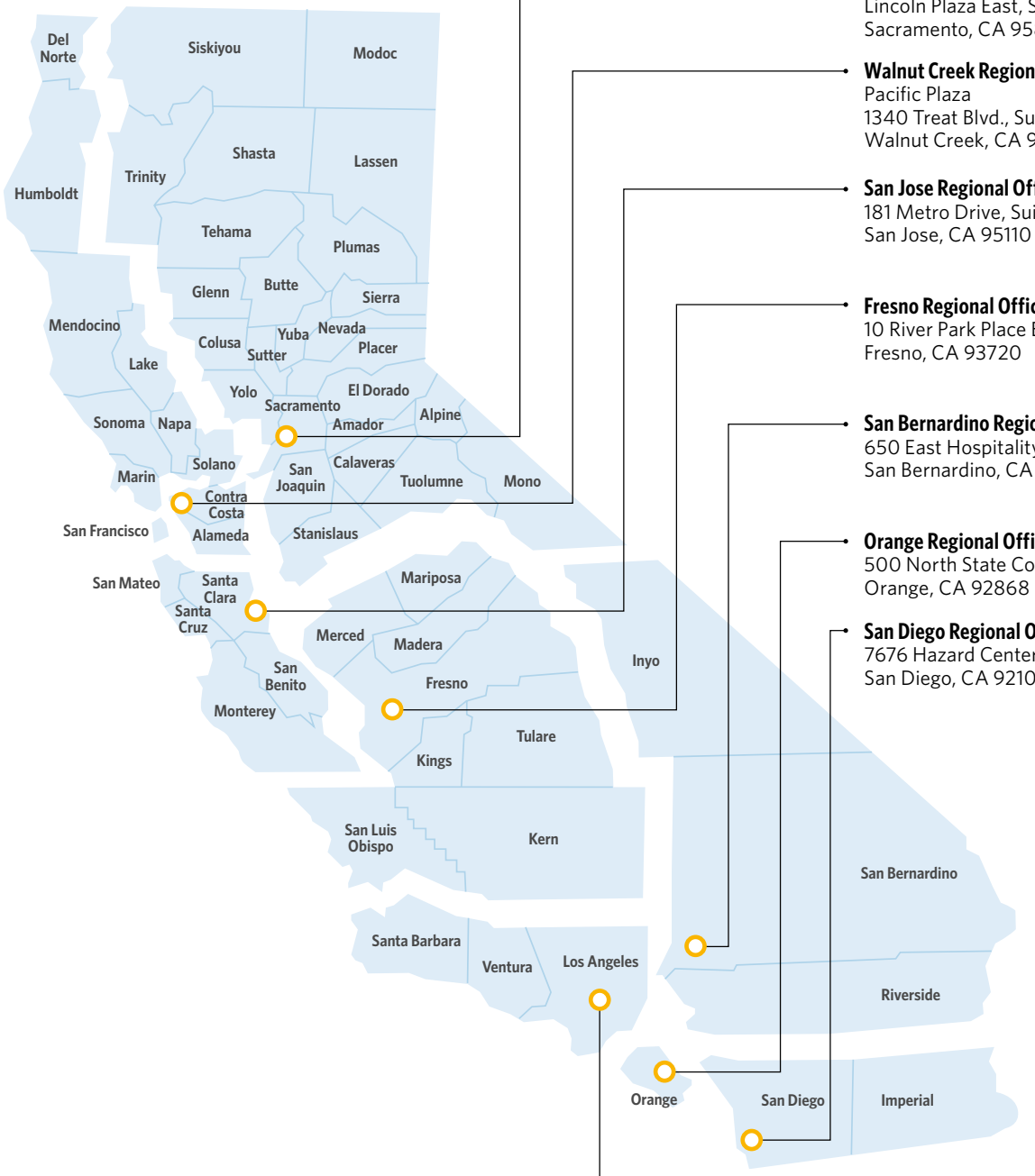
By Mail or Fax

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
Fax (800) 959-6545

In Person

To schedule a Regional Office appointment, log in to your myCalPERS account and select the Education tab, then Appointments. Virtual appointments are available by request.

You can visit a Regional Office at the following locations:



Sacramento Regional Office
Lincoln Plaza East
400 Q Street
Lincoln Plaza East, Suite 1820
Sacramento, CA 95811

Walnut Creek Regional Office
Pacific Plaza
1340 Treat Blvd., Suite 200
Walnut Creek, CA 94597

San Jose Regional Office
181 Metro Drive, Suite 520
San Jose, CA 95110

Fresno Regional Office
10 River Park Place East, Suite 230
Fresno, CA 93720

San Bernardino Regional Office
650 East Hospitality Lane, Suite 330
San Bernardino, CA 92408

Orange Regional Office
500 North State College Blvd., Suite 750
Orange, CA 92868

San Diego Regional Office
7676 Hazard Center Drive, Suite 350
San Diego, CA 92108

Glendale Regional Office
Glendale Plaza
655 North Central Ave., Suite 1400
Glendale, CA 91203

Contacting Your Health Plan

To obtain up-to-date contact information for the health plans, please refer to the ***Health Benefit Summary*** or go to the CalPERS website at **www.calpers.ca.gov**. Contact your health plan with questions about identification cards, verification of provider participation, service area boundaries (covered ZIP Codes), or Individual Conversion Policies. Your plan benefits, deductibles, limitations, and exclusions are outlined in detail in your health plan's Evidence of Coverage. You can obtain the Evidence of Coverage on the **Forms & Publications** page of our website at **www.calpers.ca.gov** or by contacting your health plan directly.

Resolving Problems

Your health plan and CalPERS work together to ensure timely delivery of services for you and your family; however, disagreements may occur. To resolve an issue, you should first contact your health plan. Following is information about specific ways your health plan and CalPERS can help.

Cancellation of Your Coverage and CalPERS Administrative Review Process

If CalPERS cancels your health coverage, you can request an Administrative Review. The Administrative Review process helps us decide if your coverage should be reinstated. You must ask for an Administrative Review within 90 days of losing coverage by writing to:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715

Once we have all your information, we will review your request. We will tell you within 60 days if your coverage will be reinstated. If your coverage is not reinstated, we will tell you why.

Appealing a Health Plan's Decision

If you receive a written response about a grievance you have filed and you are not satisfied with the decision, you may also appeal your plan's decision as follows:

HMO and EPO Appeal Process

The appeals process for CalPERS Health Maintenance Organization (HMO) and Exclusive Provider Organization (EPO) Basic health plans is regulated by the Department of Managed Health Care (DMHC). There are five available levels of review, each with important timelines that must be followed.

Review Level	Process	Timeline
Review 1 Health Plan Review	The health plan accepts, reviews, and issues a written decision.	• Within 30 calendar days for standard cases or 72 hours for urgent cases. • Requests for a health plan review must be made within 180 days of the denial of the benefit or service.
Review 2 DMHC Review	Members not satisfied with the decision by the health plan can submit a complaint to the DMHC Help Center. They will review all the information provided by you and the health plan and will issue a written determination.	• Within 7 days for urgent and within 45 days for standard appeals. • If the decision is adverse, in whole or in part, members can request a CalPERS Administrative Review.
Review 3 CalPERS Administrative Review (AR)	Members must exhaust the health plan and DMHC appeal processes before they request a CalPERS review. The AR request must be received within 30 days of the DMHC denial.	• The CalPERS appeals team will review the information provided by the health plan, DMHC, and the member. • CalPERS will issue a determination within 3 business days from the date all pertinent information is received for urgent requests and 60 days for standard requests. • If the decision is adverse, in whole or in part, members may request a CalPERS Administrative Hearing.
Review 4 CalPERS Administrative Hearing (AH)	A request for a hearing must set forth the facts and the law upon which the request is based. The request may include any additional arguments and evidence not previously submitted to the health plan, DMHC, or CalPERS.	• A hearing is set before an Administrative Law Judge (ALJ). The member or their representative presents their case. • The ALJ prepares a proposed decision within 30 days of the hearing. • The CalPERS Board of Administration (Board) either adopts or rejects the proposed decision at its public meeting. • If the member does not agree with the Board's decision, they may request reconsideration by the Board
Review 5 Reconsideration by the Board	If the Board accepts the reconsideration, the Board will set a date to hear the case. Additional information is available in the EOC.	• N/A

PPO Appeal Process

Preferred Provider Organization (PPO) plans are self-funded by CalPERS and regulated under the Public Employees' Medical and Hospital Care Act. PPO appeals are not reviewed by the DMHC or the Department of PPO Appeal Process Insurance. This process applies to Basic plan medical and prescription drug appeals based on medical necessity or benefit. The only difference is that benefit denials are not eligible for an Independent External Review.

Review Level	Process	Timeline
Review 1 Health Plan Review	If the service or benefit has already been provided (post-service), the health plan will issue a written decision within 60 days of the appeal request. If the service or benefit has not yet been provided (pre-service), the health plan will issue a written decision within 72 hours if the case is urgent or 30 days for standard appeals.	• For appeals with the pharmacy benefit manager, a decision is rendered within 24 hours for urgent cases and 72 hours for standard cases. • If the decision is adverse, in whole or in part, members have the next level of review available.
Review 2 Independent External Review (IRO)	An external IRO is responsible for reviewing an appeal that has been denied, in whole or in part, by the health plan to determine if an independent medical reviewer agrees with the decision of the health plan. The IRO is independent of the health plan and its decision is binding on the health plan. The IRO will review all the information provided by the health plan and the patient in rendering a determination.	• In general, the IRO issues a written determination within 72 hours for urgent appeals and within 45 days for standard appeals. • IRO decisions are binding on the health plan, meaning that if the IRO overturns the health plan's denial, the plan must provide the requested service, even if the health plan • disagrees. If the decision is adverse for the member, in whole or in part, they have the next level of review available.
Review 3 CalPERS Administrative Review (AR)	Members must exhaust the health plan and IRO appeal processes before they request a CalPERS review. The request must be received within 30 days of the health plan or IRO denial.	• The CalPERS appeals team will review the information provided by the health plan, IRO, and the member. • CalPERS will issue a written determination within 3 business days from the date all pertinent information is received for urgent requests and 60 days for standard requests. • If the decision is adverse, in whole or in part, members may request a CalPERS Administrative Hearing.
Review 4 CalPERS Administrative Hearing (AH)	A request for a hearing must set forth the facts and the law upon which the request is based. The request may include any additional arguments and evidence not previously submitted to the health plan, IRO, or CalPERS.	• A hearing is set before an ALJ. The member or their representative presents their case. The ALJ prepares a proposed decision within 30 days of the hearing. • The Board either adopts or rejects the proposed decision at its public meeting. If the member does not agree with the Board's decision, they may request reconsideration by the Board.
Review 5 Reconsideration by the Board	If the Board accepts the reconsideration, the Board will set a date to hear the case. Additional information is available in the EOC.	• N/A

Members may not begin civil legal remedies until after exhausting the administrative procedures.

Medicare Appeal Process

The U.S. Centers for Medicare & Medicaid Services (CMS) oversees and regulates Medicare grievances and appeals. Information about the Medicare appeal process is explained at **www.medicare.gov/claims-appeals/how-do-i-file-an-appeal**.

CalPERS Medicare Supplemental plans offer Benefits Beyond Medicare. Denials for Benefits Beyond Medicare can be pursued through the CalPERS preferred provider organization (PPO) Appeal Process.

Binding Arbitration

Binding arbitration is a method used by some health plans to resolve conflicts. It requires you to agree in advance that any claims or disagreements will be settled through a neutral, legally binding resolution, replacing court or jury trials. In some instances, you can choose to appeal to CalPERS rather than go through binding arbitration. If your plan requires binding arbitration, the process will be described in your plan's Evidence of Coverage booklet, which you can obtain from your health plan.

The California Patient's Guide

The California Patient's Guide: Your Health Care Rights and Remedies informs you of your rights to receive quality health care and what steps you can take if you encounter problems. The full text of the guide is available at **www.calpatientguide.org**, or you can request a copy by calling the DMHC HMO Consumer Help Center at (888) 466-2219.

CalPERS Notice of Agreement for Arbitration

Enrolling in certain health benefit plans constitutes your agreement that any dispute(s) you have with the plan, including medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, as well as any dispute(s) relating to the delivery of service under the plan will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. By enrolling in one of these plans, you are giving up your constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Please refer to the health plan's ***Evidence of Coverage*** for details.

Your Rights & Privacy

Patient Bill of Rights

As a member of the CalPERS Health Program, you have important rights. These rights protect your privacy, your access to quality health care, and your right to participate fully in medical decisions affecting you and your family.

How and where to get help

If you have a concern about your rights and health care services, we urge you to first discuss it with your physician, hospital, or other provider, as appropriate. Many complaints can be resolved at this level because your health plan wants satisfied customers. If you still have concerns, you may have the right to appeal the health plan's decision directly to CalPERS or, in many health plans, through the grievance procedure. Consult your ***Evidence of Coverage*** booklet for information on the benefits covered or your appeal rights. You can contact CalPERS at **888 CalPERS** (or **888**-225-7377) for further information.

As a patient and a CalPERS member, you have the right to:

- Be treated with courtesy and respect
- Receive health care without discrimination
- Have confidential communication about your health
- Have your medical record or information about your health disclosed only with your written permission
- Access and copy your medical record
- Have no restrictions placed on your doctor's ability to inform you about your health status and all treatment options
- Be given sufficient information to make an informed decision about any medical treatment or procedure, including its risks and benefits
- Refuse any treatment
- Designate a surrogate to make your health care decisions if you are incapacitated
- Access quality medical care, including specialist and urgent care services, when medically necessary and covered by your health plan
- Access emergency services when you, as a "prudent layperson," could expect the absence of immediate medical attention would result in serious jeopardy to you
- Participate in an independent, external medical review when covered health care services are denied, delayed, or limited on the basis that the service was not medically necessary or appropriate, after the health plan's internal grievance process has been exhausted
- Discuss the costs of your care in advance with your provider
- Get a detailed, written explanation if payment or services are denied or reduced
- Have your complaints resolved in a fair and timely manner and have them expedited when a medical condition requires treatment

You can help protect your rights by doing the following:

- Express your health care needs clearly
- Build mutual trust and cooperation with your providers
- Give relevant information to your health care provider about your health history, condition, and all medications you use
- Contact your providers promptly when health problems occur
- Ask questions if you don't understand a medical condition or treatment
- Be on time for appointments
- Notify providers in advance if you can't keep your health care appointment
- Adopt a healthy lifestyle and use preventive medicine, including appropriate screenings and immunizations
- Familiarize yourself with your health benefits and any exclusions, deductibles, copayments, and treatment costs
- Understand that cost controls, when reasonable, help keep good health care affordable

CalPERS Notice of Privacy Practices

Effective Date: June 12, 2023

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please write to the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715 or call CalPERS at **888-CalPERS** (or **888**-225-7377).

Why We Ask for Information About You

The Information Practices Act of 1977 and the Federal Privacy Act require CalPERS to provide certain information to individuals who are asked to supply information. The information requested is collected pursuant to Government Code (Section 20000, et seq.) and is used by the CalPERS Board of Administration to administer its duties under the Public Employees' Retirement Law (PERL), the Social Security Act (SSA), and the Public Employees' Medical and Hospital Care Act (PEMHCA), as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, and insurance carriers but only in strict compliance with current statutes regarding confidentiality.

Please do not include information that is not requested.

You have the right to review your CalPERS membership file. For questions concerning your rights under the Information Practices Act (IPA) of 1977, please contact the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715.

How We Use Your Social Security Number (SSN)

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires any federal, state, or local governmental agency, requesting an individual disclose their SSN, inform the individual whether the disclosure is mandatory or voluntary; by which statutory or other authority the number is solicited; and what uses will be made of the number.

Section 111 of Public Law 110-173 requires group health plans to collect and provide member SSNs for the coordination of federal and state benefits. Furthermore, the CalPERS health program requires each enrollee's SSN for identification and verification purposes.

The CalPERS health program uses SSNs for the following purposes:

- Enrollee identification for eligibility processing and verification
- Payroll deduction and state contribution for state employees
- Billing of public agencies for employee and employer contributions
- Reports to CalPERS and other state agencies
- Coordination of benefits among health plans
- Resolution of member complaints, grievances, and appeals with health plans, and
- Uses and disclosures required by the federal Affordable Care Act (ACA), such as reports to employees and the Internal Revenue Service (IRS).

How We Safeguard Your Protected Health Information (PHI)

We understand that PHI about you is personal and CalPERS is committed to safeguarding the PHI in our possession. This notice applies to your PHI under CalPERS Health and Long-Term Care programs. The particular group health or long-term care plan in which you are enrolled may have different policies or notices regarding its use and disclosure of your PHI.

The remainder of this notice will tell you about the ways in which we may use and disclose PHI about you. It also describes your rights and our obligations regarding the use and disclosure of PHI.

PHI is any information created or received by a health care provider or health plan or long-term care plan that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for your health care. However, such information is only PHI if the information identifies you or contains information that can reasonably be used to

identify you. Such information is PHI during your lifetime and remains PHI for a period of 50 years after your death.

The Federal HIPAA Privacy Regulations (Title 45, Code of Federal Regulations, sections 164.500, et seq.) require us to:

- Make sure PHI that identifies you is kept private
- Provide you with certain rights with respect to your PHI
- Give you this notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the notice that is currently in effect.

How We May Use And Disclose Your PHI

The following categories describe different ways CalPERS may use and disclose your PHI. For each category of uses or disclosures, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. All of the ways we are permitted to use and disclose information under HIPAA, however, will fall within one of the categories.

- **For Payment.** We may use or disclose your PHI for payment purposes, such as to determine your eligibility for benefits; to facilitate payment for the treatment and services you receive from health care providers; to determine the amount of your benefits; or to coordinate payment of benefits with other health or long-term care coverage you may have.
- **For Health Care Operations.** We may use and disclose PHI about you to operate CalPERS Health and Long-Term Care programs. The use and disclosure of PHI is necessary to run these programs and make sure that all of our enrollees receive quality care. For example, we may use and disclose PHI about you to confirm your eligibility and to enroll you in the health or long term care plan that you select; to evaluate the performance of the health or long term care plans in which you are enrolled; or to resolve a complaint, grievance, or appeal with the health plan or long term care program. We may also combine PHI about many CalPERS Health and Long-Term Care benefit enrollees to assist in rate setting or underwriting; to evaluate plan or program performance; to measure quality of care provided; or for similar health care operations.
- **For Treatment.** We may use or disclose PHI to a health care provider to facilitate medical treatment or services. For example, if your health care provider refers you to a specialist for treatment, we may disclose your PHI to the specialist to whom you have been referred, so the specialist can become familiar with your medical condition, prior diagnoses, treatment, or prognoses. It is more likely, though, that a health care provider would receive your PHI for treatment purposes from another health care provider rather than from us.

  In some cases, we may obtain PHI about you from a participating health plan, provider, or third-party administrator for certain health care operations. If the PHI received is from others as part of our health care operations, the uses and disclosures are in compliance with these guidelines. We will, however, never use or disclose your genetic information for underwriting purposes.
- **To Business Associates.** We may contract with third parties, known as Business Associates, to perform various functions or provide certain services on our behalf. Subcontractors of these third parties may also be our Business Associates in certain cases. For example, the entities who serve as third-party administrators for CalPERS Health or Long-Term Care programs are Business Associates. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use, and/or disclose your PHI for plan administration and other permitted purposes, after contractually agreeing to implement appropriate safeguards regarding your PHI. In addition, our Business Associates are required by law to protect PHI and comply with most of the same HIPAA standards that we do.
- **To the Plan Sponsor.** We will disclose your PHI to certain CalPERS employees for the purpose of administering health and long-term care plans. Those authorized employees, however, will only use or disclose your PHI as necessary to perform plan administration functions, or other functions required by HIPAA, unless you have authorized further use and disclosures. Your PHI cannot be used for employment purposes without your specific written authorization.
- **Incidental Uses and Disclosures.**There are certain other incidental uses and disclosures that may result from or in connection with an otherwise permitted use or disclosure, such as a use or disclosure related to providing services or conducting business. We use all reasonable efforts, however, to limit these uses and disclosures.

- **For Health-Related Benefits and Services.** We may use and disclose your PHI to tell you about health-related benefits or services, such as treatment alternatives, disease management, or wellness programs that may be of interest to you.
- **As Required by Law.** We will disclose PHI about you when required to do so by federal, state, and local law or regulation.
- **For Research.** We may use and disclose your PHI for research purposes. However, this use and disclosure requires your prior authorization, unless authorized by an Institutional Review Board (IRB). IRBs ensure CalPERS' research activities involve no more than the minimal risk to the privacy of the research subjects; involve information that is mostly anonymous and is subject to a data use agreement; or are solely used to prepare a research protocol.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Minimum Necessary Standard.** To the extent possible, when using or disclosing your PHI, or when requesting your PHI from another organization subject to HIPAA, we will not use, disclose, or request more than the minimum amount of your PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

  However, the minimum necessary standard will not apply to:
  - Disclosures to or requests by a health care provider for treatment
  - Uses by you or disclosures to you of your own PHI
  - Disclosures made to the Secretary of the U.S. Department of Health and Human Services (HHS)
  - Uses or disclosures that may be required by law
  - Uses or disclosures that are required to comply with legal regulations, and
  - Uses and disclosures for which we have obtained your authorization.

Special Situations

- **Workers' Compensation.** We may release PHI about you for workers' compensation or similar programs, as authorized by law. These programs provide benefits for work-related injuries or illnesses.
- **Coroners, Medical Examiners and Funeral Directors.** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about you to funeral directors as necessary to carry out their duties.
- **Military.** If you are a member of the armed forces, we may disclose PHI about you as required by military command authorities.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for oversight activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure proceedings. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Public Health Activities.** We may disclose PHI to public health or government authorities for public health activities authorized by law. These include, for example, health investigations, health surveillance, and reporting of abuse, neglect, or domestic violence.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if you have been given proper notice and an opportunity to object.
- **Law Enforcement.** We may release your PHI if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process.
- **National Security and Intelligence Activities.** We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose PHI about you to authorized federal or state officials, so they may provide protection to the President, other authorized persons, or foreign heads of state.
- **Privacy Rule Investigations.** We may disclose PHI to the Secretary of HHS as required to cooperate with a review of our compliance with the HIPAA Privacy Rule.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- **Disaster Relief Purposes.** In the event of a disaster, PHI may be disclosed to a public or private entity, authorized by law or by its charter to assist in disaster relief efforts. This information may be used to assist in notifying a family member, personal representative, or another person responsible for the member's care of a member's location, condition, or death.

Disclosures to Personal Representatives and Family Members

- **Personal Representatives.** We will disclose your PHI to individuals who are your personal representatives under state law. For example, in most situations, we will disclose PHI of minor children to the parents of such children. We will also disclose your PHI to other persons authorized by you in writing to receive your PHI, such as your representative under a medical power of attorney, so long as we are provided with a written authorization and any supporting documentation (i.e. power of attorney).

  Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
  - You have been, or may be, subjected to domestic violence, abuse or neglect by such person
  - Treating such person as your personal representative could endanger you, or
  - In the exercise of our professional judgment, it is not in your best interest to treat the person as your personal representative.
- **Family Members.** Unless otherwise allowed by HIPAA, we will not orally disclose your PHI to your spouse, domestic partner, or parent (if you are an adult child), unless you have agreed to such disclosure. With limited exceptions, however, we will send all mail to the named insured. This includes mail relating to the named insured's family members, including information on the use of benefits and denial of benefits to the named insured's family members. If you have requested restrictions on the use and disclosure of your PHI, and we have agreed to the request, we will send mail as provided by the request. See the "Your Right to Request Restrictions" bullet under the "Your Rights Regarding Your PHI" section for more details.

  Upon your death, we may disclose your PHI to a family member, other relative, or close friend involved in your health care or payment of your health care, prior to your death. This is done to the extent that the PHI is relevant to such person's involvement and such disclosure is not inconsistent with your prior expressed preference known to us.

Rights Regarding Your PHI

You have the following rights regarding the PHI we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy PHI about you that is maintained by CalPERS Health and Long-Term Care programs.

  To inspect and copy your PHI, maintained by CalPERS Health or Long-Term Care programs, you must submit your request in writing to the HIPAA Unit at P. O. Box 942715, Sacramento, CA 94229-2715. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

  If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic format you request, if the information can be readily produced in that format. If the information cannot be readily produced in that electronic format, we will work with you to come to an agreement on another suitable format. If we cannot agree on an electronic format, we will provide you with a paper copy.

  We may deny your request to inspect and copy your PHI in limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed. To request a review, you must submit your request in writing to the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2714. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend.** If you feel the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment

for as long as the information is kept by or for CalPERS health or long-term care programs.

To request an amendment, you must submit your request in writing to the HIPAA Unit at P. O. Box 942715, Sacramento, CA 94229-2715. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the PHI kept by or for CalPERS
- Is not part of the information which you would be permitted to inspect and copy, or
- Is accurate and complete.

If we deny your request for amendment, you can request a copy of our review and you have the right to submit a written addendum, not to exceed 250 words, with respect to the item in your record you believe is incomplete or incorrect. If your written addendum clearly indicates that you want the document to be made part of your health record, we will attach it to your records and include it with any disclosure of the item in question.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made regarding your PHI. The accounting will not include disclosures made for purposes of treatment, payment, or health care operations, disclosures made to you, disclosures made pursuant to a written authorization from you, disclosures made to friends or family in your presence or because of an emergency, disclosures made for national security purposes, and disclosures deemed incidental or otherwise permissible.

  To request an accounting of disclosures, you must submit your request in writing to the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715.

  Your request must:

  - State a time period, which may not be longer than six years prior to the date of the request.
  - Indicate in what form you want the accounting (paper or electronic).

  The first accounting of disclosures you request, within a 12-month period, will be free. For additional accountings within a 12-month period, we may charge you for the costs of providing it. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request except in limited circumstances. We will agree to your request if the PHI pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full. In other instances, we may not agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

  To request restrictions, you must submit your request in writing to the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715. In your request, you must tell us the following:

  - What information you want to limit,
  - Whether you want to limit our use, disclosure, or both, and
  - To whom you want the limits to apply.
- **Right to Request Alternative Communications.** You have the right to request that we communicate with you about your PHI by alternative means and/or to alternative locations, if you believe that our normal method or your location of communication could endanger you. For example, you can ask that we only contact you at work or by mail to a specific address.

  To request alternative communications, you must submit your request in writing to the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715. Your request must specify how or where you wish to be contacted. We will not ask you to provide the reason for your request, but your request must include a statement explaining how our normal method or your location of communication could endanger you. We will

accommodate all reasonable requests for alternative communications that include this required statement.

- **Breach Notification.** If and when required by HIPAA, we will notify you of a breach of the HIPAA privacy rules involving your PHI. If HIPAA requires us to send you a notice, the notice will contain:
  - A description of the breach
  - The type of PHI that was breached
  - What steps you could take to protect yourself from potential harm
  - What steps we are taking to investigate the breach, mitigate harm and protect from further breaches, and
  - Who to contact for additional information.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy, contact the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715 or visit our website at **www.calpers.ca.gov** to print out a copy. Search "Notice of Privacy Practices" to easily access the notice on our website.

Changes to this Notice

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already maintain about you, as well as any information we receive in the future. We will post a copy of the current notice on the CalPERS website at **www.calpers.ca.gov**. The notice will contain the effective date at the top of the first page. In addition, a copy of the current notice will be included in the annual CalPERS open enrollment mailing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with CalPERS or with the Secretary of HHS by going to the **www.hhs.gov** website. To file a complaint with CalPERS, contact the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Other Uses of PHI

Other uses and disclosures of PHI not covered by this notice will be made only with your written permission or authorization. If you provide us permission to use or disclose PHI about you, you may revoke that permission at any time. You may submit your request in writing to the HIPAA Unit at P.O. Box 942715, Sacramento, CA 94229-2715. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your written authorization. However, please understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of your participation in CalPERS Health and Long-Term Care programs.

Note: *CalPERS does not discriminate on the basis of age, ancestry, citizenship, color, denial of Family Medical Care Leave, disability, domestic violence victim status, gender, gender identity/ expression, genetic information, marital status, medical condition, military/veteran status, national origin, political affiliation, race, religion, religious creed, requests for leave under the California Family Rights Act, sex (including pregnancy, childbirth, and breastfeeding or medical conditions relating to pregnancy, childbirth, and breastfeeding), sexual orientation, or any other classification protected by federal, state or local laws or ordinances.*

Definition of Terms

Affordable Care Act (ACA)
The Affordable Care Act (ACA) requires most Americans to have qualifying health insurance called "minimum essential coverage." Under the ACA's individual shared responsibility provision (also known as the "individual mandate"), most Americans must maintain minimum essential coverage.

Annuitant
A person who has retired within 120 days of separation from employment and who receives a retirement allowance from the retirement system provided by the employer, or a surviving family member who receives the retirement allowance in place of the deceased, or a survivor of a deceased employee entitled to special death benefits and survivor allowance under Section 21541, 21546, 21547, or 21547.7 of the Public Employees' Retirement Law, or similar provisions of any other state retirement system. Additional definitions of an annuitant are contained in Government Code 22760.

CalPERS Basic Health Plan
A CalPERS Basic health plan provides health benefits coverage to members who are under age 65 or who are over age 65 and still working. Members who are 65 years of age or older and not eligible for Medicare Part A may also be eligible to enroll in a Basic health plan.

CalPERS Medicare Health Plan
A CalPERS Medicare health plan provides health benefits coverage to members who are over age 65, retired, and are enrolled in Medicare Parts A and B with the Social Security Administration (SSA).

For active employees and their dependents of any age, federal law limits enrollment in a CalPERS Medicare health plan to those diagnosed with Amyotrophic Lateral Sclerosis (ALS) or End-Stage Renal Disease (ESRD) who have completed any applicable coordination periods with SSA.

The Consolidated Omnibus Budget Reconciliation Act (COBRA)
The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 provides for continuation of group health coverage that otherwise might be terminated. COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage is only available when coverage is lost due to certain events.

Coinsurance
The amount you may be required to pay for service after you pay the deductible.

Combination Plan
A combination plan means at least one family member is enrolled in a Medicare health plan and at least one family member is enrolled in a Basic health plan through the same health carrier. CalPERS requires all family members to have the same health carrier.

Contracting Agency
A Public Agency that contracts with CalPERS for retirement benefits, health benefits, or both.

Copay
The amount you pay for a doctor visit or for receiving a covered service or prescription.

Deductible
The amount you must pay for health care before the health plan starts to pay.

Dependent
A family member who meets the specific eligibility criteria for coverage in the CalPERS Health Program.

Dependent Eligibility Verification
Dependent Eligibility Verification (DEV) is the process of re-verifying the eligibility of your spouse, domestic partner, children, stepchildren, and domestic partner children (dependents) enrolled in health and/or dental benefits. To ensure only eligible dependents are enrolled in employer-sponsored health benefits, Government Code section 19815.9 and California Code of Regulations section 599.855 mandates that you re-verify the eligibility of your dependents. Government Code section 22959 authorizes the review of your dependents' dental benefits enrollment.

Employer Contribution
The amount your current or former employer contributes towards the cost of your health premium.

Emergency Services
Medical services to treat an injury or illness that could result in serious harm if you don't get care right away.

Exclusive Provider Organization (EPO)
A plan that offers the same covered services as an HMO plan, but you must seek services from the plan's network of preferred providers. You are also able to access physicians and specialists that participate in the network without a referral.

Health Insurance Portability & Accountability Act (HIPAA)
This federal law protects health insurance coverage for workers and their families when they change or lose their jobs. It also includes provisions for national standards to protect the privacy of personal health information.

Health Maintenance Organization (HMO)
A plan provides health care from specific doctors and hospitals under contract with the plan.

Non-Participating Provider
Non-preferred providers that have not contracted with the health plan.

Out-of-Pocket Costs
Generally refers to the actual costs individuals pay to receive health care. These costs are the total of the premium (minus any employer contribution) plus any additional costs such as copayments and deductibles.

Open Enrollment Period
A specific period of time, as determined by the CalPERS Board of Administration, when you can enroll in or change health plans or add eligible family members who are not currently enrolled in the CalPERS Health Program.

Public Employees' Medical and Hospital Care Act (PEMHCA)
A state law that requires participating contracting agency employers to offer all eligible active and retired employees an opportunity to enroll in a CalPERS health plan of their choice. PEMHCA also requires employers to contribute toward the cost of their active and retired members' health care premiums.

Preferred Provider
This is a provider that participates in a preferred provider network. You will pay less to visit a preferred provider.

Preferred Provider Organization (PPO)
A plan that is similar to a traditional "fee-for-service" plan, but you must use doctors in the PPO provider network or pay higher co-insurance (percentage of charges).

Premium
The monthly amount a health plan charges to provide health benefits coverage.

Primary Care Provider (PCP)
The doctor who works with you and other doctors to provide, prescribe, approve, and coordinate all your medical care and treatment (also referred to by some health plans as "Personal Physician").

Public Agency
Any city, county, district, other local authority, or public body of or within California.

Retiree
A person who has retired within 120 days of separation from employment with the State or a contracting agency and who receives a retirement allowance from the retirement system provided by the employer.

Retirement Date
The date you select on your application to retire with CalPERS.

Separation Date
The last day you were considered an employee in your organization.

Service Area
The geographic area in which your health plan provides coverage. You must reside or work in the health plan's service area to enroll in and remain enrolled in a plan. For some plans, the Medicare service area may not be identical to the Basic service area.

Specialist
A doctor who has special training in a specific kind of medical care, for example, cardiology (heart), neurology (nervous system), or oncology (cancer).

State Agency
A state office, officer, department, division, bureau, board, or commission, or any other state body or agency.

Urgently Needed Services
A non-emergency situation when you need to see a doctor, but are away from your health plan's service area. See your health plan's ***Evidence of Coverage*** booklet for more details.

CalPERS Health Benefits Program
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