CHWD's comprehensive benefits package includes:

Flexible 4/40 Work Schedule & Telework: The District observes a 4/40 work schedule with all employees on a Monday through Thursday work schedule, with the option to telework up to one day per week.

Pay-for-Performance System: The District offers an innovative Pay-for-Performance System, which is in conjunction with the annual employee performance evaluation. Based on an employee's performance rating, both merit adjustments and one-time rewards and recognition amounts may be awarded. Employees at the top of their salary are also eligible for Pay and Performance each year ("extended range" merit performance pay of 1-5%). Please refer to page 3 for an example of the Pay-for-Performance system.

Retirement: The District offers CalPERS with Social Security. Benefit is 2% @ 55 for classic members and 2% @ 62 for new members as defined by PEPRA, subject to the limitations set by PERS. Employee pays the employee portion.

Social Security: The District has contracted to continue employee participation in the US Social Security (SSA) Old-Age Survivors and Disability Insurance (OASDI) program.

Deferred Compensation Plan: The District offers optional enrollment in pre-tax and/or post-tax Roth 457(b) payroll-deducted plans (MissionSquare Retirement, formerly known as ICMA- RC). The District offers up to a 6% employer match based on annual limits established by the Internal Revenue Service.

Relocation Assistance: Eligible new hires may qualify for up to $15,000 in relocation reimbursement to cover moving expenses and/or temporary housing within a reasonable commute.

Health Benefits:

- **Medical:** The District provides health insurance plan options for employees and dependents.
    - The District covers up to the full premium of a Kaiser Platinum plan for employee and dependents; if the employee selects a plan that does not exceed the Kaiser Platinum premiums, excess funds will be contributed by the District to a Health Reimbursement Arrangement (HRA) plan administered by MidAmerica. Pages 4-9 show the Kaiser Platinum plan summary of benefits and coverage
    - or a $400 monthly medical stipend (compensation subject to state and federal withholding) for employees who do not enroll in the District's health plan.
- Dental and Vision: The District provides dental and vision coverage to employees and dependents through Principal Insurance Group. 100% of the premium is covered by the employer.

Short-Term Disability/Long-Term Disability: The District provides short-term disability and long-term disability coverage to employees through Principal Insurance Group. 100% of the premium is covered by the employer.

Supplemental Benefits: Employees may purchase additional supplemental insurance coverage through Aflac for benefits such as critical illness, accidental injury, cancer or specified disease, hospital confinement indemnity, and short-term disability.

Vacation Leave: New employees accrue 8 hours of Annual Leave (vacation) hours per month; additional accrual rates are based on years of service shown below:

Schedule B: For employees hired or re-hired on or after October 15, 2008

Duration of District Employment at end of calendar month	Hours Accrued Per Reg Hr Paid	Maximum Hours Accrued Annually
0.00 to 3.99 years	.04616	96
4.00 to 7.99 years	.05770	120
8.00 to 11.99 years	.06924	144
12.00 to 15.99 years	.08077	168
16.00 to 19.99 years	.09231	192
20.00 years or more	.10385	216

Sick Leave: Employees accrue 8 hours of sick leave per month. At retirement, all accrued but unused sick leave may be converted to CalPERS service credit as permitted by law and the District's then-current contract with CalPERS.

Floating Holiday: All District employees receive 10 hours of floating holiday (cash-out available) per year.

Paid Furlough: District offices and operations are closed during the week between Christmas and New Year's Day, all employees will be "furloughed" with pay during this week.

Life Insurance: The District pays $250,000 for employee life insurance. Additional supplemental life insurance coverage is available to employees at their own expense.

Education Assistance Program: Following one year of employment, the District offers up to a maximum of $1,950 per calendar year for further education and training.

CITRUS HEIGHTS WATER DISTRICT

CITRUS HEIGHTS WATER DISTRICT
PAY FOR PERFORMANCE SYSTEM
2025 Evaluation Period – effective pay date 1/29/2026

Performance Rating	Unsatisfactory	Needs Improvement	Meets Expectations	Meets Expectations Plus	Commendable	Commendable Plus	Exceptional
	Employee does not meet job requirements and/or responsibilities.	Job performance is below expectations and improvement is needed.	Job performance generally meets all requirements and/or responsibilities and is within expectations.		Job performance consistently meets and frequently exceeds expectations. Job performance is above average.		Employee far exceeds expectations, even on most complex duties. Job performance is exemplary and distinguished.
Merit Adjustment	0%	0%	0%	3%	3.45%	3.75%	4%
One–time Rewards and Recognition Amount							
Executive Staff	$0	$0	$0	$500	$2275	$2500	$3000
Supervisors	$0	$0	$0	$800	$2500	$3000	$3500
All Staff	$0	$0	$0	$900	$2750	$3250	$3750

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.kp.org/plandocuments or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at http://www.healthcare.gov/sbc-glossary or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,500 Individual / $9,000 Family. $350 Child / $700 Children for Child Dental.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, and health care services this plan doesn't cover, indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	None
	Specialist visit	$30 / visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $30 / encounter Lab tests: $20 / encounter	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 / procedure	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs (Tier 1)	$5 / prescription (retail), $10 / prescription (mail order)	Not covered	Up to a 30-day supply retail and a 100-day supply mail order. Contraceptives are no charge. Subject to formulary guidelines.
	Preferred brand drugs (Tier 2)	$20 prescription (retail), $40 / prescription (mail order)	Not covered	Up to a 30-day supply retail and a 100-day supply mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	$20 prescription (retail), $40 / prescription (mail order)	Not covered	The cost-sharing for non-preferred brand drugs under this plan aligns with the cost-sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	10% coinsurance up to $250 / prescription	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 / procedure	Not covered	None
	Physician/surgeon fees	Not Applicable	Not covered	Physician/Surgeon Fee is included in the Facility Fee.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 / visit	$150 / visit	Copayment is waived if admitted to hospital as inpatient.
	Emergency medical transportation	$150 / trip	$150 / trip	None
	Urgent care	$20 / visit	Not covered	Non-Plan providers covered when temporarily outside the service area: $20 / visit
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / day up to 5 days	Not covered	None
	Physician/surgeon fees	Not Applicable	Not covered	Physician/Surgeon Fee is included in the Facility Fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / individual visit. No charge for other outpatient services.	Not covered	Mental / Behavioral health: $10 / group visit Substance Abuse: $5 / group visit
	Inpatient services	$250 / day up to 5 days	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Not Applicable	Not covered	Professional services are included in the Facility Fee.
	Childbirth/delivery facility services	$250 / day up to 5 days	Not covered	None
If you need help recovering or have other special health needs	Home health care	$20 / visit	Not covered	Up to 2 hours / visit, up to 3 visits / day, up to 100 visits / year.
	Rehabilitation services	Inpatient: $250 / day up to 5 days. Outpatient: $20 / visit	Not covered	None
	Habilitation services	Inpatient: $250 / day up to 5 days. Outpatient: $20 / visit	Not covered	None
	Skilled nursing care	$150 / day up to 5 days	Not covered	Up to 100 days limit / benefit period.
	Durable medical equipment	10% coinsurance	Not covered	Up to $2,000 supplemental benefit limit / year for certain items. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Plan Provider (You will pay the least)	Non-Plan Provider (You will pay the most)	
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	No charge	Not covered	Limited to one pair of glasses/year from select frames and lenses
	Children's dental check-up	No charge	Not covered	Limited to two check-ups / year

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture (plan provider referred)
- Bariatric surgery
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.gov

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)

Traditional Chinese (中文): 如果需要中文的幫助， 請撥打這個號碼 1-800-757-7585 (TTY: 711)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-278-3296 (TTY: 711) uff

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711)

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-278-3296 (TTY: 711)

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$250**
- **Other (blood work) copayment** **$20**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$450**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$250**
- **Other (blood work) copayment** **$20**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$450**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$250**
- **Other (x-ray) copayment** **$30**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The plan would be responsible for the other costs of these EXAMPLE covered services.0