

2009

RETIREE BENEFITS GUIDE

County of San Bernardino • Retired Employees



EMPLOYEE
BENEFITS AND SERVICES
HUMAN RESOURCES

- ◆ Medical Plans
- ◆ Dental Plans

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This Guide is designed to help you understand your Benefit Enrollment options. Included are brief summaries of your plan choices for medical and dental insurance. You will also find comparison charts for convenient at-a-glance referencing, contact information, phone numbers, web sites, and answers to frequently asked questions. Please read your materials carefully, and then choose the plan(s) that best meets your needs.

As you prepare to enroll or make changes in your coverage, consider your benefit needs carefully. Think about the types and levels of coverage that you might need, both now and throughout the plan year. Factor costs into your benefits picture.

The County is very concerned with the escalating insurance premiums. The rising cost of healthcare is a national crisis and the Employee Benefits and Services Division (EBSB) remains committed to seeking alternative solutions to this continuing problem.

Benefit Changes for 2009

The same plans and coverage that were offered in 2008 will be available in 2009, with the following modification:

- ◆ The Kaiser Permanente Medicare Advantage High Option plan emergency room co-pay is increasing from \$20 to \$50.

Gym Memberships

Retirees are eligible to receive reduced gym memberships through the following gyms: 24 Hour Fitness, The Club in Twin Peaks, American Sports University Fitness Center in San Bernardino, and Power Source Gym in Running Springs. Contact EBSB for additional details.

Tell Us What You Think!

Providing exceptional customer service is EBSB's top priority. Please tell us how we are doing by participating in a brief survey. The link to the survey site is www.surveymonkey.com/s.asp?u=486291762554, or if you prefer to complete a paper survey, please contact EBSB at (909) 387-5787 or email us at ebsd@hr.sbcounty.gov.

This Guide only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between this Guide and the official documents, the official plan documents will prevail.

Contact Information

	Address	Phone
Employee Benefits and Services Division	157 West Fifth Street, First Floor. San Bernardino, CA 92415 www.sbcounty.gov/hr/benefits	1-909-387-5787 1-888-743-1474
	All Retiree Medical and Dental Plans www.co.san-bernardino.ca.us/hr/benefits/default.asp	1-909-387-9674 1-909-387-5846
	COBRA	1-909-387-5552
Providers:		
Delta Dental PPO	P.O. Box 7736, San Francisco, CA 94120 www.deltadentalca.org	1-888-335-8227
Kaiser Permanente	Kaiser Permanente Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109 www.kp.org	1-800-464-4000
Kaiser Permanente Medicare Advantage	Kaiser Permanente Advantage Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109 www.kp.org	1-877-882-2687
Health Net ELECT Open Access	P.O. Box 9103, Van Nuys, CA 94109-9103 www.healthnet.com	1-800-522-0088
Health Net PPO	Health Net Commercial Claims P.O. Box 14702, Lexington, KY 40512 www.healthnet.com	1-800-676-6976
Health Net Seniority Plus	Health Net P.O. Box 10198, Van Nuys, CA 91409 www.healthnet.com	1-800-596-6565
Health Net Private Fee-for-Service (PFFS)	Health Net P.O. Box 870501, Surfside Beach, SC 29587-8712 www.healthnet.com	1-800-977-8221
ING	1200 California Street, Suite 108 Redlands, CA 92374 www.ingretirementplans.com/custom/sanbernardino	1-909-948-6468 1-800-584-6001
Administration Resources Corp. (ARC)	P.O. Box 548 Anoka, MN 55303	1-866-898-4371 1-763-772-1370 Fax

Helpful Resources and Referral Services:

American Association of Retired Persons	www.aarp.org	1-888-687-2277
American Heart Association	www.americanheart.org	1-800-242-8721
American Cancer Society	www.cancer.org	1-800-227-2345
CMS (for Medicare information)	www.medicare.gov	1-800-633-4227
Social Security Administration (SSA)	www.socialsecurity.gov	1-800-772-1213
San Bernardino County Employees' Retirement Association (SBCERA)	348 West Hospitality Lane, Third Floor San Bernardino, CA 92415-0014 www.sbcera.org	1-909-885-7980 1-877-722-3721

Open Enrollment Meeting Schedule Please note there will be separate meetings for Medicare eligible retirees (meetings listed in blue) and non-Medicare eligible retirees (meetings listed in gray). Take advantage of this opportunity to discover your options. Insurance plan representatives will be at each meeting to answer your questions.

November 2008 Open Enrollment Meetings

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 Start of Open Enrollment 9-10:15 am 10:30-11:45 am Behavioral Health Resource Center Room C105 850 E. Foothill Blvd., Rialto	4	5 5:30-6:45 pm 7-8:15 pm Government Center Joshua Room 385 N. Arrowhead Ave., San Bernardino	6	7	8
9	10	11	12 9-10:15 am 10:30-11:45 am TAD 881 W. Redlands Blvd., Redlands	13 8:30-4 pm Health Fair & 9-10:15 am 10:30-11:45 am 1-2:15 pm 2:30-3:45 pm meetings SBPEA 433 N. Sierra Way, San Bernardino	14	15
16	17 9-10:15 am 10:30-11:45 am DAAS, Haven Room 9445 Fairway Pl., Ste. 110, Rancho Cucamonga	18	19 10-11:15 am 11:30-12:45 pm PERC Victorville, Room V2 17270 Bear Valley Rd., Victorville	20 1:30-2:45 pm 3-4:15 pm General Services Building 777 E. Rialto Ave., San Bernardino	21	22
23	24	25	26	27	28	29
30	December 1 End of Open Enrollment Deadline to submit all forms					

January 1, 2009 Effective date of new premium rates and any changes you make to your plan elections or coverage levels. If you need help verifying eligibility or with the enrollment process, please call EBSD.

Eligibility

To participate in the County-sponsored retiree plans, you must be a San Bernardino County Employees' Retirement Association (SBCERA) retiree or eligible dependent. You pay the cost of coverage and your insurance premium is deducted from your monthly retirement warrant.

You will be eligible to **enroll** in a County-sponsored Retiree medical and/or dental plan if you experience any of the following events:

- ◆ You retire from the County of San Bernardino;
- ◆ You are a SBCERA retiree or eligible dependent and you separate from your current employer;
- ◆ You are a SBCERA retiree or eligible dependent and your COBRA, or Cal-COBRA coverage ends due to exhaustion of the maximum time allowed;
- ◆ You are a SBCERA retiree or eligible dependent and you relocate into or out of a network service area;
- ◆ You are a SBCERA retiree or eligible dependent, covered under your spouse or domestic partner's plan and she/he loses that insurance;
- ◆ You are a SBCERA retiree or eligible dependent, covered under your spouse or domestic partner's plan and you get divorced, legally separated, or you terminate the domestic partnership.

Note: It is very important that you contact our office within 31 days from the qualifying event date or you may lose the opportunity to enroll in a County-sponsored plan.

Please contact EBSD if you are unsure of your eligibility status.

Dependent Eligibility

If you are eligible to participate in the County-sponsored plans, your eligible dependents may also participate. Your eligible dependents include:

- ◆ Your legal spouse (a copy of your marriage certificate is required)
- ◆ State-Registered Domestic Partner (photocopy of the certificate of state registered domestic partnership or equivalent out-of-state certificate is required)
- ◆ Your unmarried children who are*:
 - Less than 19 years old
 - 19 years old, but less than 24 years old, enrolled in school as a full-time student and supported primarily by you (birth certificate or proof of dependence and Over-Age Dependent Certification Form must accompany the Medical and/or Dental Plan Enrollment/Change Form)
- ◆ 19 or more years old and supported primarily by you and incapable of self-sustaining employment by reason of mental or physical disability (a birth certificate and Over-Age Dependent Certification Form with proof of physical or mental condition must accompany the Medical and/or Dental Plan Enrollment/Change Form). Please note that it is the medical plan that evaluates and makes the final determination on the disability status.

* Your children include children born to you, legally adopted by you (including those children during any waiting period before the finalization of their adoption), your stepchildren, children for whom you are the legal guardian, and children you support as a result of a valid court order. Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, children under age 24 who marry and subsequently

divorce, and relatives other than those listed above are **not eligible**. (*Kaiser Permanente allows coverage for grandchildren if the dependent child was enrolled with Kaiser Permanente prior to giving birth to the grandchild. Coverage for the grandchild may continue as long as the retiree's dependent child is covered.*)

Reminder — Proof of Dependent Eligibility Required for Newly Enrolled Dependents
To enroll a new dependent under your County plans, you must submit proof of your dependent's eligibility. Additionally, if a dependent aged 19 to 23, is a full-time student or is mentally or physically disabled and aged 19 or over, an "Over-Age Dependent Certification" must be completed and submitted to EBSD. If you do not provide proof when required, your dependents will not be added to your plan and you will be responsible for any costs incurred.



Enrollment

When you retire, you have the opportunity to continue your medical and/or dental coverage through COBRA or you may enroll in one of the County-sponsored retiree plans.

During this Open Enrollment, you may cancel your medical and/or dental plan coverage, change medical plans, and/or add/delete eligible dependents to/from your coverage. Before making changes, be sure to read your enrollment materials carefully. The following plans are available:

Medical Plans (choice of High and Low Options)

- ◆ Health Net ELECT Open Access
- ◆ Health Net PPO
 - In California
 - Out of State
- ◆ Kaiser Permanente HMO

Medicare Integrated Plans

- ◆ Kaiser Permanente Medicare Advantage (High and Low Option)
- ◆ Health Net Seniority Plus (High and Zero Premium Option)
- ◆ Health Net PFFS (High and Low Option)

Dental Plan

- ◆ Delta Dental PPO

*Open Enrollment for 2008
is November 3 through
December 1*

If You Are Enrolling or Making Changes

To enroll or make changes, submit a completed and signed Medical and/or Dental Plan Enrollment/Change Form (with appropriate attachments such as a marriage or birth certificate, if applicable) to EBSD at 157 W. Fifth Street, San Bernardino, CA 92415-0440 by December 1, 2008.

These are the forms contained in this Guide:

- ◆ **Medical Plan Enrollment/Change Form**
Required to enroll or make changes.
- ◆ **Dental Plan Enrollment/Change Form**
Required to enroll or make changes.
- ◆ **Medical and/or Dental Plan Cancellation Form**
- ◆ **Over-Age Dependent Certification Form**
Required to enroll dependents age 19 or older (attach to a Medical and/or Dental Plan Enrollment/Change Form).
- ◆ **Kaiser Senior Advantage Election Form**
- ◆ **Health Net Seniority Plus Group Enrollment Form**
- ◆ **Health Net PFFS Enrollment Form**
- ◆ **VEBA Health Savings Plan Claim for Reimbursement**

If You Are Not Making Changes

If you are not making changes to your current medical and/or dental coverage, you do not need to take any actions. Your current coverage will continue automatically.

If You Are Canceling Coverage

You may cancel coverage at any time during the year. To cancel coverage, complete the Medical and/or Dental Plan Cancellation Form and submit it to EBSD at 157 W. Fifth Street, San Bernardino, CA 92415-0440.

Note: Requests to cancel a dental plan enrollment are subject to the two-year enrollment period provisions.

Medical and/or Dental Plan ID Cards

Within 4 to 6 weeks following the effective date of your coverage, you should receive an identification (ID) card from your medical and/ or dental plan. You may, however, begin using your medical and/or dental plan before receiving your ID card as of January 1, 2009. If you do not receive your ID card, or if you need a replacement card, call your plan's member services department.

If you have a problem accessing care, call EBSD. See the Contact Information section of this Guide.

Open Enrollment and Confirmation Statements

After Open Enrollment ends, you will receive a Confirmation Statement verifying your 2009 elections.

The Confirmation Statement will be mailed to your home and will list the plan(s) you elected, dependents covered, and the effective date of your coverage.

Open Enrollment elections are effective January 1, 2009

Mid-Year Changes

If you are enrolled in a San Bernardino County sponsored medical and/or dental plan, you will have to wait until the next Open Enrollment Period to change medical and/or dental plan, or to add dependents UNLESS you experience one of the following events:

- ◆ You get married
- ◆ You enter into a State Registered Domestic Partnership
- ◆ You get divorced (final decree) or legally separated
- ◆ You terminate a domestic partnership
- ◆ Your spouse, domestic partner or dependent dies
- ◆ A child is born or placed with you for adoption or legal guardianship
- ◆ Your spouse or domestic partner begins or ends employment
- ◆ Your eligible dependent (child) becomes eligible for own insurance
- ◆ Your eligible dependent (child) loses eligibility due to age, student status, or marital status
- ◆ Your spouse or domestic partner begins or returns from an unpaid leave of absence
- ◆ You relocate into or outside of a network service area
- ◆ You or your dependent becomes entitled to Medicare
- ◆ Your spouse/domestic partner's COBRA, or Cal-COBRA coverage ends due to exhaustion of maximum time allowed under COBRA or Cal-COBRA.
- ◆ Please note: IRS after tax premium deductions allow you to remove dependents at any time.

If you experience a qualifying event and you want to request a mid-year change, you must:

- 1 Complete a Medical and/or Dental Plan Enrollment/Change Form; the forms are included in this Guide, and also available by contacting EBSD, or by going online at <http://www.co.san-bernardino.ca.us/hr/benefits/default.asp>
- 2 Include supporting documentation with your Enrollment/Change form. Examples of acceptable documentation are:
 - Copies of birth, death, marriage or domestic partner certificates
 - Copies of court papers for divorces, separations or adoptions
 - Copy of letter from employer verifying loss or gain of spouse's (or domestic partner's) employment

Mid-year changes must be consistent with and due to the qualifying event for which you are requesting the change, and must meet the guidelines of County contracts/agreements and plan documents.

Warning: EBSD must receive your Medical and/or Dental Plan Enrollment/Change Form within 31 days of the qualifying event. If you do not submit the form and supporting documentation within 31 days, you could be denied the opportunity to make plan changes until the next Open Enrollment Period.



Effective Date of Mid-Year Changes

Dependent coverage is effective the first day of the month following the qualifying event. Exceptions: newborns are covered on the date of their birth; children placed for adoption are covered on the date they are placed in the home. You will be billed for any premiums owed as a result of the addition of eligible dependents. If the qualifying event results in a decrease in premiums, you may receive a refund for the premium overpayment.

To reduce the time for the adjustment process, you are encouraged to submit your paperwork as soon as possible, and no later than the 15th of the month. If you have questions about mid-year changes, please call EBSD.



EBSD Appeals Procedure

General Information

The County of San Bernardino EBSD maintains and provides documents that explain the policies, requirements, and limits of coverage for all retiree benefit programs. In the event that a retiree or beneficiary believes that a request or claim for a benefit under a health and welfare plan has been improperly denied,

he or she may appeal the decision within the parameters set forth in the following procedure.

Appeals for claims that are denied solely by one of the County's benefit carriers must be submitted within the guidelines established by that carrier. EBSD, if requested to do so, will act as an advocate and will assist to ensure that the appeal receives due consideration.

Timeframes

Any retiree or beneficiary whose request or claim for benefits is denied has the right to request a review by filing an appeal in writing directly with EBSD within 30 calendar days of the notice of denial or adverse decision. The appeal should include the basis for the appeal, as well as, any supporting documentation. Within 15 calendar days of the date the appeal is received, EBSD will review the facts and respond in writing of its findings. Should special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 15 days. EBSD will provide written notification if an extension is needed.



COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was enacted in 1986 to offer employees and their covered dependents the opportunity to elect a temporary extension of their plan coverage in certain instances where coverage would otherwise end.

The covered spouse of a retiree has the right to elect continuation coverage if Plan coverage is lost due to any of the following Qualifying Events:

- The death of the spouse or domestic partner
- Divorce, legal separation or dissolution of domestic partnership
- Spouse becomes enrolled in Medicare (Part A, Part B or both).

The covered dependent child of a retiree has the right to elect continuation coverage if Plan coverage is lost due to any of the following Qualifying Events:

- The death of the retiree parent.
- Parent's divorce, legal separation or dissolution of domestic partnership.
- The retiree parent becomes enrolled in Medicare (Part A, Part B or both).
- The child ceases to be a "dependent child" under the terms of the Plan(s).

Retirees and qualified beneficiaries are eligible to continue health and dental coverage for a maximum period of eighteen (18) months from the qualifying event date. The retiree or qualified beneficiary is responsible for the full applicable premium plus a 2% administration fee. Under California law, an extension of coverage is available for up to 18 additional months for medical coverage only (the cost may be 110% of the premium).

The information in this section is only a highlight of COBRA and does not include specific rights and responsibilities. You must notify EBSD within 60 days of a COBRA qualifying event. For more information or questions regarding COBRA, contact EBSD.



Retirement Medical Trust Fund

The Retirement Medical Trust Fund, also known as VEBA, was established by the County of San Bernardino to assist eligible retirees and their dependents with the high cost of medical and dental expenses. It provides a method for eligible participants to pay, on a non-taxed basis, for qualified expenses including medical, dental and long-term care premiums (as defined in Internal Revenue Code section 213), that are not otherwise covered by insurance.

Eligibility

Eligibility in the Retirement Medical Trust is determined by meeting the following criteria:

- ◆ You must have been a member of a bargaining unit that was participating in this benefit prior to retirement.
- ◆ You must meet the minimum years of public service requirement as determined by your bargaining unit.

Who Maintains the Funds

The funds are placed into an individual account maintained by ING. The funds are automatically transferred to this account from the County of San Bernardino. You have the option to invest the funds in six different mutual fund options. For more information on the funds or to receive assistance from an ING representative you can contact our local ING office at (909) 748-6468 or visit our ING custom webpage at www.ingretirementplans.com/custom/sanbernardino.

Access to the Funds

A participant can access the funds after separation from County service and reaching the County's normal retirement age (50 yrs for Safety and 55 yrs for General employees).

Administration Resources Corporation (ARC) is the third party administrator designated by ING to disburse funds for qualifying expenses. VEBA funds are used to reimburse a participant for qualifying health-related expenses not covered by the medical/dental plans, this includes medical/dental premiums and copays for prescriptions and doctor visits.

To receive reimbursement for eligible expenses a participant completes a "VEBA Health Savings Plan Claim for Reimbursement" form and mails it together with verification of the expense to:

Administration Resources Corporation
P.O. Box 548
Anoka, MN 55303-0548

A claim form is enclosed on page 63 of this book. Participants can access their account, see a list of qualifying expenses or obtain additional claim forms via the ARC website at www.arcbenefitaccess.com.



*We encourage you to
keep this guide the
entire year.*

Health Net ELECT Open Access: *HMO Reliability + specialist self-referral convenience*

Health Net ELECT Open[®] AccessSM plan is an HMO-style plan with the added coverage of letting you go straight to a specialist (within the network) for examinations and evaluations. You choose between two tiers of benefits – HMO or Open Access – whenever you need care. It works like this:

- ◆ Pick a Participating Physician Group (PPG) and Primary Care Physician (PCP) from within that group. Each member of your family may choose a different PCP.
- ◆ Call your PCP when you need routine or hospital care:
 - Pay a fixed copayment (so there are never any cost surprises)
 - Say goodbye to paperwork – you do not have to deal with claim forms when you use your HMO benefits.

Certain services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your PCP in order to be covered by Health Net.

- ◆ See a specialist without a referral, under the Open Access, PPO Tier 2 benefits.
 - Arrange office visits, consultation, evaluation and treatment – most procedures that can be performed in the doctor's office only – for a single co-payment.
 - Your costs will be higher and you may need claim forms for certain services
- ◆ Go directly to the closest emergency room if you have an emergency. Emergency and urgent care is available worldwide. You don't have to call your PCP first. If you're admitted to a facility, have a family

member or hospital staff contact Health Net as soon as possible.

Is Health Net Elect Open AccessSM Right For You?

Yes, if you want:

- ◆ The convenience of having your PCP coordinate services
- ◆ Predictable costs, with fixed co-payments for most services
- ◆ No claim form filing
- ◆ Ability to choose a separate PCP and medical group for each family member
- ◆ The option to self-refer to specialists for exams and evaluations
- ◆ Wide range of covered services

More from Health Net

When you choose Health Net, you get more than health care coverage. You get helpful tools and services to make the most of your health. And we give them all to you at no extra cost!

Decision PowerSM

This decision-support program helps Health Net members make health care choices that are right for them. If you enroll with Health Net, you can use Decision Power to:

- ◆ Talk to Health Coaches
- ◆ Obtain and watch support videos
- ◆ Access information resources

Wellsite — Healthnet.com

The Wellsite brings together trusted sources of health and medical information to make it easier to stay healthy, balance the demands of work and family, and manage emotional or financial challenges. Delivered in partnership with WebMD[®] and conveniently located

within the Health Net member website, the Wellsite brings powerful and easy-to-use programs right to your fingertips. Among the highlights:

- ◆ Free programs
- ◆ Online Health Risk Questionnaire
- ◆ Self-help programs
- ◆ Mental health support
- ◆ Health and fitness
- ◆ Discounts

Disclaimer: This plan is subject to regulatory filing and approval. If there are any discrepancies between this Guide and Health Net contract documents, the contract documents will prevail.



Kaiser Permanente HMO

The Kaiser Permanente Plan is a health maintenance organization (HMO). The benefits listed in this Guide are for retirees and their eligible dependents living within the Kaiser Permanente zip code service areas of California. A list of these areas is included in the Kaiser Permanente Member Handbook. If you need a Kaiser Permanente Member Handbook, call EBSD. If you live outside

California, please call EBSD to verify if your zip code is eligible for enrollment.

How the Plan Works

Kaiser Permanente offers two benefit plans: Kaiser Permanente High Option and Kaiser Permanente Low Option.

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente facilities. You have access to virtually full-service, unlimited medical care. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers. Otherwise, you will receive no benefits, except in a life-threatening situation. The County has also contracted for premiums to cover durable medical equipment. See the durable medical equipment insert located in your Kaiser Permanente materials for specific benefit information.

Emergency Care If you think you have an emergency medical condition and cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. Please see your evidence of coverage for more details on your coverage and benefits.

Out-of-Area Care If you need medical care and cannot get to a Kaiser Permanente facility, call the 800 number on the back of your ID card for guidance.

Claim Forms Under Kaiser Permanente, you do not have to file claim forms except for out-of-area urgent or emergency care.

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart in this Guide for a list of key covered expenses. Refer to the Kaiser Permanente plan booklet for information about what is not

covered under your plan. If you do not have the plan booklet, contact EBSD for the plan's informational packet.

How to Get in Touch with Kaiser Permanente

If you need information, call Kaiser Permanente's Member Services at 1- 800-464-4000, or go to Kaiser Permanente's website at www.kp.org.

Kaiser Permanente Online Services

Wherever they go, members can:

- ◆ e-mail their doctor's office or pharmacy
- ◆ schedule, view and cancel appointments; order prescription refills
- ◆ use valuable online health calculators, information, and resources.

With Healthy Lifestyle programs, members customize and monitor their own programs to lose weight, quit smoking, improve their nutrition, and more.

With a single click, members can check immunization records, details of past office visits, vital signs, certain test results, and diagnosed health conditions. So staying connected to your health is easier.



Health Net PPO:

The freedom to choose, the support to choose wisely

If freedom of choice is what you want, Health Net PPO is the plan for you. You can go to a doctor or hospital in the Health Net PPO network – there are over 48,000 providers and 300 hospitals to choose from. Or you can see a provider not in the Health Net network.

In general, you get more for less when you use Health Net PPO network. It works like this:

- ◆ When you choose a participating network provider, you pay:
 - A calendar-year deductible
 - A fixed copayment or coinsurance after you've met your calendar-year deductible (up to the calendar year copayment maximum)
- ◆ When you see a non-participating provider, you pay:
 - A calendar-year deductible
 - A copayment or coinsurance after you've met your calendar-year deductible (up to the calendar-year copayment maximum).

Note that the copayment/coinsurance is higher when you go out of network, which means you'll pay more.

 - Charges that exceed allowances for covered services

Some services may be covered only when you receive them from in-network physicians and facilities. And all hospital care (including outpatient procedures) requires pre-certification.

Of course, in an emergency, go to the closest emergency facility. If you're admitted, have someone call Health Net as soon as possible. Emergency care is available worldwide.

Is Health Net PPO Right For You?

Yes, if you want:

- ◆ Freedom of choice, no referrals required
- ◆ Control over how much you spend – your costs are lower when you use our network
- ◆ Broad network access throughout California. When traveling, we have more than 4,700 hospitals and 490,000 providers available nationwide through an arrangement with First Health,[®] a national PPO network.
- ◆ Time savings convenience – no claim forms to file when you use network services

More From Health Net

When you choose Health Net, you get more than health care coverage. You get helpful tools and services to make the most of your health. And we give them all to you at no extra cost!

Decision PowerSM

This decision-support program helps Health Net members make health care choices that are right for them. If you enroll with Health Net, you can use Decision Power to:

- ◆ Talk to Health Coaches
- ◆ Obtain and watch support videos
- ◆ Access information resources

Wellsite — Healthnet.com

The Wellsite brings together trusted sources of health and medical information to make it easier to stay healthy, balance the demands of work and family, and manage emotional or financial challenges. Delivered in partnership with WebMD[®] and conveniently located within the Health Net member website, the Wellsite brings powerful and easy-to-use programs right to your fingertips. Among the highlights:

- ◆ Free programs
- ◆ Online Health Risk Questionnaire

- ◆ Self-help programs
- ◆ Mental health support
- ◆ Health and fitness
- ◆ Discounts

*A Medicare integrated plan
combines your Medicare
coverage with the benefits of an
insured medical plan.*

Important Notice from the County of San Bernardino About Your Prescription Drug Coverage and Medicare

2009 Certificate of Creditable Medicare Prescription Drug Coverage

The County of San Bernardino hereby certifies that the prescription drug coverage it provides to Medicare eligible is expected to pay out, on average for all such participants, at least as much as the standard Part D coverage would pay. It is therefore designated as providing “creditable coverage,” meaning that any participant who later enrolls in a Part D plan will not be charged a late enrollment penalty.

If you have any questions about this benefit, please call EBSD, or request a copy in writing from the County of San Bernardino, Human Resources Department, Employee Benefits and Services Division, 157 West Fifth Street, First Floor, San Bernardino, CA 92415-0440. You will be informed if the County’s plan ever loses its creditable coverage status.

Medicare Integrated Plans — Important Information

A Medicare integrated plan combines your Medicare coverage with the benefits of an insured medical Plan. Effective January 1, 2006, all such County integrated plans incorporated Medicare Part D pharmacy benefits at no additional cost. In order to enroll in a Medicare integrated plan, you must be enrolled in Medicare Parts A and B. When you enroll in a Medicare integrated plan, you assign your Medicare A, B and D benefits to the medical plan. As such, you do not need to enroll in a separate Medicare Part D pharmacy plan and you do not pay a separate Part D premium.

When you assign all of your Medicare benefits to the plan, you agree to receive all your medical care through the plan's network of providers and utilize the plan's Medicare Part D formulary. Premiums for Medicare integrated plans are typically much less expensive than purchasing a medical plan without the assignment of Medicare benefits.

Your Medicare benefits will not be available to you outside the Medicare integrated plan network. As a County retiree or eligible dependent, you have six County-sponsored Medicare integrated plans available to you:

- ◆ Kaiser Medicare Advantage (High and Low)
- ◆ Health Net Seniority Plus (High and Zero Premium)
- ◆ Health Net Private Fee-for-Service (High and Low)

Conditions

- ◆ You must receive all of your care from your medical plan except for emergency care and/or urgent care (while traveling outside of the service area) and authorized referrals.

- ◆ You must utilize the plan's Medicare Part D formulary for all of your prescription needs.
- ◆ You must meet these eligibility requirements:
 - You have Medicare Parts A and B
 - You live in the medical plan's service area
 - You are free of end stage renal disease
 - You are not in a hospice program
- ◆ It is important to evaluate your benefits needs and the different Medicare integrated plans each year.
- ◆ If you move out of the service area of your medical plan, you must "disenroll" from the Medicare integrated plan.
- ◆ To disenroll from a Medicare integrated plan, contact EBSD at (909) 387-9674. Please note that due to the Centers For Medicare & Medicaid Services (CMS), disenrollments from County-sponsored plans and enrollments on other plans may be delayed due to CMS final eligibility determination and processing of your request.

Caution: Individual Medicare integrated plans (that are not sponsored by the County) do not cover dependents who are not eligible for Medicare Parts A and B.

For answers to questions regarding Medicare, please contact:

- ◆ Your local Social Security Administration Office at 1-800-772-1213
- ◆ The Medicare Program at 1-800-MEDICARE (1-800-633-4227)
- ◆ The official Medicare website at www.medicare.gov
- ◆ The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, which offers health insurance counseling for California seniors. Their website is www.aging.ca.gov/html/programs/hicap.html

◆ You can also write to:

Medicare Publications
 Department of Health and Human Services
 Centers for Medicare and Medicaid
 6325 Security Blvd.
 Baltimore, MD 21207



Health Net Seniority Plus:

Why nearly a half million people have already chosen Health Net Medicare plans

Health Net understands some of your most important concerns about your medications, your doctor and the cost of coverage. It's all taken care of!



Health Net Seniority Plus:

◆ **Helps you maintain a close relationship with your doctor:** With the large network of physicians and hospitals, you won't have to worry about finding a new doctor to learn about you and your conditions. Most likely, your doctor is in the Health Net network.

◆ **Provides services tailored to Medicare beneficiaries:** Health Net is familiar with the conditions most likely to affect you, and the medications you're most likely to need. The Prescription Drug Plan for Medicare offers coverage for many commonly prescribed, brand name drugs. Even if your physician changes your medications, your new prescription will most likely still be on the list of covered drugs.

◆ **Makes it easy to use your Part D Prescription Drug benefit:** Medical and drug benefits are integrated into one plan with only one ID card.

◆ **Offers the highest quality care possible:** Health Net has built a vast network of contracted physicians, hospitals, pharmacies and medical professionals that has been built with precision and care to give you access to the best care we possibly can.

Is Health Net Seniority Plus Right For You?

With Health Net Seniority Plus, you will have access to:

Resources – Health Coaches available anytime, health information you can trust, and online health monitoring tools

Network – Available to you 24 hours a day, seven days a week. You can find a doctor online using DocSearch, order a new ID card, change your doctor, and much more.

Features – Thousands of physicians and hospitals to choose from, possibly including your current physician.

- Integrated medical and drug plans with predictable costs
- Broad choice of the brand-name drugs Medicare beneficiaries are most likely to use
- Over a decade of experience working in Medicare

More from Health Net

When you choose Health Net, you get more than health care coverage. You get helpful tools and services to make the most of your health. And we give them all to you at no extra cost!

Decision PowerSM

This decision-support program helps Health Net members make health care choices that are right for them. If you enroll with Health Net, you can use Decision Power to:

- ◆ Talk to Health Coaches
- ◆ Obtain and watch support videos
- ◆ Access information resources

Health Net Seniority Plus Zero-Premium

Health Net Seniority Plus Zero-Premium has NO monthly premium. Yes! No monthly premium for you to pay in exchange for a great benefit package which includes free Health Club Membership, 30 free trips to your doctor, and much more. The Seniority Plus Zero-Premium plan offering is better than any Medicare Street plan Health Net could offer you outside of our group coverage.

Disclaimer for Health Net Seniority Plus:

- ◆ This plan is subject to regulatory filing and approval.
- ◆ If there are discrepancies between this Guide and Health Net contract documents, contract documents will prevail.



Kaiser Permanente Medicare Advantage

Kaiser Permanente's Medicare Advantage plan combines your Medicare coverage with Kaiser Permanente's 60 years of health care experience, quality, and convenience.

One broad-based plan, one monthly premium, with benefits that help you thrive in every way. All the perks of Medicare, including Part D prescription drug coverage, and more.

- ◆ 24-hour convenience, and services when you need them.
- ◆ Health and wellness advice and information by phone or online.
- ◆ Over one hundred medical facilities to choose from, and virtually no paperwork.
- ◆ Just some of the reasons why Medicare Advantage is the wise choice for your Medicare dollar.

Explore Kaiser Permanente on kp.org

- ◆ Check out our featured health topics for tips on healthy aging.
- ◆ Meet our doctors in our medical staff directory.
- ◆ Find the medical offices closest to you in the facility directory.
- ◆ Learn more about us and get decision help.

Anyone with Medicare Parts A and B may apply, including persons with disabilities. You must enroll in the Kaiser Permanente service area in which you reside. Members must use plan and affiliated providers for routine care and continue to pay the Medicare Part B premium.

Kaiser Permanente Online Services

Wherever they go, members can e-mail their doctor's office or pharmacy; schedule, view and cancel appointments; order prescription refills; and use valuable online health calculators, information, and resources.

With Healthy Lifestyle programs, members customize and monitor their own programs to lose weight, quit smoking, improve their nutrition, and more.

With a single click, members can check immunization records, details of past office visits, vital signs, certain test results, and diagnosed health conditions.



Health Net Private Fee-for-Service Plan

What is a Private Fee-for-Service Plan? A Private Fee-for-Service (PFFS) plan is a Medicare Advantage health plan offered by private insurance companies, like Health Net, who are under contract with the federal government to provide coverage to Medicare beneficiaries. This plan allows you the freedom to obtain care from any licensed physician, hospital or service provider who accepts payment from Medicare, including specialists who are willing to accept your plan's terms and conditions of payment.

Why Health Net PFFS May Be Right For You

Health Net PFFS gives Medicare beneficiaries freedom of choice at an attractive price. Like Medicare Supplement plans, members can go to any physician or hospital that accepts payment from Medicare, so there's no network to deal with, no need for referrals and no need

to sign up with a Primary Care Physician. In fact, if you are currently a member of an HMO plan, you may want to consider the freedom that Health Net PFFS plan offers.

Advantages for Members of Health Net's Private Fee-For-Service Plan

- ◆ **Plan Availability** – The Health Net PFFS plan is available to those retirees residing both in California as well as those residing out-of-state. If you reside in California the PFFS plan will be available to you only if you live outside of a Seniority Plus serviced area. Please contact EBSD to confirm your eligibility.
- ◆ **No Network Restrictions** – Members can visit any licensed provider who accepts Health Net terms and conditions.
- ◆ **Simplicity** – Comprehensive coverage under one health plan without addition of a Medicare Supplement Plan.
- ◆ **Extensive Drug Coverage** – Health Net offers a vast range of the prescription drugs you're most likely taking, so even if your physician were to change your prescription, or add new ones, these medicines will likely still be covered under Health Net's extensive drug formulary. Additionally, you will have access to many drugs not covered by Medicare.
- ◆ **No Preauthorization Requirements** – Members don't need to get authorization to visit specialists.
- ◆ **Expanded Benefits** – Above and beyond original Medicare plan coverage.
- ◆ **Transition Ease** – If you are currently enrolled in an indemnity option or Medicare Supplement plan, your transition to the Health Net PFFS plan will be seamless, because it provides open access to all Medicare accepting providers with no preauthorization requirements.

- ◆ **Administrative Ease** – One stop enrollment, billing and administration.

Disclaimer for Health Net PFFS Plan:

- ◆ This plan is subject to regulatory filing and approval.
- ◆ If there are discrepancies between this Guide and Health Net contract documents, contract documents will prevail.



Delta Dental PPO

Delta Dental PPO is administered by Delta Dental. Delta Dental PPO allows you to choose to receive care from a network provider or from an out-of-network provider. It is your choice. You may change between in- and out-of-network dentists anytime without notifying Delta Dental in advance.

How the Plan Works

Retirees selecting to enroll in the Delta Dental PPO Plan will be required to participate in the Plan for a consecutive 24-month period.

In-Network When you receive your dental care from a Delta Dental PPO network dentist, you will pay a percent of the dentist's discounted Delta Dental PPO rates. Enrollees are eligible for crowns, inlays, onlays and cast restorations only after being continuously enrolled in this plan for 12 months. This waiting period is waived if the enrollee provides proof of 12 months continuous dental coverage under another group plan prior to enrollment in this plan. To know what your cost will be in advance, you may request a preauthorization.

Out-of-Network When you receive care from an out-of-network dentist, you will pay a percentage of the dentist's nondiscounted fees plus any charges over Delta Dental base allowance. Your share of the cost will be the difference between what the plan covers out-of-network and what your out-of-network dentist is charging you. This cost will vary by provider.

For example: assume you had an out-of-network periodontic root planing and your out-of-network dentist charged \$125. If Delta Dental determined that their base allowance for that service was \$100, then you would pay 40% of \$100 or \$40 plus any cost over the Delta Dental base allowance or \$25. Your total out-of-pocket expense for this procedure would be \$65. If you used a network dentist, the average contracted charge for this procedure is \$85. You would pay 20% of \$85 or \$17. (Note: the numbers cited are for example purposes only. They may not be the actual rates associated with this procedure.)

Out-of-Area Care If you need dental care away from home, call Delta Dental at 1-888-335-8227. If possible, you will be

directed to an available in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit automatically.

Claim Forms Under Delta Dental PPO, your network dentist will submit a standard claim form directly to Delta Dental. If your dentist needs a claim form, call the Delta Dental Claims Department at 1-888-335-8227.

If your dentist is an out-of-network dentist, Delta Dental will make claim payments directly to you. It is your responsibility to pay your dentist for services rendered.

How To Get In Touch With Delta Dental PPO

For information about Delta Dental PPO, including if you:

- ◆ have a benefits question
- ◆ need a provider directory
- ◆ need a member ID card
- ◆ have an eligibility question
- ◆ have a claims question

call Delta Dental at 1-888-335-8227 or visit Delta's website at www.deltadentalca.org.



Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER
	HIGH OPTION		LOW OPTION		HIGH OPTION
	Tier One	Tier Two	Tier One	Tier Two	
Allergy testing	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay
Ambulance	No charge if medically necessary	Not covered	\$300	Not covered	No charge if medically necessary
Chiropractic care	Not covered	Not covered	Not covered	Not covered	Not covered
Choice of providers	HMO network providers	CA PPO physicians only	HMO network providers	CA PPO physicians only	Kaiser only
Deductibles: Calendar year	None	None	None	None	None
Hospital/ ambulatory surgical & skilled nursing facility	None	Not covered	None	Not covered	None
Non-certification	None	None	None	None	None
Diagnostic X-ray/ lab	No charge	Physician's office only; MRI, MUGA, PET, SPECT not covered	No charge	Physician's office only; MRI, MUGA, PET, SPECT not covered	No charge
Durable medical equipment	No charge	Not covered	No charge (limit \$2,000 per CY)	Not covered	No charge
Emergency room	\$50; waived if admitted	Not covered	\$250	Not covered	\$50; waived if admitted

CY = Calendar Year

C&R = Customary and Reasonable

UCR = Usual and Customary Rates

PERMANENTE	HEALTH NET PPO				
	LOW OPTION	HIGH OPTION		LOW OPTION	
		In-Network	Out-of-Network	In-Network	Out-of-Network
\$20 copay	20% coinsurance (CY deductible waived)	40% of C&R after CY deductible	30% coinsurance after CY deductible	50% of C&R after CY deductible	
\$150/trip after deductible	20% coinsurance after CY deductible	40% of C&R after CY deductible	30% coinsurance after CY deductible	50% of C&R after CY deductible	
Not covered	20% after deductible up to 30 visits per CY combined with OON	40% of C&R after CY deductible	20% coinsurance after CY deductible	50% of C&R after CY deductible	
Kaiser only	CA PPO providers	Any in CA, but cost is 30% after deductible plus costs over UCR	CA PPO providers	Any in CA, but cost is 50% after deductible plus costs over UCR	
\$500/person, \$1,000/family	\$500/individual, \$1,500/family	\$500/individual, \$1,500/family	\$1,500 per member, no family maximum	\$1,500 per member, no family maximum	
Deductible applies	\$250 per admit/surgery plus coinsurance	\$250 per admit/surgery plus coinsurance	\$500 per admission, \$500 per outpatient surgery	\$500 per admission, \$500 per outpatient surgery	
None	\$250 per admit or visit	\$250 per admit or visit	\$250 per admission plus payment reduced to 50% / \$50 charge per outpatient visit; payment reduced to 50% on specific procedures	\$250 per admission plus payment reduced to 50% / \$50 charge per outpatient visit; payment reduced to 50% on specific procedures	
\$10 per encounter (\$50 MRI, CT, PET) after deductible)	20% coinsurance after deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
20% coinsurance, no deductible	20% coinsurance after deductible; up to \$5,000 per year (CY maximum not applicable to Orthotics & Diabetic Footwear)	40% coinsurance after deductible plus costs over UCR; up to \$5,000 per year (CY maximum not applicable to Orthotics & Diabetic Footwear)	30% coinsurance after CY deductible up to \$2,000 CY maximum	50% coinsurance after CY deductible up to \$2,000 CY maximum	
20% coinsurance, after deductible	\$100 copay per visit plus 20% coinsurance	\$100 deductible per visit + 20% coinsurance + costs over UCR	\$100 deductible per visit (waived if admitted); 30% coinsurance after CY deductible	\$100 deductible per visit (waived if admitted); 30% coinsurance after CY deductible	

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County of San Bernardino

UCR = Usual and Customary Rates

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER
	HIGH OPTION		LOW OPTION		HIGH OPTION
	Tier One	Tier Two	Tier One	Tier Two	
Family planning: Infertility services	50% coinsurance; excludes GIFT, ZIFT, IVF	Not covered	Not covered	Not covered	50% coinsurance excludes GIFT, ZIFT and IVF
Tubal ligation	\$10 copay	Not covered	\$150 copay	Not covered	\$10 copay
Vasectomy	\$10 copay	Not covered	\$50 copay	Not covered	\$10 copay
Home health services	No charge if medically necessary	Not covered	\$50 copay	Not covered	No charge if medically necessary
Hospice	No charge if medically necessary	Not covered	No charge if medically necessary	Not covered	No charge
Hospital	No charge	Not covered	\$1,000 per admission	Not covered	No charge, if medically necessary
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Maternity care	No charge; except \$10 for 1st prenatal/postnatal visit	Not covered	\$50	Not covered	\$10 copay for 1st visit; no charge thereafter
Mental health: Inpatient	No charge; up to 30 days per year	Not covered	Not covered	Not covered	No charge; up to 30 days per year
Outpatient	\$20 copay; up to 20 visits per year (combined with substance abuse)	Not covered	Not covered	Not covered	\$10 copay; up to 20 visits per year
Severe mental disorders: Inpatient	No charge; unlimited days	Not covered	\$50 copay per visit	Not covered	No charge; unlimited days

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OON = Out-of Network

PERMANENTE	HEALTH NET PPO				
	LOW OPTION	HIGH OPTION		LOW OPTION	
		In-Network	Out-of-Network	In-Network	Out-of-Network
50% coinsurance; excludes GIFT, ZIFT, IVF	Not covered	Not covered	Not covered	Not covered	
\$20 copay	30% after deductible	50% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
\$20 copay	30% after deductible	50% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
No charge if medically necessary	20% coinsurance after deductible; up to 100 visits per year	40% coinsurance after deductible plus costs over UCR; up to 100 visits per year	30% coinsurance after CY deductible up to \$110 max. per day; 120 visits per CY	50% coinsurance after CY deductible up to \$110 max per day; 120 visits per CY	
No charge	20% coinsurance after deductible; combined lifetime maximum of \$10,000	40% coinsurance after deductible plus costs over UCR; combined lifetime max \$10,000	30% coinsurance after CY deductible. \$10,000 lifetime maximum combined with OON	50% of C&R after CY deductible. \$10,000 lifetime maximum combined with OON	
20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
Unlimited	\$5 million (combined with OON)	\$5 million (combined with PPO)	\$5 million (combined with OON)	\$5 million (combined with PPO)	
\$10 copay per visit	20% after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
20% coinsurance after deductible; up to 30 days per year	100% coinsurance up to max allowable per day of \$175	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible up to 30 days combined with Chemical Dependency	50% coinsurance after CY deductible up to 30 days combined with Chemical Dependency	
\$20 copay (no deductible); up to 20 visits per year	100% coinsurance up to max per visit of \$25 (CY deductible waived)	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible up to 30 visits combined with Chemical Dependency	50% coinsurance after CY deductible up to 30 visits combined with Chemical Dependency	
20% coinsurance after deductible; up to 30 days per year	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	

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UCR = Usual and Customary Rates

OON = Out-of Network

County of San Bernardino

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Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER
	HIGH OPTION		LOW OPTION		HIGH OPTION
	Tier One	Tier Two	Tier One	Tier Two	
Outpatient	\$10 copay; unlimited visits	Not covered	\$50 copay per visit	Not covered	\$10 copay; unlimited visits
Out-of-pocket maximum	\$1,500 member/ \$3,000 family	Not applicable	\$3,000 single/ \$6,000 two party/ \$9,000 family	N/A	\$1,500 member/ \$3,000 family
Outpatient services: Chemotherapy	No charge	Not covered	No charge	Not covered	No charge
Renal dialysis	No charge	Not covered	No charge	Not covered	\$10 copay
Outpatient surgery	No charge	Not covered	\$750 per surgery	Not covered	\$10 copay
Physician services: Hearing screenings	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay
Home visits	\$10 copay	Not covered	\$50 copay	Not covered	No charge if medically necessary
Hospital services	No charge	Not covered	No charge	Not covered	No charge
Immunizations/ injections	\$10 copay	\$30 copay	\$50 copay	\$80 copay	No charge
Office visits	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay
Routine physicals	\$10 copay; one per calendar year	Not covered	Not covered	Not covered	\$10 copay
Specialists	\$10 copay	\$30 copay	\$70 copay	\$80 copay	\$10 copay

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OON = Out-of Network

PERMANENTE	HEALTH NET PPO				
	LOW OPTION	HIGH OPTION		LOW OPTION	
		In-Network	Out-of-Network	In-Network	Out-of-Network
\$20 copay; unlimited visits	Same as any other illness	Same as any other illness	Same as any other illness	Same as any other illness	
\$3,000 member/ \$6,000 family	\$2,500 individual/ \$5,000 family	\$5,000 individual/ \$10,000 family	\$6,000 member/ no family maximum	\$12,000 member/ no family maximum	
No charge	20% coinsurance after deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible for children through age 16	50% of C&R deductible for children through age 16	
No charge (no deductible)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
No charge	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
No charge	20% coinsurance after CY deductible. Foreign travel/occupation immunizations not covered.	40% coinsurance after deductible plus costs over UCR. Foreign travel/occupational immunizations not covered	Not covered	Not covered	
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
\$20 copay	Not covered	Not covered	Not covered	Not covered	
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	

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OON = Out-of Network

County of San Bernardino

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER
	HIGH OPTION		LOW OPTION		HIGH OPTION
	Tier One	Tier Two	Tier One	Tier Two	
Surgical services	No charge	\$30 copay, physician's office only	\$50 copay	\$80 copay, physician's office only	\$10 copay
Well baby/ well child care	\$10 copay	\$30 copay	\$50 copay	\$80 copay	No charge (0-23 months)
Well woman exam (annual)	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay
Physical and occupational therapy	\$10 copay	\$30 copay; up to 12 visits per year	\$40 copay	\$80/12 visits max limited to office visit only	\$10 copay; up to 60 visits per year
Pre-existing condition	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions
Prescription drugs – Retail	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 100-day supply
Generic	\$5 copay	\$5 copay	\$10 copay	\$10 copay	\$10 copay
Brand formulary	\$10 copay	\$10 copay	\$100 CY brand name deductible per member plus \$30 copay	\$100 CY brand name deductible per member plus \$30 copay	\$15 copay
Non-formulary	\$25 copay	\$25 copay	\$100 CY brand name deductible per member plus \$50 copay	\$100 CY brand name deductible per member plus \$50 copay	Not covered
Prescription drugs – Mail order	Up to 90-day supply	Up to 90-day supply	Up to 90-day supply	Up to 90-day supply	Up to 100-day supply
Generic	\$10 copay	\$10 copay	\$20 copay	\$20 copay	\$10 copay
Brand formulary	\$20 copay	\$20 copay	\$100 CY brand name deductible per member plus \$60 copay	\$100 CY brand name deductible per member plus \$60 copay	\$15 copay

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PERMANENTE	HEALTH NET PPO				
	LOW OPTION	HIGH OPTION		LOW OPTION	
		In-Network	Out-of-Network	In-Network	Out-of-Network
20% coinsurance after deductible	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% of C&R after CY deductible	
\$10 per visit (0-23 months)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR. \$20 maximum payable per exam.	30% coinsurance after CY deductible	50% after CY deductible	
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible	50% after CY deductible	
\$20 copay; up to 60 days after deductible	20% coinsurance after CY deductible. Combined limit of 30 visits per CY.	40% coinsurance after deductible plus costs over UCR. Combined limit of 30 visits per CY. \$25 max per visit	30% coinsurance after CY deductible up to 20 visits per CY	50% of C&R after CY deductible up to 20 visits per CY	
No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	
\$100 deductible for brand drugs (retail or mail) up to 100-day supply \$10 copay	Up to 30-day supply \$10 copay	Up to 30-day supply \$10 copay plus 50% of expense	Up to 30-day supply \$10 copay	Up to 30-day supply \$10 copay plus 50% of covered expense	
\$30 copay	\$25 copay	\$25 copay plus 50% of expense	\$25 copay	\$25 copay plus 50% of covered expense	
Not covered	\$35 copay	\$35 copay plus 50% of expense	\$35 copay	\$35 copay plus 50% of covered expense	
Up to 100-day supply \$10 copay	Up to 90-day supply \$20 copay	Up to 90-day supply Not covered	Up to 90-day supply \$20 copay	Up to 90-day supply Not covered	
\$30 copay	\$50 copay	Not covered	\$50 copay	Not covered	

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County of San Bernardino

UCR = Usual and Customary Rates

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER
	HIGH OPTION		LOW OPTION		HIGH OPTION
	Tier One	Tier Two	Tier One	Tier Two	
Non-formulary	\$50 copay	\$50 copay	\$100 CY brand name deductible per member plus \$100 copay	\$100 CY brand name deductible per member plus \$100 copay	Not covered
Skilled nursing facility	No charge	Not covered	\$1,000 copay per admit	Not covered	No charge; up to 100 days per year
Speech therapy	\$10 copay	\$30 copay; up to 12 visits per year	\$40 copay	\$80/12 visits max limited to office visit only	\$10 copay; up to 60 days per year if medically necessary
Substance abuse: Rehab – Inpatient	No charge; up to 30 days per year (combined with non-severe mental health)	Not covered	Not covered	Not covered	\$100 per admit; up to 60 days per year
Outpatient	\$20 copay; up to 20 visits per year (combined with non-severe mental health)	Not covered	Not covered	Not covered	\$10 copay individual/ \$5 copay group
Detox – Inpatient	No charge; up to 3 days per year	Not covered	\$1,000 copay per admit	Not covered	No charge
Outpatient	Not covered	Not covered	Not covered	Not covered	\$10 copay individual/ \$5 copay group
Urgent care	\$25 copay	Not covered	\$100 copay	Not covered	\$10 copay
Vision exams	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay

Notes _____

PERMANENTE	HEALTH NET PPO				
	LOW OPTION	HIGH OPTION		LOW OPTION	
		In-Network	Out-of-Network	In Network	Out of Network
Not covered	\$70 copay	Not covered	\$70 copay	Not covered	
20% coinsurance after deductible; up to 100 days per year	\$250 deductible; 20% coinsurance; combined limit of 100 days per year	\$250 per admission; 40% coinsurance of C&R; combined limit of 100 days per year	30% coinsurance after CY deductible up to 100 days per CY	50% of C&R after CY deductible up to 100 days per CY	
\$20 copay; up to 60 days per year; after deductible	20% coinsurance after CY deductible up to 24 visits per CY	40% coinsurance after deductible up to \$30 max per visit plus costs over UCR; up to 24 visits per year	30% coinsurance after CY deductible up to 20 visits per CY	50% coinsurance after CY deductible up to 20 visits per CY	
20% coinsurance after deductible to 60 days per year	100% up to \$175 allowable/day up to 30 days per CY	\$250 deductible/admission; 40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible up to 30 days combined with Chemical Dependency	50% coinsurance after CY deductible up to 30 days combined with Chemical Dependency	
\$20 copay individual/ \$5 copay group (no deductible)	100% up to \$25 max per visit; up to 50 visits per CY (CY deductible waived)	40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible up to 30 visits combined with Chemical Dependency	50% coinsurance after CY deductible up to 30 visits combined with Chemical Dependency	
20% coinsurance after deductible	\$250 deductible per admission; 100% up to \$175 allowable/day (CY deductible waived) up to 30 days per CY	\$250 deductible per admission; 40% coinsurance after deductible plus costs over UCR	30% coinsurance after CY deductible up to 3 days	50% coinsurance after CY deductible up to 3 days	
\$20 copay individual/ \$5 copay group	100% up to \$25 max per visit; up to 50 visits per CY (CY deductible waived)	40% coinsurance after deductible plus costs over UCR	Not covered	Not covered	
\$20 copay	\$35 copay per visit plus 20% coinsurance	\$35 copay per visit plus 20% coinsurance plus costs over UCR	\$100 deductible per visit; 30% coinsurance after CY deductible	\$100 deductible per visit; 30% coinsurance after CY deductible	
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible	Children thru age 16 only; 30% after CY deductible	Children thru age 16 only; 50% after CY deductible	

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between this Comparison Chart and the official documents, the official plan documents will prevail.

Medical Plans Comparison Chart *(Medicare Eligible)*

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	ZERO-PREMIUM
Allergy testing	No charge	No charge
Ambulance	No charge	\$125
Chiropractic care	\$10 (limited to the Medicare allowed Chiro benefit)	\$0 (limited to the Medicare allowed Chiro benefit)
Choice of providers	California HMO Health Net Network of Providers	California HMO Health Net Network of Providers
Deductibles: Calendar year	None	None
Hospital/ambulatory surgical skilled nursing facility	None	No charge
Non-certification	Services not provided through the Member's assigned PCP/PPG require Prior Authorization	Services not provided through the Member's assigned PCP/PPG require Prior Authorization
Diagnostic X-ray/lab	No charge	\$0 to \$250 based on Medicare Allowable Cost (X-ray no charge)
Durable medical equipment	No charge	20% (adequately meets the member's medical needs as determined by Seniority Plus PPG)
Emergency room	\$20; waived if admitted	\$50; waived if admitted
Family planning: Infertility services	Not covered	Not covered
Tubal ligation	Not covered	Not covered
Vasectomy	Not covered	Not covered
Home health services	No charge	No charge
Hospice	Reimbursed directly by Medicare when enrolled in a Medicare-certified Hospice	Not covered
Hospital	No charge	No charge (unlimited days)

COMPARISON CHART

PCP = Primary Care Physician

PPG = Participating Physician Group

KAISER PERMANENTE MEDICARE ADVANTAGE		HEALTH NET PRIVATE FEE-FOR-SERVICE (PFFS)	
HIGH OPTION	LOW OPTION	HIGH OPTION	LOW OPTION
\$10 copay	\$25 copay	No charge	No charge
No charge	\$50 per trip	No charge	\$125
Some services covered at \$10 copay	Not covered	\$10 (limited to the Medicare allowed Chiro benefit)	\$0 (limited to the Medicare allowed Chiro benefit)
Kaiser only	Kaiser only	California HMO Health Net Network of Providers	California HMO Health Net Network of Providers
None	None	None	None
None	\$300 per day	None	No charge
None	None	N/A	N/A
No charge	No charge	No charge	\$0 to \$250 based on Medicare Allowable Cost (X-ray no charge)
No charge	20% coinsurance	No charge	20% (adequately meets the member's medical needs as determined by Seniority Plus PPG)
\$50; waived if admitted	\$50; waived if admitted	\$20; waived if admitted	\$50; waived if admitted
\$10 copay	\$25 copay	Not covered	Not covered
\$10 copay	\$25 copay	Not covered	Not covered
\$10 copay	\$25 copay	Not covered	Not covered
No charge	No charge if medically necessary	No charge	No charge
No charge	No charge	Reimbursed directly by Medicare when enrolled in a Medicare-certified Hospice	Not covered
No charge	\$300 per day	No charge	No charge (unlimited days)

PCP = Primary Care Physician

PPG = Participating Physician Group

Medical Plans Comparison Chart *(Medicare Eligible)*

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	ZERO-PREMIUM
Lifetime maximum	Unlimited	None
Maternity care	Covered same as any other illness	Covered same as any other illness
Mental health:		
Inpatient	No charge (lifetime maximum of 190 days per member)	\$900 per admit (lifetime maximum of 190 days per member)
Outpatient	\$20 copay	\$25 copay (unlimited)
Severe mental disorders:		
Inpatient	No charge (lifetime maximum of 190 days per member)	\$900 per admit (lifetime maximum of 190 days per member)
Outpatient	\$20 copay	\$25 copay
Out-of-pocket maximum	N/A	N/A
Outpatient services:		
Chemotherapy	No charge (professional services only)	If treatment falls under Part B = 20%
Renal dialysis	No charge (professional services only)	\$25 copay
Outpatient surgery	No charge	No charge
Physician services:		
Hearing screenings	\$10 copay	No charge
Home visits	\$10 copay	No charge
Hospital services	No charge (excluding care for mental disorders)	No charge (excluding care for mental disorders)
Immunizations/injections	No charge (except for foreign travel/occupation at 20%)	No charge (except for foreign travel/occupation at 20%)
Office visits	\$10 copay	No charge
Podiatry	\$10 copay	No charge
Routine physicals	\$10 copay	No charge
Specialists	\$10 copay	No charge
Surgical services	No charge	No charge

KAISER PERMANENTE MEDICARE ADVANTAGE		HEALTH NET PRIVATE FEE-FOR-SERVICE (PFFS)	
HIGH OPTION	LOW OPTION	HIGH OPTION	LOW OPTION
Unlimited	Unlimited	Unlimited	None
\$10 copay	\$25 for first visit; \$5 thereafter	Covered same as any other illness	Covered same as any other illness
No charge; up to 45 days per year	\$300 per day; up to 45 days per year	No charge (lifetime maximum of 190 days per member)	\$900 per admit (lifetime maximum of 190 days per member)
\$10 copay; unlimited visits	\$25 copay; up to 20 visits per year	\$20 copay	\$25 copay (unlimited)
No charge; unlimited days	\$300 per day; unlimited days	No charge (lifetime maximum of 190 days per member)	\$900 per admit (lifetime maximum of 190 days per member)
\$10 copay; unlimited visits	\$25 copay; unlimited visits	\$20 copay	\$25 copay
\$1,500 member/ \$3,000 family	\$1,500 member/ \$3,000 family	N/A	N/A
No charge	No charge	No charge (professional services only)	If treatment falls under Part B = 20%
No charge	\$25 copay	No charge (professional services only)	\$25 copay
\$10 copay	\$25 copay	No charge	No charge
\$10 copay	\$25 copay	\$10 copay	No charge
No charge	No charge	\$10 copay	No charge
No charge	No charge	No charge (except for care for mental disorders)	No charge (except for care for mental disorders)
No charge	No charge	No charge (except for foreign travel/occupation at 20%)	No charge (except for foreign travel/occupation at 20%)
\$10 copay	\$25 copay	\$10 copay	No charge
\$10 copay	No charge	\$10 copay	No charge
\$10 copay	\$25 copay	\$10 copay	No charge
\$10 copay	\$25 copay	\$10 copay	No charge
\$10 copay	\$25 copay	No charge	No charge

Medical Plans Comparison Chart *(Medicare Eligible)*

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	ZERO-PREMIUM
Well baby/well child care	Not covered	Not covered
Well woman exam (annual)	No charge	No charge
Physical and occupational therapy	No charge	No charge
Pre-existing condition	ESRD	ESRD
Prescription drugs – Retail	Up to 30-day supply	Up to 30-day supply
Generic	\$10 copay	\$10 copay
Brand formulary	\$20 copay	\$30 copay
Non-formulary	Not covered	\$60 copay
Prescription drugs – Mail order	Up to 90-day supply	Up to 90-day supply
Generic	\$20 copay	\$20 copay
Brand formulary	\$40 copay	\$60 copay
Non-formulary	Not covered	\$150 copay
Initial coverage limit	None	\$3,000 (generics only after ICL)
Skilled nursing facility	No charge (limited to 100 days per benefit period)	Days 1-20; no charge (limited to 100 days per benefit period) Days 21-100; \$75 per day
Speech therapy	No charge	No charge
Substance abuse: Rehab – Inpatient	No charge	\$900 per admit (lifetime maximum of 190 days per member)
Outpatient	\$20 copay	\$25 copay

ESRD = End Stage Renal Disease

ICL = Initial Coverage Limit

KAISER PERMANENTE MEDICARE ADVANTAGE		HEALTH NET PRIVATE FEE-FOR-SERVICE (PFFS)	
HIGH OPTION	LOW OPTION	HIGH OPTION	LOW OPTION
\$10 copay	\$5 copay	Not covered	Not covered
\$10 copay	\$25 copay	No charge	No charge
Inpatient no copay/ outpatient \$10 copay	\$25 copay	No charge	No charge
No exclusion for pre-existing condition	No exclusion for pre-existing condition	ESRD	ESRD
Up to 100-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply
\$10 copay	\$10 copay	\$10 copay	\$10 copay
\$20 copay	\$25 copay	\$20 copay	\$30 copay
Not covered	Not covered	Not covered	\$60 copay
Up to 100-day supply	Up to 100-day supply	Up to 90-day supply	Up to 90-day supply
\$10 copay	\$20 copay	\$20 copay	\$20 copay
\$20 copay	\$50 copay	\$40 copay	\$60 copay
Not covered	Not covered	Not covered	\$150 copay
None	None	None	\$3,000 (generics only after ICL)
No charge up to 100 days per year	No charge up to 100 days per year	No charge (limited to 100 days per benefit period)	Days 1-20; no charge (limited to 100 days per benefit period) Days 21-100; \$75 per day
\$10 copay	\$25 copay	No charge	No charge
No charge; \$100 per admit for non-medical transitional residential recovery setting up to 120 days every 5 years	\$300 per day up to 60 days in a calendar year	No charge	\$900 per admit (lifetime maximum of 190 days per member)
\$10 copay individual/ \$5 copay group	\$25 per visit	\$20 copay	\$25 copay

ESRD = End Stage Renal Disease

ICL = Initial Coverage Limit

Medical Plans Comparison Chart *(Medicare Eligible)*

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	ZERO-PREMIUM
Detox – Inpatient	No charge	\$900 per admit (lifetime maximum of 190 days per member)
Outpatient	\$20 copay	\$25 copay
Urgent care	\$20 copay (waived if admitted directly to the hospital)	\$10 copay (waived if admitted directly to the hospital)
Vision exams	\$10 copay	No charge
Other benefits: Bone mass measurements	No charge	No charge
Diabetes self-monitoring training and supplies	No charge	No charge
Fitness	No charge	No charge
Medical nutrition therapy (for members with diabetes and kidney disease)	\$10 copay	No charge
MHN specialized programs for legal and financial consultations as well as smoking cessation, discounts for weight management and nutrition	No charge	No charge
Silver & Fit	No charge	No charge
Transportation	No charge (30 trips per year)	No charge (30 trips per year)

COMPARISON CHART

Notes _____

KAISER PERMANENTE MEDICARE ADVANTAGE		HEALTH NET MEDICARE PRIVATE FEE-FOR-SERVICE (PFFS)	
HIGH OPTION	LOW OPTION	HIGH OPTION	LOW OPTION
No charge; \$100 per admit for non-medical transitional residential recovery setting up to 120 days every 5 years	\$300 per day	No charge	\$900 per admit (lifetime maximum of 190 days per member)
\$10 copay individual/ \$5 copay group	\$25 per visit	\$20 copay	\$25 copay
\$10 copay	\$25 copay	\$20 copay (waived if admitted directly to the hospital)	\$10 copay (waived if admitted directly to the hospital)
\$10 copay	\$25 copay	\$10 copay	No charge
Contact Kaiser Permanente for information about Healthy Living Programs	Contact Kaiser Permanente for information about Healthy Living Programs	No charge	No charge
Contact Kaiser Permanente for information about Healthy Living Programs	Contact Kaiser Permanente for information about Healthy Living Programs	No charge	No charge
N/A	N/A	N/A	N/A
Contact Kaiser Permanente for information about Healthy Living Programs	Contact Kaiser Permanente for information about Healthy Living Programs	\$10 copay	No charge
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A

This Comparison Chart only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between this Comparison Chart and the official documents, the official plan documents will prevail.

Dental Plan Comparison Chart Summary

		DELTA DENTAL PPO		
Category	ADA Dental Codes	Description	In-Network (You pay...)	Out-of-Network (You pay...plus any costs over Delta Dental Base Allowance)
Preventive Care (NO WAITING PERIOD)	00120	Periodic oral examination	0%	30%
	00210	Full mouth X-ray (panoramic), once in a five-year period	0%	30%
	00270-77	Bitewing, 1 per calendar year or as needed	0%	30%
	09110	Emergency, palliative treatment of dental pain	0%	30%
	09430	Office visit for observation	0%	30%
	00460	Pulp vitality test	0%	30%
	01201	Topical Fluoride (child)	0%	30%
	01351	Sealant (per tooth)	20%	40%
	00470	Diagnostic casts	0%	30%
	01110	Prophylaxis (to remove tartar/stains)	0%	30%
Restorative Dentistry (NO WAITING PERIOD)	02110	Amalgam ("silver" fillings) on primary or permanent teeth: 1 surface	20%	40%
	02120	Amalgam on primary teeth: 2 surfaces	20%	40%
	02130-31	Amalgam on primary teeth: 3 or 4 surfaces	20%	40%
	02140	Amalgam on permanent teeth: 1 surface	20%	40%
	02150	Amalgam on permanent teeth: 2 surfaces	20%	40%
	02160-61	Amalgam on permanent teeth: 3 or 4 surfaces	20%	40%
	02330	Composite resin (white), anterior teeth only, 1 surface	20%	40%
	02951	Pin retention	20%	40%
	01510	Space maintainers	20%	40%
	Periodontics (NO WAITING PERIOD)	04240	Gingival flap, per quadrant	20%
04341		Periodontal scaling (deep cleaning), per quadrant	20%	40%
04260		Osseous surgery (reshaping bone), per quadrant	20%	40%
04210		Gingivectomy/gingivoplasty (gum surgery), per quadrant	20%	40%
04220		Gingival curettage, per quadrant	20%	40%
04910		Periodontal maintenance procedures	20%	40%
Endodontics (NO WAITING PERIOD)		03110	Pulp capping	20%
	03220	Therapeutic pulpotomy	20%	40%
	03310	Anterior (front) teeth root canal therapy	20%	40%
	03320	Bicuspid root canal therapy	20%	40%
	03330	Molar root canal therapy	20%	40%
	03920	Hemisection	20%	40%
	03450	Root amputation (per root)	20%	40%
	03410	Apicoectomy	20%	40%
	03426	Periradicular surgery (each additional root)Retrograde filling (per root)	20%	40%
	03430	Retrograde filling (per root)	20%	40%

Oral Surgery (NO WAITING PERIOD)	07286	Biopsy of soft oral tissue			40%	
	07110	Uncomplicated extraction, single tooth			40%	
	07220	Extraction — impacted soft tissue, per tooth		20%	40%	
	07230	Extraction — impacted partially bony, per tooth		20%	40%	
	07240	Extraction — impacted completely bony, per tooth		20%	40%	
	09215	Local anesthesia		20%	40%	
	09220	General anesthesia (first 30 minutes)		20%	40%	
	07320	Alveoplasty (reshape bone) per quad, w/out extraction		20%	40%	
	07310	Alveoloplasty (reshape bone) per quad, with extraction		20%	40%	
	07130	Removal of residual/exposed tooth roots		20%	40%	
	07510	Incision and drainage of abscess		20%	40%	
	07960	Frenulectomy (includes frenectomy or frenotomy)		20%	40%	
	07350	Vestibuloplasty		20%	40%	
	Crowns and Bridges (WAITING PERIOD)	06790	Crown — full cast high noble metal (gold)		50%	50%
		06780	Crown — ¾ cast high noble metal (gold)		50%	50%
02792		Crown — full cast noble metal (silver)		50%	50%	
02810		Crown — ¾ cast metallic		50%	50%	
02752		Crown — porcelain fused to noble metal (silver)		50%	50%	
02722		Crown — resin with noble metal (silver)		50%	50%	
02710		Crown — resin (laboratory)		50%	50%	
06930		Recement fixed partial denture		50%	50%	
02920		Recement crown		50%	50%	
Prosthetics (WAITING PERIOD)		05110	Complete upper denture		50%	50%
	05120	Complete lower denture		50%	50%	
	05211	Upper partial denture — resin base		50%	50%	
	05212	Lower partial denture — resin base		50%	50%	
	05750-51	Reline upper or lower denture, laboratory		50%	50%	
	05510	Repair broken or lower denture, no tooth damage		50%	50%	
	05410	Complete denture adjustment		50%	50%	
	05520	Replace broken tooth on denture		50%	50%	
	05710-11	Rebase complete maxillary or mandibular denture		50%	50%	
	06210	Denture pontics, cast high noble metal (gold)*		50%	50%	
06720	Denture crown, resin with high noble metal (gold)*		50%	50%		
Deductible Calendar Year Benefit Maximum		Deductible is per patient per year	\$50	\$50	\$50	
			\$1,000	\$1,000	\$1,000	

When to Complete Forms

You must complete the Medical and/or Dental Plan Enrollment/Change Form included in this Guide to:

- ◆ Elect your medical and dental plans as a new retiree
- ◆ Change your medical and/or dental plans (not your provider)
- ◆ Add eligible dependents to your medical and/or dental plans
- ◆ Delete dependents from your medical and/or dental plans

You must complete the Medical and/or Dental Plan Cancellation Form included in this Guide to cancel your coverage.

You do not need to complete an enrollment/change form if:

- ◆ You are not making any changes to your medical and/or dental plans.
- ◆ You want to change your primary care physician (PCP) or provider group; to make changes, call your plan's member services department directly

How to Complete Forms

Section A	Medical/Dental	Check the box for the appropriate reason you are completing the form.
Section B	Medical/Dental	Check the box for the plan and the option you are electing. For PPO and PFFS, please select California or Out-of-State. Enter your previous plan
Section C	Medical/Dental	Complete all fields.
Section D	Medical/Dental	Complete this section only if your are enrolling in this plan for the first time, changing plans, or adding dependents. List all dependents you want to cover. For Health Net HMO, you must enter a primary care physician (PCP) and medical group number. If you omit this field, Health Net will assign you to any PCP in your area.
Section E	Medical/Dental	Complete this section if you are not changing plans, but are only adding or deleting dependents. You must enter a PCP and medical group number if you are enrolled in Health Net HMO.
Section F	Medical/Dental	Complete if applicable.
Section G	Medical/Dental	Complete if you have other medical/dental insurance.
Section H	Medical	Complete if anyone to be covered by this medical plan is enrolled in both Medicare Parts A and B.
Section H	Dental	Read, sign and date.
Sections I-M	Medical	Read, sign and date pages 2 and 3 of the enrollment/change form.

*For Medicare integrated plans, please complete both the County **and** health plan enrollment form

IMPORTANT! By submitting a completed and signed medical and/or Dental Plan Enrollment/Change Form, you are acknowledging that you have read and understand the terms and conditions for the plan you have chosen. You are also acknowledging that you accept the benefits, conditions, exceptions and restrictions of the plan as defined in the summary plan description.



San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

RETIREE
MEDICAL PLAN
ENROLLMENT/CHANGE FORM

Effective Date Month Day Year
Group #
Employee ID #

A NEW RETIREE OPEN ENROLLMENT CHANGE IN STATUS

B I CHOOSE THIS MEDICAL PLAN:

- Kaiser Permanente
Kaiser Medicare Advantage*
Health Net ELECT Open Access HMO
Health Net PPO
Health Net Seniority Plus*
Health Net Seniority Plus Zero-Premium*
Health Net PFFS*

Option:
High Option
Low Option

For PPO & PFFS only

- California
Out-of-State

*Medicare integrated plan. Please complete both the County and the health plan enrollment form.

PREVIOUS MEDICAL PLAN:

C RETIREE INFORMATION

1. Social Security No.
2. Check One: Male Female
3. Date Of Birth Month Day Year
4. Check One: Married Widowed Single Divorced Domestic Partner
5. Last Name
6. First Name
7. MI
8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address
10. Home Phone Work Phone
11. City
12. State
13. Zip Code
14. Health Net HMO and Seniority Plus Primary Care Physician ID No./Group ID No. Previously Visited? Yes No

D NEW ENROLLMENT ONLY

IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED

Health Net HMO & Seniority Plus Enrollees Only

Table with columns: Last Name, First Name, Social Security #, Date of Birth, Relationship, Primary Care Physician's ID No./Group No., Previously Visited? (Yes/No)

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next annual open enrollment period.

E ENROLLMENT CHANGES ONLY

IF YOU ARE ADDING OR DELETING DEPENDENT(S) (BUT NOT CHANGING PLANS), COMPLETE THIS SECTION

Health Net HMO & Seniority Plus Enrollees Only

Table with columns: Last Name, First Name, Date of Birth, Relationship, Primary Care Physician's ID No./Group No., Previously Visited? (Yes/No)

F IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH
DOMESTIC PARTNERSHIP DISSOLUTION
MARRIAGE DIVORCE DEATH

G OTHER MEDICAL COVERAGE

H MEDICARE COVERAGE

Are you or any other member of your family covered by other group medical insurance?
Insurance company
Policy no.
Spouse's employer
Phone number

List all family members enrolled in both Parts A & B of Medicare:
Name (first, middle, last)
ID no. Date of birth (month, day, year)
Name (first, middle, last)
ID no. Date of birth (month, day, year)

PLEASE READ THE FOLLOWING SECTIONS I THROUGH M AND SIGN WHERE INDICATED

I

KAISER PERMANENTE MEMBERS ONLY
(THIS SECTION APPLIES IF ENROLLING IN THE KAISER PERMANENTE PLAN)

I understand that (except for Small Claims Courts cases, claims subject to a Medicare appeals procedure, and if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

J

HEALTH NET MEMBERS ONLY
(THIS SECTION APPLIES IF ENROLLING IN THE HEALTH NET PLAN)

I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex) to Health Net Entities. Health Net Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the web site at www.healthnet.com or through Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this page. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. California law prohibits an HIV test from being required or used by insurance companies as a condition of obtaining health insurance coverage.

ACKNOWLEDGEMENT AND AGREEMENT: I understand and agree that by enrolling with or accepting services from Health Net Entities, I and any enrolled dependents are obligated to understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. I have read and understand the terms of this Application is complete, true and correct, and I accept these terms.

ARBITRATION AGREEMENT: I understand and agree that any and all disputes or disagreements between Group (or enrolled members) and the Health Net Entities Exc, regarding the construction, interpretation, performance or breach of the Health Net Entities Group Policies, or regarding other matters relating to or arising out of the Health Net Entities Group Policies, Group Services Agreement, Group Certificates of Insurance and/or Evidences of Coverage, whether stated in tort, contract or otherwise, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities are giving up their constitutional rights to extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes with the Health Net Entities involving claims for medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Health Net Entities Group Policies. Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U. S. C. 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net Entities and/or the Fidelity Entities to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net Entities and/or the Fidelity Entities to deny, reduce, terminate or not pay for all or a part of a benefit. However, I and Health Net Entities may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

K

QUALIFIED CHANGE IN STATUS EVENT

I understand that I may elect to add or delete eligible dependents to my medical plan if a "Qualifying Change in Status Event" occurs. Qualifying events are:

- Marriage, domestic partnership, divorce, dissolution of domestic partnership or legal separation of the member
- Birth or adoption of a child by the member
- Death
- Termination or commencement of a spouse's or domestic partner's employment
- Over age dependent
- A significant change in the medical coverage of the member or dependents attributable to the spouse's or domestic partner's employment, such as offering insurance for the first time or a significant increase or decrease in premium cost
- Medicare entitlement

To add or delete dependents, I understand that I must submit a new Medical Plan Enrollment/Change Form within thirty (30) days of a Qualifying Change in Status Event. If I do not submit a Medical Plan Enrollment/Change Form within thirty (30) days, my request may be denied. All requests must be consistent with the stated qualifying event.

L

I hereby acknowledge that I understand the following in connection with the County of San Bernardino's Low Option Health Plan (Low Option) through either Kaiser Permanente or Health Net of California or any subsequent health plan provider(s):

- My decision to participate in the Low Option Plan is completely voluntary and is made with full understanding of the risks and potential additional expenses including applicable deductibles and increases in co-payments or co-insurances.
- I understand that by selecting the Low Option Plan my out-of-pocket expenses for medical care will increase.
- The County and the health plans have provided me with access to education and communications on the Low Option Plan.

I hereby release the County of San Bernardino and the Board of Supervisors from any fiduciary (or other) liability and responsibility for any losses incurred or other adverse consequences experienced in connection with my Low Option decisions.

M

AGREEMENT

I hereby elect the medical plan designated in **Section B**. In Section **D/E**, I have also listed eligible dependents added to the medical plan, or to be deleted from the plan.

I authorize the County of San Bernardino to deduct from my salary or retirement allowance the amount required to cover my share of the payment (including any future premium increases).

I agree for myself and my dependents, effective immediately and for as long as necessary to process claims

- To be bound by the terms and conditions of the Group Agreement as it may be amended
- To obtain all medical services from providers associated with the medical plan, unless the plan specifically provides otherwise
- To authorize providers who have rendered services to me and my dependents to make medical information and records regarding those services available to the medical plan and their providers who, in turn, may share such records among themselves. This information may also be released to appropriate government agencies
- To complete and submit consents, releases assignments and other documents related to protecting the medical plan's rights under the Group Agreement. This includes coordinating benefits with other group medical plans, insurance policies or Medicare. I also agree to pay the cost incurred by the medical plan out of any awards, settlements or payments made to me in connection with personal injuries sustained by me or my dependents, and

I acknowledge and understand that health care providers may disclose health information about me or my dependents, including information regarding substance abuse, mental/emotional conditions, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex) to my health insurance carrier for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement and disease or care management programs. The health insurance carrier's Notice of Privacy Practices is included in their evidence of coverage or certificate of insurance for coverage. A copy of this notice can be obtained by calling the health insurance carrier's member services.

I certify that, to the best of my knowledge, all information furnished by me here is true and correct. I certify that the names of the persons listed in Section H are enrolled in Parts A & B of Medicare.

I also certify that I accept the above terms of the plan to which I subscribe.

Subscriber's Signature _____ Date _____

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440



San Bernardino County
 Employee Benefits and Services Division (EBSB)
 157 West Fifth Street, First Floor
 San Bernardino, CA 92415-0440
 (909) 387-5787 Fax (909) 387-5566

RETIREE DELTA DENTAL PPO PLAN ENROLLMENT/CHANGE FORM

Effective Date	Month	Day	Year
Group #			
Employee ID #			

A NEW RETIREE OPEN ENROLLMENT CHANGE IN STATUS

B Previous Dental Plan: _____

C **RETIREE INFORMATION**

1. Social Security No.	2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth Month Day Year	4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address <input type="checkbox"/>		10. Home Phone () Work Phone ()	
11. City	12. State	13. Zip Code	

D **NEW ENROLLMENT ONLY** IF YOU ARE ENROLLING IN THIS DENTAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED

Last Name	First Name	Social Security No.	Date of Birth	Relationship
Spouse/Domestic Partner:				
				<input type="checkbox"/> Husband <input type="checkbox"/> Wife
Children:				
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter

I understand that if I do not enroll my eligible dependent(s) at this time, I will not be able to enroll my dependent(s) until the next Open Enrollment Period.

E **ENROLLMENT CHANGES ONLY** IF YOU ARE ADDING OR DELETING DEPENDENT(S) BUT NOT CHANGING PLANS, COMPLETE THIS SECTION

Name of family member(s) to be added or deleted:	Social Security No.	Date of Birth	Relationship
<input type="checkbox"/> Add Spouse/Domestic Partner: <input type="checkbox"/> Delete			<input type="checkbox"/> Husband <input type="checkbox"/> Wife
<input type="checkbox"/> Add Children: <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter
<input type="checkbox"/> Add <input type="checkbox"/> Delete			<input type="checkbox"/> Son <input type="checkbox"/> Daughter

F IF ADDING SPOUSE/DOMESTIC PARTNER, SHOW DATE OF MARRIAGE/DOMESTIC PARTNERSHIP. IF DELETING, SHOW DATE OF DIVORCE/DISSOLUTION OR DEATH MONTH DAY YEAR DOMESTIC PARTNERSHIP DISSOLUTION
 MARRIAGE DIVORCE DEATH

G **OTHER DENTAL COVERAGE**

Are you or any other member of your family covered by other group dental insurance? Yes No

Insurance company _____ Spouse's/Domestic Partner's employer _____

Policy no. _____ Phone number () _____

H I hereby authorize my dentist, dental care practitioner, hospital, clinic, or other dental or dental-related facility to furnish any and all records pertaining to dental history, services rendered, or treatment given for purpose of review, investigation or evaluation of an application or a claim. I also authorize disclosure to a hospital or dental care plan, employer, self-insurer or insurer any such dental information obtained if such disclosure is necessary to allow the processing of any claims or for purposes of utilization review or financial audit. This authorization shall become effective immediately and shall remain in effect as long as it is necessary to enable claims processing.

I elect to enroll in (or make the above changes to) the dental plan as shown above and authorize deduction to be made from my retiree pay warrant to cover my share of the cost of enrollment as it is now or as it may be in the future.

Retiree's Signature _____ Date _____

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440



RETIREE MEDICAL AND/OR DENTAL PLAN CANCELLATION FORM

San Bernardino County
Employee Benefits and Services Division (EBSB)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

Effective Date	Month	Day	Year
Group #			
Employee ID #			

A I CHOOSE TO CANCEL MY MEDICAL AND/OR DENTAL COVERAGE

Medical plan name _____

Delta Dental PPO

B RETIREE INFORMATION

1. Social Security No.		2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date Of Birth Month Day Year		4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner	
5. Last Name		6. First Name		7. MI	8. For Name Change, List Former Name Here		
9. Mailing Address Check Here If New Address <input type="checkbox"/>				10. Home Phone () Work Phone ()			
11. City		12. State	13. Zip Code				

Subscriber's Signature _____

Date _____

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440



**County of San Bernardino
OVER-AGE DEPENDENT CERTIFICATION
(Dependent child age 19 or over)**

Must print in Black or Blue ink ONLY.

Employee ID #	Last Name, First Name
Name of Medical Plan	Name of Dental Plan

COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 19 OR OVER

Dependent Name	Date of Birth
Relationship to Retiree	

Check one of the following:

- Dependent is 19 or more years of age and is incapable of self-sustaining employment because of a physical or mental condition. (Proof of physical or mental condition required.)
- Dependent is an unmarried, full-time student between the ages of 19 through 23 and is financially dependent upon retiree in accordance with Internal Revenue Code Section 125.

Note: Full-time student status requires 12 semester/quarter units.

The above-named dependent is enrolled as a full-time student at:

School Name		School Telephone
School Address		
For School Year	Number of Units	Type of Unit <input type="checkbox"/> Quarter <input type="checkbox"/> Semester

I certify that, to the best of my knowledge, all information furnished by me here is true and correct.

Retiree Signature	Telephone	Date
--------------------------	------------------	-------------

RETURN FORM TO:

San Bernardino County
Employee Benefits and Services Division (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440



ELECTION FORM Employer Group Plan

Important information about this election form

PLEASE READ ALL PAGES BEFORE SIGNING THIS ELECTION FORM.

Please type or print legibly, using a black or blue ballpoint pen, and press firmly.

- Completing and returning this election form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, please fill out this form for yourself and a separate one for your spouse. For assistance completing this election form, please contact the Kaiser Permanente Member Service Call Center toll free at **1-800-443-0815** (TTY **1-800-777-1370** for the hearing or speech impaired) seven days a week, from 8 a.m. to 8 p.m.
- You are entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this election form signifies that you have read, understand, and agree to these provisions. Kaiser Permanente is a Medicare Advantage organization with a Medicare contract.
- You will need to provide us with verification that you are entitled to Medicare Part A and enrolled in Medicare Part B and you must live inside our Kaiser Permanente Senior Advantage service area for us to enroll you. Please check the zip codes listed in the *Evidence of Coverage* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is also true:
 - You were diagnosed with ESRD while you were already a Kaiser Permanente member, and you are enrolling during an allowable election period.
 - You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
 - You have had a successful kidney transplant and you attach a note or records from your doctor showing that you have had a kidney transplant and no longer need regular dialysis.

If you have health coverage from an employer or trust fund, joining Kaiser Permanente Senior Advantage may change how your current coverage works. Read the communications your employer or trust fund sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

ABOUT THE APPLICATION PROCESS

Submitting your election form

- After completing pages 1–3 of this election form, please read the sections titled “Kaiser Foundation Health Plan Arbitration Agreement,” “Release of Information,” and “Conditions of Election” at the end of this form. Then sign and date page 3.
- Please keep the pink copy of this election form for your records. If required, send the bottom white copy to your employer group or trust fund. Return the top, signed white copy to:

**California Service Center
P.O. Box 232400
San Diego, CA 92193-2400**
- When we receive your election form, we will screen it for completeness and signatures and we will then acknowledge receipt by mail.
- We will notify Medicare that you have applied to join Kaiser Permanente Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we will confirm the effective date of your coverage.
- You may receive a Kaiser Permanente ID card and information for new members.

ELECTION FORM

Page 1 of 3 for applicant to complete

PLEASE COMPLETE THE INFORMATION BELOW

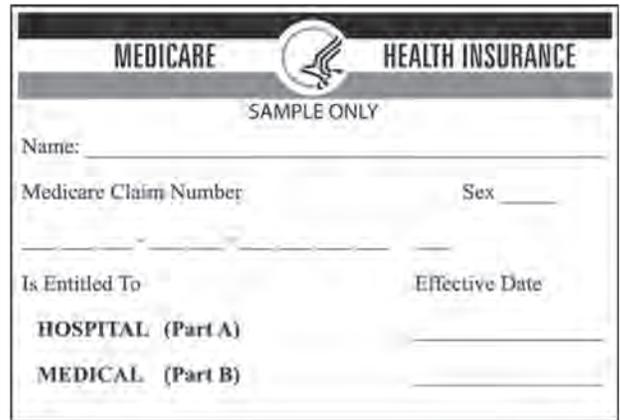
Last Name	First Name	Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Permanent residence street address (Street Address ONLY – No P.O. Box)			Apt. #
County	City	State	Zip
Mailing address (if different from permanent residence)			Apt. #
County	City	State	Zip
Daytime phone number	Evening phone number		Date of Birth
Social Security Number (SSN) – providing this information is optional		E-mail address – providing this information is optional	
Other contact: Name – providing this information is optional		Phone number	

MEDICARE HEALTH INSURANCE CARD INFORMATION

Please complete this sample Medicare Health Insurance card with the information found on your own Medicare card. Please copy each line exactly as it appears.

If you prefer, you may include a photocopy of your Medicare verification letter (Letter of Award from the Social Security Administration or Railroad Retirement Board) that provides the same information.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.



Employer group/trust fund name _____
Employer group ID # _____ Requested Effective Date _____

Last Name: _____ First Name: _____

ADDITIONAL INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? yes no
 If yes: Current Former Kaiser Permanente ID # _____

2. A) Do you currently have end-stage renal (kidney) disease? yes no
 B) Diagnosis date (MM/DD/YYYY) ____/____/_____
 C) Transplant date (MM/DD/YYYY) ____/____/_____

See the section titled "Important information about this election form" on the cover page for additional information about enrolling with ESRD.

3. Are you a resident in a long-term care facility, such as a nursing home? yes no
 If yes, please provide the following information:
 Date of admission (MM/DD/YYYY) ____/____/_____
 Name of Institution _____ Phone number _____
 Address _____ City _____ State ____ Zip _____

4. Are you enrolled in Medi-Cal (state-subsidized medical plan)? yes no
 If yes, please provide your Medi-Cal number _____

5. Do you or your spouse work? yes no

6. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs.
 Will you have other prescription drug coverage in addition to Kaiser Permanente Senior Advantage? yes no

If yes, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: _____

ID # for this coverage: _____ Group # for this coverage: _____

Last Name: _____ First Name: _____

**KAISER FOUNDATION HEALTH PLAN
ARBITRATION AGREEMENT**

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review

of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

RELEASE OF INFORMATION

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including any prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this election form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

Applicant Signature _____ Date _____

OR

Signature of authorized representative by law _____ Date _____

Authorized representative name _____ Relationship _____
(please print)

Address _____ Phone _____

Signature of any person who assisted in completing this form _____ Date _____

INTERNAL USE ONLY

Date Stamp _____ Language Preference _____ Rep's Name _____

Election type: ICEP AEP OEP OEPI OEPNEW SEP _____

CONDITIONS OF ELECTION

By completing this election form, I agree to the following:

1. I will read the Kaiser Permanente Senior Advantage *Evidence of Coverage* when I receive it to know which rules I must follow in order to receive coverage in this Medicare Advantage plan.
2. I understand that Kaiser Permanente Senior Advantage is a Medicare Advantage plan and I must maintain my enrollment in Medicare Part A and Part B insurance.
3. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
4. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
5. I understand that if I do not have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
6. I understand that I must enroll in the Kaiser Permanente Senior Advantage service area in which I reside. Further, I understand that it is my obligation to notify Kaiser Permanente if I permanently move or leave the service area for more than 6 months in a row.
7. Enrollment in this plan is generally for the entire year.
8. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day, 7 days a week.
9. I understand that starting on the effective date of my coverage, I must receive all of my medical care from Kaiser Permanente, except for emergency care, out-of-area urgent care, or dialysis care while temporarily outside the service area, or authorized referrals. Neither Medicare nor Kaiser Permanente will pay for doctor or hospital care received from non-Kaiser Permanente physicians/facilities (non-Plan providers), except for emergency care, out-of-area urgent care, or dialysis care while temporarily outside the service area, or authorized referrals.
10. Once I become a member of Kaiser Permanente Senior Advantage, I have the right to appeal plan decisions about payment or services.
11. If I am a Medicare Cost member enrolling in Senior Advantage, I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot re-enroll in the Medicare Cost plan.

RETURN FORM TO:

California Service Center
P.O. Box 232400
San Diego, CA 92193-2400



Health Net Seniority Plus Group Enrollment Form

Please keep the pink copy of this form as your temporary ID card.

Please return to: Health Net Enrollment Services, P.O. Box 10420, Van Nuys, CA 91410-0420

To enroll in Health Net Seniority Plus, please provide the following information:

Employer Name:		Group #:			
Last name	First name	Middle Initial	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Birth Date: (mm/dd/yyyy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (optional):		Home Phone Number: ()	
Permanent Residence Street Address:		Apt#:	City:	State:	ZIP
Mailing Address (only if different from above):		Apt#:	City:	State:	ZIP

Please provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare Card
- OR -
- Attach a copy of your Medicare Card or your letter from the Social Security Administration or Railroad Retirement Board

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

MEDICARE				HEALTH INSURANCE	
SAMPLE ONLY					
Name: _____					
Medicare Claim Number _____				Sex _____	

Is Entitled To			Effective Date		
HOSPITAL (Part A)			_____		
MEDICAL (Part B)			_____		

Provider Selection	Language Preference	Participating Physician Group (PPG)	Primary Care Physician (PCP) Name
	<input type="checkbox"/> English	_____	_____
	<input type="checkbox"/> Spanish	PPG ID# _____	PCP ID# _____
	<input type="checkbox"/> Other		

Please read and answer these important questions:
NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms

Are you the retiree? <input type="checkbox"/> Y <input type="checkbox"/> N	Are you covering a spouse or dependents under this employer plan? <input type="checkbox"/> Y <input type="checkbox"/> N
If yes, retirement date (mm/dd/yy): _____	If yes, name of spouse: _____
If no, name of retiree: _____	Name of dependents: _____

Do you or your spouse work? Y N

NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms

Do you receive Medicaid benefits? Y N If yes, please provide your Medicaid number: _____

Do you have End Stage Renal Disease (ERSD)? Y N
If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you do not need dialysis or have had a successful kidney transplant.

Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Health Net Seniority Plus? Y N
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:
Name of other coverage: _____ ID# for coverage: _____

Are you a resident in a long-term care facility, such as a nursing home? Y N
If "yes" please provide the following information:
Name of institution: _____
Address & Phone Number of institution: _____

Please Read the Reverse Side and Sign Below

Your Signature:	Today's Date:
If you are the authorized representative, you must provide the following information:	
Name:	Relationship to Enrollee:
Address:	Phone Number:

Office Use Only

Name of HN Rep (if assisted in enrollment):	ICEP/IEP:	Rep ID:
Group #:	AEP:	OEP:
Effective Date of Coverage:		SEP(type):

By completing this enrollment application, I agree to the following:

Health Net Seniority Plus is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Health Net Seniority Plus or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Health Net Seniority Plus serves a specific service area. If I move out of the area that Health Net Seniority Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net Seniority Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Seniority Plus when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Health Net Seniority Plus coverage begins, I must get all of my health care from Health Net Seniority Plus, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by Health Net Seniority Plus and other services contained in my Health Net Seniority Plus Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET SENIORITY PLUS WILL PAY FOR THE SERVICES.**

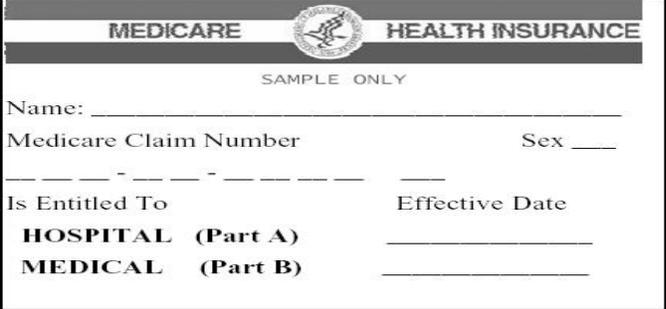
I understand that if I am injured through the actions of a third party and am entitled to a recovery from this injury, I will cooperate with Health Net Seniority Plus in obtaining recovery. I will reimburse Health Net Seniority Plus for provided services from the proceeds of any liability insurance settlement, no matter how the settlement is delineated (drafted or outlined).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Seniority Plus or by Medicare.



Health Net Group Enrollment Form Pearl Private Fee-For-Service Plan

Please return to: Health Net Enrollment, P.O. Box 870500, Surfside Beach, SC 29587-8711
Please keep the pink copy of this form as your temporary ID card.

To enroll in Health Net Pearl, please provide the following information:					
Employer Name:			Group #:		
Last name		First name		Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (mm/dd/yyyy)		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number (optional):		Home Phone Number: ()
Permanent Residence Street Address:			Apt#:	City:	State: ZIP
Mailing Address (only if different from above):			Apt#:	City:	State: ZIP
Please provide Your Medicare Insurance Information Please take out your Medicare Card to complete this section. <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare Card - OR - Attach a copy of your Medicare Card or your letter from the Social Security Administration or Railroad Retirement Board You must have Medicare Part A and Part B to join a Medicare Advantage plan.					
			Please read and answer these important questions: NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms		
Are you the retiree? <input type="checkbox"/> Y <input type="checkbox"/> N		Are you covering a spouse or dependents under this plan? <input type="checkbox"/> Y <input type="checkbox"/> N			
If yes, retirement date (mm/dd/yy):		If yes, name of spouse: _____			
If no, name of retiree:		Name of dependents: _____			
Do you or your spouse work? <input type="checkbox"/> Y <input type="checkbox"/> N					
Do you receive Medicaid benefits? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please provide your Medicaid number: _____					
Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare drug coverage since you became eligible to join a Medicare drug plan? <input type="checkbox"/> Y <input type="checkbox"/> N					
If no, you may have to pay a penalty. Health Net may ask you to provide evidence that some or all of your previous drug coverage was at least as good as Medicare drug coverage. If you have questions about the enrollment penalty, call Health Net at 1-800-596-6565, 8:00am-8:00pm, 7 days a week.					
Do you have End Stage Renal Disease (ERSD)? <input type="checkbox"/> Y <input type="checkbox"/> N					
If you answered "yes" to this question and you do not need regular dialysis anymore, or have had a successful kidney transplant, please attach a note or records from your doctor showing you do not need dialysis or have had a successful kidney transplant.					
Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, or State pharmaceutical assistance programs.					
Will you have other <u>prescription</u> drug coverage in addition to Health Net Pearl? <input type="checkbox"/> Y <input type="checkbox"/> N					
If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:					
Name of other coverage:			ID# for coverage:		
Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Y <input type="checkbox"/> N					
If "yes" please provide the following information:					
Name of institution: _____					
Address & Phone Number of institution: _____					
Name(s) of your current physician(s) or clinic(s): [optional]*					
Physician/Clinic Name		Specialty		City	
Phone Number					
*Providing this information will allow us to send educational materials to your physician(s)/clinic(s) about how your plan works.					
Please Read the Reverse Side and Sign Below					
Your Signature:			Today's Date:		
If you are the authorized representative, you must provide the following information:					
Name:			Relationship to Enrollee:		
Address:			Phone Number:		
Office Use Only					
Name of HN Rep (if assisted in enrollment):			ICEP/IEP:		Rep ID:
Group #:			AEP:		OEP:
Effective Date of Coverage:					SEP(type):

HEALTH NET PFFS ENROLLMENT FORM

FORMS

By completing this enrollment application, I agree to the following:

Health Net Pearl is a Medicare Advantage plan and I will need to keep my Parts A and B. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to Health Net Pearl or by calling 1-800-Medicare. TTY users should call 1-877-486-2048.

Health Net Pearl serves a specific service area. If I move out of the area that Health Net Pearl serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Health Net Pearl, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Pearl when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan.

I understand that beginning on the date Health Net Pearl coverage begins, I must get all of my health care from Health Net Pearl, with the exception of emergency or urgently needed services or out-of-area dialysis services. Medicare beneficiaries are generally not covered under Medicare while out of the county except for limited coverage in Canada and Mexico. Services authorized by Health Net Pearl and other services contained in my Health Net Pearl Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET PEARL WILL PAY FOR THE SERVICES.**

I understand that if I am injured through the actions of a third party and am entitled to a recovery from this injury, I will cooperate with Health Net Pearl in obtaining recovery. I will reimburse Health Net Pearl for provided services from the proceeds of any liability insurance settlement, no matter how the settlement is delineated (drafted or outlined).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Health Net Pearl or by Medicare.



**VEBA HEALTH SAVINGS PLAN
CLAIM FOR REIMBURSEMENT**

E-V011780

Employer Name: _____ Preferred Email Address: _____ Change in Email Address yes no
 Employee Name: _____ Employee Social Security #: _____ Change in Address yes no
 Employee Address: _____

UNREIMBURSED MEDICAL EXPENSE CLAIMS

A	B	C	D	E	F
Line	Date Expense Incurred (mo/day/yr.)	Expense Amount Claimed	Detailed Description of Expense	Person for Whom Expense Incurred (self, spouse, etc.)	Name of Service Provider
1		\$			
2		\$			
3		\$			
4		\$			
5		\$			
6		\$			
7		\$			
8		\$			
9		\$			
10		\$			
11		\$			
12		\$			
13		\$			
14		\$			
15		\$			
Total Medical Expense Claim		\$			

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered by the Employer's Plan with respect to such expenses and that the expenses have not been reimbursed, or are not reimbursable, from any other source. By signing this form, I certify that the expenses claimed for reimbursement or payment are eligible for reimbursement under the Plan, and were incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, and that if an expense for which payment or reimbursement is claimed is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes, including federal, state, or local income tax, on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ Date _____

- Attach a copy of bill, invoice or written statement, including the date of service, from a third-party supporting the request. NOTE: Provider Certification in box F may be furnished in place of a copy of a bill.
- Attach a copy of any explanation of benefit statement that shows the deductible, co-insurance or amounts not covered by medical/dental plan.

MAIL OR FAX CLAIM TO: Administration Resources Corporation, P. O. Box 548, Anoka, MN 55303-0548 • FAX (763) 772-1370 • PHONE (763) 772-1390 OR (866) 898-4371 •

PLAN CLAIM REIMBURSEMENT INFORMATION

Your VEBA Plan (the “Plan”) enables you to be reimbursed for certain health care expenses on a tax-free basis. Please see your plan summary for a description of the reimbursable items.

SUBMITTING CLAIMS

To claim benefits under the plan, complete the claim for reimbursement form, attach appropriate documentation of expenses and forward to Administration Resources Corporation, P.O. Box 548, Anoka, MN 55303-0548. **Claims may be faxed to ARC with documentation to the following fax number - (763) 772-1370.** Faxed claims that are received by ARC after 1:00 PM Central Time will be processed on the next business day. Whether you submit claims and documentation by mail or by fax, it is important that you make sure the documentation that you submit to ARC is legible. If ARC is unable to read any of the following items because of the quality of the copy or the fax, the claim will be denied and resubmission of legible documentation. The documentation must *clearly* identify -

1. the nature of the service
2. the date the service was incurred
3. the name of the provider
4. the amount of the expense.

You may use one line on the claim form to enter expenses which are identical in nature (i.e. office visit co-pays, RX co-pays, etc.) even if the expenses have been incurred on different dates. However, please make sure to attach documentation verifying each individual expense.

If your claim is denied, in part or in full, you can file an appeal. You can find the appeal procedure in your Summary Plan Description.

Unfortunately, because of IRS regulations, you *cannot* submit claims online at ARC’s website because your claims must be accompanied by independent, third party documentation. Therefore, you can only submit claims by mail or by fax.

MEDICAL EXPENSE CLAIMS

To be eligible for reimbursement under the Plan, you must provide proof that the expenses were **incurred**. You may attach a copy of an itemized statement from the provider, the amount of the expense(s) indicated reflects only the portion of the expense(s) for which you are responsible (i.e., the portion not paid by insurance or reimbursed in any other manner). A copy of your Explanation of Benefits (EOB) form, provided by an insurer or health plan, will also qualify as acceptable documentation. **Balance due bills, credit card receipts, cancelled checks, or payment receipts will not be sufficient documentation to support the expense.**

Expenses are only eligible if they are incurred while you are participating in the Plan. Expenses may be incurred by you, your spouse, or other individuals who qualify as eligible dependents under federal tax rules.

Examples of eligible expenses include co-payments, deductibles, unreimbursed medical, dental, and vision expenses, therapy you receive as medical treatment, prescription drug your plan allows, over-the-counter medication (e.g. aspirin, antacids, pain relievers, cold medication, allergy medicine), hearing aids, guide dogs, transplants, and therapy you receive for medical treatment.

To expedite claim processing, please identify each piece of documentation with the corresponding line number from the claim form. Sign and date the form and mail or fax it with your documentation. Forms that are not signed and dated will result in the denial of the claims. We suggest that you photocopy your form and documentation for your own records before submitting them.

CLAIMS REIMBURSEMENT PROCESS

Your requests for reimbursement will be processed monthly, as of the last day of each month (see the Reimbursement Schedule provided). Payments will be made on the 15th day of the following month. Reimbursement checks or Notices of Deposit (if you request automatic direct deposit to your checking or savings account) will be sent to your home address, so be sure to apprise ARC of any change in address.

Each time you receive a reimbursement check or Notice of Deposit from ARC, we will also send you a new Request for Reimbursement Form and pre-addressed envelope to use for your next claim. In addition, each check stub or Notice of Deposit Form will include complete information about the status of your account balance.

To access your account information, log on to www.arcbenefitaccess.com and click on the Participant Login button.

ARC101305VEBA

Questions & Answers

1 *My spouse (or domestic partner) works for the County and I am covered as a dependent under my spouse's (or domestic partner's) medical plan. Do I have to enroll in one of the retiree medical plans also?*

No. As a retiree, your participation in a retiree medical plan is completely voluntary. You may continue your coverage as a dependent under your spouse's (or domestic partner's) County coverage. If your spouse (or domestic partner) loses medical coverage under a County-sponsored medical plan because of a reduction in work hours, termination of employment, or retirement, you and your spouse (or domestic partner) might be eligible to continue group coverage through COBRA. Also, if your covered spouse (or domestic partner) retires, your spouse (or domestic partner) will have 31 days to elect coverage as a retiree. Your spouse (or domestic partner) may then enroll you as a covered dependent.



2 *If my spouse (or domestic partner) works for the County, may I enroll in a retiree medical plan and be a dependent on my spouse's (or domestic partner's) County medical plan?*

No. The retiree medical plans are administered by the County of San Bernardino. County employees, retirees and eligible dependents may not be covered by two County-sponsored medical plans at the same time.

3 *What portion of the cost of my medical coverage am I responsible for?*

You pay the full monthly insurance premium for medical and dental plan coverage.

4 *What should I do if the premium for my medical plan coverage is not being deducted or is incorrect?*

When you enroll in a medical plan or make changes to your coverage, you should check your retirement warrant carefully to verify that the proper deduction is being taken. If the deduction is not being taken or is incorrect, contact EBSD immediately and tell them about the discrepancy.

5 *May I switch medical plans when I retire?*

At the time of retirement, you may select the retiree plan of your choice. However, if you elect COBRA continuation coverage, you may not switch plans unless you move out of your plan's service area (see question 11). You may change to another medical plan ONLY during Open Enrollment.

6 *When may I add new eligible dependents to my coverage?*

You may enroll your eligible dependents (i.e., newborn, newly adopted child, new spouse, or stepchild) within 31 days of the date of birth, marriage, custody, etc. To enroll your eligible

dependents, you must submit a Medical Plan Enrollment/ Change Form (with any required attachments and verifications) within 31 calendar days. You may add dependents only during Open Enrollment unless you experience a qualifying event. New dependent coverage is effective the first day of the month following the event. Exceptions: newborns are covered on the date of their birth; children placed for adoption are covered on the date placed in the home.

7 *What happens to my dependents' health coverage if I die?*

Your eligible dependents may continue to participate in the retiree medical and/or dental plans.

8 *When does a dependent lose eligibility?*

Here are some examples of when a dependent loses eligibility (see the Dependent Eligibility section of this Guide):

- ◆ Your child is 19 or more years old and ceases to be a full-time student
- ◆ Your child marries
- ◆ Your child attains age 24 (exception: a disabled child)
- ◆ The final divorce decree or legal separation document is granted



◆ Termination or dissolution of a domestic partnership

Your former spouse must be deleted from your plan coverage even if the divorce settlement requires you to provide coverage. Your ex-spouse will be eligible for COBRA if you provide notice of your divorce within 60 days of the event date. See the COBRA section of this Guide.

9 *Do I have to notify anyone when a dependent becomes ineligible?*

Yes! You are responsible for notifying EBSD within 60 days of the date your dependent becomes ineligible. If you do not notify EBSD, you could be liable for any claims paid or services rendered on behalf of an ineligible dependent.

10 *If I am enrolled in a HMO, do I have to change medical plans if I move outside the service area of my current HMO?*

Yes. If you move outside the service area of your plan, you can be required to enroll in another County medical plan within 31 calendar days after the move or cancel your coverage. Until you change your enrollment, you will only be covered under the "Out-of-Area Emergency" provision of your current HMO for 90 days.

11 *What should I do if I become (or a dependent becomes) eligible for Medicare?*

Three months before your 65th birthday, or when a question of eligibility comes up, you should:

- ◆ Call the Social Security office regarding enrollment and Medicare insurance benefits
- ◆ Call EBSD for medical insurance options

12 *Who determines if I am eligible for Medicare?*

Eligibility is determined by the Social Security Administration. If you are not receiving monthly Social Security payments, apply for Medicare through your local Social Security office no later than three months before your 65th birthday. If you do not apply at that time, there could be a delay in your Medicare coverage and your retiree medical premium costs could be higher due to late enrollment penalty.

13 *How often are changes made to the medical and dental plans and monthly premium rates?*

Medical plan provisions and costs are subject to change each year or as determined by the terms of the contract between the County and the medical insurance carrier.

14 *Who may I call for additional information?*

See the Contact Information section of this booklet for telephone numbers and web site addresses.





County of San Bernardino - Human Resources Department - Employee Benefits & Services Division
157 West Fifth Street, First Floor, San Bernardino, CA 92415-0440

