

2015



San Bernardino County

# Retiree Benefits & Enrollment Guide



## INSIDE YOU'LL FIND:

- ✓ What's new for 2015
- ✓ Your benefit options
- ✓ Enrollment forms
- ✓ What you need to do
- ✓ Who's eligible



## Human Resources Employee Benefits and Services

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### **Welcome to the 2015 Retiree Benefits Guide!**

This Guide is designed to help you understand your health benefits options during open enrollment and throughout the year. Included in this Guide are brief summaries of your medical and dental plan choices as well as comparison charts for convenient at-a-glance referencing. It also contains medical and dental plan rates, enrollment forms, and answers to frequently asked questions.

To learn more about the plans, we encourage you to view the plans' Evidence of Coverage (EOC) and Patient Charge Schedules. These documents are available online at [http://www.sbcounty.gov/hr/Benefits\\_Retire.aspx](http://www.sbcounty.gov/hr/Benefits_Retire.aspx) or you may request a copy from the Employee Benefits and Services Division (EBS) by calling 909-387-5787 or 1-888-743-1474.

Open enrollment provides you an opportunity to evaluate your current medical and dental coverage and to elect the benefit plans that best fit your and your dependents' needs. During Open Enrollment you have the option to:

- ✓ Enroll in a plan
- ✓ Change plans
- ✓ Terminate coverage
- ✓ Add or drop dependents

A series of informational Open Enrollment meetings will be held October 31 – November 20, 2014. Representatives from the medical and dental plans, as well as staff from the EBS, will be at each meeting to answer your questions. You can find the meeting schedule on page 7 of this Guide.

**Open Enrollment for 2015 is November 1 through November 30, 2014.** Any elections and changes made during this Open Enrollment Period, as well as new benefit enhancements and rate changes, will be effective January 1, 2015.

Please contact the EBS at 909-387-5787, toll-free at 1-888-743-1474, or via email at [ebss@hr.sbcounty.gov](mailto:ebss@hr.sbcounty.gov) if you have any questions about your retiree health benefits options or need help during open enrollment.

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## What's New for 2015

### Preventive Medications and Screenings

Beginning on January 1, 2015, select preventive anti-cancer medications that are prescribed by a plan provider will be available at no cost to women who are at an increased risk for breast cancer. This benefit will be added to the Blue Shield and Kaiser non-Medicare plans.

In addition, as of January 1, 2015, computed tomography (CT) scans to screen for lung cancer will be provided at no cost to members with a significant recent history of smoking. This benefit will be added to the Blue Shield and Kaiser Medicare and non-Medicare plans.

**Note:** Members must meet certain eligibility criteria to receive benefits listed above. Contact your provider for more information.

### Out-of-Pocket Maximum Inclusions

Effective January 1, 2015, amounts paid for outpatient prescriptions provided by Kaiser

Permanente pharmacies or by pharmacies that accept Blue Shield insurance will count toward the plan's out-of-pocket maximum. This benefit will be added to the Blue Shield Medicare and non-Medicare plans and the Kaiser non-Medicare plans.

### Dental Implants

Effective January 1, 2015, dental implants will be covered under the Cigna Dental PPO (DPPO) plan. Cigna will pay 50% of the cost of implants, up to the annual maximum of \$1,000.

### Gym Memberships

Effective July 1, 2014, the County will continue to offer discounted gym membership rates through LA Fitness; however, discounts to 24 Hour Fitness will be offered directly through the medical and/or dental providers. For complete details on discounted gym membership offerings please visit the website(s) for Blue Shield, Kaiser Permanente, or Cigna dental.

## Important Dates

- ✓ **Oct. 31, 2014** First open enrollment meeting (see p. 7 for complete Open Enrollment (OE) meeting schedule)
- ✓ **Nov. 1, 2014** First day of open enrollment
- ✓ **Nov. 11, 2014** EBSD office closed (Veteran's Day)
- ✓ **Nov. 27-28, 2014** EBSD office closed (Thanksgiving)
- ✓ **Nov. 30, 2014** Last day of open enrollment\*
- ✓ **Dec. 12, 2014** Last day to submit proof of dependency and/or dependent disability
- ✓ **Jan. 1, 2015** First day of 2015 plan effective date of any new premium rates and changes you make to your plans or coverage levels
- ✓ **Feb. 1, 2015** Election/Enrollment confirmation statements will be mailed by this date

\* Due to the holiday schedule, you will have until 5 p.m. on Dec. 1, 2014, to submit enrollment/change and cancellations forms to EBSD.

## Health Plans

The following medical and dental plans are available to retirees and their eligible dependents:

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

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

### Medicare Integrated Plans (choice of High and Low Options)

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

### Medicare Coordination of Benefits Plans

- ◆ Blue Shield PPO Medicare Coordination of Benefits (COB)
  - California
  - Out of State

### Dental Plans

- ◆ Cigna Dental Care HMO
- ◆ Cigna Dental PPO



**January 1, 2015**, is the effective date of the 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 909-387-5787 or 1-888-743-1474.

## 2015 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 (EBSB) 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, add the "1 Dependent" rate or "2 Dependents" rate to the "Retiree only" rate.

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) . . \$223.97

**Dependent:** Blue Shield Signature - 1 Dependent, under 65, no Medicare (High Option) . . \$1,071.72

**Total Monthly Premium** . . . . . \$1,295.69

Monthly Medical Plan Rates		
Effective January 1, 2015 Plan and Coverage Level	2015 Rates*	
<b>Blue Shield Signature (HMO)</b>	<b>High</b>	<b>Low</b>
Retiree only, <b>under</b> 65, no Medicare	\$936.90	\$770.36
1 Dependent, under 65, no Medicare	\$1,071.72	\$880.29
2 Dependents, under 65, no Medicare	\$1,817.60	\$1,492.95
Retiree only, <b>over</b> 65, no Medicare	\$936.90	n/a
1 Dependent, over 65, no Medicare	\$1,071.72	n/a
2 Dependents, over 65, no Medicare	\$1,817.60	n/a
<b>Blue Shield 65 Plus (HMO) Medicare Advantage</b>	<b>High</b>	<b>Low</b>
Retiree only, over 65, with Medicare A and B	\$223.97	\$93.19
1 Dependent, over 65, with Medicare A and B	\$219.61	\$88.84
2 Dependents, over 65, with Medicare A and B	\$439.22	\$177.68
<b>Blue Shield PPO Medicare COB – California and Out of State</b>	<b>High</b>	<b>Low</b>
Retiree only, over 65, with Medicare A and B	\$701.51	n/a
1 Dependent, over 65, with Medicare A and B	\$697.16	n/a
2 Dependents, over 65, with Medicare A and B	\$1,394.32	n/a

## Monthly Medical Plan Rates (continued)

Effective January 1, 2015 Plan and Coverage Level	2015 Rates*	
	High	Low
<b>Blue Shield PPO – California and Out of State</b>		
Retiree only, under 65, no Medicare	\$1,522.21	\$1,192.01
1 Dependent, under 65, no Medicare	\$1,558.39	\$1,219.35
2 Dependents, under 65, no Medicare	\$3,244.23	\$2,522.83
<b>Kaiser Permanente (HMO)</b>		
Retiree only, <b>under</b> 65, no Medicare	\$949.11	\$722.16
1 Dependent, under 65, no Medicare	\$944.75	\$717.80
2 Dependents, under 65, no Medicare	\$1,728.89	\$1,313.57
Retiree only, <b>over</b> 65, no Medicare	\$1,244.48	\$1,164.33
1 Dependent, over 65, no Medicare	\$1,240.12	\$1,159.97
2 Dependents, over 65, no Medicare	\$2,480.24	\$2,319.94
<b>Kaiser Permanente Medicare Advantage</b>		
Retiree only, over 65, with Medicare A and B	\$207.88	\$126.73
1 Dependent, over 65, with Medicare A and B	\$203.52	\$122.37

## Monthly Dental Plan Rates

	Cigna Dental DPPO	Cigna Dental DHMO
Retiree only	\$40.90	\$19.56
Retiree + 1	\$74.96	\$30.22
Retiree + 2 or more	\$128.55	\$43.05

\*Premium rates are pending approval by the Board of Supervisors.

**Contact EBSD for information if your specific plan is not listed in the rates table.**

## Contact Information

	Address	Phone
<b>Employee Benefits and Services Division</b>	157 West Fifth Street, First Floor San Bernardino, CA 92415 <a href="http://www.sbcounty.gov/hr/benefits">www.sbcounty.gov/hr/benefits</a>	1-909-387-5787 1-888-743-1474
	All Retiree Medical and Dental Plans <a href="http://www.sbcounty.gov/hr/Benefits_Retire.aspx">http://www.sbcounty.gov/hr/Benefits_Retire.aspx</a>	1-909-387-9674
<b>Providers:</b>	COBRA	1-909-387-5552
Cigna Dental Care (DHMO)	P.O. Box 188046, Chattanooga, TN 37422-8045 <a href="http://www.cigna.com">www.cigna.com</a>	1-800-238-5834
Cigna Dental PPO	P.O. Box 188037, Chattanooga, TN 37422-8037 <a href="http://www.cigna.com">www.cigna.com</a>	1-800-238-5834
Kaiser Permanente	Kaiser Permanente Foundation Health Plan, Inc. P.O. Box 7141, Pasadena, CA 91109-7141 <a href="http://www.my.kp.org/ca/sbcounty">www.my.kp.org/ca/sbcounty</a>	1-800-464-4000
Kaiser Permanente Senior Advantage	Kaiser Permanente -Medicare Unit. (for membership enroll/disenroll) P.O. Box 232400, San Diego, CA 92193-2400 <a href="http://www.my.kp.org/ca/sbcounty">www.my.kp.org/ca/sbcounty</a>	1-800-443-0815
Blue Shield Signature	P.O. Box 272540, Chico, CA 95927-2540 <a href="http://www.blueshieldca.com">www.blueshieldca.com</a>	1-800-642-6155
Blue Shield PPO and Non-Medicare	Blue Shield of California P.O. Box 272540, Chico, CA 95927-2540 <a href="http://www.blueshieldca.com">www.blueshieldca.com</a>	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
Voya (formerly ING)	1200 California Street, Suite 108 Redlands, CA 92374 <a href="http://www.voyaretirementplans.com/custom/sanbern">www.voyaretirementplans.com/custom/sanbern</a>	1-909-748-6468 1-800-584-6001
Genesis Employee Benefits, Inc. (Genesis)	P.O. Box 1578, Minneapolis, MN 55440-1578 <a href="http://www.GenesisBenefits.net">www.GenesisBenefits.net</a>	1-866-678-8322 1-866-450-1480 Fax

### Helpful Resources and Referral Services:

American Association of Retired Persons	<a href="http://www.aarp.org">www.aarp.org</a>	1-888-687-2277
American Heart Association	<a href="http://www.heart.org/HEARTORG/">www.heart.org/HEARTORG/</a>	1-800-242-8721
American Cancer Society	<a href="http://www.cancer.org">www.cancer.org</a>	1-800-227-2345
CMS (for Medicare information)	<a href="http://www.medicare.gov">www.medicare.gov</a>	1-800-633-4227
Social Security Administration (SSA)	<a href="http://www.socialsecurity.gov">www.socialsecurity.gov</a>	1-800-772-1213
State of California Health Care Exchange, Covered California	<a href="http://www.coveredca.com">www.coveredca.com</a>	1-800-300-1506
Health Insurance Counseling and Advocacy Program (HICAP)	<a href="http://www.aging.ca.gov/hicap">www.aging.ca.gov/hicap</a>	1-800-434-0222
San Bernardino County Employees' Retirement Association (SBCERA)	348 West Hospitality Lane, Third Floor San Bernardino, CA 92415-0014 <a href="http://www.sbcera.org">www.sbcera.org</a>	1-909-885-7980 1-877-722-3721

**Open Enrollment Meeting Schedule** Take advantage of this opportunity to discover your options. Blue Shield, Kaiser, and Cigna representatives will be at each meeting to answer your questions. Please note that this year we will not be having separate Medicare and non-Medicare meetings. Information for all plan types will be presented in the same session.

## 2014 Open Enrollment Meetings

Monday	Tuesday	Wednesday	Thursday	Friday
				<b>Oct 31</b> <b>10:00-12:00</b> Government Center <i>Board Chambers</i> 385 N. Arrowhead Ave. San Bernardino
<b>Nov 3</b>	<b>Nov 4</b> <b>1:00-3:00</b> TAD <i>Forest Falls Room</i> 32353 Yucaipa Blvd. Yucaipa	<b>Nov 5</b> <b>10:00-12:00</b> TAD <i>Oasis Room</i> 15010 Palmdale Rd. Victorville	<b>Nov 6</b>	<b>Nov 7</b>
<b>Nov 10</b>	<b>Nov 11</b> <b>Veterans Day</b> <b>EBSD Office</b> <b>closed</b>	<b>Nov 12</b> <b>9:00-11:00</b> DAAS <i>Haven Room</i> 9445 Fairway View Place Suite 110 Rancho Cucamonga	<b>Nov 13</b>	<b>Nov 14</b>
<b>Nov 17</b>	<b>Nov 18</b> <b>10:00-12:00</b> San Bernardino County Health Services Auditorium 850 E. Foothill Blvd. Rialto	<b>Nov 19</b>	<b>Nov 20</b> <b>1:30-3:30</b> Department of Public Works <i>Hearing Room</i> 825 East Third St. San Bernardino	<b>Nov 21</b>
<b>Nov 24</b>	<b>Nov 25</b>	<b>Nov 26</b>	<b>Nov 27</b>	<b>Nov 28</b> <b>Thanksgiving Holiday</b> <b>EBSD Office</b> <b>closed</b>

## 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 may be deducted from your monthly retirement benefit payment. If you do not receive a monthly retiree benefits payment, you will need to make payments directly to EBSD.

If you are a surviving spouse or child of a retired or active employee, you may also be eligible to enroll in County-sponsored retiree health benefits. Please contact EBSD at 909-387-9674 if you are unsure of your eligibility status.

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 plan's 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 until the next open enrollment period.

## Dependent Eligibility

If you are participating in a County-sponsored retiree 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:
  - Under age 26
  - Over age 26, 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/

**Open Enrollment elections are effective January 1, 2015**

Change Form. Please note that it is the medical plan that evaluates and makes the final determination on the disability status.

\* Your children include children born to you, legally adopted by you (including those children during any waiting period before the finalization of their adoption), your stepchildren, children of your state-registered domestic partner, 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 your 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**.

**Note:** 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.

Your last day to submit proof of dependency and proof of disability is **December 12, 2014**.

## Enrollment

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 enrollment options you elect during the 2015 Open Enrollment Period will remain in effect for the entire plan year and you must wait until the next open enrollment period to make changes, unless you experience a Change-in-Status Event (see page 13).

### COBRA After Retirement

When you retire, you may continue the medical, dental and vision coverage you had as an active employee through COBRA before enrolling in one of the County-sponsored retiree plans. (Note: There is no County-sponsored vision plan for retirees.)

If you elect COBRA continuation coverage, you are eligible for 18 months of medical, dental, and vision coverage under federal COBRA. You are also eligible for an additional 18 months of medical coverage under Cal COBRA. Vision and dental coverage are not available under Cal COBRA.

Contact EBSD at 909-387-5787 if you need help deciding which option is best for you.

## 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, 2014.

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

- ◆ **Medical Plan Enrollment/Change Form**  
Required to enroll or make changes.
- ◆ **Dental Plan Enrollment/Change Form**  
Required to enroll or make any changes.
- ◆ **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).

### 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](http://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](http://www.Cigna.com) or by calling 800-238-5834.

You will need to complete one of the following forms, in addition to the County Medical Plan Enrollment/Change form, if newly enrolling in a Medicare Plan:

- ◆ **Blue Shield 65 Plus (HMO) Group Enrollment Form**
- ◆ **Blue Shield of California Medicare Rx Plan (PPO) Form**
- ◆ **Kaiser Senior Advantage Election Form**

### 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 by November 30, 2014, 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.



## 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. If you are enrolled in a Medicare plan, you will also need to complete and submit the appropriate Medicare disenrollment form.

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 dental plan enrollments are subject to the two-year enrollment provision of the Cigna Dental Contract. 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 on the effective date of your coverage.

New elections made during the 2015 Open Enrollment Period will be effective January 1, 2015. Any enrollments made outside of open enrollment will be effective the first day of the calendar month following the election.

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's website.

## Confirmation Statements

After Open Enrollment, you will receive a Confirmation Statement verifying your 2015 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 the information contained in your statement.

## Mid-Year Enrollments and Changes

The enrollment options you elect during the 2015 Open Enrollment Period will remain in effect for the entire plan year. You must wait until the next open enrollment period to make changes, UNLESS you experience a Change in Status Event as noted in the Change in Status Event Matrix on the following page.

The two exceptions to mid-year changes are removing dependents and cancelling coverage. 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.

For all other mid-year changes, your request to make a mid-year change must:

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



## Effective Date of Mid-Year Changes

All elections made during the plan year will become effective the first calendar day of the month following the date that the 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:** Under Blue Shield, newborn children will be covered under the same medical group in which the natural mother is enrolled for the first 60 days. If the natural mother of the newborn is not enrolled as a member or if the child has been placed with the subscriber for adoption, the personal physician selected must be a physician in the same medical group or Individual Practice Association (IPA) as the subscriber. Under Kaiser, newborn children are covered for the first 31 days. Newly adopted children or child placed with you for adoption are eligible for coverage the first date in which you or your spouse or domestic partner gain the legal right to control the child's health care. Retiree subscribers must still enroll the newborn under their respective plan through the County. Contact EBSD to complete the newborn's 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
<p>Gain Dependent</p> <ul style="list-style-type: none"> <li>• Marriage</li> <li>• Domestic Partnership</li> <li>• Birth/Adoption/Placement for Adoption/Legal Guardianship</li> </ul>	Retiree may enroll newly eligible dependent(s)	<p>To enroll dependent in health benefits, you must submit the following forms (within 60 days of event):</p> <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable)</li> <li>• Retiree Dental Enrollment/Change Form</li> <li>• Marriage Certificate, Domestic Partner Certificate and/or Birth Certificate(s) or Court Documentation</li> </ul>
<p>Lose Dependent</p> <ul style="list-style-type: none"> <li>• Divorce or annulment</li> <li>• Domestic Partnership Termination</li> <li>• Death</li> </ul>	Retiree must remove spouse; may also enroll self and eligible dependent(s) if other group coverage is lost	<p>To remove spouse or enroll self/dependent(s) in health benefits, you must submit the following forms (within 60 days of event):</p> <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable)</li> <li>• Retiree Dental Enrollment/Change Form</li> <li>• Divorce, legal separation, annulment, or Termination of Domestic Partnership decree</li> <li>• Death Certificate</li> </ul>
<p>Court Ordered Dependent Coverage</p> <p>Judgment, decree, or order resulting from divorce, annulment or change in legal custody that requires medical/dental coverage for your dependent child(ren)</p>	Retiree may enroll dependent children	<p>To enroll dependent(s) in health benefits, you must submit the following forms (within 60 days of event):</p> <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable)</li> <li>• Retiree Dental Enrollment/Change Form</li> <li>• Birth Certificate(s)</li> <li>• Court Documentation</li> </ul>
Gain of Spouse's Employment or Other change in status that results in eligibility under spouse's plan	Retiree may cancel enrollment <b>Exception:</b> Dental plan benefits (retiree must maintain enrollment in dental plan for a period of 24 months)	<p>To cancel enrollment from health benefits, you must submit the following forms (within 60 days of event):</p> <ul style="list-style-type: none"> <li>• Retiree Medical and/or Dental Cancellation Form (and Medicare forms if applicable)</li> <li>• Proof of other coverage</li> </ul>

## 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): <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable) (enrollment)</li> <li>• Retiree Dental Enrollment/Change Form</li> <li>• Proof of spouse's employment and benefit plan loss</li> </ul>
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): <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form</li> <li>• Retiree Dental Enrollment/Change Form</li> </ul>
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: <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable)</li> <li>• Retiree Dental Enrollment/Change Form</li> </ul>
Lose eligibility for Medicare or Medicaid	Retiree may cancel medical plan enrollment or enroll self and eligible dependents in non-Medicare plan	To remove self and dependents from a medical plan and enroll in a new plan, you must submit the following forms (within 60 days of event): <ul style="list-style-type: none"> <li>• Retiree Medical and/or Dental Cancellation Form (Please note, dental cannot be cancelled for this event)</li> <li>• Retiree Medical Enrollment/Change Form</li> <li>• Proof of loss of Medicare or Medicaid</li> </ul>
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): <ul style="list-style-type: none"> <li>• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable)</li> <li>• Retiree Dental Enrollment/Change Form</li> <li>• Marriage Certificate, State Registered Domestic Partner Certificate and/or Birth Certificate(s)</li> <li>• Proof of loss of COBRA coverage</li> </ul>

## COBRA Continuation Coverage for Retiree Plans

The Consolidated Omnibus Budget Reconciliation Act (COBRA) offers employees/retirees and their covered dependents the opportunity to elect a temporary extension of their health coverage in certain instances where coverage would otherwise end.

Since retirees do not usually lose eligibility for retiree health benefits, they are not typically offered COBRA continuation coverage. Retirees who voluntarily cancel their retiree medical coverage are not entitled to COBRA coverage (e.g., due to non-payment). On the other hand, dependents of retirees may lose their eligibility for retiree health benefits due to a qualifying event. Eligible dependents who are enrolled in a County-sponsored retiree health plan on the day before a “qualifying event” are considered to be “qualified beneficiaries” who are entitled to COBRA continuation coverage. Each qualified beneficiary has independent election rights to COBRA. Domestic partners, however, are not considered to be qualified beneficiaries under COBRA law.

If you are the spouse of a retiree and are covered by a County-sponsored retiree health plan, you have the right to elect COBRA continuation coverage if you lose coverage due to the following qualifying events:

- ◆ Divorce or legal separation.

The covered dependent child of a retiree has the right to elect continuation coverage if plan coverage is lost due to any of the following qualifying events:

- ◆ Parent’s divorce, legal separation or dissolution of domestic partnership.

- ◆ The child ceases to be a “dependent child” under the terms of the Plan(s) (e.g., child turns 26 years of age).

To elect COBRA, you must notify EBSD of your qualifying event within 60 days of the event date. You will not be enrolled in COBRA continuation coverage until you make a COBRA election and all premiums are paid. Once an election is made and premiums are paid, your coverage will be retroactively reinstated back to your loss of coverage date. The qualified beneficiary is responsible for the full premium plus a 2% administration fee.

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.

**Note:** Surviving spouses, domestic partners, and children have the option of remaining on the retiree plan without enrolling in COBRA. If you experience this type of qualifying event, please contact EBSD at 909-387-5787 for guidance.



## EBSB Appeals Procedure

### General Information

EBSB 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 eligible dependent believes that a request for a benefit under a health 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. EBSB, 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 EBSB 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, EBSB 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. EBSB will provide written notification if an extension is needed. Appeal decisions will be administered in line with our contract terms and conditions and/or applicable law.



## 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 will be covered under this benefit.

- 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](http://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

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.

- ◆ 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](http://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](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** No claim form filing is required; however, you may have to file claim forms 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 26-53 of this Guide for a list of key covered expenses. Refer to the Kaiser Permanente EOC for information about what is not covered under your plan. If you do not have the plan booklet, contact EBSD at 909-387-5787.

## 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](http://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

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](http://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](http://www.blueshieldca.com)

## 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 About Your Medicare Prescription Drug Coverage

### 2015 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.

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

- ◆ 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](http://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, Anytime Fitness, Fitness 19, YMCAs and many others. Women-only locations, including Curves®, are also available nationwide.
- ◆ SilverSneakers is available online at [www.silversneakers.com](http://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](http://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)

Services	BLUE SHIELD SIGNATURE HMO			
	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

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 CY, preferred and non-pref providers combined.	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)

Services	BLUE SHIELD SIGNATURE HMO			
	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

MEDICAL PLAN SUMMARIES

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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	\$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 Services – 20% if not admitted, waived if admitted. 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
No charge	No charge	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

MEDICAL PLAN SUMMARIES

CY = Calendar Year

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## Medical Plans Comparison Chart (Non Medicare Eligible)

Services	BLUE SHIELD SIGNATURE HMO			
	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

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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 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

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## Medical Plans Comparison Chart (Non Medicare Eligible)

Services	BLUE SHIELD SIGNATURE HMO			
	High Option		Low Option	
	Level 1	Level 2	Level 1	Level 2
<b>Mental Health</b> 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
<b>Severe Mental Disorders - Inpatient</b>	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
<b>Out-of-Pocket Maximum</b>	\$1,500 per Member \$3,000 per Family	None	\$3,000 Per Member \$6,000 Two Members \$9,000 Three or more Members	None
<b>Outpatient Services</b> 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
<b>Outpatient Surgery (Facility)</b>	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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MEDICAL PLAN SUMMARIES

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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)

<b>BLUE SHIELD SIGNATURE HMO</b>				
<b>Services</b>	<b>High Option</b>		<b>Low Option</b>	
	<b>Level 1</b>	<b>Level 2</b>	<b>Level 1</b>	<b>Level 2</b>
<b>Physician Services</b> <b>Hearing Screening</b>	\$0 copay (preventive care)	\$30 copay	\$0 copay (preventive care)	\$80 copay
<b>Home Visits</b>	\$10 copay	Refer to Level 1 benefit	\$50 copay	Refer to Level 1 benefit
<b>Hospital Services</b>	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit
<b>Immunizations</b>	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.

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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	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)

Services	BLUE SHIELD SIGNATURE HMO			
	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
No charge	No charge, no deductible	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)

Services	BLUE SHIELD SIGNATURE HMO			
	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	20% coinsurance, no deductible	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)

Services	BLUE SHIELD SIGNATURE HMO			
	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)

Services	BLUE SHIELD SIGNATURE HMO			
	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)	For visits to non-participating providers, the maximum per member per calendar year reimbursement is \$60 for an ophthalmologic exam and \$50 for an optometric exam	\$10 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	For visits to non-participating providers, the maximum per member per calendar year reimbursement is \$60 for an ophthalmologic exam and \$50 for an optometric exam

MEDICAL PLAN SUMMARIES

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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OON = Out-of-Network

## Medical Plans Comparison Chart (Medicare Eligible)

Services	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	\$0 copay consultation \$0 copay outpatient surgery
Vasectomy	\$10 copay consultation \$10 copay outpatient surgery	\$0 copay consultation \$0 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	No charge	No charge
Mental Health Inpatient	No charge Unlimited days	\$500 per admit Unlimited days

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N/A = Not Applicable

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<b>BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)</b>	
<b>High Option</b>	<b>Low Option</b>
No charge	No charge
No charge for emergency or non-emergency transportation. Non-emergency transportation requires a PCP referral and medical group approval before services are rendered.	\$125 copay for emergency and non-emergency transportation. Non-emergency transportation requires a PCP referral and medical group approval before services are rendered.
\$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

CY = Calendar Year

N/A = Not Applicable

## Medical Plans Comparison Chart (Medicare Eligible)

Services	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	Low Option
Outpatient	\$10 copay for individual; \$5 copay group; unlimited visits	\$25 copay individual; \$12 copay group; unlimited visits
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

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.

<b>BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)</b>	
<b>High Option</b>	<b>Low Option</b>
\$10 copay	No charge
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)	No charge (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

CY = Calendar Year

N/A = Not Applicable

## Medical Plans Comparison Chart (Medicare Eligible)

Services	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
	High Option	Low Option
Physical and Occupational Therapy	Inpatient: No copay Outpatient: \$10 copay	\$25 copay
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

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.

<b>BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)</b>	
<b>High Option</b>	<b>Low Option</b>
No charge	No charge
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

CY = Calendar Year

N/A = Not Applicable

## Medical Plans Comparison Chart (Medicare Eligible)

	KAISER PERMANENTE MEDICARE ADVANTAGE PLAN	
Services	High Option	Low Option
Catastrophic Coverage Limit	None	None
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	No charge. Includes eyewear (purchased at plan offices) allowance of \$150 every 24 months.	No charge. Includes eyewear (purchased at plan offices) allowance of \$150 every 24 months.
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

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.

<b>BLUE SHIELD BLUE SHIELD 65 PLUS (HMO)</b>	
<b>High Option</b>	<b>Low Option</b>
Once out-of-pocket expenses for a CY reach \$4,550, payment is limited to the lesser of 5% or applicable copay for the drug	Once out-of-pocket expenses for a CY reach \$4,550, payment is limited to the lesser of 5% or applicable copay for the drug
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

CY = Calendar Year

N/A = Not Applicable





## Cigna Dental Care (DHMO)

Cigna Dental Care is an HMO-style dental plan (DHMO) which provides you and your family with quality comprehensive dental benefits at an affordable cost. The information below is a general summary of Cigna DHMO Plan benefits. Please refer to the Dental Plans Comparison Chart on pages 60-64 for a listing of the most highly utilized procedures and applicable co-pay amounts. For a complete listing of benefits, please refer to your plan's Evidence of Coverage (EOC) and Patient Charge Schedule (PCS) which can be found on-line at [www.sbcounty.gov/hr/Benefits\\_Retire\\_Cig.aspx](http://www.sbcounty.gov/hr/Benefits_Retire_Cig.aspx).

In addition, 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 card requests; and/or claims information. You can contact member services at 1-800-238-5834.

### How the Plan Works

If you enroll in the Cigna DHMO Plan, you must select and utilize an in-network dentist who will coordinate all of your dental care. Each family member may select their own dentist, up to three dentists per family.

**In-Network Providers:** Cigna has a large network of DHMO 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 amounts 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. To find an in-network provider in your area call Cigna Member Services at 1-800-238-5834

or go to [www.cigna.com](http://www.cigna.com). If you are already enrolled in Cigna's DHMO Plan and would like to change your dental provider, please contact Cigna Member Services or go to [www.mycigna.com](http://www.mycigna.com).

**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 fee as described in your Evidence of Coverage.

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

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

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

**Orthodontia Coverage:** You and your covered dependents may obtain comprehensive and/or limited orthodontic care from any Cigna DHMO orthodontist.

For comprehensive, limited and/or interceptive orthodontic treatment, you pay a \$380 startup (banding) fee along with a \$67 copayment for adults and a \$46 copayment for adolescents per month for 24 months of treatment. In addition, you pay a \$260 copayment for pretreatment records and diagnostic services. Additional fees may apply depending on your individual treatment 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 the Cigna Dental Oral Health Integration Program (OHIP), which provides proactive care to members with such medical conditions. This program provides 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 in the following states:

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

Please note that even if a state is listed, there may be some areas within the state that are not covered. We advise you to call Cigna Member Services at 1-800-238-5834 to verify if DHMO coverage is available in your area. The list is subject to change.

**Emergency Care:** Emergency services are limited to relieving sudden and severe pain, controlling excessive bleeding, or eliminating serious and sudden (“acute”) infection. Routine restorative procedures or definitive treatments (e.g., root canal) are not considered 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 Member Services at 1-800-238-5834 and you will be directed to an available Cigna Dental Care dentist.

**Emergency Care Away From Home or After Hours:** If you are away from home or unable to contact your assigned in-network dentist, you may receive emergency services by any licensed dentist for the conditions listed above. Call Cigna Member Services at 1-800-238-5834 24 hours a day/7 days a week for assistance.

Be aware that you will be responsible for all applicable copayments including an additional charge for services received after regularly scheduled office hours if applicable. Refer to the Patient Charge Schedule at [www.sbcounty.gov/hr/Benefits\\_Retire\\_Cig.aspx](http://www.sbcounty.gov/hr/Benefits_Retire_Cig.aspx) for the list of copayments for emergency services.

## How to Enroll

Complete a County of San Bernardino Retiree Dental Plan Enrollment/Change Form and submit it 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

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

## What's Covered

The Cigna DHMO Plan provides you with comprehensive dental benefits. The plan helps pay benefits for covered expenses you incur while enrolled in 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 Member Services at 1-800-238-5834 for additional information. Generally, root canals, dentures, crowns and bridge that are in-progress are not covered for new plan members. In addition, placement, repair, maintenance or removal of dental implants are not covered.

## Cigna Dental (DPPO)

The Cigna Dental PPO (DPPO) Plan allows you to seek services from an in-network provider (Advantage Network, formerly the Core Network), a Cigna DPPO Network provider (Dental Network Savings Program; DNSP), or an out-of-network provider. You may change dentists anytime without notifying Cigna Dental. It is your choice; however, it is important to note that your co-pays may be higher for select services if you choose to go out-of-network or to a Cigna DPPO Network provider. Please refer to the Dental Plans Comparison Chart on pages 60-64 for a list of the most 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 which can be found on-line at [www.sbcounty.gov/hr/Benefits\\_Retire\\_Cig.aspx](http://www.sbcounty.gov/hr/Benefits_Retire_Cig.aspx).

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 card requests; and/or claims information. You can contact member services at 1-800-238-5834.

## How the Plan Works

The amount you pay for services will depend on whether you visit an Advantage Network dentist, a Cigna DPPO Network dentist, or an out-of-network dentist.

**In-Network Providers:** When you receive your dental care from an Advantage Network dentist, you will pay a percentage of the dentist's discounted Cigna DPPO contracted rate.

Cigna has a large network of DPPO providers for you to choose from. In the DPPO plan, individual dentists are contracted as DPPO

providers, not entire groups. It is important to ask whether or not your dentist participates in the Cigna DPPO **Advantage Network** to determine if he or she is an in-network provider.

To find an in-network DPPO provider in your area call Cigna Member Services at 1-800-238-5834 or go to [www.cigna.com](http://www.cigna.com). Please note that in-network dentists who appear in [www.cigna.com](http://www.cigna.com) are noted as “In-Network for Cigna DPPO **Advantage.**”

**Out-of-Network Providers:** The DPPO plan allows you to seek services from an out-of-network provider; however you will incur a higher copayment for select services. 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 cost-comparison below demonstrates the cost difference between obtaining a service from an in-network versus an out-of-network provider. (Note: the numbers cited are for example purposes only. They may not be the actual rates associated with this procedure.)



### EXAMPLE

Procedure: Root Planning

Cigna’s maximum allowance payable for the procedure: \$100

If the procedure is performed by an **in-network** dentist:

- In-network fee (flat amount based on contracted fee): \$85
- In-network copayment (patient’s responsibility):  
20% of in-network fee  
 $\$85 \times 20\% = \$17$
- **Patient pays \$17**

If the procedure is performed by an **out-of-network** dentist:

- Out-of-network fee (will vary by provider): \$125
- Out-of-network copayment (patient’s responsibility): 40% of maximum allowance plus the difference between the out-of-network fee and the maximum allowance.  
 $\$100 \times 40\% = \$40$ , plus  
 $\$125 - \$100 = \$25$
- **Patient pays \$65**

**Cigna DPPO Network Providers:** Dentists who participate in the Dental Network Savings Program (DNSP) are now part of a network called “In-Network for Cigna DPPO.” If you seek services from a dentist in the “Cigna DPPO,” the out-of-network rates will apply; however, you will not pay costs over the maximum allowance since Cigna DPPO providers have contracted rates with Cigna dental.

**Copayments:** For most preventive and restorative services, you pay nothing out-of-pocket when you obtain services from an in-network provider. For other services, you pay a

copayment as described in your evidence of coverage. As previously noted, copayments will be higher when you receive services from an out-of-network dentist.

**Deductibles:** The Cigna DPPO plan has a \$50 per person or \$150 per family calendar year annual deductible. However, the deductible does not apply to preventive services such as routine cleanings and exams.

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

If your dentist is 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 per person. Once you reach the annual maximum, you will be responsible for 100% of the cost for services received until the end of the calendar year. On January 1st, each member will receive a new annual maximum of \$1,000.

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

**Predetermination of Covered Benefits:** A predetermination is particularly useful for more costly procedures such as crowns, wisdom teeth extractions, bridges, dentures or periodontal surgery. When your dentist predetermines treatment with Cigna, you'll receive an estimate of your share of the cost and how much Cigna will pay before treatment begins.

To predetermine treatment, your dentist sends Cigna a proposed treatment plan, along with x-rays relevant to the case. Cigna then checks to be sure the services are

covered by your dental program. Cigna also calculates how any coinsurance and dollar maximum limits might affect your share of the cost. Your dentist then receives an estimate of the amount Cigna will pay for approved services. Please call Cigna Member Services at (800) 238-5834 if you or your dentist has questions about predetermination of benefits.

**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 the Cigna Dental Oral Health Integration Program (OHIP), which provides proactive care to members with such medical conditions. This program provides 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:** 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 DPPO in-network or out-of-network provider of choice.

## How to Enroll

Complete and submit a County of San Bernardino Retiree Dental Plan 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

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

### 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).

**Note:** If more than one covered service will treat a dental condition, payment is limited to the least costly treatment, provided it is a professionally accepted, necessary and appropriate treatment. If you accept or request a more costly covered service, you will be responsible for expenses that exceed the amount covered for the least costly service. This practice is called the **Alternate Benefit Provision** and is described in the plan's EOC. The Alternate Benefit Provision typically applies to crowns, bridges, and dentures. It also applies to white fillings (Resin Composite) on molars when the service is provided by an out-of-network dentist. For this reason, a Predetermination of Covered Benefits is highly recommended before you begin these types of treatments.

It is recommended that you obtain and agree to a prescribed treatment plan issued by your dental provider prior to receiving treatment. 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

Some restorative dentistry procedures, such as inlays, crowns, bridges, and dentures are subject to a 12-month waiting period if you are newly enrolled in the Cigna DPPO Plan and have not had continuous dental coverage prior to enrolling in the Plan. To waive the 12-month waiting period, you will need to submit proof of prior coverage with your enrollment form.

Generally, root canals, dentures, crowns, and bridges that are in-progress are not covered for new plan members.

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.



## Dental Plans Comparison Chart

Please note services denoted with asterisks (\* or \*\*):

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

\*\*This procedure may be subject to additional costs based on materials used and/or location of the tooth/teeth within the mouth (e.g., See Alternate Benefit Provision on page 59). 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.

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, including all of the limitations and exclusions, 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 (Advantage)	Cigna DPPO and Out-of-Network
<b>Calendar Year Maximum Benefit</b>			
Not applicable		\$1,000 per person	
<b>Annual Deductible</b>			
Not applicable		\$50 per person/\$150 per family	

DENTAL PLAN SUMMARIES

Category	Procedure Code	Description	You Pay	You Pay	You Pay (plus costs over maximum allowance for Out-of-Network)
Preventive Care	D0120	Periodic oral evaluation (2 per calendar 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) (2 per calendar year)	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%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Advantage)	Cigna DPPO and Out-of-Network
			You pay	You pay	You pay (plus costs over maximum allowance for Out-of-Network)
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 (1 per 24 months)	\$90.00	50%	50%
	D9951	Occlusal adjustment, limited	\$12.00	20%	40%
	D9952	Occlusal adjustment, complete	\$18.00	20%	40%
	D7270	Tooth 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%**
	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
Restorative Dentistry – 12 month waiting period applies for DPPO**	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

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Advantage)	Cigna DPPO and Out-of-Network
			You pay	You pay	You pay (plus costs over maximum allowance for Out-of-Network)
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%
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%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Advantage)	Cigna DPPO and Out-of-Network
			You pay	You pay	You pay (plus costs over maximum allowance for Out-of-Network)
Oral Surgery*	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
Crowns and Bridges – 12 month waiting period applies for DPPO* **	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 – resin with 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%

Category	Procedure Code	Description	Cigna Dental Care (DHMO)	Cigna Dental PPO	
			In-Network Only	In-Network (Advantage)	Cigna DPPO and Out-of-Network
			You pay	You pay	You pay (plus costs over maximum allowance for Out-of-Network)
Prosthetics – 12 month waiting period applies for DPPO* **	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%
	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	50%	50%
Orthodontics	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

## 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:

- ◆ Prior to retirement, the benefit must have been provided in your Memorandum of Understanding (MOU) Employment Contract, Salary Ordinance or Exempt Compensation Plan.
- ◆ You must meet the minimum years of public service requirement as determined by your MOU Employment Contract, Salary Ordinance or Exempt Compensation Plan.

### 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 or a guaranteed return account.

Your account is maintained by Voya (formerly ING), in partnership with Genesis Employee Benefits (Genesis). Genesis is a partner to Voya 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 Voya 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 a Voya representative, you can contact our local Voya office at 909-748-6468, toll free at 800-452-5842, or visit the Voya custom webpage at [www.voyaretirementplans.com/custom/sanbern](http://www.voyaretirementplans.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 Voya 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 <http://voyacd.com/hra/genesis> 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 99 of this book. To receive assistance from a Genesis representative, call 1-866-678-8322. Participants can access their account, see a list of qualifying expenses or obtain additional claim forms via the Genesis website at <http://voyacd.com/hra/genesis>

## Health Club Membership Discounts

County retirees are eligible for a health club membership at a reduced rate at 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 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.

### 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](mailto: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.



## 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 coverage.

### 3 **What should I do if the premium for my medical plan 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 **Is there a vision plan for retirees?**

The County of San Bernardino does not offer a retiree vision plan. However, if you are newly retired, you may continue your EyeMed vision coverage for up to 18 months by electing COBRA. In addition, you may be able to obtain vision coverage from the State Association of County Retirement Systems/ Vision Service Plan (VSP) or the San Bernardino Public Employees Association (SBPEA) if you are a member. For information about these plans, contact VSP at 1-800-400-4569 or SBPEA at 1- 877-312-3333.

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

You may add dependents only during Open Enrollment unless you experience a qualifying event. 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. 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.

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

Your eligible dependents may continue to participate in the retiree medical and/or dental plans as long as they pay the cost of the premiums.

## 8 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 of age
- ◆ The final divorce decree is granted
- ◆ Dissolution of a domestic partnership

Your former spouse must be removed from your medical and dental plans 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.

## 9 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.

## 10 If I am enrolled in an HMO plan, do I have to change medical plans if I move outside the HMO's service area?

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.

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

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

- ◆ Call the Social Security office 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

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

Yes. When you sign and date the COBRA Medical Plan Enrollment/Change Form or the COBRA Dental Plan Enrollment/Change Form you authorize the County of San Bernardino to deduct the monthly COBRA payments from your monthly retiree benefit payment.

# 13

**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.

# 14

**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.



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

# Retiree Medical Plan Enrollment/Change Form

County of San Bernardino—Retirees

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

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

**B. CHOOSE A MEDICAL PLAN AND A HIGH OR LOW OPTION**

<input type="checkbox"/> Kaiser Permanente Traditional HMO Plan <input type="checkbox"/> Kaiser Medicare Advantage * <input type="checkbox"/> Kaiser Permanente Medicare COB	<input type="checkbox"/> Blue Shield Signature HMO <input type="checkbox"/> Blue Shield PPO <input type="checkbox"/> Blue Shield PPO COB <input type="checkbox"/> Blue Shield 65 Plus (HMO) *	<p><b>Option:</b></p> <input type="checkbox"/> High Option <input type="checkbox"/> Low Option
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**\*Medicare integrated plan. Please complete both the County and the Medicare enrollment forms.**

**Previous Medical Plan:** \_\_\_\_\_

**For PPO Only:**

 California  
 Out of State

**C. RETIREE OR ELIGIBLE DEPENDENT INFORMATION**

Social Security Number	Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth Month   Day   Year	Date of Retirement Month   Day   Year	Check One <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
Last Name		First Name	MI	For Name Change, List Former Name Here
Mailing Address <input type="checkbox"/> Check Here If New Address			Home Phone (   ) (   ) (   )	
City			State	Zip Code
Residential Address (if different from mailing address)			Blue Shield Signature HMO and 65 Plus HMO Primary Care Physician ID No./Group ID No.	
			Previously Visited? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**D. NEW ENROLLMENT ONLY**    IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME, LIST ALL DEPENDENTS TO BE COVERED    **Blue Shield HMO & 65 Plus HMO Enrollees Only**

Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
Spouse/Domestic Partner:		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Children:		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> M <input type="checkbox"/> F				Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**E. ENROLLMENT CHANGES ONLY**    IF YOU ARE ADDING OR DROPPING DEPENDENTS, LIST DEPENDENTS AND INDICATE IF ADDING OR REMOVING    **Blue Shield HMO & 65 Plus HMO Enrollees Only**

Last Name	First Name	Sex	Social Security #	Date of Birth	Relationship	Primary Care Physician's ID No. / Medical Group No.	Previously Visited?
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Spouse/Domestic Partner (See Section F):		<input type="checkbox"/> M <input type="checkbox"/> F			Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove	Children:		<input type="checkbox"/> M <input type="checkbox"/> F			Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove			<input type="checkbox"/> M <input type="checkbox"/> F			Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove			<input type="checkbox"/> M <input type="checkbox"/> F			Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Add <input type="checkbox"/> Remove			<input type="checkbox"/> M <input type="checkbox"/> F			Physician's No. Group No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

	Month	Day	Year	<input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Dissolution <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Death
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PLEASE READ THE FOLLOWING DISCLOSURES AND SIGN YOUR AGREEMENT ON THE LAST PAGE OF THIS FORM  
NOTE: KAISER MEMBERS ALSO NEED TO SIGN THE KAISER ARBITRATION AGREEMENT (SECTION I) ON THE FOLLOWING PAGE



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** \_\_\_\_\_

**RETURN FORM TO:**

San Bernardino County  
Employee Benefits and Services Division (EBSB)  
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 SURVIVOR**

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

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:	Sex	Social Security No.	Date of Birth	Relationship
<input type="checkbox"/> Add Spouse/Domestic Partner:	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add Children :	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add Children :	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add Children :	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> Remove				
<input type="checkbox"/> Add Children :	<input type="checkbox"/> M <input type="checkbox"/> F			
<input type="checkbox"/> 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** **Employee 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.

DENTAL PLAN ENROLLMENT/CHANGE FORM

FORMS

**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 inconsistencies 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).

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. 10/24/12

**RETURN FORM TO:**

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

County of San Bernardino  
 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 AND/OR DENTAL  
 PLAN CANCELLATION FORM**

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

A I CHOOSE TO CANCEL THE FOLLOWING MEDICAL AND/OR DENTAL COVERAGE							
<b>Plan Name</b>	<b>Effective Date of Cancellation (must be 1<sup>st</sup> of the month)</b>						
Medical:	<table border="1"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> <tr> <td></td> <td>1</td> <td></td> </tr> </table>	Month	Day	Year		1	
Month	Day	Year					
	1						
Dental:	<table border="1"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> </tr> <tr> <td></td> <td>1</td> <td></td> </tr> </table>	Month	Day	Year		1	
Month	Day	Year					
	1						

B RETIREE INFORMATION			
Social Security No.	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Of Birth Month    Day    Year	Check One <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
Last Name	First Name	MI	For Name Change, List Former Name Here
Mailing Address	Check Here If New Address <input type="checkbox"/>		Home Phone (    ) Alternate Phone (    )
City	State	Zip Code	

C DEPENDENT INFORMATION (enrolled in a retiree plan)			
Last Name, First Name	Social Security #	Enrolled in Dental	Enrolled in Medical—Plan name if different from above
Spouse/Domestic Partner:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:
Children:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name:

Subscriber's Signature \_\_\_\_\_

Date \_\_\_\_\_

**RETURN FORM TO:**

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

Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

## Disabled Dependent Certification (Dependent child age 26 or older)

Must print in Black or Blue ink ONLY

<b>Employee ID</b>	<b>Rcd No.</b>	<b>Employee Last Name, First Name</b>	
<b>E-mail Address</b>		<b>Telephone</b>	<b>Department</b>
<b>Name of Medical Plan</b>		<b>Name of Dental Plan</b>	

### COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 26 OR OLDER

<b>Dependent Name</b>	<b>Date of Birth</b>	<b>Relationship to Employee</b>
-----------------------	----------------------	---------------------------------

**Provider Certification:**

By providing my information and signature below, I certify that the dependent listed above is incapable of self-sustaining employment due to physical or mental disability. I also certify that all dependent information provided is true and correct to the best of my knowledge.

Please provide the following:

<b>Type of disability:</b> <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary		<b>If temporary, provide end date:</b>
<b>Name of Provider:</b>		
<b>Provider Address:</b>		
<b>License No.:</b>		<b>Telephone:</b>
<b>Provider Signature</b>		<b>Date:</b>

**Employee Certification:**

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 obtained verification of this disability from the licensed healthcare provider listed above, 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.

<b>Employee (Print &amp; Sign)</b>	<b>Date:</b>
------------------------------------	--------------

<b>Payroll Specialist (Print &amp; Sign)</b>	<b>Telephone:</b>	<b>Date:</b>
--	-------------------	--------------

DISTRIBUTION: Original - EBSD-HR (0440)

*Office Use Only*

<b>Reviewed by (Employee ID)</b>	<b>Date</b>

REV. HR 06/11/2014

Disabled Dependent Certification

**RETURN FORM TO:**

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

## 2015 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<sup>SM</sup>, 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	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (__ __/__ __/__ __ __ __) (MM / DD / Y Y Y Y)	Sex <input type="checkbox"/> M <input type="checkbox"/> 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) ( )
------------------------------	--------------------------------	--------------------------------

Email address (optional) \_\_\_\_\_

- I am willing to receive required plan materials via email (i.e., enrollment notifications, the Annual Notice of Changes and, *Evidence of Coverage*, and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. 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\_14\_223A\_08212014

**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 your spouse and 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. 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 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. \_\_\_\_\_

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) \_\_\_\_\_

**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**] if you need information in another format or language. Our office hours are 7 a.m. to 8 p.m., seven days a week from October 1 through February 14. However, after February 14, your call will be handled by our automated phone system on weekends and holidays. TTY users should call 711.

**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 former employer group/union'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.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Blue Shield 65 Plus, he/she may be paid based on my enrollment in Blue Shield 65 Plus.

**Release of information**

By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and healthcare 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 (EBSB)  
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 \_\_\_\_\_

## 2015 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, 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	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth date (MM/DD/YYYY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	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) ( )
------------------------------	--------------------------------	--------------------------------

Email address (optional) \_\_\_\_\_

- I am willing to receive required plan materials via email (i.e., enrollment notifications, the Annual Notice of Changes, Evidence of Coverage, and plan newsletter) in place of mailed printed copies.
- I am willing to receive non-required plan materials via email (i.e., benefit promotions and event invitations) in place of mailed printed copies.

Not checking the boxes above means you will receive printed plan materials via the mail. 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\_14\_223B\_08212014

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: \_\_\_\_\_

Medicare Claim Number \_\_\_\_\_ Sex \_\_\_\_\_

Is Entitled To \_\_\_\_\_ Effective Date \_\_\_\_\_

**HOSPITAL (Part A)** \_\_\_\_\_

**MEDICAL (Part B)** \_\_\_\_\_

**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 your spouse or 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. 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 \_\_\_\_\_

5. 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 **711**], 7 a.m. to 8 p.m., seven days a week, if you need information in another format or language. Our office hours are 7 a.m. to 8 p.m., seven days a week from October 1 through February 14. However, after February 14, your call will be handled by our automated phone system on weekends and holidays. TTY users should call 711.

## 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.

**If you currently have health coverage from an employer or union, joining the Blue Shield of California Medicare Rx Plan could affect your employer or union health benefits.** You could lose your employer or union health coverage if you join the Blue Shield of California Medicare Rx Plan. Read the communications your employer or union send you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

## 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 your former employer group/union's open enrollment period or during the Annual Enrollment Period from 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.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with the Blue Shield of California Medicare Rx Plan, he/she may be paid based on my enrollment in the Blue Shield of California Medicare Rx Plan.

**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 (EBSB)  
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 \_\_\_\_\_



## BLUE SHIELD 65 PLUS<sup>SM</sup> (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

**RETURN FORM TO:**

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

Kaiser Permanente Senior Advantage (HMO)

# GROUP ELECTION REQUEST FORM

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:

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

2. 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.
3. We'll notify Medicare that you've applied to join Senior Advantage.
4. 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.

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**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:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Birth Date: (__/__/____) (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ( )	Alternate Phone Number: ( )
Are you a current or former member of any Kaiser Permanente health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Current <input type="checkbox"/> Former			
Kaiser Permanente Medical/Health Record Number: _____			
Permanent Residence Street Address (P.O. Box is not allowed): _____			
City:	County:	State:	ZIP Code:
<b>Mailing Address</b> (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:
<b>E-mail Address:</b> _____			

**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 B, however some employer groups require both Parts A and B to join a Medicare Advantage plan.

<b>MEDICARE</b>			<b>HEALTH INSURANCE</b>	
SAMPLE ONLY				
Name: _____				
Medicare Claim Number			Sex _____	
_____ - _____ - _____				
Is Entitled To			Effective Date	
<b>HOSPITAL (Part A)</b>			_____	
<b>MEDICAL (Part B)</b>			_____	

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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(s) of dependent(s): \_\_\_\_\_
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  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**.

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, or the ERISA claims procedure regulation, and any other 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 be only 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

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_

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.

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 or 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: \_\_\_\_\_

2015 NCAL or SCAL Group Plan Election Form

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**RETURN FORM TO:**

San Bernardino County  
Employee Benefits and Services Division (EBSB)  
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)**



**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: <input type="checkbox"/> M <input type="checkbox"/> F	HOME PHONE NUMBER	
<b>PLEASE SELECT A DISENROLLMENT REASON BELOW</b>			
<input type="checkbox"/> I have moved out of the Kaiser Permanente service area			
<input type="checkbox"/> I have joined another health plan			
<input type="checkbox"/> My employer group coverage has ended			
<input type="checkbox"/> 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 (EBSB)  
157 West Fifth Street, First Floor  
San Bernardino, CA 92415-0440



## MEDICAL EXPENSE CLAIM FORM



Instead of completing this form you may file your claim online at <http://voyacdn.com/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					
<b>Total Medical Expense Claim</b>					<b>\$</b>

**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 forms to:**

Local Claims eFax: 952-460-1480	Genesis Employee Benefits	Local Phone: 952-653-4422
Toll-Free Claims eFax: 866-450-1480	PO Box 1578	Toll-Free Phone: 866-678-8322
Email: <a href="mailto:Claims@GenesisBenefits.net">Claims@GenesisBenefits.net</a>	Minneapolis, MN 55440-1578	<a href="mailto:CustomerCare@GenesisBenefits.net">CustomerCare@GenesisBenefits.net</a>

Check the status of your claim online at <http://voyacdn.com/hra/genesis>.

**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 <http://voyacdn.com/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  
PO Box 1578  
Minneapolis, MN 55440-1578***

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











157 West Fifth Street, First Floor, San Bernardino, CA 92415-0440



**Human Resources**  
Employee Benefits and Services