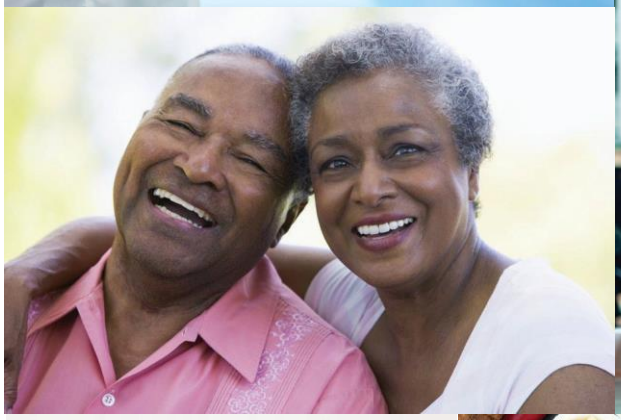
Retiree | 2026 Benefit Guide



People Services & Strategies

SMUD®

Introduction

This Benefit Guide is for retirees, and it summarizes the health and dental benefits we provide to you as a former employee of the Sacramento Municipal Utility District (SMUD). You'll want to review it to find out about changes in eligibility requirements, plan options and premium charges for the coming year.

Staying informed will help you make the best decisions on coverage for you and your family. We've included important phone numbers in case you need more information at the end of this guide.

This is a summary only. The complete terms of our benefits plan are spelled out in a document called the Evidence of Coverage (EOC). The EOC determines exactly how and when benefits are provided. It should be your primary reference for more specific information.

We reserve the right to modify, change, amend or terminate all or any part of the plan or any of our employee or retiree medical or dental benefit programs or plans at any time and for any reason. In no event will you or any other person become entitled to any vested rights under the plan or any of our medical, dental, life insurance or other benefit programs.

If you have questions about any of our benefits or related programs, we encourage you to call People Services & Strategies – Benefits Department at **916-732–6062** or visit your Retiree website at **retiree.smud.org** or our Virtual Benefits Fair at **virtualfairhub.com/smud/public/welcome**.

Effective 01/01/2026

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Defense of Marriage Act

On June 26, 2013, two U.S. Supreme Court rulings allowed same-sex married couples to be recognized as “spouses” in California. These rulings permit our employees and retirees with same- sex marriages to consider enrolling their partner as their spouse in our benefit plans.

For newly married retirees, you’ll have 31 days from the date of marriage to enroll a new spouse and dependent children. Benefit coverage begins the first day of the month following the receipt of all required documentation. Coverage for surviving spouses will terminate if they remarry.

There are a few things you should consider since same-sex married couples are now recognized as spouses in California.

You may want to speak with a tax consultant to determine the impact on your personal tax obligations since payments toward same-sex spouses for health and dental benefits are now tax exempt and there may be tax implications.

- IRA, 401(k) and 457 accounts can now roll over to a same-sex spouse and the minimum required distribution for a same-sex spouse is not until age 70½ or later.
- If you previously designated a child or other relative as a beneficiary in any of our benefits and you now have a same-sex spouse, the beneficiary designation will be invalid unless you submit a waiver from your spouse.

If you have any questions or require any further information, please contact the Benefits Department in People Services & Strategies at **916-732-6062**.

Health plans

We’re committed to providing good-quality benefits for you and your family at a reasonable cost.

In turn, we appreciate your efforts to keep these costs down by taking responsibility for your health and using your health plan wisely. For example, for your own well-being, have a balanced nutrition plan, exercise regularly and get enough rest. Examples of using your health plan wisely include calling the free Advice Nurse for simple questions about your health, seeing your Primary Care Physician instead of going to the Emergency Room or Urgent Care for non-emergency and non-urgent health concerns, taking advantage of our mail-order prescription program for maintenance medication and using generic drugs when they’re available. All these actions help to keep health care costs in line.

Your costs

What you pay will depend on (see the charts on the next page for details):

- When you worked for SMUD
- Which health plan you choose
- How many dependent(s) you cover
- Whether you and/or your dependent(s) are enrolled in Medicare
- How long you worked for SMUD

Years of service are calculated from the date of hire or rehire, based on the actual time worked, converted to equivalent full years.

Our contribution formula for eligible retirees

(Non-Medicare plans)

Tier 1: If you were hired BEFORE

- **Jan. 1, 1991 (IBEW)**
- **July 1, 1991 (OSE)**
- **Jan. 1, 1993 (non-represented employees)**

Retiree's years of continuous service	Percent (%) of our contribution for retiree	Percent (%) of our contribution for dependent(s) for 2 lowest cost plans	Percent (%) of our contribution for dependent(s) for 2 lowest cost plans
5 or more	100	90	85

2025	Kaiser HMO		UnitedHealthcare HMO Signature Value		UnitedHealthcare HMO Signature Alliance		UnitedHealthcare PPO in CA		UnitedHealthcare PPO out of CA		UnitedHealthcare Group Medicare Advantage PPO	
Non-Medicare health plan choices	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays
Retiree only	0	$986.07	0	$1,382.13	0	$1,161.78	0	$2,022.16	0	$2,022.16	0	N/A
Retiree +1 dependent	$98.61	$1,873.53	$153.42	$2,762.87	$128.96	$2,322.40	$336.69	$3,930.07	$336.69	$3,930.07	N/A	N/A
Retiree + family	$197.21	$2,761.00	$279.19	$3,894.82	$234.68	$3,273.90	$612.71	$5,494.20	$612.71	$5,494.20	N/A	N/A
Surviving spouse	$98.61	$887.46	$138.21	$1,243.92	$116.18	$1,045.60	$303.32	$1,718.84	$303.32	$1,718.84	N/A	N/A
Surviving spouse +1 dependent	$197.21	$1,774.93	$291.63	$2,624.65	$245.14	$2,206.22	$640.01	$3,626.75	$640.01	$3,626.75	N/A	N/A
Surviving spouse + family	$295.82	$2,662.39	$417.40	$3,756.61	$350.86	$3,157.72	$916.04	$5,190.87	$916.04	$5,190.87	N/A	N/A

Our contribution formula for eligible Medicare retirees

Medicare plans

Tier 1: If you were hired BEFORE

- **Jan. 1, 1991 (IBEW)**
- **July 1, 1991 (OSE)**
- **Jan. 1, 1993 (non-represented employees)**

We pay 100% of the **retiree portion** of the monthly premium. For your dependents, we contribute 90% of the monthly costs for the 2 lowest-cost plans and 85% for the higher-cost plans.

2026	Kaiser HMO		UnitedHealthcare HMO Signature Value		UnitedHealthcare HMO Signature Alliance		UnitedHealthcare PPO In CA		UnitedHealthcare PPO Out of CA		UnitedHealthcare Group Medicare Advantage PPO	
Medicare health plan choices	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays	You pay	SMUD pays
Retiree only (M)	0	$336.42	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	$517.08
Retiree (M) + dependent (M)	$33.64	$639.20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$51.71	$982.45
Retiree (M) + dependent (NM)	$98.61	$1,223.88	$138.21	$1,761.00	$116.18	$1,562.68	$303.32	$2,235.92	$303.32	$2,235.92	N/A	N/A
Retiree (NM) + dependent (M)	$33.64	$1,288.85	$51.71	$1,847.50	$57.71	$1,627.15	$77.56	$2,461.68	$77.56	$2,461.68	N/A	N/A
Retiree (M) + dep (M) + child (NM)	$132.25	$1,526.66	$192.68	$2,251.23	$170.21	$2,048.97	$361.10	$2,735.65	$361.10	$2,735.65	N/A	N/A
Retiree (M) + dep (M) + child (M)	$67.28	$941.98	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$103.42	$1,447.82
Retiree (M) + dep (NM) + child (NM)	$197.21	$2,111.35	$279.19	$3,029.77	$234.68	$2,629.20	$612.71	$3,989.12	$612.71	$3,989.12	N/A	N/A
Retiree (NM) + dependent (M) + child (NM)	$132.25	$2,176.31	$192.68	$3,116.28	$170.21	$2,693.67	$361.10	$4,240.73	$361.10	$4,240.73	N/A	N/A
Surviving spouse only (M)	$33.64	$2302.78	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$51.71	$402.37
Surviving spouse (M) + dependent (M)	$67.28	$605.56	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$103.42	$930.74

Note: (M) = Medicare
(NM) = Non-Medicare

Our contribution formula for eligible Medicare retirees

(continued)

Tier 2: If you were hired ON or AFTER

- **Jan. 1, 1991 (IBEW)**
- **July 1, 1991 (OSE)**
- **Jan. 1, 1993 (non-represented employees)**

Retiree's years of continuous service	Percent (%) of our contribution for retiree	Percent (%) of our contribution for dependent(s) for 2 lowest cost plans	Percent (%) of our contribution for dependent(s) for all other sponsored plans
Less than 10	0	0	0
10	50	45	42.5
11	55	49.5	46.75
12	60	54	51
13	65	58.5	55.25
14	70	63	59.5
15	75	67.5	63.75
16	80	72	68
17	85	76.5	72.25
18	90	81	76.5
19	95	85.5	80.75
20	100	90	85

***Note**: Retirees are eligible for Non-Medicare and Medicare Plans listed in Tier 1.*

We'll contribute up to one hundred percent (100%) of the retiree-only portion of the medical insurance premium for all sponsored medical insurance plans according to the Tier 2 schedule.

For dependent(s) covered under the retiree's plan, we contribute 90% of the percentage it contributes for the retiree's medical insurance premium (based on the Tier schedule) on the two (2) lowest cost health insurance plans or 85% of the percentage it contributes for the retiree's medical insurance premium (based on the Tier schedule) for all other sponsored health plans.

Every Jan. 1, we recalculate the dollar amount of retiree contributions to reflect any changes in the medical premium rates.

Our contribution formula for eligible retirees

(continued)

Tier 3: If you were hired ON or AFTER • Jan. 1, 2007 (IBEW) • Jan. 1, 2006 (OSE) • Jan. 1, 2007 (non-represented employees)			
Retiree's years of continuous service	Percent (%) of our contribution for retiree	Percent (%) of our contribution for dependent(s) for 2 lowest cost plans	Percent (%) of our contribution for dependent(s) for all other sponsored plans
Less than 10	0	0	0
10	25	22.5	21.25
11	27.5	24.75	23.38
12	30	27	25.5
13	32.5	29.25	27.63
14	35	31.5	29.75
15	37.5	33.75	31.88
16	40	36	34
17	42.5	38.25	36.13
18	45	40.5	38.25
19	47.5	42.75	40.38
20	50	45	42.5
21	55	49.5	46.75
22	60	54	51
23	65	58.5	55.25
24	70	63	59.5
25	75	67.5	63.75

***Note**: Retirees are eligible for Non-Medicare and Medicare Plans listed in Tier 1.*

We contribute up to seventy-five percent (75%) of the retiree-only portion of the medical insurance premium for all sponsored medical insurance plans according to the Tier 3 schedule.

Tier 3 employees with continuous service and who retire with 25 years of service after the age at which they reach Medicare eligibility or age 65, we will contribute 100% of the retiree-only portion of the monthly medical insurance premium for all sponsored Medicare health plans.

For dependent(s) covered under the retiree's plan, we will contribute 90% of the percentage it contributes for the retiree's medical insurance premium (based on the Tier schedule) on the two (2) lowest cost health insurance plans or 85% of the percentage it contributes for the retiree's medical insurance premium (based on the Tier schedule) for all other sponsored health plans.

Every Jan. 1, we will recalculate the dollar amount of retiree contributions to reflect any changes in the medical premium rates.

Our contribution formula for eligible retirees

(continued)

Tier 4: If you were hired ON or AFTER • **Jan. 1, 2018**			
Retiree's years of continuous service	Percent (%) of our contribution for retiree	Percent (%) of our contribution for dependent(s) for 2 lowest cost plans	Percent (%) of our contribution for dependent(s) for all other sponsored plans
Less than 15	0	0	0
15	25	22.5	21.25
16	27.5	24.75	23.38
17	30	27	25.5
18	32.5	29.25	27.63
19	35	31.5	29.75
20	37.5	33.75	31.88
21	40	36	34
22	42.5	38.25	36.13
23	45	40.5	38.25
24	47.5	42.75	40.38
25	50	45	42.5

***Note**: Retirees are eligible for Non-Medicare and Medicare Plans listed in Tier 1.*

We contribute up to fifty percent (50%) of the retiree-only portion of the medical insurance premium for all sponsored medical insurance plans according to the Tier 4 schedule.

For dependent(s) covered under the retiree's plan, we will contribute 90% of the percentage it contributes for the retiree's medical insurance premium (based on the Tier schedule) on the two (2) lowest cost health insurance plans or 85% of the percentage it contributes for the retiree's medical insurance premium (based on the Tier schedule) for all other sponsored health plans.

Every Jan. 1, we will recalculate the dollar amount of retiree contributions to reflect any changes in the medical premium rates.

Terms and conditions for participation

If you participate in any of our retiree health plans, you agree to the following terms and conditions of participation.

You understand and accept the terms and conditions of our sponsored plans that you're enrolled in, as explained in this guidebook and in our policies and regulations.

You acknowledge that we reserve the right to change (1) the share of the retiree's premium expenses, (2) the level of benefits provided and (3) the health care providers made available for a retiree to choose from.

You certify that all family members are eligible for coverage based on the definitions and rules specified in this guidebook (see page 12).

If you enroll family members, appropriate proofs of eligibility will be required such as (but not limited to):

- Marriage certificate
- Certification of domestic partnership
- Birth certificate/adoption paperwork
- Divorce paperwork/legal separation paperwork
- Legal guardianship paperwork

Please note: *We reserve the right to request proof of eligibility at any time during your participation in a sponsored plan. Failure to provide documentation will result in a retroactive disenrollment of your dependent(s).*

You agree that you'll repay all costs we or the medical carrier incur, due to the continued enrollment of an ineligible dependent.

You authorize deductions from your retirement check to cover your premium share, if any, for the plans you have chosen for yourself and your eligible family members. This authorization will remain in effect until you change, cancel or opt out of coverage.

If you opt out of coverage, you affirm that you're covered by another health insurance plan through a spouse or individual coverage. If your alternate coverage expires, it's your responsibility to complete the Life Event Enrollment process within 31 days of the loss of coverage.

You understand that any contributions we make on behalf of your registered domestic partner and/or your partner's children will be considered a taxable event by the Internal Revenue Service (IRS). Each year the value of our contribution will be reported on an IRS form 1099 and mailed to your attention the January after the year you made the contributions. You must file a form 1099 with the year's income tax return.

You acknowledge forfeiture of your rights to privacy when you request one of our representatives to intervene on your behalf with your insurance plan. In doing so, you authorize your insurance plan to release to us copies of all relevant records pertaining to you and your family member(s). You also authorize us to provide the insurance plan any relevant information pertaining to your cause and hold us harmless or any of our representatives acting on your behalf harmless.

You certify that all the information you have provided is true and correct to the best of your knowledge.

Please direct questions about the “terms and conditions for participation” to People Services & Strategies – Benefits Department at **916-732-6062**. Or mail written correspondence to:

SMUD
People Services & Strategies, Benefits Dept., MS B251
P.O. Box 15830 Sacramento, CA 95852-0830

Eligibility and enrollment

Eligibility requirements for you

You're eligible to take part in our retiree medical and dental benefits if you:

- Worked as a regular full-time or part-time employee for the equivalent of at least 5 continuous years of service before you retired.
- You're an eligible survivor of a deceased retiree and you choose to continue coverage.
- You "opted out" of coverage as a retiree on or after Jan. 1, 2005.

Eligibility requirements for dependents

If you enroll in our group medical and dental plans, you may enroll certain family members as your dependents in those plans. Be sure that they meet the following definitions.

The following individuals are also eligible to be covered under our retiree benefit plans:

- Your legally married spouse/registered domestic partner with the State of California.
- Children (biological, adopted, stepchildren or legal wards) under age 19.
- For medical: eligible dependent children up to the age of 26 (never married or not in Military).
- For dental: you or your spouse's/registered domestic partner's children or legal wards under age 19, or under age 24, if a full-time student (12 units) who have never married or are not in the military.
- You or your spouse's/registered domestic partner's unmarried children of any age who are incapable of self-support due to a mental or physical condition that existed prior to the limiting age.

Please note: *Ineligible family members include but are not limited to legally separated spouses, former spouses or registered domestic partners, parents, siblings, in-laws, cousins, grandchildren and the spouses of your children or grandchildren, as well as non-verifiable dependents. Trade and vocational schools are not considered "accredited colleges" to qualify for this benefit.*

Once your family member is no longer eligible for benefits, please notify People Services & Strategies (PS&S) within 31 days. If you don't notify PS&S, you'll be responsible for reimbursing us for costs that we paid for your ineligible dependent, and even for costs that we incurred to recover what is owed to us. If we're not reimbursed for those costs, we may pursue collection activities to recover what is owed.

For more information or to remove a dependent, please visit the Benefits website at **www.smud.hrintouch.com**.

Dual coverage

As a retiree, you may enroll your eligible family members in our medical and dental insurance plans. However, dual coverage isn't permitted. A retiree or employee can't be both a subscriber and a dependent, they also can't be a dependent on 2 SMUD enrollments.

If both parents are enrolled in medical coverage through SMUD, a dependent child(ren) can be enrolled in only 1 parent's medical plan. Children who are also employees may enroll only as a subscriber of their own plan – not as a dependent of a parent's plan. We provide benefits under only 1 plan for a retiree who is also the dependent through marriage or domestic partnership of another retiree or employee.

If dual coverage is discovered, the enrollment that duplicated the coverage will be retroactively cancelled. We may collect repayment for any duplicate premium payments and costs incurred because of the duplicate enrollment.

Retirees may drop coverage ("opt-out")

To drop coverage, you must have verifiable health insurance. You'll need to show proof of coverage, which may include a copy of a current medical provider ID card with the name of your insurance carrier.

If you lose alternate medical coverage, you must notify us within 31 days of your benefits being terminated. Once you show evidence of interruption or termination of coverage, you can re-enroll in our group health plan.

If you choose to opt out of our retiree group health plan, you can't opt back into the plans until the next open enrollment period, unless you experience an eligible life event (see "Life Event and Family Status Changes"), such as a termination of alternate health coverage.

Enrollment

In this section, you'll find out when to enroll yourself and eligible family members or make changes to your plan.

Are you a new retiree or newly eligible retiree?

You have 31 days from your date of retirement to enroll in our retiree group plans. Your coverage becomes effective the first day of the month following the date you retired. Your designation of retirement must be made prior to your departure to be eligible to enroll.

How to make changes to your plans or re-enroll after opting out

Make your benefit choices during the annual retiree open enrollment period, usually held during the fall. During open enrollment, you may enroll (if you have opted out), change plans and add or drop dependents.

Making changes mid-year

During the year, you may drop a dependent or opt out of coverage at any time. You may not add a dependent or opt into coverage until the next open enrollment period unless you experience an eligible life event or family status change. Even then, the changes you can make are limited.

You must request the change within 31 days of the event. Please visit the Benefits website at **www.smud.hrintouch.com** and complete the Life Event process.

Life event and family status changes

Certain events in your life or changes in family status may affect your benefits.

What are qualified change-of-status events?

- Marriage or registration of a domestic partner
- Divorce or legal separation from a registered domestic partner
- Birth or adoption of a child
- Death of a spouse/registered domestic partner or dependent
- Change in your spouse/registered domestic partner's employer's medical coverage
- Child's loss of eligibility due to age, change in student status or marital status (dental and vision only)
- A residence change effecting eligibility for you, your spouse, registered domestic partner or a dependent
- You, your spouse, registered domestic partner or dependent becomes eligible for Medicare or Medicaid
- A judgment, decree, or court order that requires a coverage change

When coverage ends

Family members lose eligibility when they no longer meet our eligibility requirements. Coverage for your ineligible family member ends on the last day of the month in which they lose eligibility. Coverage also will end if you don't pay your portion of the premium (if any).

See "Eligibility requirements for dependents" section above to review eligibility requirements for dependents.

What happens to my dependent's coverage if I die?

In the event of your death, your eligible covered dependents may continue coverage under our retiree medical plans unless one of the following events occurs:

- Remarriage of spouse or new domestic partner relationship
- Dependent children become ineligible (over age, marriage, military service)
- Surviving spouse/registered domestic partner/dependent cancels insurance
- Nonpayment of premiums/failure to enroll in Medicare
- Death of spouse or registered domestic partner

What happens if I am the surviving spouse of a SMUD retiree?

Your coverage will continue under our retiree health plans.

If you re-marry or enter a new registered domestic partner relationship, you become ineligible to participate. At that point, it's your responsibility to notify us within 31 days of the change.

Continuing benefits (COBRA)

If you or a family member loses eligibility for a sponsored health or dental plan, you may be able to continue group coverage through the **Consolidated Omnibus Reconciliation Act of 1985 (COBRA).**

Health and dental plans can be extended as long as 36 months if the original qualifying event is a divorce or legal separation, or a child ceases to be a dependent. COBRA coverage for your dependents remains in effect until one of the following events occurs:

- You fail to pay the premiums
- You or your dependent becomes entitled to Medicare
- Your dependent becomes eligible for coverage in another group health plan

Our COBRA Administrator will send notification of COBRA eligibility to qualifying family member(s). You must enroll within 60 days after the date of the event. Coverage must be continuous. Premiums are 102% of the group's monthly premium rate.

Certificate of coverage

When you or your eligible family member(s) terminate medical coverage, you'll receive a certificate of coverage from the medical plan as required by the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Please contact your health carrier directly if you don't receive a certificate.

Health plans

Medical Plan Choices

Depending on where you live, you have a choice of medical plans that are available through several plan design options outlined below:

Health Maintenance Organization (HMO)

One medical plan option available to retirees is called a Health Maintenance Organization, or HMO. Under any HMO plan, a Primary Care Physician (PCP) directs all medical care and specialty referrals for members. Both Kaiser and UnitedHealthcare offer HMO plans.

You and each of your enrolled family members must select a PCP. For routine care, each family member may choose a different PCP. Any specialty care you need will be coordinated through your PCP and will usually require a referral or authorization. You must first contact your PCP in order for your health care to be covered. For emergencies, you can go for treatment at the closest Emergency Room facility.

Preferred Provider Organization (PPO)

We also offer retirees a medical plan option called a Preferred Provider Organization, or PPO through UnitedHealthcare. A PPO plan allows you the freedom of choice because you may choose your doctor or specialist without a referral from a PCP.

Members can choose to see a physician not connected with the health plan. This increased access requires members to pay deductibles, co-insurance and any amount above what UnitedHealthcare covers.

PPO plans have a calendar-year deductible, which is the amount that must be paid by each member before benefits will be paid. After the deductible is satisfied, you're obligated to pay the co-insurance or co-payment to your preferred provider.

The PPO plan offered by UnitedHealthcare has a list of contracted preferred providers that you can choose from. Members pay less for using a contracted provider. You can choose any medical group or specialty care physician listed in the UnitedHealthcare directory.

Medicare Advantage Plans

We offer 2 Medicare Advantage plans for retirees and/or their dependents that are eligible for Medicare. To be eligible, the member must enroll in Medicare Parts A and B. Enrollment in the plan automatically enrolls the member in Medicare Part D.

All Medicare benefits are assigned to the plan you choose. Except for emergencies, you have to go through the plan for health care. Enrollment in either of these 2 plans requires assignment of Part B and Part D, meaning you won't be able to use them outside of the plan. You can enroll in another health insurance plan and assign your Medicare benefits to it, but you would lose your enrollment in our plan. All eligible retired members and covered eligible dependents must enroll in Medicare Part A and Part B. Failure by a member or dependent to enroll in Medicare by required deadlines will result in a change in or loss of medical coverage. If you're not currently receiving Social Security, it's your responsibility to contact the Social Security Administration to apply for Medicare at least 3 months prior to your 65th birthday or when you become disabled. Failure to do so could result in penalties being assessed by the Social Security Administration and the Health Service System. If you have a Social Security-qualified disability or End Stage Renal Disease (ERSD, permanent kidney failure requiring dialysis or transplant), you should contact the Social Security Administration immediately to apply for Medicare.

Here are the 2 plans to choose from:

- **The Kaiser Senior Advantage Plan**
  This plan is based on an HMO setting. Your Kaiser physician authorizes and coordinates all your medical services. You must live within the service areas served by Kaiser since it's an HMO. If your permanent residence isn't part of the Kaiser service area, you must enroll in the UnitedHealthcare plan.

- **The UnitedHealthcare Group Medicare Advantage (PPO) Plan®**
  This plan is considered a PPO plan with a Medicare contract and is available both inside and outside of California. You may receive services from any doctor who accepts you as a Medicare patient.

Plans for those who live outside of California

If you live outside of California and you're under age 65, you must enroll in the UnitedHealthcare PPO Plan. If you're over 65 or otherwise eligible for Medicare, you are eligible to enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan.

Medical ID cards

You'll need your identification card when you seek health care. If you don't receive a card within 30 days of initially enrolling or by **Jan. 31, 2026** for open enrollment changes, contact your health plan directly. If you need care before your card arrives, call your health plan at the number listed below under "Contact Information" or our Benefits Department in People Services & Strategies at **916-732-6062**.

Medicare

Medicare is a federal health insurance program for:

- People age 65 and older, or have a qualifying disability, who are U.S. citizens or permanent residents and who have worked at least 10 years for a “Medicare-covered” employer.
- People under age 65 who receive Social Security disability benefits.
- People with end-stage renal disease (ESRD) such as permanent kidney failure, those being treated with dialysis, or those awaiting a kidney transplant or who have had transplants.

There are 4 parts to Medicare coverage:

- Part A (hospitalization insurance) covers inpatient hospital care as well as hospice care, home health care and care in skilled nursing facilities. You generally pay no premiums for Part A.
- Part B (medical insurance) covers doctor visits, outpatient hospital care and other medical services such as physical therapy and durable medical equipment like walkers and wheelchairs. You generally pay a monthly premium for Part B, which is deducted from your Social Security check.
- Part C (Medicare Advantage) is insurance in which you can opt to receive Part A and Part B benefits, plus other coverage through a private insurance company. Medicare pays part of the premium and you pay an additional amount. SMUD’s retiree medical plans for those over 65 are Part C plans.
- Part D (prescription drugs) is private prescription drug insurance. To get Part D coverage, you must enroll in stand-alone plans, which are approved and regulated by Medicare but run by private companies. SMUD’s retirement medical plans include Part D coverage.

What if I am eligible for Medicare?

If you are eligible for Medicare, you must submit your Medicare Advantage application on time. We must receive the application BEFORE the month you become eligible for Part B. If the application is received late, you will pay a higher premium. If we receive the application more than 60 days from the date you became eligible for Part B, coverage with our group health plan will be terminated.

Who pays for Medicare?

For most people, there is no cost for Part A premiums. Those who did not contribute to Social Security may be eligible to purchase Part A benefits. Everyone is eligible to purchase Part B benefits at age 65. You must continue to pay your Medicare Part B premium. You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for extra help, call CMS (the Centers for Medicare & Medicaid Services), Social Security or your state Medicaid office. The monthly premium amount is determined by Medicare and is subject to change each calendar year.

Do I have to enroll in Medicare to be covered by a SMUD retiree health plan?

Yes. You and your dependent(s) must enroll in Medicare at age 65 to participate in our retiree healthcare plans. You're eligible for Medicare on the first day of the month you turn 65; however, you can sign up for Medicare up to 3 months before the month of your 65th birthday. You'll need to confirm with Medicare that you will be enrolled in Part A and Part B. Medicare should automatically send you a Medicare card about three months before your 65th birthday.

You'll then need to complete an application for our retiree medical care plan. You must send this to us before the month you turn 65. You'll automatically be enrolled in Part D as part of your application.

Why do I need to be in a SMUD retiree plan if I'm covered by Medicare?

Our plans help pay for many of the medical costs that Medicare doesn't cover under Part A, B and D. They also offer broader prescription coverage than many other Part D plans. Your benefits in general will remain the same as those in our health plan for retirees under 65.

Summary of benefits and co-payments

Plan benefits[1]	Retiree co-payments	
	Kaiser HMO	UnitedHealthcare Signature Value/ Signature Alliance HMO
Visit to physician's office	$20	$20
Routine physical maintenance exam	$0	$0
Physician's office - Severe mental illness treatment[2]	$20	$20
Prenatal care	$0	$20
Routine vision/hearing exam	$0	$20
X-ray and lab procedures	$0	$0
Hospitalization	$0	$0
Mental health inpatient[2]	$0	$0
Outpatient surgery	$20	$0
Durable medical equipment (basic)	$0	$0
Emergency (ER) care	$75	$75
Prescription drugs (cost at pharmacy)		
Generic	$10	$10
Brand name	$30	$30
Non-formulary[3]	n/a	$50
Mail order program only	$20/$60 100-day supply	$20 / $60 / $90 90-day supply

1. This is a brief summary of your health benefits, not a contract. Consult your Evidence of Coverage (EOC) which contains the exact terms and conditions of your health coverage. Contact Human Resource Services for an individual plan brochure with more details.
2. See EOC for complete description of covered services for mental health and chemical dependency rehabilitation.
3. Some non-formulary drugs may be excluded from coverage or require prior authorization.

UnitedHealthcare PPO

Plan benefits[1,2] **In-network** Preferred Provider care is provided by doctors and hospitals contracted with UnitedHealthcare PPO. **Out-of-network** care is provided by any licensed doctors and hospitals outside of UnitedHealthcare PPO.	**UnitedHealthcare PPO**	
	PPO – in-network	**PPO – out-of-network**
Deductibles and maximums[3]		
Routine physical maintenance exam	None	None
Deductibles (per person)	$200	$200
Out-of-pocket maximum (per person)	$1,100	$3,300
What you pay for services		
Physician's office visit	$20 (deductible waived)	30%
Specialist's office visit	$35 (deductible waived)	30%
Routine physical exams adult/child	$0	Not covered
Vision exams	Not covered	Not covered
Hearing exams associated with hearing aids	10%	30%
X-ray and lab diagnostic services	10%	30%
Hospitalization	10%	30%
Surgery	10%	30%
Durable medical equipment (basic)	10%	10%
Emergency services	10%	10%
	$50 separate deductible (waived if admitted to hospital)	
Rx Drugs		
Generic/brand name/non-formulary	$10 / $30 / $50 Additional cost for prescription obtained at non-participating pharmacy.	
Mail order program	90-day supply	

1. This is a brief summary of your health benefits, not a contract. Consult your Evidence of Coverage (EOC) for exact terms and conditions of your health care coverage and a complete description of covered services for mental health and chemical dependency rehabilitation.
2. PPO Benefits paid at negotiated rates. Out-of-network benefits paid at customary and reasonable rates.
3. After the annual deductible is met, you will not pay for covered services.

***Note**: There are certain services not subject to the deductible (i.e., periodic health exams). Co-payments do not apply to any deductible. Some services require certification for PPO coverage, and if you don't provide the certification, your benefit level will be reduced, and a penalty charged.*

Kaiser Medicare Senior Advantage and UnitedHealthcare Medicare Advantage Plans

Plan benefits[1,2]	Retiree co-payments	
	Kaiser Medicare Senior Advantage	UnitedHealthcare Medicare Advantage (PPO)
Deductibles and maximums		
Deductibles (per person)	None	None
Out-of-pocket maximum (per person)	$1500	$1500
Visit to physician's office	$20	$15
Visit to specialist	$20	$30
Routine physical exams	$0	$0
Vision/hearing exams	$20	$30/$0
X-ray and lab procedures	No charge	$30 X-Ray $75 Comp X- Ray $0 lab
Surgery - inpatient	No charge	No charge
Surgery - outpatient	$20	$50
Hospitalization	No charge	No charge
Speech/physical/occupational therapy	$20	$30
Inpatient (hospital/nursing facility)	$20	$0/$See EOC
Outpatient (office and home visits)	$20	$15 PCP/$30 Spec.
Durable medical equipment[3]	No charge	10% co-insurance
Emergency (ER) care	$50 (waived if admitted)	$50 (waived if admitted)
Prescription drugs (cost at pharmacy)		
Generic	$10	$10
Brand name	$25	$30
Non-formulary[4]	N/A	$60
Non-specialty and specialty injectables; specialty drugs		30% co-insurance $95 max co-pay
Mail order program	2 co-payments	[See EOC]
Silver sneakers wellness/gym program	Included	Included

1. This is a brief summary of your health benefits, not a contract. Consult your Evidence of Coverage (EOC) which contains the exact terms and conditions of your health coverage. Contact PS&S for an individual plan brochure for more details.
2. See EOC for complete description of covered services for mental health and chemical dependency rehabilitation.
3. $100 co-pay after the deductible is met on Medicare-covered durable medical equipment and related supplies costing $750 or more if no authorization was obtained beforehand.
4. Some non-formulary drugs may be excluded from coverage or require prior authorization.

Dental insurance

Delta Dental

Under our plan with Delta Dental, you and your dependents may visit any licensed dentist of your choice. You can change dentists at any time, go to a dental specialist of your choice, and receive dental care anywhere in the world. To make the most of your benefits and pay the lowest out-of-pocket costs under the Delta Dental PPO plan, we recommend you visit a Delta Dental PPO network dentist.

To see if your current provider is a Delta Dental PPO dentist or for a list of PPO dentists in your area, search the dentist directory at **deltadentalins.com**.

Please visit Delta's website to view your eligibility and benefits, and/or print your own ID card. You do not need an ID card to verify coverage, make an appointment or receive treatment.

You can also have eligibility information faxed to you by calling toll-free **800-765-6003**.

Dental covered services

Covered services	Retiree dental plan	IBEW retiree dental plan
Deductible	$25 annual deductible for each person	$50 lifetime deductible for each person
Preventive/diagnostic services	Plan pays 80% after you pay deductible	Plan pays 100% after you pay deductible
Basic services	Plan pays 80% after deductible	Plan pays 100% after deductible
Major services	Plan pays 50% after deductible	Plan pays 70% after deductible
Calendar year maximums	$1,500 per person	$1,500 per person
Plan lifetime maximum	$500 for non-surgical treatment of temporal mandibular joint dysfunction (TMJ)	TMJ not covered

Please note: *You do not need an ID card to verify coverage, make an appointment or receive treatment.*

Contact information

SMUD

People Services & Strategies – Benefits Dept., MS B251

P.O. Box 15830 Sacramento, CA 95852-0830

916-732-6062 or **Benefits@SMUD.org**

SMUD Retiree Website

https://retiree.smud.org

Kaiser Permanente

Member services: **1-800-464-4000**
kp.org

UnitedHealthcare

Member Services HMO: **1-800-624-8822**
myuhc.com

UnitedHealthcare Group Medicare Advantage (PPO)

Member Services Medicare: **1-877-714-0178**
TTY 711 | 8 a.m.- 8 p.m. local time | 7 days a week
www.UHCRetiree.com

CalPERS

Member Services: **1-888-225-7377**
calpers.ca.gov

Fidelity Investments

Participant Services: **1-800-343-0860**
netbenefits.com/smud

Medicare

Member Services: **1-800-633-4227**
medicare.gov

Social Security Administration

Member Services: **1-800-772-1213**
www.ssa.gov

Sacramento Municipal Utility District
Health Plan Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by the employer health plan—whether received in writing, in an electronic medium, or as an oral communication. This Notice describes the privacy practices of the following Sacramento Municipal Utility District ("SMUD") group health plans: the SMUD Health Plan and the SMUD Wellness Program.

The SMUD Health Plan and the SMUD Wellness Plan are affiliated covered entities under HIPAA and as such are treated as a single covered entity under HIPAA. They are collectively referred to as "the Plan" in this Notice, unless specified otherwise.

The Plan is a hybrid entity under the HIPAA Privacy Rule that includes health care components subject to HIPAA and non-health care components that are not subject to HIPAA. This Notice applies only to the health care components subject to HIPAA.

The Plan is part of an organized health care arrangement under the HIPAA Privacy Rule. As applicable, the Plan and the insurers participating in the organized health care arrangement will share PHI with each other as necessary to carry out Treatment, Payment, or Health Care Operations relating to the organized health care arrangement. If you participate in an insured plan option, you will receive a notice directly from the insurer.

The Plan and SMUD's responsibilities

The Plan is required by law to maintain the privacy and security of your PHI. If a breach occurs that may have compromised the privacy or security of your PHI, you will be notified promptly of this breach by the Plan. The Plan is required to follow the duties and privacy practices described in this Notice and provide you with a copy of the Notice. The Plan will not use or share your PHI other than as described in this Notice unless you provide written authorization to do otherwise.

SMUD, as plan sponsor of the Plan, may act on behalf of the Plan in carrying out the Plan's duties and functions. As the plan sponsor, HIPAA does not directly apply to SMUD, but SMUD has agreed and given assurances to the Plan that SMUD will safeguard the privacy and security of your PHI. SMUD will not use or disclose your PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of SMUD.

How the Plan may use or disclose your health information

The HIPAA Privacy Rule generally allows the use and disclosure of your PHI without your written authorization in the following ways:

- **Treatment** to a health care provider to aid in your diagnosis or treatment only where you are unable to authorize the disclosure. F*or example, the Plan may share PHI about you with physicians who are treating you if you are unconscious and unable to provide a written authorization to the Plan.*
- **Payment** which can include activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*
- **Health care operations** which can include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities and business planning and development. The Plan will not use genetic information to decide whether coverage is offered and the price of that coverage. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*
- **To Business Associates of the Plan.** Certain services are provided to the Plan by third-party administrators known as "business associates" that are required to comply with HIPAA. In so doing, the Plan will disclose your PHI to its business associates so that the business associates can perform services on behalf of the Plan. The Plan will require its business associates, through written agreements, to appropriately safeguard your PHI. Each business associate may use or disclose your PHI only as permitted or required by HIPAA and its written agreement with the Plan. *For example, the Plan may place information about your health care treatment into an electronic claims processing system maintained by a business associate so that your claim for health care benefits may be paid.*

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA Privacy Rule. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health- related benefits and services that may be of interest to you.

How the Plan may share your health information with SMUD

The Plan, or its health insurers, may disclose your PHI without your written authorization to SMUD for plan administration purposes. SMUD may need your PHI to administer benefits under the Plan. SMUD agrees not to use or disclose your PHI other than as permitted or required by the Plan documents and by law.

Here's how additional information may be shared between the Plan and SMUD, as allowed under the HIPAA rules:

- The Plan, or its insurers, may disclose "summary health information" to SMUD if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims history, claims expenses, or types of claims paid by the Plan information, but from which names and other identifying information have been removed.
- The Plan, or its insurers, may disclose to SMUD information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that SMUD cannot and will not use PHI obtained from the Plan for any employment-related actions. However, health information collected by SMUD from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws). information to administer benefits under the Plan. SMUD agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. People Services & Strategies and Medical Services employees are the only SMUD employees who will have access to your health information for plan administration functions.

Other allowable uses or disclosures of your health information

In certain cases, your PHI can be disclosed without your written authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care.

Information describing your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts).

You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your PHI may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your PHI without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your PHI is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your PHI to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA Privacy Rule
Required by law	Disclosures of your PHI when required to do so by other federal, state or local law, including those laws that require the reporting of certain types of wounds or other physical injuries, provided that the use or disclosure is limited to the relevant requirements of the law
Required uses and disclosures	Upon your request, the Plan is required to give you access to certain portions of your PHI for inspection and copying, or for an accounting of disclosures of health information

The Plan is allowed to use or disclose your PHI only with your written authorization for the following scenarios:

Psychotherapy notes	Use or disclosure of psychotherapy notes, except to carry out certain treatment, payment or health care operations, or as otherwise required by law
Marketing	Any use or disclosure of your PHI for marketing purposes, except if the communication is in the form of face-to-face communications with you or a promotional gift of nominal value
Sale	Any use or disclosure of your PHI that is in the form of a sale of PHI

Except as described in this Notice, other uses and disclosures will be made only with your written authorization.

You may revoke your authorization as allowed under the HIPAA Privacy Rule at any time. To revoke your authorization, please send your written request to the HIPAA Privacy Officer, whose contact information is below in the Contact section. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your Choices

For certain health information, you have the right to tell the Plan your choices about what the Plan can share. If you have a clear preference for how the Plan shares your information in the situations described below, tell the Plan in writing what you want the Plan to do, and the Plan will follow your instructions.

In these situations, you have both the right and the choice to tell the Plan to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation

If you're unable to tell the Plan your preference, for example, if you're unconscious, the Plan may share your information if the Plan believes it's in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to your health or safety.

Your individual rights

You have the following rights with respect to your PHI the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the Notice describes how you may exercise each individual right. See the "Contact" section at the end of this Notice for contact information for submitting requests.

Right to request restrictions on certain uses and disclosures of your PHI and the Plan's right to refuse.

You have the right to ask the Plan to restrict the use and disclosure of your PHI for Treatment, Payment, or Health Care Operations, except for uses or disclosures Required by Law. You have the right to ask the Plan to restrict the use and disclosure of your PHI to family members, close friends, or other persons you identify as being involved in your care or payment for your care.

You also have the right to ask the Plan to restrict use and disclosure of PHI to notify those persons of your location, general condition, or death—or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing and sent to the HIPAA Privacy Officer.

The Plan is not required to agree to a requested restriction unless the disclosure is for payment or health care operations and not otherwise required by law or the PHI pertains solely to a health care item or service that has been paid in full. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for PHI created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose PHI about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your PHI by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of your PHI from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing, sent to the HIPAA Privacy Officer, and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your PHI

With certain exceptions, you have the right to inspect or obtain a copy of your PHI in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings.

To the extent your PHI is maintained in one or more Designated Record Sets electronically, you also have the right to request a copy of the PHI in a specified electronic form and format.

The Plan will provide access in the electronic form and format you requested. However, if the requested form and format is not readily producible, the Plan will provide the copy in a readable electronic form and format that is agreed to by you and the Plan. You may request that the paper or electronic copy of your PHI be sent to another entity or person that you designate, so long as that request is in writing, signed by you, and clearly identifies the designated entity or person and where to send the copy of the PHI.

In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

The access or copies you requested;

- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees.

The Plan may also charge reasonable cost-based fees for copies, postage and supplies for creating the paper or electronic media if you request that the electronic copy be provided on portable media.

If the Plan doesn't maintain the PHI but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your PHI that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your PHI in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the PHI is accurate and complete, was not created by the Plan (unless the person or entity that created the PHI is no longer available), is not part of the Designated Record Set or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing and sent to the Plan's HIPAA Privacy Officer, and you must include a statement to support the requested amendment.

Within 60 days of receipt of your request, the Plan will:

- Inform you that your request is granted and make the amendment as requested. The Plan will ask you to identify and agree that the Plan shall notify relevant persons who need the amendment;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your PHI

You have the right to a list of certain disclosures the Plan has made of your PHI. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities or in similar situations listed in the table earlier in this Notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back six (6) years from the date of your request, but not earlier than April 14, 2003 (the date that the HIPAA Privacy Rule was first effective). You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment or health care operations;
- To you about your own PHI;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (PHI that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing and must be directed to the HIPAA Privacy Officer. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this Notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

You have the right to designate someone as your personal representative. Your personal representative may exercise your rights and make choices about your health information as though they were you exercising those rights. Your personal representative may be someone to whom you have given medical power of attorney or your legal guardian. The Plan may decline to recognize a person as your personal representative under the HIPAA Privacy Rule if the Plan reasonably believes you have been or may be the subject of domestic violence, abuse, neglect or endangerment and that such recognition is not in your best interests.

File a complaint if you feel your rights are violated

If you believe your privacy rights have been violated, you may file a complaint with the Plan by contacting the Plan's HIPAA Privacy Officer using the contact information below. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1-877- 696-6775** or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html**.

Neither the Plan nor SMUD will penalize or retaliate against you for filing a complaint.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, or to obtain a paper copy of this Notice, contact the Plan's Privacy Official:

HIPAA Compliance Officer
6201 S Street, MS B251
Sacramento, CA 95817
916-732-5582

Changes to the information in this Notice

The Plan must abide by the terms of the Notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time, and to make new provisions effective for all PHI that the Plan maintains. This includes PHI that was previously created or received, not just PHI created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this Notice, you will be provided with a revised Notice or updated on the changes to the Notice and directed to the new Notice.

Effective date of this Notice

The effective date of this Notice is **Dec. 1, 2018**.

Powering forward.
Together.

SMUD®