2014 Retiree Benefits Guide

County of San Bernardino

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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. Comprehensive benefit information can be found in the applicable benefit plan contracts and corresponding Evidence of Coverage (EOC). 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. Open enrollment provides you an opportunity to evaluate your current medical and dental coverage needs and elect new benefit plan coverage that will best fit the needs for you and your dependents.

As you prepare to enroll or make changes to your coverage, consider all of 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.

What's New for 2014

Over-the-Counter Prescription Coverage

In accordance with guidelines issued by the Department of Health and Human Services (HHS), nongrandfathered plans (except for retiree-only plans) will have certain over-the-counter drugs and items covered at $0 cost sharing when prescribed by a plan physician. These include aspirin to reduce the risk of heart attack and stroke, oral fluoride for children to reduce the risk of tooth decay, folic acid for women to reduce the risk of birth defects, iron supplements for children to reduce the risk of anemia, and female contraceptives that don't require a prescription by law. This change is effective for all contracts, regardless of renewal date, on January 1, 2014.

Transgender Services

Due to regulatory developments in California, transgender services are now being covered. This change is effective immediately. Covered services include sexual reassignment surgery and mastectomy with chest reconstruction, in addition to mental health and hormone therapy services.

Important Information for New Blue Shield and Cigna HMO Plan Enrollees:

EBSD must receive enrollment forms from you indicating your choice of a primary care provider. If you do not select a primary care provider (and a medical group for medical plans), the carrier will select one for you based on your home address.

For Blue Shield provider information, you may visit their website at www.blueshieldca.com or call 800-642-6155 for non-Medicare plans or 800-776-4466 for Medicare plans. Information for Cigna Dental providers can be found at www.Cigna.com or by calling 800-238-5834.

Important Information for Medicare-Eligible Enrollees:

For those newly enrolling in a Medicare Plan, the Centers for Medicare and Medicaid Services (CMS) requires a signed enrollment form in order to process coverage under the plan. If a signed enrollment form is not received, you will not be enrolled in medical coverage through the County. Your next opportunity to enroll in County-sponsored coverage will be during the next Open Enrollment period in November 2015.

Open Enrollment for 2014 is November 1 through November 30, 2013.

2014 Retiree Medical and Dental Premium Rates

The rates listed below are the most frequently used rates. Rates are based upon retiree/dependent age and Medicare eligibility. If your specific status is not listed or if you are not sure what your rate will be, please call the Employee Benefits and Services Division (EBSD) at 909-387-5787. We will be happy to assist you!

How to calculate your total monthly medical premium if you have dependents:
If you have one or more dependents on your coverage, please make sure to add the "Retiree only" rate to the "1 Dependent" or "2 Dependents" rate, as applicable.

For example:
You are a retiree over 65, with Medicare A and B. You live in a Medicare service area, and you have one dependent, under 65, without Medicare. If you select Blue Shield as your carrier, your total monthly premium will be:

Retiree: Blue Shield 65 Plus - Retiree only, over 65, with Medicare A and B (High Option) . . $220.28

Dependent: Blue Shield Signature - 1 Dependent, under 65, no Medicare (High Option) . . .1,030.40

Total Monthly Premium $1,250.68

Monthly Medical Plan Rates

Effective January 1, 2014 Plan and Coverage Level	2014 Rate	
Blue Shield Signature (HMO)	**High**	**Low**
Retiree only, **under** 65, no Medicare	$900.95	$740.83
1 Dependent, under 65, no Medicare	$1,030.40	$846.35
2 Dependents, under 65, no Medicare	$1,747.52	$1,435.39
Retiree only, **over** 65, no Medicare	$900.95	n/a
1 Dependent, over 65, no Medicare	$1,030.40	n/a
2 Dependents, over 65, no Medicare	$2,060.80	n/a
Blue Shield 65 Plus (HMO) Medicare Advantage	**High**	**Low**
Retiree only, over 65, with Medicare A and B	$220.28	$91.70
1 Dependent, over 65, with Medicare A and B	$215.92	$87.34
2 Dependents, over 65, with Medicare A and B	$431.84	$174.68
Blue Shield PPO Medicare COB – California and Out of State	**High**	**Low**
Retiree only, over 65, with Medicare A and B	$659.95	n/a
1 Dependent, over 65, with Medicare A and B	$655.59	n/a
2 Dependents, over 65, with Medicare A and B	$1,311.18	n/a

Monthly Medical Plan Rates (continued)

Effective January 1, 2014 Plan and Coverage Level	2014 Rate	
Blue Shield PPO – California	**High**	**Low**
Retiree only, under 65, no Medicare	$1,431.72	$1,121.20
1 Dependent, under 65, no Medicare	$1,465.47	$1,146.65
2 Dependents, under 65, no Medicare	$3,050.80	$2,372.42
Blue Shield PPO – Out of State	**High**	**Low**
Retiree only, under 65, no Medicare	$1,431.72	$1,121.20
1 Dependent, under 65, no Medicare	$1,465.47	$1,146.65
2 Dependents, under 65, no Medicare	$3,050.80	$2,372.42
Kaiser Permanente (HMO)	**High**	**Low**
Retiree only, no Medicare	$875.09	$665.93
1 Dependent, no Medicare	$870.74	$661.57
2 Dependents, no Medicare	$1,593.46	$1,210.66
Retiree only, **over** 65, no Medicare	$1,240.17	$1,144.20
1 Dependent, over 65, no Medicare	$1,235.81	$1,139.84
2 Dependents, over 65, no Medicare	$2,471.62	$2,279.68
Kaiser Permanente Medicare Advantage	**High**	**Low**
Retiree only, over 65, with Medicare A and B	$229.06	$139.47
1 Dependent, over 65, with Medicare A and B	$224.70	$135.11

Monthly Dental Plan Rates

	Cigna Dental DPPO	Cigna Dental DHMO
Retiree only	$39.09	$18.78
Retiree + 1	$71.51	$28.93
Retiree + 2 or more	$122.53	$41.15

We encourage you to keep this Guide the entire year.

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 http://www.sbcounty.gov/hr/Benefits_Retire.aspx	1-909-387-9674
	COBRA	1-909-387-5552

Providers:

Cigna Dental Care (DHMO)	P.O. Box 188046, Chattanooga, TN 37422-8037 www.cigna.com	1-800-238-5834
Cigna Dental PPO	P.O. Box 188037, Chattanooga, TN 37422-8037 www.cigna.com	1-800-238-5834
Kaiser Permanente	Kaiser Permanente Foundation Health Plan. P.O. Box 7102, Pasadena, CA 91109 www.my.kp.org/ca/sbcounty	1-800-464-4000
Kaiser Permanente Medicare Advantage	Kaiser Permanente Advantage Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109 www.my.kp.org/ca/sbcounty	1-877-882-2687
Blue Shield Signature	P.O. Box 272540, Chico, CA 95927-2540 www.blueshieldca.com	1-800-642-6155
Blue Shield PPO and Non-Medicare	Blue Shield of California P.O. Box 272540, Chico, CA 95927-2540 www.blueshieldca.com	1-800-642-6155
Blue Shield 65 Plus (HMO)	Blue Shield 65 Plus (HMO) Member Services P.O. Box 927, Woodland Hills, CA 91365-9856	1-800-776-4466
ING	1200 California Street, Suite 108 Redlands, CA 92374 www.ingretirementplans.com/custom/sanbern	1-909-748-6468 1-800-584-6001
Genesis Employee Benefits, Inc. (Genesis)	P.O. Box 1578, Minneapolis, MN 55440-1578 www.GenesisBenefits.net	1-866-678-8322 1-866-450-1480 Fax

Helpful Resources and Referral Services:

American Association of Retired Persons	www.aarp.org	1-888-687-2277
American Heart Association	www.heart.org/HEARTORG/	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
State of California Health Care Exchange, Covered California	www.coveredca.com	1-800-300-1506
Health Insurance Counseling and Advocacy Program (HICAP)	www.aging.ca.gov/hicap	1-800-434-0222
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 color, denoted by "M") and non-Medicare eligible retirees (meetings listed in black, denoted by "NM"). Take advantage of this opportunity to discover your options. Insurance plan representatives will be at each meeting to answer your questions.

November 2013 Open Enrollment Meetings

Monday	Tuesday	Wednesday	Thursday	Friday
				1 **Start of Open Enrollment** **9:00-10:15 am NM** **10:30-11:45 am M** Government Center Board Chambers 385 N. Arrowhead Ave., San Bernardino
4 **1:30-2:45 pm NM** **3:00-4:15 pm M** TAD Forest Falls Conf. Room 32353 Yucaipa Blvd., Yucaipa	5	6 **9:00-10:15 am NM** **10:30-11:45 am M** TAD Oasis Room 15010 Palmdale Rd., Victorville	7 **5:30-6:45 pm NM** **7:00-8:15 pm M** Government Center Board Chambers 385 N. Arrowhead Ave., San Bernardino	8
11 Holiday EBSD Office Closed	12 **9:00-10:15 am NM** **10:30-11:45 am M** DAAS Haven Room 9445 Fairway View Place Suite 110, Rancho Cucamonga	13	14 **9:00-10:15 am NM** **10:30-11:45 am M** City of Hesperia Library Community Room 9650 Seventh Ave., Hesperia	15
18	19	20	21	22
25 **1:30-2:45 pm NM** **3:00-4:15 pm M** Government Center Board Chambers 385 N. Arrowhead Ave., San Bernardino	26	27	28 Holiday EBSD Office Closed	29 **End of Open Enrollment** **Deadline to submit all forms** Holiday EBSD Office Closed

January 1, 2014 is the 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 any part of the enrollment process, please call EBSD at 909-387-9674.

Eligibility

To participate in a County-sponsored retiree plan, you must be a San Bernardino County Employees' Retirement Association (SBCERA) retiree or eligible dependent. You or your eligible dependent pay the cost of coverage and your insurance premium is deducted from your monthly retirement benefit payment. If you do not receive a monthly payment as an eligible dependent, you will need to make timely payments directly to EBSD and your eligibility for benefits will be verified by EBSD.

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

- 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 and become eligible for Medicare;
- You are a SBCERA retiree, covered under your spouse or domestic partner's plan and you get divorced or you terminate the domestic partnership.

Note: It is very important that you contact our office within **60** days of the qualifying event date or you may lose the opportunity to enroll in a County-sponsored plan.

Please contact EBSD at 909-387-9674 if you are unsure of your eligibility status.

Dependent Eligibility

If you are participating in a County-sponsored plan, 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 (copy of the certificate of state registered domestic partnership or equivalent out-of-state certificate is required)
- Your children* who are:
  - Less than 26 years old and ineligible for other group health plan coverage
  - 26 or more years old, supported primarily by you and incapable of self-sustaining employment by reason of mental or physical disability. A Disabled Dependent Certification Form with proof of physical or mental condition from your health care provider 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.

Open Enrollment elections are effective January 1, 2014

* 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.

(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.)

Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates and relatives other than those listed above are **not eligible**. If you do not submit all necessary forms and supporting documentation 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.

Please Note: If you elect COBRA medical and/or dental coverage, you are eligible for a total of 36 months of coverage for your medical insurance under COBRA and Cal-COBRA. You are only eligible for 18 months of dental coverage under COBRA.

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

Non-Medicare Plans (choice of High and Low Options)

- Blue Shield Signature HMO
- Blue Shield PPO
  - California
  - Out of State
- Kaiser Permanente HMO

Medicare Coordination of Benefits Plans

- Blue Shield PPO Medicare Coordination of Benefits (COB)*
  - California
  - Out of State
- Kaiser Permanente HMO Medicare Coordination of Benefits (COB)*
  - California

*Please contact EBSD at 909-387-9674 for a summary.

Medicare Integrated Plans (choice of High and Low Options)

- Blue Shield 65 Plus (HMO)
- Kaiser Permanente Medicare Advantage

Dental Plans

- Cigna Dental Care HMO
- Cigna Dental PPO

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 all appropriate documentation such as a marriage or birth certificate, if applicable) to EBSD at 157 W. Fifth Street, First Floor, San Bernardino, CA 92415-0440 by November 30, 2013.

The following enrollment/change forms are contained in this Guide:

- Medical Plan Enrollment/Change Form
Required to enroll or make any changes.
- Dental Plan Enrollment/Change Form
Required to enroll or make any changes.
- Medical and/or Dental Plan Cancellation Form

- Disabled Dependent Certification Form
Required for dependents age 26 or older (attach to a Medical and/or Dental Plan Enrollment/Change Form along with medical verification of disability).
- Blue Shield 65 Plus (HMO) Group Enrollment Form
- Blue Shield Medicare Program Group Disenrollment Form
- Kaiser Senior Advantage Election Form
- Kaiser Senior Advantage Disenrollment Form
- RMT Health Savings Plan Claim for Reimbursement

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, First Floor, San Bernardino, CA 92415-0440.

The following cancellation forms are contained in this guide:

- Medical and/or Dental Plan Cancellation Form
- Blue Shield Medicare Program Group Disenrollment Form
- Kaiser Senior Advantage Disenrollment Form

Note: Requests to cancel a dental plan enrollment are subject to the two-year enrollment commitment provisions of those contracts. Please contact EBSD to see if you have met this minimum requirement prior to canceling your dental coverage.

Medical and Dental Plan ID Cards

Within 4 to 6 weeks of 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, 2014.

If you do not receive your ID card, or if you need a replacement card, call your plan's member services department (please see page 6 of this Guide for your plan's contact information). You may also request a replacement card online through the plan website.

Confirmation Statements

After Open Enrollment, you will receive a Confirmation Statement verifying your 2014 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.

Please be sure to review your confirmation statements carefully. Contact EBSD if there is a concern or question about your statement.

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.

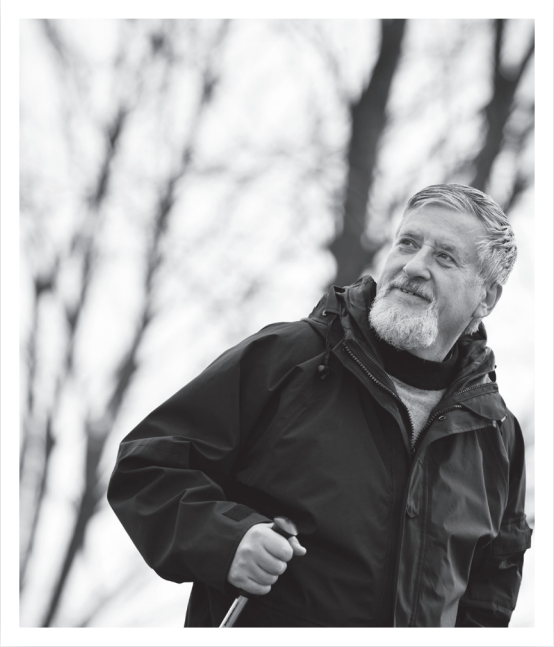
Mid-Year Changes

The enrollment options you elect during the 2014 Open Enrollment period will remain in effect for the entire plan year. You must wait until the next Open Enrollment period to make changes, except as defined in the notation below or UNLESS you experience a Change in Status Event as noted in the Change in Status Event Matrix on the following page.

Please note, as your premiums are paid on an after-tax basis, you may revoke your election and/or remove your dependents from your plan at any time, subject to the terms of the medical and dental plan contracts.

Your request to make a mid-year change must:

1. Be consistent with the qualifying event
2. Meet the guidelines of County contracts/ agreements
3. Be received by EBSD within 60 days of the qualifying event



Effective Date of Mid-Year Changes

All elections made during the plan year shall become effective the first day of the calendar month following the date that the properly completed Enrollment Forms and documentation are received by EBSD. You will be billed for any premiums owed as a result of the addition of eligible dependents. If the Change in Status Event results in a decrease in premiums, you will receive a refund for the premium overpayment. To reduce the time for a refund or to reduce the amount of premiums owed, you are encouraged to submit your paperwork as soon as possible.

Newborn and Adopted Children: Blue Shield/ Kaiser newborn children will be covered under the medical group the mother (parent) is assigned to, for the first 30 days for Blue Shield and 31 days, including the date of birth for Kaiser. Newly adopted children or child placed with you for adoption are eligible for coverage the first date in which you or your Spouse gain the legal right to control the child's health care. For children who are adopted at birth, the child will be covered for the first 31 days including the day of birth.

Retiree subscribers must still enroll the newborn under their respective plan through the County. Contact EBSD to complete the newborn enrollment.

Change in Status Event Matrix

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

Qualifying Change-in-Status Event	Medical/Dental	Documentation Required
Gain Dependent • Marriage • Domestic Partnership • Birth/Adoption/Placement for Adoption/Legal Guardianship	Retiree may enroll newly eligible dependent(s)	To enroll dependent in health benefits, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Enrollment/Change Form (and Medicare forms if applicable) • Domestic Partner Certificate and/or Birth Certificate(s) or Court Documentation
Lose Dependent • Divorce or annulment • Domestic Partnership Termination • Death	Retiree must remove spouse; may also enroll self and eligible dependent(s) if other group coverage is lost	To remove spouse or enroll self/dependent(s) in health benefits, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Enrollment/Change Form (and Medicare forms if applicable) • Divorce, legal separation, annulment, or Termination of Domestic Partnership decree • Death Certificate • Marriage/Birth Certificate(s)
Court Ordered Dependent Coverage Judgment, decree, or order resulting from divorce, annulment or change in legal custody that requires medical/dental coverage for your dependent child(ren)	Retiree may enroll dependent children	To enroll dependent(s) in health benefits, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Enrollment/Change Form (and Medicare forms if applicable) • Birth Certificate(s) • Court Documentation
Gain of Spouse's Employment or Other change in status that results in eligibility under spouse's plan	Retiree may cancel enrollment **Exception:** Dental plan benefits (retiree must maintain enrollment in dental plan for a period of 24 months)	To cancel enrollment from health benefits, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Cancellation Form (and Medicare forms if applicable)

Change in Status Event Matrix (continued)

Qualifying Change-in-Status Event	Medical/Dental	Documentation Required
Loss of Spouse's Employment	Retiree may enroll self if coverage is lost and may enroll eligible dependent(s)	To enroll self/dependent(s) in health coverage, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Enrollment/Change Form (and Medicare forms if applicable) (enrollment) • Proof of spouse's employment and benefit plan loss • Marriage/Birth Certificate(s)
Dependent Ceases to Satisfy Plan Eligibility Requirements (e.g. over age dependent)	Retiree must remove dependent	To remove dependent from health benefits, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Enrollment/Change Form
Removal of Dependent(s)	Retiree may remove dependent(s) anytime during plan year as premium is paid on after-tax basis	To remove dependent from health benefits, you must submit the following forms: • Retiree Medical and/or Dental Enrollment/Change Form (and Medicare forms if applicable)
Lose eligibility for Medicare or Medicaid	Retiree may cancel medical plan enrollment or enroll self and eligible dependents in non-Medicare plan	To cancel enrollment or enroll self and dependent(s) from health benefits you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Cancellation Form (Please note, dental cannot be cancelled for this event) • Retiree Medical and/or Dental Enrollment/Change Form • Proof of gain/loss of Medicare or Medicaid • Marriage/Birth Certificate(s)
Spouse/Domestic Partner's COBRA or Cal-COBRA coverage ends due to exhaustion of benefit	Retiree may enroll self and eligible dependent(s)	To enroll dependent in health benefits, you must submit the following forms (within 60 days of event): • Retiree Medical and/or Dental Enrollment/Change Form (and Medicare forms if applicable) • Marriage Certificate, State Registered Domestic Partner Certificate and/or Birth Certificate(s) • Proof of loss of COBRA coverage

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 of any of the following Qualifying Events:

- The death of the retiree or domestic partner. Dependents do have the option of remaining on County Coverage. If you experience this type of qualifying event, please contact EBSD for guidance.
- Divorce, legal separation or dissolution of domestic partnership.
- Retiree 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 of 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 medical 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).

Please note: Medicare eligibility/enrollment may affect your entitlement to COBRA coverage. Please contact EBSD if you have questions about how Medicare interacts with COBRA at 909-387-5552.

EBSD Appeals Procedure

General Information

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 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 eligible enrollee whose request 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 necessary supporting documentation. Within 15 calendar days of the date the appeal is received, EBSD will review the facts and respond in writing with its findings. Should special circumstances require an extension of time for a decision or review, the review period may be extended by an additional 15 days. EBSD will provide written notification if an extension is needed.

Retirement Medical Trust Fund

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

Eligibility

Eligibility for the RMT is determined by 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 in your name. The funds are automatically transferred to this account from the County of San Bernardino. You have the option to invest the funds in several different mutual funds.

Your account is maintained by ING, in partnership with Genesis Employee Benefits (Genesis). Genesis is a new partner to ING in the recordkeeping and administration of your RMT account. Genesis will maintain your RMT account and provide online and toll free access to your account while ING provides access to a menu of investment options

nearly identical to those found in the County's 457(b) Deferred Compensation plan.

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, toll free at 800-452-5842, or visit the ING custom webpage at www.ingretirementplans.com/custom/sanbern.

Access to the Funds

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

Genesis is the administrator designated by ING to disburse funds for qualifying expenses. RMT funds are used to reimburse a participant for qualifying health-related expenses not covered by an insurance plan. This includes medical/dental premiums and copays for prescriptions and doctor visits.

To receive reimbursement for eligible expenses, file a claim online at www.GenesisBenefits.net or complete a "Claim for Reimbursement" form and mail it together with verification of the expense to:

Genesis Employee Benefits, Inc.
P.O. Box 1578
Minneapolis, MN 55440-1578

A claim form is enclosed on page 97 of this book. Participants can access their account, see a list of qualifying expenses or obtain additional claim forms via the Genesis website at www.GenesisBenefits.net.

Health Club Membership Discounts

County retirees are eligible for a health club membership at a reduced rate at 24 Hour Fitness and L.A. Fitness. Eligible dependents may also be added to the retiree's membership at a reduced rate. Retirees who already have a non-County membership at 24 Hour Fitness or L.A. Fitness are eligible to have monthly dues reduced to the County's discounted rate.

New enrollees must show proof of retirement from the County of San Bernardino using their SBCERA retirement benefit payment, and current enrollees will use the same proof to reduce their current rate to the discounted County rate.

24 Hour Fitness

24 Hour Fitness offers members:

- ✓ Weight training
- ✓ Cardiovascular equipment
- ✓ Group exercise classes
- ✓ Kids' Club

	RETIREE ONLY	EACH ADDITIONAL MEMBER
Initiation and Processing Fee	$0	$0
Monthly Fee for One-Club Access	$23.00	N/A
Monthly Fee for All-Club Sport Access	$27.00	$24.99
Monthly Fee for All-Club Super Sport Access	$41.99	$39.99
Monthly Fee for Ultra Sport Access	$69.99	$59.99

Upon initial enrollment, retirees will be responsible for immediate payment of first and last month's dues, plus any add-on fees. Monthly dues are paid thereafter by

electronic funds transfer (EFT). Memberships may be canceled at any time with adequate notice as described in the retiree's 24 Hour Fitness membership agreement.

For more information, call 1-800-204-2400, email AMcLeod@24hourfit.com or contact any 24 Hour Fitness facility.

LA Fitness

LA Fitness provides members with the added benefit of knowing, regardless of which facility they use, that the features and amenities are identical. LA Fitness offers members:

- ✓ Indoor heated lap pool, whirlpool spa and saunas
- ✓ State-of-the-art equipment and cardio area
- ✓ Group fitness classes
- ✓ Kids' Klub (babysitting)
- ✓ And much more

	RETIREE ONLY	EACH ADDITIONAL MEMBER
Initiation and Processing Fee	$0	$0
Monthly Fee for One-Club Access	$29.99	$29.99

You must contact EBSD at 909-387-5787 or via email at mhm@hr.sbcounty.gov to receive a voucher number prior to enrolling at a LA Fitness facility.

Upon initial enrollment, retirees will be responsible for immediate payment of first and last month's dues, plus any add-on fees. Monthly dues are paid thereafter by EFT or credit card payment. Memberships may be canceled at any time, subject to the notice requirements described in the retiree's LA Fitness membership agreement.

For more information, call EBSD at 909-387-5787, or any LA Fitness facility.

Blue Shield Signature HMO

HMO Reliability + specialist self-referral convenience

Blue Shield Signature HMO for retirees is an HMO-style plan with the added benefit of allowing you to utilize a PPO level specialist (within the network, but outside your Medical Group) for examinations and evaluations. You choose between two tiers of benefits.

Level 1 (HMO) or Level 2 (PPO) – whenever you need care. It works like this:

◆ Designate your Primary Care Physician (PCP) and Medical Group from within the Shield Signature network. Each member of your family may choose a different PCP.

◆ Your PCP coordinates your care to include referrals to specialist within the Level 1 HMO benefit.

◆ 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 under the plan.

◆ Accessing Level 2 benefits - Seeing a specialist without a referral.

❍ Arrange office visits, consultation, evaluation and treatment – only procedures that can be performed in the doctor's office – for a single copayment.

❍ Your copayments will be slightly 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 are 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 Blue Shield as soon as possible.

Is Blue Shield Signature HMO Right For You?

Yes, if you want:

◆ The convenience of having your PCP coordinate services

◆ Predictable costs, with fixed copayments 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

◆ A wide range of covered services

blueshieldca.com

Blue Shield provides a convenient way to access your benefits and plan information. Some of the many tools available at your fingertips include:

◆ Detailed benefit plan information
◆ Online Health Risk Questionnaire
◆ Self-help programs
◆ Mental health support
◆ Health and fitness
◆ Discounts

How to Get in Touch with Blue Shield

If you need information, call Blue Shield at 1-800-642-6155, or go to Blue Shield's website at www.blueshieldca.com.

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. If you would like to determine if your zip code* is eligible for enrollment or if you would like a Kaiser Permanente Member Handbook, please call EBSD at 909-387-5787.

*Some zip codes outside of California are eligible for the County's Kaiser Permanente HMO plan. Please call EBSD at 909-387-5787 to determine if your zip code outside California is eligible.

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 contracted 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. You can access the Kaiser HMO EOC, High and Low option, on the County website at http://www.sbcounty.gov/hr/Benefits_Retire.aspx

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.

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.

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart on pages 28-55 of 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 at 909-387-5787 for the plan's informational packet.

Helpful Information for New Members – Non Medicare

If you make the decision to enroll in a Kaiser non-Medicare plan, please know that there is a New Member Entry Department that can help you:

- Find a Kaiser Permanente facility near you
- Choose your new doctor
- Transfer your prescriptions
- Schedule your first visit
- Learn about programs and resources to keep you healthy

For Southern California members, contact the New Member Entry Department, toll free, Monday through Friday from 7 a.m. to 7 p.m. at 888-956-1616.

If you are receiving care for a serious health issue, such as an acute condition, pending surgery or advanced pregnancy, you may be eligible for Kaiser's Continuity of Care program. This program can allow you to continue getting care from your current doctor or hospital. New members must meet certain criteria to qualify for Continuity of Care. As a new member, to apply for Continuity of Care, please call 1-800-464-4000, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m.

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.my.kp.org/ca/sbcounty.

Blue Shield PPO

If freedom of choice is what you want, then the Blue Shield PPO is the plan for you. You can go to any doctor or hospital in the Blue Shield PPO network or you can choose to see a provider not in the Blue Shield PPO network – it's your choice!

In general the Blue Shield PPO network 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: The copayment/coinsurance is higher when you go out of network, which means you'll pay more out of pocket.
  - Charges that exceed allowances for covered services

PLAN SUMMARIES

Some services may be covered only when you receive them from in-network physicians and facilities. For a complete list of limitations please consult the applicable benefit plan contracts and the corresponding Evidence of Coverage.

In an emergency, go to the closest emergency facility. If you're admitted, have someone call Blue Shield as soon as possible. Emergency care is available worldwide.

Is the Blue Shield PPO Right For You?

Yes, if you want:

- Freedom of choice
- Control over how much you spend – your costs are lower when you use our network
- Broad network access throughout California and Nationwide
- Time savings convenience – no claim forms to file when you use network services

blueshieldca.com

Blue Shield provides a convenient way to access your benefits and plan information. Some of the many tools available at your fingertips include:

- Detailed benefit plan information
- 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 Blue Shield contract documents, the contract documents will prevail.

How to Get in Touch with Blue Shield

If you need Non-Medicare Plan information, call Blue Shield at 1-800-642-6155, or go to Blue Shield's website at www.blueshieldca.com.

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

Blue Shield PPO Medicare Coordination of Benefits (COB) Plan

What is a Medicare COB PPO Insurance Plan?

The Blue Shield PPO Medicare COB insurance plan is offered to Medicare-eligible retirees. The PPO Medicare COB insurance plan works just like a traditional PPO insurance plan, but coordinates the cost of care with Medicare as the primary payer.

How does the plan work?

The Blue Shield PPO Medicare COB insurance plan gives you coverage beyond Original Medicare, and a greater level of choice. You may seek care from any provider in the United States but pay less out of pocket costs when you use a Blue Shield PPO Medicare COB in-network or contracted provider.

Is Medicare or Blue Shield the primary payer for plan benefits?

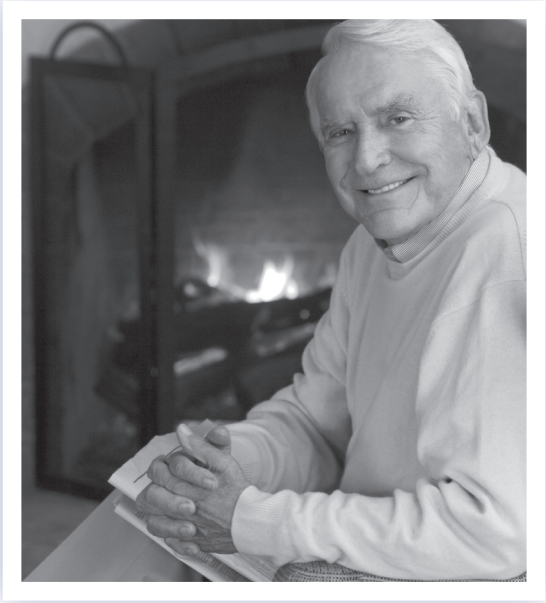
Under the Blue Shield PPO Medicare COB plan, Medicare is the primary plan and Blue Shield is the secondary plan. Here's how it works:

◆ Your provider submits claims to the Medicare intermediary for determination and payment of allowable amounts.

◆ The Medicare intermediary then sends a Medicare Summary Notice to the provider of service, who will then submit a claim to Blue Shield. Blue Shield is responsible for paying the difference between the amount Medicare paid and the Blue Shield allowed amount for the covered service. You will receive a copy of the Medicare Summary Notice showing a summary of benefits paid on your behalf by Medicare. Some secondary claims are sent electronically to Blue Shield by Medicare and do not require that the provider of service submit a claim.

How do I know if I'm eligible for Medicare Coordination of Benefits?

You are eligible if you are enrolled in both Medicare Part A and Part B and continue to pay the Medicare Part B premium. If either you or your spouse is over the age of 65 and actively employed, neither of you are eligible for the PPO Medicare COB Plan. Contact the County for COB plan details.



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

2014 Certificate of Creditable Medicare Prescription Drug Coverage

The County of San Bernardino has determined that the prescription drug coverage it provides to Medicare-eligible retirees is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you have any questions about this benefit, please call EBSD at 909-387-5787, 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 should any County plan ever lose creditable coverage status.

Medicare Integrated Plans — Important Information

A Medicare integrated plan combines your Medicare coverage with the benefits of an insured medical Plan. All County integrated plans incorporate 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. You must pay the Medicare Part B premium. 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 of 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 more affordable 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 four County-sponsored Medicare integrated plans available to you:

- Kaiser Medicare Advantage (High and Low)
- Blue Shield 65 Plus (HMO) (High and Low)

Conditions

- You must receive all of your care from your medical plan except for emergency care, 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 benefit 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 909-387-5787. Please note that disenrollments from County-sponsored plans and enrollments in other plans may be delayed due to the Center for Medicare & Medicaid Services (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 https://www.aging.ca.gov/hicap/

Blue Shield 65 Plus (HMO)

Blue Shield understands some of your most important concerns about your medications, your doctor, and the cost of coverage. With Blue Shield 65 Plus (HMO) there is no need to worry – It's all taken care of!

Blue Shield 65 Plus (HMO):

◆ Helps you maintain a close relationship with your doctor: With a large network of physicians and hospitals, chances are your doctor is in the Blue Shield 65 Plus (HMO) network, you won't have to worry about finding a new doctor to learn about you and your conditions.

◆ Provides services tailored to Medicare beneficiaries: Blue Shield 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: Blue Shield offers a vast network of contracted physicians, hospitals, pharmacies and medical professionals to give you access to the best possible care.

Is Blue Shield 65 Plus (HMO) Right For You?

With Blue Shield 65 Plus (HMO), you will have access to:

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

Network You can find a doctor online using the "Find a Provider" tool, order a new ID card, change your doctor, and much more.

This information is available to you online 24 hours a day, seven days a week.

Features A user friendly Medicare plan that offers:

- Integrated medical and prescription 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 with Medicare

Blue Shield 65 Plus (HMO) Benefits

Blue Shield 65 Plus (HMO) is a great benefit package which includes access to free Health Club Membership, 30 free trips to your doctor, and much more.

SilverSneakers

SilverSneakers is a program provided free of charge to Blue Shield 65 Plus (HMO) enrollees that includes:

◆ Members have access to more than 10,000 participating locations across the country, including 24 Hour Fitness, Bally Total Fitness®, YMCAs and many others. Women-only locations, including Curves®, are also available nationwide.

◆ SilverSneakers is available online at www.silversneakers.com where members have a comprehensive, easy-to-use wellness resource in the member pages.

◆ SilverSneakers Steps is a personalized fitness program that fits the lifestyle of members who don't have convenient access to a SilverSneakers location (a location is 15 miles or more from their home). Steps members receive a kit with the wellness tools they need to get fit.

Please contact Blue Shield 65 Plus at 800-776-4466 [TTY 800-794-1099], 7 a.m. to 8 p.m., seven days a week.

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.

Explore Kaiser Permanente on kp.org

◆ Check out our featured health topics for tips on healthy aging.

◆ Meet our doctors using 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.

Helpful Information for New Members – Medicare

If you make the decision to enroll in a Kaiser non-Medicare plan, please know that there is a New Member Entry Department that can help you:

- Find a Kaiser Permanente facility near you
- Choose your new doctor
- Transfer your prescriptions
- Schedule your first visit
- Learn about programs and resources to keep you healthy

For Southern California members, contact the New Member Entry Department, toll free, Monday through Friday from 7 a.m. to 7 p.m. at 1-800-443-0815.

If you are receiving care for a serious health issue, such as an acute condition, pending surgery or advanced pregnancy, you may be eligible for Kaiser's Continuity of Care program. This program can allow you to continue getting care from your current doctor or hospital. New members must meet certain criteria to qualify for Continuity of Care. As a new member, to apply for Continuity of Care, please call 1-800-464-4000, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m.

Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Allergy Testing	$10 copay	$30 copay	No charge	$80 copay
Ambulance	No charge if medically necessary	Refer to Level 1 benefit	$300 per transport	Refer to Level 1 benefit
Chiropractic	Not covered	Not covered	Not covered	Not covered
Choice of Providers	Signature Level I HMO Plan Providers	Signature Level II Preferred Providers	Signature Level I HMO Plan Providers	Signature Level II Preferred Providers
Deductibles: Calendar Year	None	None	None	None
Hospital/Ambulatory Surgical	None	None	None	None
Non-Certification	All services require prior authorization and/or referral by your Personal Physician or the same IPA/Medical Group as the Personal Physician HMO		All services require prior authorization and/or referral by your Personal Physician or the same IPA/Medical Group as the Personal Physician HMO	

CY = Calendar Year OON = Out-of-Network

COMPARISON CHART

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.

KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$20 copay	20% coinsurance–CY ded waived	40% coinsurance after CY ded Allergy Testing & Allergy Serum	30% coinsurance Allergy Testing & Allergy Serum Deductible waived for testing & serum	50% coinsurance Allergy Testing & Allergy Serum
No charge if medically necessary	$150 per trip after deductible	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance
Not covered	Not covered	20% coinsurance	40% up to 30 visits per CY, preferred and non-pref providers combined.	$25 copay per visit	50% coinsurance
Kaiser Permanente Providers only	Kaiser Permanente Providers only	Preferred Providers Out of state - Blue Card	Non Preferred Providers	Preferred Providers Out of state - Blue Card	Non Preferred Providers
None	$500 per member/$1,000 per family	$500 per member/$1,000 per family, combined In-Network & Out-of-Network		$1,500 per member/No Family Maximum, combined In-Network & Out-of-Network	
None	Deductible applies	$250 per admission copay semiprivate room or ICU	40% coinsurance	$500 per admission copay semiprivate room or ICU	50% coinsurance Outpatient & Inpatient hospital/ Ambulatory Surgical Center
None	None	Preauthorization required for selected inpatient admissions and outpatient services. Additional $250 may be required in addition to CY deductible to inpatient hospital charges for failure to follow Blue Shield Benefits Management Program. Failure to obtain preauthorization may result in denial of payment for services		Preauthorization required for selected inpatient admissions and outpatient services. Additional $250 may be required in addition to CY deductible to inpatient hospital charges for failure to follow Blue Shield Benefits Management Program. Failure to obtain preauthorization may result in denial of payment for services	

CY = Calendar Year OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Diagnostic X-Ray/Lab	No charge	No charge in Physician's Office only. Not covered: MRI, MUGA, PET, SPECT	No charge	No charge in Physician's Office only. Not covered: MRI, MUGA, PET, SPECT
Durable Medical Equipment	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit
Emergency Room	$50 copay for facility; $0 for Professional Services Copay waived if admitted	Refer to Level 1 benefit	$250 copay for facility; $0 for Professional Services Copay waived if admitted	$250 copay for facility; $0 for Professional Services Copay waived if admitted
Family planning:				
Infertility Services	50% copay Applies to professional services; inpatient and outpatient care, treatment by injection and prescription drugs. Excludes GIFT, ZIFT, IVF	Refer to Level 1 benefit	Not covered - Applies to professional services, inpatient and outpatient care, treatment by injection & prescription drugs	Not covered - Applies to professional services, inpatient and outpatient care, treatment by injection & prescription drugs
Tubal Ligation	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit
Vasectomy	$10 copay	Refer to Level 1 benefit	$50 copay	Refer to Level 1 benefit

CY = Calendar Year OON = Out-of-Network

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.

KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge	$10 per encounter ($50 per MRI, CT, PET after deductible)	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge	20% coinsurance No deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$50 copay Waived if admitted	20% coinsurance after deductible	Facility: $100/visit + 20% Professional svcs - no charge. Covered the same PPO/OON if not admitted, if admitted follows PPO inpatient hospital benefits		Facility: $100/visit + 30% Applies to both Facility & Professional Services. Waived if admitted	
50% coinsurance (excludes GIFT, ZIFT, and IVF)	50% coinsurance (excludes GIFT, ZIFT, and IVF)	Not covered	Not covered	Not covered	Not covered
$10 copay for consultation $10 copay for procedure	$20 copay consultation 20% coinsurance, after deductible for procedure	No charge Not subject to CY deductible	40% coinsurance	No charge Not subject to CY deductible	50% coinsurance
$10 copay for consultation $10 copay for procedure	$20 copay consultation 20% coinsurance, after deductible for procedure	30% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance

CY = Calendar Year OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Home Health Services	No charge. Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits/day, 2 hrs/visit (8 hrs total) up to 100 visits per CY	Refer to Level 1 benefit	$50 copay Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits per day, 2 hours per visit (8 hours total) up to the visit limit per calendar year	Refer to Level 1 benefit
Hospice	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit
Hospital (Facility)	No charge	Refer to Level 1 benefit	Inpatient Hospital: $1,000 per admission	Refer to Level 1 benefit
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Maternity Care	1st Visit $10, No charge after initial visit	Refer to Level 1 benefit	$50 copay per visit	Refer to Level 1 benefit

CY = Calendar Year OON = Out-of-Network

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.

KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge if medically necessary Limit of 100 visits per CY	No charge if medically necessary Limit of 100 visits per CY	20% coinsurance	Must be preauthorized. When these services are preauthorized, In-Network copayment is applicable	30% coinsurance	Must be preauthorized. When these services are preauthorized, In-Network copayment is applicable
No charge	No charge, no deductible	24-hour continuous home care: 20% coinsurance General respite care: 20% coinsurance Routine home care: No charge In-patient respite care: No charge	Must be preauthorized. When these services are preauthorized, In-Network copayment is applicable	24-hour continuous home care: 30% coinsurance General respite care: 30% coinsurance Routine home care: No charge In-patient respite care: No charge	Must be preauthorized. When these services are preauthorized, In-Network copayment is applicable
No charge	20% coinsurance after deductible	$250 hospital deductible per confinement + 20%	40% coinsurance	$500 hospital deductible per confinement + 20% coinsurance	50% coinsurance
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
After confirmed pregnancy, no charge per prenatal visit and initial post partum visit	After confirmed pregnancy, no charge per prenatal visit and initial post partum visit	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance

CY = Calendar Year OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Mental Health Non-Severe Mental Disorders - Inpatient	No charge	Refer to Level 1 benefit	$1,000 copay per confinement	Refer to Level 1 benefit
Non-Severe Mental Disorders - Outpatient	$10 copay	Refer to Level 1 benefit	$30 copay per visit	Refer to Level 1 benefit
Severe Mental Disorders - Inpatient	No charge	Refer to Level 1 benefit	$1,000 copay per confinement	Refer to Level 1 benefit
Severe Mental Disorders - Outpatient	$10 copay	Refer to Level 1 benefit	$30 copay per visit	Refer to Level 1 benefit
Out-of-Pocket Maximum	$1,500 per Member $3,000 per Family	None	$3,000 Per Member $6,000 Two Members $9,000 Three or more Members	None
Outpatient Services Chemotherapy (Professional)	No charge	Refer to Level 1 benefit	No charge (Professional Services Only)	Refer to Level 1 benefit
Renal Dialysis (Professional)	No charge	Refer to Level 1 benefit	No charge (Professional Services Only)	Refer to Level 1 benefit
Outpatient Surgery (Facility)	No charge	Refer to Level 1 benefit	$750 copay per surgery performed at outpatient hospital facility or ambulatory surgical center. $50 copay when performed in PCP office visit	Refer to Level 1 benefit

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COMPARISON CHART

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KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge	20% coinsurance after deductible	$250 hospital deductible per confinement + 20% coinsurance	40% coinsurance	$500 hospital deductible per confinement + 20% coinsurance	50% coinsurance
$10 copay for individual; $5 copay group unlimited visits	$20 copay individual; $10 copay group; no deductible unlimited visits	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge Unlimited Days	20% coinsurance after deductible	$250 hospital deductible per confinement + 20% coinsurance	40% coinsurance	$500 hospital deductible per confinement + 20% coinsurance	50% coinsurance
$10 copay Unlimited Visits	$20 copay Unlimited Visits	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$1,500 per Member $3,000 per Family	$3,000 per Member $6,000 per Family	$2,500 per Member PPO $5,000 per Family PPO	$5,000 each member OON $10,000 family OON	$6,000 each member PPO No Family Maximum	$10,000 per member
No charge	No charge	20% Professional Services	40% Professional Services	30% Professional Services	50% Professional Services
$10 copay	$20 copay	20% Professional Services	40% Professional Services	30% Professional Services	50% coinsurance
$10 copay	20% coinsurance after deductible	$250 deductible + 20% coinsurance	40% coinsurance	Ambulatory Surgery: 20% coinsurance Outpatient Hospital: $250 per surgery + 20% coinsurance	50% coinsurance

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Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Physician Services Hearing Screening	$0 copay (preventive care)	$30 copay	$0 copay (preventive care)	$80 copay
Home Visits	$10 copay	Refer to Level 1 benefit	$50 copay	Refer to Level 1 benefit
Hospital Services	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit
Immunizations	Immunizations: $0 copay - part of preventive care office visit; Other: $10 copay per prescription. Infertility injections 50% of allowed charges.	$30 copay. Injections for Infertility Not covered	No charge (Infertility Injections are not covered)	$80 copay - Applies to allergy testing; office based Injectable meds per dose $0 copay - applies to allergy serum; allergy injection svcs; immunizations for occupational or foreign travel and other immunizations; Infertility injections are not covered Self Injectables are only covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency. See Pharmacy benefits.

CY = Calendar Year OON = Out-of-Network

COMPARISON CHART

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.

KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$20 copay	No charge	40%	No charge	50% coinsurance
No charge	No charge No deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge	No charge	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge Includes allergy serum and injection services during office visits	No charge Includes allergy serum and injection services during office visits No deductible	Covered under Preventative Care; Injections covered at 20% coinsurance; Immunizations for Foreign Travel are not covered. Self Injectables are only covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. See Pharmacy benefits.	Covered under Preventative Care; Injections covered at 40% coinsurance; Immunizations for Foreign Travel are not covered. Self Injectables are only covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency. See Pharmacy benefits.	Covered under Preventative Care; Injections covered at 20% coinsurance; Immunizations for Foreign Travel are not covered. Self Injectables are only covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. See Pharmacy benefits.	Covered under Preventative Care; Injections covered at 40% coinsurance; Immunizations for Foreign Travel are not covered. Self Injectables are only covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. See Pharmacy benefits.

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Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Office Visits	$10 copay	$30 copay	$50 copay	$80 copay
Preventive Care	No charge	$30 copay	$0 copayment (preventive care)	$80 copay
Routine Physicals	No charge	$30 copay	$0 copayment (preventive care)	$80 copay
Specialists	$10 copay	$30 copay	$70 copay	$80 copay
Surgical Services (Physician's Office)	No charge	No charge	No charge	No charge
Well Baby/Well Child	No charge	$30 copay	$0 copay (preventive care)	$80 copay
Well Woman Exam (Annual)	No charge	$30 copay	$0 copay (preventive care)	$80 copay
Physical and Occupational Therapy	$10 per visit applies to physical, speech, occupational and respiratory therapy when performed in an outpatient or office visit setting.	$30 copay; up to 12 visits per CY year when Medically Necessary	$40 per visit applies to physical, speech, occupational and respiratory therapy when performed in an outpatient or office visit setting.	$80 copay; up to 12 visits per CY office visit only when Medically necessary
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 Drug - Retail	Up to 30-day supply	Refer to Level 1 benefit	Up to 30-day supply	Refer to Level 1 benefit
Generic	$5 copay	Refer to Level 1 benefit	$10 copay	Refer to Level 1 benefit
Brand Formulary	$10 copay	Refer to Level 1 benefit	$30 copay	Refer to Level 1 benefit

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KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$20 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge	No charge	No charge	40% coinsurance	No charge	50% coinsurance
$10 copay	$20 copay	No charge	40% coinsurance	No charge	50% coinsurance
$10 copay	$20 copay	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$10 copay	20% coinsurance after deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge (0-23 months)	No charge (0-23 months)	No charge	40% coinsurance	No charge	50% coinsurance
No charge	No charge	No charge	40% coinsurance	No charge	50% coinsurance
$10 copay	$20 copay after deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
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	No exclusion for pre-existing conditions
Up to 100-day supply	Up to 100-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply	Up to 30-day supply
$10 copay	$10 copay No deductible	$10 copay	25% + $10 copay	$10 copay	25% + $10 copay
$15 copay	$30 copay after $100 deductible	$25 copay	25% + $25 copay	$25 copay	25% + $25 copay

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Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Non-Formulary	$25 copay	Refer to Level 1 benefit	$50 copay	Refer to Level 1 benefit
Lancets	No charge	Refer to Level 1 benefit	$0 copay	Refer to Level 1 benefit
Specialty Drugs	Blue Shield's formulary applies. Specialty drugs are covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency.			
	30 days supply applicable retail copay applies	Refer to Level 1 benefit	30 days supply applicable retail copay applies	Refer to Level 1 benefit
Prescription Drug - Mail Order	Up to 90-day supply	Refer to Level 1 benefit	Up to 90-day supply	Refer to Level 1 benefit
Generic	$10 copay	Refer to Level 1 benefit	$20 copay	Refer to Level 1 benefit
Brand Formulary	$20 copay	Refer to Level 1 benefit	$60 copay	Refer to Level 1 benefit
Non-Formulary	$50 copay	Refer to Level 1 benefit	$100 copay	Refer to Level 1 benefit

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KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$15 copay when prescribed by a Plan physician in accordance with formulary guidelines	$30 copay when prescribed by a Plan physician in accordance with formulary guidelines	$35 copay	25% + $35 copay	$35 copay	25% + $35 copay
No charge	No charge	Applicable tier copay	25% + applicable tier copay	Applicable tier copay	25% + applicable tier copay
See applicable prescription drug copay	See applicable prescription drug copay	Blue Shield's formulary applies. Specialty drugs are covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency.			
		30 days supply applicable retail copay applies	Not covered (refer to PPO benefits)	30 days supply applicable retail copay applies	Not covered (refer to PPO benefits)
Up to 100-day supply	Up to 100-day supply	Up to 90-day supply	Up to 90-day supply	Up to 90-day supply	Up to 90-day supply
$10 copay	$10 copay No deductible	$20 copay	Not covered	$20 copay	Not covered
$15 copay	$30 copay after $100 deductible	$50 copay	Not covered	$50 copay	Not covered
$15 copay when prescribed by a Plan physician in accordance with formulary guidelines	$30 copay when prescribed by a Plan physician in accordance with formulary guidelines	$70 copay	Not covered	$70 copay	Not covered

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Medical Plans Comparison Chart (Non Medicare Eligible)

	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Skilled Nursing Facility	No charge	Refer to Level 1 benefit	$1,000 per confinement Limited to 100 days per CY	Refer to Level 1 benefit
Speech Therapy	$10 per visit copayment for office setting. When medically necessary. Inpatient and outpatient services : No charge	$30 per visit copayment for office setting. Inpatient and outpatient services : Refer to Level 1	$40 per visit copayment for office setting. When medically necessary. Inpatient and outpatient services : No charge	$80 copay Up to 12 visits per CY when medically necessary. Office Visit Only.
Substance Abuse Rehab - Inpatient	No charge	Refer to Level 1 benefit	$1,000 per confinement	Refer to Level 1 benefit
Rehab - Outpatient	$10 copay	Refer to Level 1 benefit	$30 copay	Refer to Level 1 benefit

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KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge up to 100 days per benefit period	20% coinsurance after deductible up to 100 days per benefit period	Freestanding Nursing Facility: 20% coinsurance Hospital Unit Skilled Nursing: 20% coinsurance Limit of 100 days per CY combined In & Out of Network	Freestanding Facility: 20% coinsurance w/ prior authorization Hospital Unit Skilled Nursing: 40% Limit of 100 days per CY combined on In & Out of Network	Freestanding Nursing Facility: 20% coinsurance Hospital Unit Skilled Nursing: 20% coinsurance Limit of 100 days per CY combined In & Out of Network	Freestanding Facility: 20% coinsurance w/ prior authorization Hospital Unit Skilled Nursing: 50% Limit of 100 days per CY combined on In & Out of Network
$10 copay	$20 copay after deductible	20% coinsurance	Speech Therapy provided by a speech therapist will be 20% coinsurance (same as in-network) Speech therapy by any other provider than a speech therapist 40% coinsurance	30% coinsurance	Speech Therapy provided by a speech therapist will be 30% coinsurance (same as in-network) Speech therapy by any other provider than a speech therapist 50% coinsurance
No charge Transitional residential recovery service, unlimited days	20% coinsurance after deductible $100 copay per admit for Transitional Residential Recovery Service, unlimited days	$250 per admission + 20% coinsurance	40% coinsurance	$500 per admission + 20% coinsurance	50% coinsurance
$10 copay individual $5 copay group	$20 copay individual; $5 copay group no deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance

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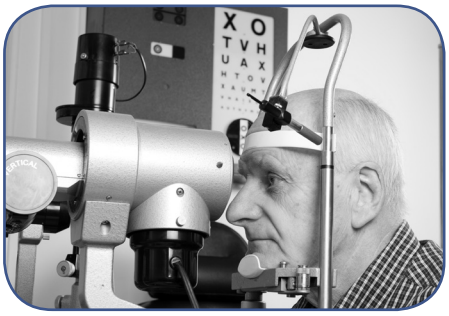
Medical Plans Comparison Chart (Non Medicare Eligible)



	BLUE SHIELD SIGNATURE			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
Detox - Inpatient	No charge	Refer to Level 1 benefit	$1,000 per confinement	Refer to Level 1 benefit
Detox - Outpatient (consultation, therapy, counseling)	See Outpatient Substance Abuse	See Outpatient Substance Abuse	$30 copay	Refer to Level 1 benefit
Urgent Care (Facility)	$10 copay	$10 copay	$10 copay	Refer to Level 1 benefit
Vision Exams	$10 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	Reimbursed at rate of $50 for ophthalmologic and $60 for optometric exam (one visit [no age limit] every 12 months).	$50 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	Reimbursed at rate of $50 for ophthalmologic and $60 for optometric exam (one visit [no age limit] every 12 months).

Notes

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KAISER PERMANENTE		BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge	20% coinsurance after deductible	$250 per admission + 20% coinsurance	40% coinsurance	$500 per admission + 20% coinsurance	50% coinsurance
$10 copay individual $5 copay group	$20 copay individual; $5 copay group no deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$10 copay	$20 copay	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.
$10 copay	$20 copay	20% coinsurance per visit for services provided by contracted Vision provider (one visit [no age limit] every 12 months)	Reimbursed at rate of $50 for ophthalmologic and $60 for optometric exam (one visit [no age limit] every 12 months).	30% coinsurance per visit for services provided by contracted Vision provider (one visit [no age limit] every 12 months)	Reimbursed at rate of $50 for ophthalmologic and $60 for optometric exam (one visit [no age limit] every 12 months)

Notes

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Medical Plans Comparison Chart (Medicare Eligible)

	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	**Low Option**
Allergy Testing	$10 copay	$25 copay
Ambulance	No charge	$50 per trip
Chiropractic	$10 copay under ASH plan provider, no referral necessary	$25 copay under ASH plan provider, no referral necessary
Choice of Providers	Kaiser Permanente Providers only	Kaiser Permanente Providers only
Deductibles Calendar Year	None	None
Hospital/Ambulatory Surgical	None	None
Non-Certification	None	None
Diagnostic X-Ray/Lab	No charge. Certain procedures subject to $10 copay	No charge. Certain procedures subject to $25 copay
Durable Medical Equipment	No charge	20% coinsurance
Emergency Room	$50 copay. Waived if admitted	$50 copay. Waived if admitted
Family planning Infertility Services	$10 copay per office visit, $10 copay per procedure (excludes GIFT, ZIFT and IVF)	$25 copay per office visit, $25 copay per procedure (excludes GIFT, ZIFT and IVF)
Tubal Ligation	$10 copay consultation $10 copay outpatient surgery	$25 copay consultation $25 copay outpatient surgery
Vasectomy	$10 copay consultation $10 copay outpatient surgery	$25 copay consultation $25 copay outpatient surgery
Home Health Services	No charge	No charge if medically necessary
Hospice	No charge	No charge
Hospital	No charge	$500 per admit
Lifetime Maximum	Unlimited	Unlimited
Maternity Care	$10 copay	$5 copay per visit
Mental Health Inpatient	No charge Unlimited days	$500 per admit Unlimited days
Outpatient	$10 copay for individual; $5 copay group; unlimited visits	$25 copay individual; $12 copay group; unlimited visits

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BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)	
High Option	**Low Option**
No charge	No charge
No charge	$125 copay
$10 copay Limited to the Medicare Allowed Benefit	No charge Limited to the Medicare Allowed Benefit
Blue Shield Providers	Blue Shield Providers
None	None
None	None
All services require prior authorization and/or referral by the Physician	All services require prior authorization and/or referral by the Physician
No charge	$0 to $250 based on Medicare Allowable Cost (X-ray no charge)
No charge	20% coinsurance
$20 copay. Waived if admitted	$50 Facility and Professional Services. Waived if admitted
Not covered	Not covered
Not covered	Not covered
Not covered	Not covered
No charge	No charge
Reimbursed directly by Medicare when enrolled in a Medicare-certified hospice	Reimbursed directly by Medicare when enrolled in a Medicare-certified hospice
No charge	No charge
Unlimited	Unlimited
Applicable benefit applies	Applicable benefit applies
No charge	No charge
$10 copay	No charge

CY = Calendar Year N/A = Not Applicable

Medical Plans Comparison Chart (Medicare Eligible)

	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	**Low Option**
Severe Mental Disorders - Inpatient	No charge Unlimited Days	$500 per admit Unlimited Days
Severe Mental Disorders - Outpatient	$10 copay for individual; $5 copay group; unlimited visits	$25 copay individual; $12 copay group; unlimited visits
Out-Of-Pocket Maximum	$1,500 per Member $3,000 per Family	$1,500 per Member $3,000 per Family
Outpatient Services Chemotherapy (Professional)	No charge	No charge
Renal Dialysis (Professional)	No charge	$25 copay
Outpatient Surgery (Facility)	$10 copay per procedure	$25 copay per procedure
Physician Services Hearing Screening	$10 copay	$25 copay
Home Visits	No charge	No charge
Hospital Services	No charge	No charge
Immunizations/ Injections	No charge; includes allergy serum and injection services during office visits	No charge; includes allergy serum and injection services during office visits
Office Visits	$10 copay	$25 copay
Podiatry	$10 copay	$25 copay
Routine Physicals	No charge	No charge
Specialists	$10 copay	$25 copay
Surgical Services (Physician's Office)	$10 copay	$25 copay
Well Baby/Well Child	$10 copay	$5 copay
Well Woman Exam (annual)	No charge	No charge
Physical and Occupational Therapy	Inpatient: No copay Outpatient: $10 copay	$25 copay

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BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)	
High Option	**Low Option**
No charge	No charge
$10 copay	No charge
$3,400 per Member	$3,400 per Member
No charge (professional services only)	No charge (professional services only)
No charge (professional services only)	$25 copay (professional services only)
$10 office visit; No charge at hospital or ambulatory surgical center	No charge
$10 copay	No charge
$10 copay	No charge
No charge	No charge
No charge (except for foreign travel/occupation at 20% coinsurance)	No charge (except for foreign travel/occupation at 20% coinsurance)
$10 copay	No charge
No copay; (including but not limited to treatment of injuries and disease of the feet such as hammer toe or heel spurs)	No copay; (including but not limited to treatment of injuries and disease of the feet such as hammer toe or heel spurs)
No charge	No charge
$10 copay	No charge
No charge	No charge
Not covered	Not covered
No charge	No charge
No charge	No charge

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Medical Plans Comparison Chart (Medicare Eligible)

	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	**Low Option**
Pre-Existing Conditions	ESRD	ESRD
Prescription Drug - Retail Generic	Up to 100-day supply $10 copay	Up to 30-day supply $10 copay
Brand Formulary	$20 copay	$25 copay
Non-Formulary	$20 copay when prescribed by a Plan physician in accordance with formulary guidelines	$25 copay when prescribed by a Plan physician in accordance with formulary guidelines
Specialty Drugs	See applicable prescription drug copay	See applicable prescription drug copay
Injectable Drugs	See applicable prescription drug copay	See applicable prescription drug copay
Prescription Drug - Mail Order Generic	Up to 100-day supply $10 copay	Up to 100-day supply $20 copay
Brand Formulary	$20 copay	$50 copay
Non-Formulary	$20 copay when prescribed by a Plan physician in accordance with formulary guidelines	$25 copay when prescribed by a Plan physician in accordance with formulary guidelines
Specialty Drugs	N/A	N/A
Injectable Drugs	N/A	N/A
Initial Coverage Limit (ICL)	None	None

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BLUE SHIELD
BLUE SHIELD 65 PLUS (HMO)

High Option	Low Option
ESRD	ESRD
Up to 30-day supply Retail 30-day, Preferred PPO pharm $10 Retail 90-day, Preferred PPO pharm $20 Retail 90-day, Other PPO pharm $30 Long term Care, 34 day supply $10	Up to 30-day supply Retail 30-day, Preferred PPO pharm $10 Retail 90-day, Preferred PPO pharm $20 Retail 90-day, Other PPO pharm $30 Long term Care, 34 day supply $10
Retail 30-day,Preferred PPO pharm $20 Retail 90-day,Preferred PPO pharm $40 Retail 90-day, Other PPO pharm $60 Long-term care, 34 day supply $20	Retail 30-day,Preferred PPO pharm $30 Retail 90-day,Preferred PPO pharm $60 Retail 90-day, Other PPO pharm $90 Long term care, 34 day supply $30
Retail 30-days, Preferred PPO pharm $40 Retail 90-day, Preferred PPO pharm $80 Retail 90-day, Other PPO pharm $120 Long term Care - 34 day supply, $40	Retail 30-days, Preferred PPO pharm $60 Retail 90-day, Preferred PPO pharm $120 Retail 90-day, Other PPO pharm $180 Long term Care - 34 day supply, $60
Retail - 30-day supply/Preferred PPO or Other PPO pharmacy - 20% up to $100 max Retail - 90-day supply/Preferred or Other PPO or Non-PPO pharmacy - 20% up to $300 max	Retail - 30-day supply/Preferred or Other PPO pharmacy, 20% up to $100 max Retail - 90-day supply/Preferred or Other PPO pharmacy, 20% up to $300 max Mail-Order - 90-day supply, 20% up to $300 max
Retail - 30-day supply/Preferred PPO or Other PPO pharmacy - 20% up to $100 max Retail - 90-day supply/Preferred or Other PPO or Non-PPO pharmacy - 20% up to $300 max	Retail - 30-day supply/Preferred or Other PPO pharmacy, 20% up to $100 max Retail - 90-day supply/Preferred or Other PPO pharmacy, 20% up to $300 max Mail-Order - 90-day supply, 20% up to $300 max
Up to 90-day supply $20 copay	Up to 90-day supply $20 copay
$40 copay	$60 copay
$80 copay	$120 copay
20% up to $300 max	20% up to $300 max
20% up to $300 max	20% up to $300 max
Once out-of-pocket expenses for a CY reach $4,750, payment is limited to the lesser of 5% or applicable copay for the drug	Once out-of-pocket expenses for a CY reach $4,750, payment is limited to the lesser of 5% or applicable copay for the drug

CY = Calendar Year N/A = Not Applicable

Medical Plans Comparison Chart (Medicare Eligible)

	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	**Low Option**
Skilled Nursing Facility	No charge up to 100 days per benefit period	No charge up to 100 days per benefit period
Speech Therapy	$10 copay	$25 copay
Substance Abuse Rehab - Inpatient	No charge	$500 per admit in plan hospital $100 per admit for non-medical transitional residential recovery setting. Unlimited days
Rehab - Outpatient	$10 copay individual $5 copay group	$25 copay individual; $5 copay group
Detox - Inpatient	No charge	$500 per admit in plan hospital $100 per admit for non-medical transitional residential recovery setting. Unlimited days
Detox - Outpatient (consultation, therapy, counseling)	$10 copay individual $5 copay group	$25 copay individual; $5 copay group
Urgent Care (Facility)	$10 copay	$25 copay
Vision Exams	$10 copay	$25 copay
Other Benefits Bone Mass Measurements	No charge if medically necessary and approved by a Plan physician	No charge if medically necessary and approved by a Plan physician
Diabetes self-monitoring training and supplies	Insulin & Syringes: covered same as other prescriptions; chem. strips & lancets 100% covered in accordance with DME formulary guidelines.	Insulin & Syringes: covered same as other prescriptions; chem. strips & lancets 100% covered in accordance with DME formulary guidelines
Fitness	Contact Kaiser Permanente for information on Healthy Living Programs	Contact Kaiser Permanente for information on Healthy Living Programs
Medical Nutrition Therapy (for members with diabetes and kidney disease)	Contact Kaiser Permanente for information on Healthy Living Programs	Contact Kaiser Permanente for information on Healthy Living Programs
MHN Specialized programs for legal and financial consultations as well as smoking cessation, discounts for weight management and nutrition	N/A	N/A

CY = Calendar Year N/A = Not Applicable

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.

BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)	
High Option	**Low Option**
No charge up to 100 days per benefit period	Days 1-20, no charge (limited to 100 days per benefit period). Days 21-100, $75 per day
No charge	No charge
No charge	No charge
$10 copay	No charge
No charge	No charge
See Outpatient Rehab	See Outpatient Rehab
$20 copay Waived if admitted	$10 copay Waived if admitted
$10 copay	No charge
No charge	No charge
No charge	No charge, patient education 20% coinsurance, diabetic supplies
See SilverSneakers	See SilverSneakers
$10 copay	No charge
No charge	No charge

CY = Calendar Year N/A = Not Applicable

Medical Plans Comparison Chart (Medicare Eligible)

	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	**Low Option**
SilverSneakers	N/A	N/A
Transportation	N/A	N/A

Notes

CY = Calendar Year N/A = Not Applicable

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.

BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)	
High Option	**Low Option**
No charge	No charge
No charge (30 one-way or 15 round trip per CY)	No charge (30 one-way or 15 round trip per CY)

Notes

CY = Calendar Year N/A = Not Applicable

Cigna Dental Care (DHMO)

Cigna Dental Care is an HMO-style dental plan which provides you and your family with quality comprehensive dental benefits at an affordable cost. The information below is a general summary of Cigna Dental Care DHMO Plan benefits. Please refer to the Dental Plans Comparison Chart on pages 62-66 for a listing of the most highly utilized procedures, applicable co-pay amounts, and annual maximum benefit payments. For a complete listing of benefits, please refer to your plan's Evidence of Coverage (EOC) and/or Patient Charge Schedule (PCS).

Please note, retirees enrolling the Cigna Dental Care HMO plan will be required to participate in a Cigna Dental Plan for a consecutive 24-month period.

How the Plan Works

Retirees enrolling in the Cigna Dental Care HMO Plan must select and utilize an in-network contract dentist or group who will coordinate all of your dental care. Each family member may select their own dentist, up to a maximum of three (3) dentists per family. If services are not obtained through the assigned dentist or group, or if Cigna Dental Care has not authorized services elsewhere, the services will not be covered.

In-Network Providers: Cigna has a large network of HMO dental providers for you to choose from. In network providers are contracted with Cigna Dental Care as a DHMO provider and have agreed to provide services at the copayment amount listed in your DHMO Evidence of Coverage and/or Patient Charge Schedule. Services obtained through a provider that is not your assigned provider will not be covered, unless they have been pre authorized by Cigna Dental Care. If you would like to change your dental provider, please contact Cigna Member Services at 1-800-238-5834.

Out-of-Network Providers: An out-of-network provider is a dentist that is not contracted with Cigna Dental. Any services obtained from an out-of-network provider will not be covered.

Copayments: For most preventive and restorative services, you pay no copayment. For other services, you pay a small fee as described in your Evidence of Coverage.

Deductibles: There are no deductibles under the Cigna Dental Care DHMO Plan.

Claim Forms: There are no claim forms to file under the Cigna Dental Care DHMO. Your selected provider completes and submits all claim forms.

Annual Maximum Benefit: There is no annual maximum benefit for the Cigna Dental Care DHMO Plan.

Orthodontia Coverage: You and your covered dependent may obtain comprehensive and/or limited orthodontic care from any Cigna Dental Care orthodontist of your choice. Pretreatment records and diagnostic services are covered at a $260 copayment for any proposed treatment phase.

For comprehensive, limited and/or interceptive orthodontic treatment, you pay a $380 startup (banding) fee along with a $67 copayment for adult and $46 copayment for adolescent per month for 24 months of usual and customary treatment.

Oral Health Programs: Based on research that showed an association between periodontal (gum) disease and certain medical conditions (cardiovascular disease, diabetes

and maternity), Cigna developed two programs, Cigna Dental Oral Health Integration Program (OHIP) and Cigna Dental Oral Health Maternity Program (OHMP) which provide proactive care to members with such medical conditions. These programs provide enhanced dental coverage to participants enrolled in Cigna Dental Plans. Participants may be eligible for additional cleanings per year. Contact Cigna Member Services at 1-800-238-5834 for information and qualification.

Out-of-State Dependent Coverage: If you have covered dependents living outside of California, benefits are available. Please contact Cigna Member Services at 1-800-238-5834 for a list of covered states.

Emergency Care: If you need emergency services, call your primary care dental office. If your primary care dental office is not able to provide emergency services within 24 hours, call Cigna Dental Member Services at 1-800-238-5834 and you will be directed to an available Cigna Dental Care dentist.

Emergency Services: If you are away from home or unable to contact your network general dentist, you may receive emergency services by any licensed dentist for unexpected but necessary services. Emergency services are limited to relieving severe pain, controlling excessive bleeding, eliminating serious and sudden ("acute") infection, or preventing an existing dental condition from getting worse.

Emergency Care Away From Home: For emergency covered services, you are responsible to pay the treatment copays listed on your Evidence of Coverage and/or Patient Charge Schedule. After your appointment, you can request some payment from Cigna: the difference, if any, between the dentist's usual fee for the emergency covered services and your normal copay, up to a total of $50 per incident (this amount will vary by state). To request reimbursement, send the emergency dental treatment reports and any x-rays to Cigna at the address listed on your plan materials.

Emergency Care After Hours: There is a copay listed on your Evidence of Coverage and/or Patient Charge Schedule for emergency care received after regularly scheduled office hours. This copay will be in addition to other copays that may apply.

How to Enroll

Complete and submit a County of San Bernardino Retiree Dental Enrollment/ Change Form and submit to EBSD by mail or fax to:

Employee Benefits and Services Division
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
Fax: 909-387-5566 Attn: Retiree Desk

What's Covered

The Cigna Dental Care Plan provides you with comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan and are subject to plan exclusions and limitations as defined in the Cigna Dental DHMO Plan Evidence of Coverage (EOC). It is recommended that you obtain and agree to a prescribed treatment plan issued by your dental provider prior to receiving treatment.

What's Not Covered

It is extremely important that you read your EOC before you obtain services in order to know what Cigna Dental will and will not cover. Exclusions and Limitations are subject

to change, please refer to the Cigna Dental Care EOC and PCS or contact Cigna Dental Customer Services at 1-800-238-5834 for additional information. Generally, root canal treatment, dentures, crown and bridge treatment in-progress are not covered under the Cigna Dental Care DHMO plan.

Cigna Dental Care Member Services

Cigna Dental Member Services is available 24 hours a day, 7 days a week to assist you with questions related to your benefit plan; locating a provider; ID cards requests; and/or claims information. You can contact member services at 1-800-238-5834.

States that DHMO Coverage is Available*

State abbreviation and name:

AL	Alabama	MI	Michigan
AR	Arkansas	MO	Missouri
AZ	Arizona	MS	Mississippi
CA	California	NJ	New Jersey
CO	Colorado	NY	New York
CT	Connecticut	NV	Nevada
DC	District of Columbia	OH	Ohio
DE	Delaware	OK	Oklahoma
FL	Florida	OR	Oregon
GA	Georgia	PA	Pennsylvania
IA	Iowa	SC	South Carolina
IL	Illinois	TN	Tennessee
IN	Indiana	TX	Texas
KS	Kansas	UT	Utah
KY	Kentucky	WA	Washington
LA	Louisiana	WI	Wisconsin
MD	Maryland		

*Please note, this list is subject to change. If the state you are looking for is not listed, please contact Cigna Member Services at 1-800-238-5834 to verify if DHMO coverage is available.

Cigna Dental (DPPO)

Cigna Dental PPO is administered by Cigna Dental. The Cigna Dental PPO Plan allows you to seek services from either an in-network provider or out-of-network provider. You may change between in and out-of-network dentists anytime without notifying Cigna Dental in advance. It is your choice; however, it is important to note your co-pays may be higher for select services if you choose to go out-of-network. Please refer to the Dental Plans Comparison Chart on pages 62-66 for a listing of the most highly utilized procedures, applicable coinsurance amounts, and annual maximum benefit payments. For a complete listing of benefits, please refer to your plan's Evidence of Coverage and/or Patient Charge Schedule.

Please note, retirees enrolling in the Cigna Dental PPO plan will be required to participate in a Cigna Dental Plan for a consecutive 24-month period.

How the Plan Works

When you receive your dental care from a Cigna Dental PPO network dentist, you will pay a percent of the dentist's discounted Cigna Dental PPO contracted rate.

In-Network Providers: Cigna has a large network of PPO providers for you to choose from. In the PPO plan individual dentists are contracted as PPO providers, not entire groups. It is important to ask whether or not your dentist participates in the Cigna PPO Core Network to determine if they are an in-network provider.

Out-of-Network Providers: The PPO plan allows you to seek services from an out-of-network provider; however you will incur a higher copayment for select services by obtaining services from an out-of-network provider. You will be responsible for the difference between the payment dental providers receive from Cigna Dental and their usual fees; this cost will vary by provider.

The table below contains a cost comparison of a periodontic root planning procedure. The table demonstrates the cost difference between obtaining the service from in-network and out-of-network providers. (Note: the numbers cited are for example purposes only. They may not be the actual rates associated with this procedure.)

Procedure	Cigna's maximum allowance payable for service	In-Network Fees (flat amount based on contracted in-network fee)	In-Network Copayment (flat copayment amount)	Out-of-Network (OON) Fees (UCR versus maximum allowable amount)	Out-of-Network Copayment (percentage of OON fee)
Root Planing	$100	$85	20% of In-Network fee or $17 Total Cost: $17	$125	OON fee of $125 minus maximum Cigna allowance of $100, plus copayment amount of 40% of maximum allowance or $40 Total Cost: $65

Copayments: For most preventive and restorative services, you pay no out of pocket when you obtain services from an in-network provider. For other services, you pay a small fee as described on your evidence of coverage.

Deductibles: There are no deductibles under the Cigna Dental PPO Plan.

Claim Forms: Under the Cigna Dental PPO, in-network dentists will submit a claim form directly to Cigna Dental.

If your dentist in not contracted (out-of-network) with Cigna Dental, you may have to file your own claims. It is your responsibility to pay your dentist for services rendered and to submit all necessary claim forms.

Annual Maximum Benefit: There is a calendar year annual maximum of $1,000 subject to change; pending final rates.

Orthodontia Coverage: This is not a covered benefit under the DPPO Plan.

Pre-existing Conditions: Generally, root canal treatment, dentures, crown and bridge treatment in-progress are not covered under the Cigna Dental PPO plan.

Oral Health Programs: Based on research that showed an association between periodontal (gum) disease and certain medical conditions (cardiovascular disease, diabetes and maternity), Cigna developed two programs, Cigna Dental Oral Health Integration Program (OHIP) and Cigna Dental Oral Health Maternity Program (OHMP) which provide proactive care to members with such medical conditions. These programs provide enhanced dental coverage to participants enrolled in Cigna Dental Plans. Participants may be eligible for additional cleanings per year.

Out-of-State Dependent Coverage: Dependents are eligible for services out of state.

Emergency Care: If you need emergency services, call your dental office. If your office is unavailable, call Cigna Dental Member Services at 1-800-238-5834 and you will be directed to an available Cigna Dental PPO or Out of Network provider of choice.

How to Enroll

Complete and submit a County of San Bernardino Retiree Dental Enrollment/ Change Form and submit to EBSD by mail or fax at:

Employee Benefits and Services Division
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
Fax: 909-387-5566 Attn: Retiree Desk

What's Covered

The Cigna Dental PPO Plan provides you with comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan and are subject to plan exclusions and limitations as defined in the Cigna Dental DPPO Plan Evidence of Coverage (EOC). It is recommended that you obtain and agree to a prescribed treatment plan issued by your dental provider prior to receiving treatment from your dental provider. To determine if you are being billed the correct copayment amounts, compare the amounts on the treatment plan to the amounts listed in your Evidence of Coverage and/or Patient Charge Schedule.

What's Not Covered

It is extremely important that you read your EOC before you obtain services in order to know what Cigna Dental will and will not cover. Exclusions and Limitations are subject to change, please refer to the Cigna Dental Care EOC or contact Cigna Dental Customer Services at 1-800-238-5834 for additional information.

Cigna Dental Care Member Services

Cigna Dental Member Services is available 24 hours a day, 7 days a week to assist you with questions related to your benefit plan; locating a provider; ID cards requests; and/or claims information. You can contact member services at 1-800-238-5834.

Dental Plans Comparison Chart

This comparison chart contains a listing of highly utilized services only and is not inclusive of all your plan benefits. For a detailed description of covered benefits, refer to your Evidence of Coverage and/or Patient Charge Schedule. 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.

Cigna Dental Care (DHMO)	Cigna Dental PPO	
In-Network Only	In-Network (Core)	Out-of-Network
Calendar Year Maximum Benefit		
Not applicable	$1,000 per person	$1,000 per person
Annual Deductible		
Not applicable	$50 per person/$150 per family	$50 per person/$150 per family

Category	Procedure Code	Description	(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Preventive Care	D0120	Periodic oral evaluation (2 per year)*	No Charge	No Charge	30%
	D0210	Full mouth X-ray (see frequency limitations)	No Charge	No Charge	30%
	D9110	Emergency, palliative treatment of dental pain	$2.00	No Charge	30%
	D1203	Topical Fluoride (child) – see limitations	No Charge	No Charge	30%
	D1110 (Adult) D1120 (Child)	Prophylaxis (cleanings) (1 per 6-month period)*	No Charge	No Charge	30%
	D1351	Sealant (per tooth) limitations may apply	$3.00	No Charge	30%
	D1352	Preventive resin restoration – permanent tooth	$3.00	No Charge	30%
Adjunctive General Services*	D9972	External bleaching – self-treatment with bleaching tray & gel	$125.00 per arch	20%	40%
	D9940	Occlusal guard (night guard), by report – limited to 1 in 3 years	$90.00	50%	50%
	D9951	Occlusal adjustment, limited	$12.00	20%	40%
	D9952	Occlusal adjustment, complete	$18.00	20%	40%

*DPPO plan services listed in this category are subject to the plan's annual deductible.

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Core)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Adjunctive General Services (continued)	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$40.00	Benefit covered through Medical Plan / Cigna pays as secondary to medical	Benefit covered through Medical Plan / Cigna pays as secondary to medical
Restorative Dentistry*	D2140 (1) D2150 (2) D2160 (3) D2161 (4)	Amalgam ("silver" fillings) on primary or permanent teeth: 1, 2, 3 or 4 surfaces	No Charge	20%	40%
	D2330 (1) D2331 (2) D2332 (3) D2335 (4)	Resin composite (white fillings), anterior (front) teeth: 1, 2, 3 or 4 surfaces	No Charge	20%	40%
	D2391 (1) D2392 (2) D2393 (3) D2394 (4)	Resin Composite (white fillings), posterior (molars): 1, 2, 3 or 4 surfaces	$35.00 $45.00 $50.00 $55.00	20%	40%
Restorative Dentistry – 12 month waiting period applies* **	D2510 (1) D2520 (2) D2530 (3+)	Metallic Inlay – Up to 3+ surfaces	$100.00 each	50% subject to annual deductible	50% subject to annual deductible
	D2650 (1)* D2651 (2) D2652 (3+)	Composite resin inlay (white) – Up to 3+ surfaces	$100.00 each*	50% subject to annual deductible	50% subject to annual deductible
	D2610 (1) D2620 (2) D2630 (3+)	Porcelain/ceramic inlay – Up to 3+ surfaces	$100.00 each*	50% subject to annual deductible	50% subject to annual deductible
Perio-dontics*	D4241 (1-3) D4240 (4+) (# of teeth)	Gingival flap, per quadrant	$90.00 $120.00	20%	40%
	D4263	Bone replacement graft – first site in quadrant	$160.00	20%	40%
	D4264	Bone replacement graft – each additional site in quadrant	$80.00	20%	40%
	D4211 (1-3) D4210 (4+) (# of teeth)	Gingivectomy/ gingivoplasty (gum surgery), per quadrant	$45.00 $70.00	20%	40%

*DPPO plan services listed in this category are subject to the plan's annual deductible.

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Core)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Endo-dontics*	D3220	Pulpotomy	$3.00	20%	40%
	D3222	Partial pulpotomy for apexogenesis-permanent tooth	$17.00	20%	40%
	D3310	Root canal – Anterior (front) teeth	$50.00	20%	40%
	D3320	Root canal – Bicuspid	$70.00	20%	40%
	D3330	Root canal – Molar	$135.00	20%	40%
Oral Surgery*	D7286	Biopsy of soft oral tissue	No Charge	20%	40%
	D7140	Uncomplicated extraction, single tooth	$2.00	20%	40%
	D7220	Extraction – impacted soft tissue, per tooth	$25.00	20%	40%
	D7230	Extraction – impacted partially bony, per tooth	$45.00	20%	40%
	D7240	Extraction – impacted completely bony, per tooth	$70.00	20%	40%
	D9215	Local anesthesia	No Charge	No Charge	No Charge
	D9220	General anesthesia – first 30 minutes (only with oral surgery)	$160.00	20%	40%
	D9221	General anesthesia – each additional 15 minutes (only with oral surgery)	$75.00	20%	40%
	D7450/ D7451	Removal of benign odontogenic cyst or tumor	No Charge	Benefit covered through Medical Plan / Cigna pays as secondary coverage under Basic Benefits	Benefit covered through Medical Plan / Cigna pays as secondary coverage under Basic Benefits

*DPPO plan services listed in this category are subject to the plan's annual deductible.

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Core)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Crowns and Bridges*	D2790	Crown – full cast high noble metal (gold)	$100.00**	50%	50%
	D6721	Crown –resin with predominantly base metal	$100.00**	50%	50%
	D6740	Crown – porcelain/ ceramic substrate	$100.00**	50%	50%
	D6722	Crown – porcelain fused to noble metal	$100.00**	50%	50%
	D6930	Recement fixed partial denture	No Charge	20%	40%
	D2920	Recement crown	No Charge	20%	40%
	D6241	Pontic – porcelain fused to predominantly base metal (front teeth or molars)	$100.00**	50%	50%
	D6980	Fixed partial denture repair, by report	Not covered	20%	40%
Pros-thetics*	D5110 (Upper) D5120 (Lower)	Complete upper or lower denture	$120.00 for either upper or lower	50%	50%
	D5211 (Upper) D5212 (Lower)	Upper or lower partial denture – resin base	$120.00 for either upper or lower	50%	50%
	D5670 (Upper) D5671 (Lower)	Replace all teeth (upper or lower) on cast metal framework	$145.00 for either upper or lower	20%	40%

*DPPO plan services listed in this category are subject to the plan's annual deductible.

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Core)	Out-of-Network
			(You pay)	(You pay)	(You pay plus any costs over maximum allowance)
Pros-thetics*	D5510	Repair broken Denture Base	$17.00	20%	40%
	D5410 (Upper) D5411 (Lower)	Complete denture adjustment	$3.00 for either upper or lower	20%	40%
	D5520	Replace broken tooth on denture	$17.00 per tooth	20%	40%
	D6010 D6012 D6040 D6050	Implants	Not covered	Not covered	Not covered
Ortho-dontics	D8660	Pre ortho visit	$45	Not Covered	Not Covered
	D8999	Ortho Treatment Plan and Records	$260	Not Covered	Not Covered
	D8080/ 8090	Banding (placement of brackets and wires)	$380	Not Covered	Not Covered
	D8670 (child)	Periodic Orthodontic Treatment Visit	$1,100	Not Covered	Not Covered
	D8670 (adult)	Periodic Orthodontic Treatment Visit	$1,600	Not Covered	Not Covered
	D8680	Retention	$260	Not Covered	Not Covered

*DPPO plan services listed in this category are subject to the plan's annual deductible.

**This procedure may be subject to additional copayment based on materials used and/or location of the tooth/teeth within the mouth. Please refer to your plan's Evidence of Coverage and/or Patient Charge Schedule for detailed information or Cigna Dental Member Services at 1-800-238-5834.

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases on its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

For more information regarding this notice, contact the plan administrator, Human Resources – Employee Benefits and Services Division at 909-387-5787.

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.

How to Complete Enrollment/Change 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 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 Blue Shield Signature HMO, you must enter a primary care physician (PCP) and medical group number. If you omit this field, Blue Shield will assign you to any PCP in your area. For Cigna Dental DHMO, you must designate your dentist on the enrollment form by providing the applicable provider number. If you omit this information, Cigna will also assign you to a Dentist in your area.
Section E	Medical/Dental	Complete this section if you are not changing plans (outside of Open Enrollment), but are only adding or deleting dependents. You must enter a PCP and medical group number if you are enrolled in Blue Shield HMO. For Dental DHMO enrollment, you will need to provide the Dentist provider number.
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-O	Medical	Read, sign and date pages 2 and 3 of the enrollment/change form.

*For Medicare integrated plans, you must complete both the County and health plan enrollment forms.

County of San Bernardino
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

For Office Use Only			
Effective Date	Month	Day	Year
Group ID #			
Emp ID #			

A. ☐ New Retiree ☐ Open Enrollment ☐ Change in Status

B. I choose the following Medical Plan:

- ☐ Kaiser Permanente Traditional HMO Plan
- ☐ Kaiser Permanente Deductible Plan (Low)
- ☐ Kaiser Medicare Advantage *
- ☐ Kaiser Permanente Medicare COB
- ☐ Blue Shield Hybrid PPO COB
- ☐ Blue Shield Signature HMO COB
- ☐ Blue Shield Signature HMO
- ☐ Blue Shield PPO
- ☐ Blue Shield PPO COB
- ☐ Blue Shield 65 Plus (HMO) *

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

Previous Medical Plan:

Option:
- ☐ High Option
- ☐ Low Option

For PPO Only:
- ☐ California
- ☐ Out of State

C. Retiree or Eligible Surviving Dependent Information

Social Security Number	Check One: ☐ Male ☐ Female	Date of Birth Month / Day / Year	Check One ☐ Married ☐ Single ☐ Domestic Partner ☐ Widowed ☐ Divorced

Last Name	First Name	MI	For Name Change, List Former Name Here

Mailing Address	☐ Check Here If New Address	Home Phone ( ) Alternate Phone ( )

City	State	Zip Code	Blue Shield Signature HMO and 65 Plus HMO Primary Care Physician ID No./Group ID No.	Previously Visited? ☐ Yes ☐ No
Residential Address (if different from mailing address)				

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

Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Blue Shield HMO & 65 Plus HMO Enrollees Only: Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
Spouse/Domestic Partner:		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
Children:		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
		☐ M ☐ F				Physician's No. Group No.	☐ 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 ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED

	Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Blue Shield HMO & 65 Plus HMO Enrollees Only: Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
☐ Add ☐ Remove	Spouse/Domestic Partner:		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove	Children:		☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove			☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove			☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No
☐ Add ☐ Remove			☐ M ☐ F				Physician's No. Group No.	☐ Yes ☐ No

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

☐ Domestic Partnership ☐ Dissolution
☐ Marriage ☐ Divorce ☐ Death

G. OTHER MEDICAL COVERAGE

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

Insurance Company_____

Policy No._____

Spouse's Employer_____

Phone Number_____

H. MEDICARE COVERAGE

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 disclosures and sign your Agreement on the last page of this form.

rev. 9.26.13

Page 1 of 3

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

Kaiser Foundation Health Plan Arbitration Agreement:
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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 our 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. BLUE SHIELD OF CALIFORNIA MEMBERS ONLY
(THIS SECTION APPLIES IF ENROLLING IN THE BLUE SHIELD PLAN)

Authorization
The following authorization section is to be signed by all retirees applying for coverage with Blue Shield of California.

I agree: All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact that my coverage may be cancelled.

I understand that coverage does not become effective until this and the County's application have been approved by Blue Shield of California.

Disclosure of Personal Health Information
Blue Shield of California (Blue Shield) understands the importance of keeping your and your dependents' personal health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department at 1-800-642-6155 or by accessing Blue Shield's website at www.blueshieldca.com.

K. DEPENDENT AFFIDAVIT

I understand and agree to each of the following:

- My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Retiree Benefits Guide and plan eligibility requirements by carrier. *A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet site.*
- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistences discovered with respect to enrollment and eligibility will be investigated and appropriate action will be taken.
- The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
  - Notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage.
  - Provide supporting documentation upon request of HR-EBSD.
  - I am responsible for any applicable cost incurred for obtaining supporting documentation.
  - The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
  - If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf.
  - Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

By signing below, I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).

L. DISABLED DEPENDENTS

Please list the names of any disabled dependents you are enrolling in the space below:

_____ _____

_____ _____

M. 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 or dissolution of domestic partnership 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 sixty (60) days of a Qualifying Change in Status Event. If I do not submit a Medical Plan Enrollment/Change Form within sixty (60) days, my request may be denied. All requests must be consistent with the stated qualifying event.

N. SELECTION OF A LOW OPTION HEALTH PLAN

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 Blue Shield 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.

O. AGREEMENT

I hereby elect the medical plan as designated on this enrollment form. 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 monthly retirement benefit payment 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_____

rev. 9.26.13

Page 3 of 3

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 (EBSD)
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 Fax (909) 387-5566

RETIREE DENTAL PLAN ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY			
Effective Date	Month	Day	Year
Group #			
Employee ID #			

A ❑ NEW RETIREE ❑ OPEN ENROLLMENT ❑ CHANGE IN STATUS

B I ELECT THIS DENTAL PLAN: ❑ Cigna Dental PPO ❑ Cigna Dental Care HMO

C **RETIREE INFORMATION OR RETIREE'S ELIGIBLE SURVIVING DEPENDENT 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: ( ) Alternate Phone: ( )	
11. City	12. State / 13. Zip Code	14. Cigna Dental Care HMO members must provide the following: Provider Name_____ Provider No._____	

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	Provider Name/No.
Spouse/Domestic Partner:				
Children:				

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 REMOVING 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	Provider Name/No.
❑ Add Spouse/Domestic Partner: ❑ Remove				
❑ Add Children: ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				
❑ Add ❑ Remove				

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 **Retiree Authorization:**

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.

Dependent Affidavit:

I understand and agree to each of the following:

- My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Retiree Benefits Guide and plan eligibility requirements by carrier. A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet site.
- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistences discovered with respect to enrollment and eligibility will be investigated and appropriate action will be taken.

- The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
- notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage
- provide supporting documentation upon request of HR-EBSD
- I am responsible for any applicable cost incurred for obtaining supporting documentation.
- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf.
- Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

By signing below:

- ✓ 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 monthly retirement benefit payment to cover my share of the cost of enrollment as it is now or as it may be in the future. **Retirees who enroll in the Dental program are required to participate for a minimum of 24 consecutive months.**
- ✓ I certify and affirm to the County of San Bernardino that the dependent eligibility information submitted is true, correct, and current as of this date. I also attest that I have read, understand, and agree to comply with the provisions of this affidavit, terms of benefit plan contracts, County policies, and related state and/or federal law(s).

Retiree's Signature _____ Date _____

Rev. 09/14/12

RETURN FORM TO:

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

Human Resources
EMPLOYEE BENEFITS AND SERVICES

RETIREE MEDICAL AND/OR DENTAL PLAN CANCELLATION FORM

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

FOR OFFICE USE ONLY			
Effective Date	Month	Day	Year
Group #.			
Employee ID #			

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

❑ Medical plan name _____

❑ Dental plan name _____

B 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 ( ) Alternate 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

DISABLED DEPENDENT CERTIFICATION

(Dependent child age 26 or older)

Employee ID	Rcd No.	Last Name, First Name	
Department		Name of Medical Plan	Name of Dental Plan

COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 26 OR OLDER

Dependent Name	Date of Birth	Relationship to Employee

By providing my signature below, I certify that the dependent listed above is incapable of self-sustaining employment due to a physical or mental disability. I have attached verification of this disability from a licensed healthcare provider, and certify that all information provided is true and correct. I also understand that failure to timely provide all requested information will result in my dependent being ineligible for coverage on my County medical and dental plans pursuant to the terms of the County medical and dental contracts.

Retiree Signature	Telephone	Date
	( )	

DISTRIBUTION: Original – EBSD-HR (0440)

RETURN FORM TO:

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

2014 Enrollment Request Form Blue Shield 65 Plus (HMO) Employer Group/Union Health Plan

This form is for Medicare-eligible retirees who want to enroll in Blue Shield 65 Plus℠, a group Medicare Advantage-Prescription Drug Plan.

To enroll, please fill in all the information requested below. Read the terms and conditions on page 3, and then sign and date.

Employer group or union name _____ Group or union No. _____
(leave blank if not provided by your employer group or union)

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date (__ __ __ __ __ __ __ __) (MM / DD / YYYY)	Sex ☐ M ☐ F	Home phone number	Alternate phone number

Permanent residence (no P.O. boxes)
Street address

City	State	ZIP code

Mailing address (only if different from your permanent residence address)
Street address

City	State	ZIP code

Emergency contact (optional)	Relationship to you (optional)	Phone number (optional)

E-mail address (optional) _____

☐ I am willing to receive required plan materials via e-mail (i.e., enrollment notifications, the Annual Notice of Change and plan newsletter) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.

You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

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 Social Security or the 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)	_____

H0504_13_176A 08022013

blue of california

blueshieldca.com

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

2. Are you covering a spouse or dependent(s) under this employer group or union plan?
☐ Yes ☐ No

If yes, name of spouse* _____

Name of dependent(s) _____

_____

* If any of the covered dependents listed above are eligible for Medicare, please ensure that each complete and return an enrollment form.

3. Do you or your spouse work? ☐ Yes ☐ No

4. Are you enrolled in your State Medicaid (Medi-Cal) program? ☐ Yes ☐ No

If yes, please provide your Medicaid (Medi-Cal) number _____

5. Do you have end-stage renal disease (ESRD)? ☐ Yes ☐ No

If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

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

Will you have other prescription drug coverage in addition to Blue Shield 65 Plus? ☐ Yes ☐ No

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

Prescription drug coverage

Name of other coverage _____

ID No. for this coverage _____ Group No. _____

Medical coverage

Name of other coverage _____

ID No. for this coverage _____ Group No. _____

7. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If yes, please provide the following information:

Name of institution _____

Address and phone number of institution (number and street) _____

_____

Please choose a primary care physician (PCP) and affiliated medical group

Your physician choice name

Physician ID No.

Name of medical group affiliated with your physician choice

Are you already a patient of this physician? ☐ Yes ☐ No

Please contact Blue Shield 65 Plus at **(800) 776-4466** [TTY **(800) 794-1099**], 7 a.m. to 8 p.m., seven days a week, if you need information in another format or language.

Please read and sign below

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

Blue Shield 65 Plus is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. 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. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (for example, during your group's open enrollment period, or during the Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Blue Shield 65 Plus serves a specific service area. If I move out of the area that Blue Shield 65 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 Blue Shield 65 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 Blue Shield 65 Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date Blue Shield 65 Plus coverage begins, I must get all of my health care from Blue Shield 65 Plus, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Blue Shield 65 Plus and other services contained in my Blue Shield 65 Plus *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD 65 PLUS WILL PAY FOR THE SERVICES**.

Release of information

By joining this Medicare health plan, I acknowledge that Blue Shield 65 Plus will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Blue Shield 65 Plus will release my information, including my 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 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 my behalf under the laws of the State where I live) 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 from Medicare.

Enrollee signature _____ Today's date _____

If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information

Name	Address
Phone number	Relationship to enrollee

RETURN FORM TO:

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

Office use only:

Name/signature of staff member/agent/broker (if assisted enrollment)

_____

Plan ID No. _____

Effective date of coverage _____

ICEP/IEP _____ AEP _____

SEP (type) _____ Not eligible _____

An Independent Member of the Blue Shield Association MG00001-FF (7/13)

2014 Enrollment Request Form Blue Shield of California Medicare Rx Plan (PDP) Employer Group/Union Prescription Drug Benefit Plan

This form is for Medicare-eligible retirees who want to enroll in the Blue Shield of California Medicare Rx Plan (PDP), a Group Prescription Drug Benefit plan.

To enroll, please fill in all the information requested below. Read the terms and conditions on page 3, and then sign and date.

Employer group or union name _____ Group or union No. _____
(leave blank if not provided by your employer group or union)

Last name	First name	Middle initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date (_____) (MM/DD/YYYY)	Sex ☐ M ☐ F	Home phone number	Alternate phone number

Permanent residence (no P.O. boxes)
Street address

City	State	ZIP code

Mailing address (only if different from your permanent residence address)
Street address

City	State	ZIP code

Emergency contact (optional)	Relationship to you (optional)	Phone number (optional)

E-mail address (optional) _____

☐ I am willing to receive required plan materials via e-mail (i.e., enrollment notifications, the Annual Notice of Change and plan newsletter) in place of mailed printed copies.

☐ I am willing to receive non-required plan materials via e-mail (i.e., benefit promotions and event invitations) in place of mailed printed copies.

You may choose to go back to printed materials at any time by calling Member Services at the number on your plan ID card.

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 Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

S2468_13_176B _08022013

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number _____ Sex _____

Is Entitled To | Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

blue of california

blueshieldca.com

Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (month/date/year) _____

If no, name of retiree _____

2. Are you covering a spouse or dependent(s) under this employer group or union plan?
☐ Yes ☐ No

If yes, name of spouse* _____

Name of dependent(s) _____

_____

* If any of the covered dependents listed above are eligible for Medicare, please ensure that each complete and return an enrollment form.

3. Do you or your spouse work? ☐ Yes ☐ No

4. Are you enrolled in your State Medicaid (Medi-Cal) program? ☐ Yes ☐ No

If yes, please provide your Medicaid (Medi-Cal) number _____

5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to the Blue Shield of California Medicare Rx Plan? ☐ Yes ☐ No

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

_____

Name of other coverage _____

ID No. for this coverage _____

Group No. for this coverage _____

6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If yes, please provide the following information

Name of institution _____

Address and phone number of institution (number and street) _____

_____

Phone number of institution _____

Please contact Blue Shield of California Medicare Rx Plan at **(888) 239-6469** [TTY **(888) 239-6482**], 7 a.m. to 8 p.m., seven days a week, if you need information in another format or language.

Please read this important information

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage plan that will meet your needs. By joining the Blue Shield of California Medicare Rx Plan, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan sends you, and if you have questions, contact your Medicare Advantage plan.

Please read and sign below

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

Blue Shield of California Medicare Rx Plan is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage.

It is my responsibility to inform Blue Shield of California Medicare Rx Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare Prescription Drug Plan at any time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in Blue Shield of California Medicare Rx Plan will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available (for example, during my group's open enrollment period or the Annual Enrollment Period, October 15 – December 7), unless I qualify for certain special circumstances.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies, except in an emergency, when I cannot reasonably use Blue Shield of California Medicare Rx Plan network pharmacies. Once I am a member of the Blue Shield of California Medicare Rx Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from Blue Shield of California Medicare Rx Plan when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the State Medicaid program and the Medicare Savings Program.

Release of information

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx Plan will release my information, including my 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 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 my behalf under State law where I live) 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 Medicare.

Enrollee signature _____ Today's date _____

If you are the authorized representative (i.e., power of attorney or legal guardian – see description above), you must provide the following information

Name	Address
Phone number	Relationship to enrollee

RETURN FORM TO:

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

Medicare Prescription Drug Plan Use Only:

Plan ID No. _____ NIPR# _____

Effective Date of Coverage _____ IEP _____ AEP _____ SEP (type) _____

Plan Representative/Agent/Broker Signature _____

PDP00045-FF (9/13)

An independent member of the Blue Shield Association

blue of california

BLUE SHIELD 65 PLUS[SM] (HMO) & BLUE SHIELD 65 PLUS CHOICE PLAN (HMO)
DISENROLLMENT FORM

If you request disenrollment, you must continue to get all medical care from Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Blue Shield 65 Plus' or Blue Shield 65 Plus Choice Plan's network. We will notify you of your effective date after we get this form from you.

Last Name First Name Middle Initial ☐Mr. ☐Mrs. ☐Miss. ☐Ms.

_____

Medicare #

_____

Birth Date Sex Home Phone Number:

_____ ☐M ☐F (____) _____-_____

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your Signature*:_____ **Date**: _____

* Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that:
1) this person is authorized under State law to complete this disenrollment and
2) documentation of this authority is available upon request by Blue Shield 65 Plus or Blue Shield 65 Plus Choice Plan or by Medicare.

If you are the authorized representative, you must provide the following information:

Name: _____
Address: _____
Phone Number: (___)____-_____
Relationship to Enrollee:_____

MR14132 (10/11)
H0504_11_202A CMS Approved 08232011

An Independent Member of the Blue Shield Association

RETURN FORM TO:

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

Kaiser Permanente Senior Advantage (HMO)

GROUP ELECTION REQUEST FORM

KAISER PERMANENTE®

Northern California or Southern California Region

IMPORTANT INFO – Read all pages before signing this form

Completing and returning this form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you will each need to complete a separate form. For help completing this form, call our Member Service Contact Center at **1-800-443-0815**, toll free (TTY **711**), seven days a week, 8 a.m. to 8 p.m.

ABOUT THE ENROLLMENT PROCESS - Submitting your form

1. Fill out the form completely and mail the signed form to:
2. San Bernardino County
   Employee Benefits and Services Division (EBSD)
   157 West Fifth Street, First Floor
   San Bernardino, CA 92415-0440

- Keep the bottom copy for your own records. If required, submit the middle copy to your employer group, union or trust fund.
- We'll review your form for completeness and required signatures. We'll then contact you by mail to let you know that we have received your form.
- We'll notify Medicare that you've applied to join Senior Advantage.
- Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

SKU 60150908 (11/2013)

NCAL or SCAL - Senior Advantage - Group

Employer Group Use Only
Optional Group Stamp Area:

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

Please contact Kaiser Permanente if you need information in another language or format (Braille).

To enroll in Kaiser Permanente Senior Advantage, please provide the following information:

Employer or Union Name			Group #
Last Name First Name Middle Initial			☐ Mr. ☐ Mrs. ☐ Ms.
Birth Date (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex ☐ M ☐ F	Home Phone Number ( )	Alternate Phone Number ( )
Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former Kaiser Permanente Medical/Health Record Number _____			
Permanent Residence Street Address (P.O. Box is not allowed)			
City	County	State	ZIP Code
Mailing Address (only if different from your Permanent Residence Address) Street Address City State ZIP Code			
E-mail Address			

Please Provide Your Medicare Insurance Information

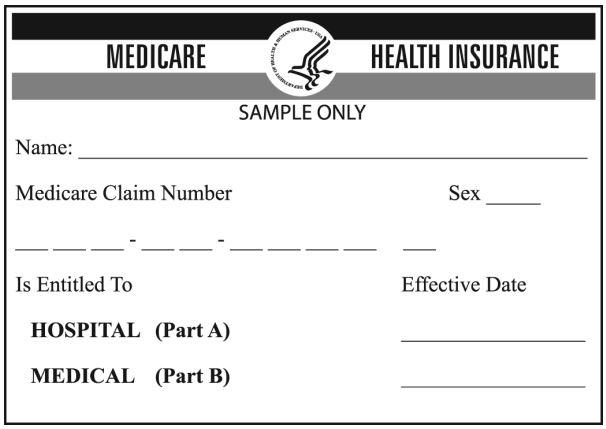
Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card

- OR -

- Attach a copy of your Medicare card, your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part B, however some employer groups require both Parts A and 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) _____

SKU 60150908 (11/2013)

NCAL or SCAL - Senior Advantage - Group

Last Name _____ First Name _____

Please read and answer these important questions:

1. Do you or your spouse work? ☐ Yes ☐ No
2. If your employer provides retiree coverage, are you the retiree? ☐ Yes ☐ No ☐ N/A
   If yes, retirement date (month/day/year) _____
   If no, name of retiree & retirement date (month/day/year)
   _____
3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse _____
   Name of dependents _____
4. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis anymore, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
5. 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 Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage ID # for other coverage
   _____ _____
6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information:
   Name of institution _____
   Address & phone number of institution (number and street) _____
   _____
7. Requested effective date (subject to CMS approval) _____/_____/_____

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

☐ Spanish

☐ Large Print, Braille, CD and Cassette

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in another format or language than what is listed above. Our office hours are seven days a week, 8 a.m. to 8 p.m. TTY users should call **711**.

SKU 60150908 (11/2013)

NCAL or SCAL - Senior Advantage - Group

Last Name _____ First Name _____

Please complete the information below.
If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose ONE employer or union/trust fund from which to receive your Senior Advantage coverage. Complete the information for that employer or union/trust fund below.

Employer Group/Union/Trust Fund Name _____

Employer Group/Union/Trust Fund ID # _____ Subgroup _____

Requested effective date (subject to CMS approval) _____

Please Read and Sign Below

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT:
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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 our 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*.

By completing this enrollment application, I agree to the following:
Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however some employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't 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. I may leave this plan at any time by sending a request to Kaiser Permanente or by calling **1-800-MEDICARE** (**1-800-633-4227** or TTY **1-877-486-2048**), 24 hours a day, 7 days a week. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

I understand that if I currently have Kaiser Permanente coverage through more than one employer or union/trust fund, I must choose one of these coverage options for my Senior Advantage plan because I can be enrolled in only one Senior Advantage plan at a time. My other employer or union/trust fund may allow me to enroll in one of their non-Medicare plans as well. I will contact the benefit administrators at each of my employers or union/trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or union/trust fund's plan to select for my Senior Advantage plan.

Kaiser Permanente serves a specific service area. If I move out of the area that Kaiser Permanente 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 Kaiser Permanente, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Senior Advantage *Evidence of Coverage* document from Kaiser Permanente when I receive it in order to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

SKU 60150908 (11/2013)

NCAL or SCAL - Senior Advantage - Group

Last Name _____ First Name _____

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency, urgently needed services or out-of-area dialysis services. Services authorized by Kaiser Permanente and other services contained in my Senior Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Kaiser Permanente, he/she may be paid based on my enrollment in Kaiser Permanente.

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 necessary for treatment, payment and health care operations. I also acknowledge that Kaiser Permanente will release my information including my 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 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 my behalf under the laws of the State where I live) 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 from Medicare.

Signature _____ **Today's Date** _____

If you are the authorized representative, you must sign above and provide the following information:

Name _____

Address _____

Phone Number (_____) _____ - _____

Relationship to Enrollee _____

Office Use Only:

Name of staff member/agent/broker (if assisted in enrollment) _____

Plan ID # _____ Effective Date of Coverage _____

ICEP/IEP _____ AEP _____ SEP (type) _____ Not Eligible _____

2014 NCAL or SCAL Group Plan Election Form

SKU 60150908 (11/2013)

RETURN FORM TO:

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

Kaiser Permanente Senior Advantage (HMO), Kaiser Permanente Medicare Cost, or Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan (HMO SNP)

KAISER PERMANENTE®

DISENROLLMENT FORM

Northern California or Southern California Region

Each individual disenrolling will need to complete his/her own form. If you have any questions, please call us toll free at **1-800-443-0815** (TTY **1-800-777-1370** for the hearing/speech impaired), seven days a week, 8 a.m. to 8 p.m.

If you request disenrollment, you must continue to get all medical care from Kaiser Permanente, until the effective date of disenrollment. Please refer to your *Evidence of Coverage* for more details. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente's network. We will notify you of your effective date of disenrollment in writing after we get this form from you.

When enrolled in the Kaiser Permanente Senior Advantage plan, you can only disenroll at certain times during the year unless you meet certain special circumstances. If you have questions about the times you may disenroll from our Plan, please call us at the number listed above.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK			
KAISER PERMANENTE MEDICAL RECORD #	LAST NAME	FIRST NAME	MI
	MAILING ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX: ☐ M ☐ F	HOME PHONE NUMBER	

PLEASE SELECT A DISENROLLMENT REASON BELOW

☐ I have moved out of the Kaiser Permanente service area

☐ I have joined another health plan

☐ My employer group coverage has ended

☐ Other—Please explain _____

Please carefully read and complete the following information before signing and dating this disenrollment form.

If I have enrolled in another Medicare Health Plan or Medicare Prescription Drug Plan, I understand Medicare will cancel my current membership in Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, or Kaiser Permanente Senior Advantage Medicare Medi-Cal Plan on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

For Kaiser Permanente Medicare Cost plan members only: If you want to return to Original Medicare (also known as the Medicare fee-for-service program), then you must complete this disenrollment form. We will notify you of the effective date of your disenrollment after we have received this form from you.

Y0043_N004869 CMS Approved (05/16/2011)
SKU 60050607 CA

If you want to join another HMO immediately following termination from Kaiser Permanente Medicare Cost, then you do **not** need to complete this form. Once you enroll in another HMO, your current membership in Kaiser Permanente Medicare Cost will automatically be cancelled. However, please note that you can generally only choose other plans at certain times of the year. I understand that the Kaiser Permanente Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

Disenrollment from the Kaiser Permanente Medicare Cost plan will be effective on the first day of the month after the month Kaiser Permanente receives the written request (unless you request a later date of disenrollment). For example, if you complete this form and submit it to Kaiser Permanente on April 30, the last day of the month, your disenrollment will be effective the next day, May 1. If you are requesting a later date, disenrollment cannot take place later than the third month after which you submit a completed disenrollment request to Kaiser Permanente. Therefore, if you submit this form on April 30, the latest disenrollment date possible would be July 1.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Kaiser Permanente Senior Advantage or Medicare Cost may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process.

For Federal Employees Health Benefit (FEHB) Program members only: The choice you make will not impact the benefits you receive through the FEHB Program. Coverage for the FEHB Program is described in your FEHB brochure. Your choice will affect the additional benefits you receive as a member of Kaiser Permanente Senior Advantage or Medicare Cost for Federal employees.

Your signature* _____ **Date** _____

*Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that: (1) this person is authorized under State law to complete this disenrollment; and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

If you are the authorized representative, you must provide the following information:

Name _____

Address _____

Phone number _____

Relationship to enrollee _____

Kaiser Permanente is a health plan with a Medicare contract.

This information is available in a different format by calling the number listed on the first page.

RETURN FORM TO:

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

Genesis Employee Benefits

MEDICAL EXPENSE CLAIM FORM

ING

Instead of completing this form you may file your claim online at www.ing.com/us/hra/genesis.
You may also track your payments, view plan balances and see claim history online anytime.

Please comply with the following instructions to file your claim for reimbursement. Failure to follow these instructions will delay processing of your claim and may result in your claim being returned to you. Additional information regarding allowable expenses is provided on the reverse of this form.

1. **Complete the entire claim form, including the itemized list of expenses**.
2. **Attach documentation, in the order it is listed on this form, supporting the expenses**. Acceptable documentation includes:
   - **For medical care --** an itemized bill from the provider or Explanation of Benefits from the insurance company showing the date of the service, provider name, type of service and/or procedure codes, and your out-of-pocket cost.
   - **For over-the-counter drugs and supplies -** the itemized receipt or drug receipt from the place of purchase showing the date, item purchased, and out of pocket cost AND a prescription from an authorized individual.
3. **Note the claim line number in the upper right corner of each attachment**. For example, note "1" in the upper right corner of your documentation for the health care expense listed first on the claim form.
4. **List all claims separately, including prescriptions**. If additional space is needed for your itemization, attach a separate sheet using the same format as the itemization on the claim form. Continue the claim line numbers on the additional sheet.
5. **SIGN and DATE the claim form after carefully reading the Certification on the reverse.**
6. Keep a copy of this form and all supporting documentation for your records.
7. **Eligible claims and substantiation received by Wednesday will be reimbursed the following week on Friday.**

Employer Name: _____ ❑ **I Am Retired**

Employee Name: _____ **SSN:** _____

Home Address: _____

_____ ❑ **Address Change**

Email Address: _____ **Telephone:** _____

MEDICAL EXPENSES

Line # note on receipts	Service Date	Provider	Type of Service (i.e. Medical, Dental, Vision, Orthodontia, Prescriptions)	Patient Name	Amount Requested
1					
2					
3					
4					
5					
6					
7					
8					
9					
				Total Medical Expense Claim	$

EMPLOYEE CERTIFICATION OF EXPENSES AND CLAIM FOR REIMBURSEMENT

I certify that I have read and understand the Certification on the reverse side of this form.

Employee Signature: _____ **Date:** _____

UPLOAD, FAX, EMAIL OR MAIL completed claim forms & supporting documentation to:

Local Claims eFax: 952-460-1480
Toll-Free Claims eFax: 866-450-1480

Genesis Employee Benefits, Inc
PO Box 1578
Minneapolis, MN 55440-1578

Local Phone: 952-653-4422
Toll-Free Phone: 866-678-8322
CustomerCare@GenesisBenefits.net

Check the status of your claim online at www.ing.com/us/hra/genesis.

© Copyright 2011
Genesis Employee B1enefits, Inc.
ING-Claim-Form-Medical 9/2/2011

MEDICAL

CERTIFICATION

Read this statement carefully then sign in the appropriate place on the front of this form.

I certify that I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for qualifying individuals. I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under any other health plan. I understand that the expense for which I am reimbursed may not be claimed as an income tax deduction. I understand that if I am reimbursed for an ineligible expense and the IRS audits my personal income tax return, I may be subjected to taxation on the reimbursement amount. I have provided sufficient documentation to support all expenses for which I am requesting reimbursement.

MEDICAL ELIGIBLE EXPENSES

Expenses allowed by your employer sponsored plan may vary from those permitted by the IRS.
Consult your plan document to determine what expenses are allowed by your plan.

- Expenses must be incurred by you, your spouse, or eligible dependents.
- Expenses must be incurred primarily for medical care as defined by the IRS, which includes "amounts paid for the diagnosis, cure, mitigation, treatment, prevention of disease, or for the purpose of affecting any structure or function of the body."
- Expenses for personal items are not reimbursable even if recommended by your physician. Generally, an expense is deemed "personal-only" if it would have been incurred in the absence of a medical condition. Examples are health club dues and dental hygiene products.
- Expenses for dual-purpose items, which may be personal or medical in nature, require substantiation of medical necessity. Examples are blood pressure monitors, acne medication, weight loss drugs or programs, massage therapy, and over-the-counter orthotics such as ankle or knee braces. Medical necessity can be substantiated through a letter or other documentation of illness or disease from your practitioner.
- Starting January 1, 2011, over the counter medicines will no longer be eligible for reimbursement from your medical FSA accounts without a doctor's prescription. For more information, see the OTC Medicine Announcement.
- Sufficient documentation to substantiate the medical necessity of the expense must be provided in order for your claim to be processed.

You may not claim expenses which have been reimbursed or are reimbursable under any other source. If you do not comply with this requirement and the IRS audits your tax return, you will be liable for any and all back taxes due on ineligible expenses.

FILE YOUR CLAIM ONLINE AT www.ing.com/us/hra/genesis

-or-

FAX or MAIL
COMPLETED CLAIM FORMS & SUPPORTING DOCUMENTATION TO:

SECURE LOCAL eFAX 952-460-1480
SECURE TOLL-FREE eFAX 866-450-1480

Genesis Employee Benefits, Inc.
PO Box 1578
Minneapolis, MN 55440-1578

CUSTOMER CARE CENTER
Local 952-653-4422
Toll-Free 866-678-8322

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ING-Claim-Form-Medical 9/2/2011

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 60 days to elect coverage as a retiree. Your spouse (or domestic partner) may then enroll you as a covered dependent.

2 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.

3 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 benefit payment 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.

4 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 9). You may change to another medical plan ONLY during Open Enrollment.

5 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 60 days of a qualifying event (birth, marriage, custody, etc.). To enroll your eligible dependents, you must submit a Medical and/or Dental Plan Enrollment/ Change Form (with any required attachments and verifications) within 60 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: See page 12 for coverage information regarding newborns and adopted children.

6 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 as long as they pay the cost of the premiums.

7 When does a dependent lose eligibility?

Here are some examples of events that cause a dependent to lose eligibility (see the Dependent Eligibility section of this Guide):

- Your non-disabled, covered child turns 26 years old or becomes eligible for other group health plan coverage, i.e. through an employer or spouse.
- The final divorce decree is granted
- 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 for more information.

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

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

9 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 will be required to enroll in another County medical plan within 60 calendar days after the move or cancel your coverage. Until you change or cancel your enrollment, you will only be covered under the "Out-of-Area Emergency" provision of your current HMO.

10 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 at 1-800-772-1213 or CMS at 1-800-633-4227 regarding enrollment for Medicare insurance benefits
- Call EBSD at 909-387-5787 for your medical insurance options

11 Can my COBRA payments be deducted from my monthly retiree benefit payment?

Yes. You need to complete an SBCERA Deduction Authorization form. You must pay the initial premium before the automatic deduction begins. The deduction will be effective the first of the month for forms received by the 15th of the prior month. Forms may be obtained by contacting the EBSD COBRA specialist at 909-387-5552 and should be returned to EBSD for processing.

12 Why can't my premiums be automatically deducted from my Retirement Medical Trust Fund, and why must I submit my receipts and forms to Genesis?

Since the program is a reimbursement program and not a prepayment program, expenses must be incurred before you can receive payment for them. Genesis is the Third Party Administrator selected by ING to process their claims.

13 Who may I call for additional information?

See the Contact Information section on page 6 of this Guide for telephone numbers and web site addresses.

Notes

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Human Resources
www.sbcounty.gov/hr

County of San Bernardino
Human Resources Department
EMPLOYEE BENEFITS AND SERVICES DIVISION
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440
(909) 387-5787 • ebsd@hr.sbcounty.gov