



County of San Bernardino

2012 Retiree Benefits Guide

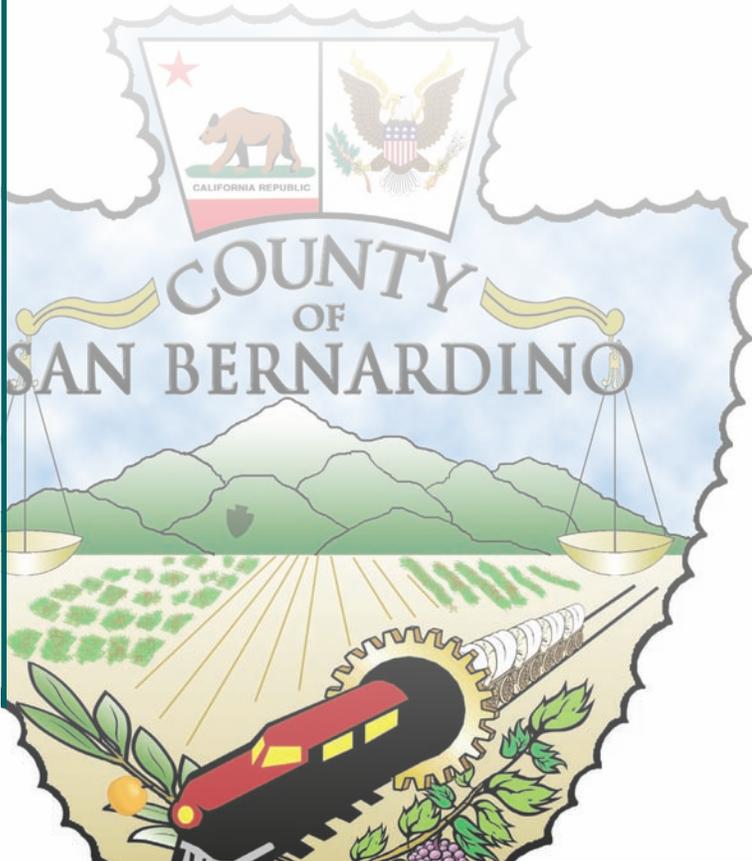


Table of Contents	Page
Monthly Medical and Dental Plan Rates	2
Introduction	
What's New for 2012	4
Contact Information	6
November 2011 Open Enrollment Meeting Schedule	7
Eligibility & Enrollment	
Eligibility	8
◆ Dependent Eligibility	8
Enrollment	8
◆ If You Are Enrolling or Making Changes	10
◆ If You Are Not Making Changes	10
◆ If You Are Canceling Coverage	10
Medical and Dental Plan ID Cards	11
Confirmation Statements	11
Mid-Year Changes	11
EBSD Appeals Procedure	13
Retirement Medical Trust Fund	13
Health Club Membership Discounts	14
Plan Summaries	
Health Net Elect Open Access HMO	16
Kaiser Permanente HMO	17
Health Net PPO	19
2012 Certificate of Creditable Medicare Prescription Drug Coverage	21
Medicare Integrated Plans – Important Information	21
Health Net Seniority Plus	22
Kaiser Permanente Medicare Advantage	24
DeltaCare USA HMO	25
Delta Dental PPO	26
Medical and Dental Plan Comparison Charts	28
When and How to Complete the Forms	50
Medical Plan Enrollment/Change Form	51
Dental Plan Enrollment/Change Form	55
Medical and/or Dental Plan Cancellation Form	57
Disabled Dependent Certification Form	59
Health Net Seniority Plus Enrollment Form	61
Health Net Medicare Programs Group Disenrollment Form	63
Health Net COB Prescription Drug Enrollment Form	65
Kaiser Permanente Senior Advantage Election Form	69
Kaiser Permanente Senior Advantage Disenrollment Form	75
Medical Trust Fund Claim for Reimbursement	77
Notice About the Early Retiree Reinsurance Program	79
Questions and Answers	80

2012 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 at (909) 387-9674. We will be happy to assist you!

How to calculate your total monthly medical premium if you have dependents:

If you have one or more dependents on your coverage, please make sure to add the “Retiree only” rate to the “1 Dependent” or “2 Dependents” rate, as applicable.

For example:

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

Retiree: Seniority Plus - Retiree only, over 65, with Medicare A and B (High Option)	\$220.28
Dependent: Elect Open Access - 1 Dependent, under 65, no Medicare (High Option)	<u>932.22</u>
Total Monthly Premium	\$1,152.50

Monthly Medical Plan Rates		
Effective January 1, 2012 Plan and Coverage Level	2012 Rate	
Health Net Elect Open Access	High	Low
Retiree only, under 65, no Medicare	\$815.53	\$670.66
1 Dependent, under 65, no Medicare	\$932.22	\$765.72
2 Dependents, under 65, no Medicare	\$1,581.02	\$1,298.63
Retiree only, over 65, no Medicare	\$1,247.11	n/a
1 Dependent, over 65, no Medicare	\$1,242.75	n/a
2 Dependents, over 65, no Medicare	\$2,485.50	n/a
Health Net Seniority Plus	High	Low
Retiree only, over 65, with Medicare A and B	\$220.28	\$74.12
1 Dependent, over 65, with Medicare A and B	\$215.92	\$69.76
2 Dependents, over 65, with Medicare A and B	\$431.84	\$139.52
Health Net PPO Medicare COB – California and Out of State	High	Low
Retiree only, over 65, with Medicare A and B	\$582.48	n/a
1 Dependent, over 65, with Medicare A and B	\$578.12	n/a
2 Dependents, over 65, with Medicare A and B	\$1,156.24	n/a

Monthly Medical Plan Rates (continued)

Effective January 1, 2012 Plan and Coverage Level	2012 Rate	
Health Net PPO – California	High	Low
Retiree only, under 65, no Medicare	\$1,320.32	\$1,034.04
1 Dependent, under 65, no Medicare	\$1,351.11	\$1,057.16
2 Dependents, under 65, no Medicare	\$2,812.71	\$2,187.26
Health Net PPO – Out of State	High	Low
Retiree only, under 65, no Medicare	\$1,403.71	\$1,099.27
1 Dependent, under 65, no Medicare	\$1,436.67	\$1,124.11
2 Dependents, under 65, no Medicare	\$2,990.86	\$2,340.19
Kaiser Permanente	High	Low
Retiree only, no Medicare	\$745.58	\$567.51
1 Dependent, no Medicare	\$741.22	\$563.15
2 Dependents, no Medicare	\$1,356.44	\$1,030.57
Retiree only, over 65, no Medicare	\$1,145.27	\$1,076.98
1 Dependent, over 65, no Medicare	\$1,140.91	\$1,072.62
2 Dependents, over 65, no Medicare	\$2,281.82	\$2,145.24
Kaiser Permanente Medicare Advantage	High	Low
Retiree only, over 65, with Medicare A and B	\$244.82	\$148.95
1 Dependent, over 65, with Medicare A and B	\$240.46	\$144.59

Monthly Dental Plan Rates

	Delta Dental PPO	Delta Dental HMO
Retiree only	\$39.86	\$19.08
Retiree + 1	\$72.98	\$29.42
Retiree + 2 or more	\$125.09	\$41.99

Rates subject to change pending Board approval.

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

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

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

What's New for 2012

The same plans and coverage that were offered in 2011 will be available in 2012. Please read on for details of changes to your benefits that will occur on or before January 1, 2012.

Health Net Prescription Drug Benefit Changes

Seniority Plus

For the Seniority Plus High Option plan, non-formulary medications will now be covered at a \$40 copay.

Medicare Coordination of Benefits (COB) Plans only

Effective January 1, 2012 members enrolled in COB plans must use their Part B coverage for Part B drugs and diabetic supplies. The Centers for Medicare & Medicaid Services (CMS) changed the way Part B drugs and diabetic supplies are billed by pharmacies. Currently pharmacies submit both Part B and diabetic supply claims to Health Net with Health Net as the primary payer. Beginning January 1, 2012 pharmacies will submit claims for Part B drugs and diabetic supplies directly to Medicare as the primary payer; and applicable coinsurance and deductibles may apply to the member.

More detailed information and instructions will be sent by Health Net to all Health Net members regarding this change.

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.

Kaiser Medicare Benefit Changes

Copays for routine physicals and well woman examinations have been eliminated for both the high and low option Medicare Advantage plans.

Health Care Reform – Early Retiree Reimbursement Program

The County applied and received approval to participate in the Early Retiree Reimbursement Program (ERRP) that was established under Health Care Reform. Under this program, the County may receive a reimbursement of up to 80% of the cost of claims between \$15,000 and \$90,000 paid under its non-Medicare retiree plans. Any reimbursement monies the County receives will be used to lower health care costs (i.e. premiums) for enrollees. Affected participants will be notified when the County will apply any reductions in premiums due to monies received under ERRP. See page 79 of this Guide for additional information and the County's role as a Plan Sponsor.

**Open Enrollment
for 2012 is
November 1
through
November 30,
2011.**



Contact Information

	Address	Phone
Employee Benefits and Services Division	157 West Fifth Street, First Floor San Bernardino, CA 92415 www.sbcounty.gov/hr/benefits	1-909-387-5787 1-888-743-1474
	All Retiree Medical and Dental Plans http://www.sbcounty.gov/hr/Benefits_Retire.aspx	1-909-387-9674
Providers:	COBRA	1-909-387-5552
DeltaCare USA HMO	12898 Towne Center Drive, Cerritos, CA 90703-8456 www.deltadentalins.com	1-800-422-4234
Delta Dental PPO	P.O. Box 997330, Sacramento, CA 95899-7330 www.deltadentalins.com	1-888-335-8227
Kaiser Permanente	Kaiser Permanente Foundation Health Plan. P.O. Box 7102, Pasadena, CA 91109 www.my.kp.org/ca/sbcounty	1-800-464-4000
Kaiser Permanente Medicare Advantage	Kaiser Permanente Advantage Foundation Health Plan P.O. Box 7102, Pasadena, CA 91109 www.my.kp.org/ca/sbcounty	1-877-882-2687
Health Net Elect Open Access	P.O. Box 10348, Van Nuys, CA 91409-0348 www.healthnet.com	1-800-676-6976
Health Net PPO	Health Net Life Insurance Company. P.O. Box 10348, Van Nuys, CA 91049 www.healthnet.com	1-800-861-7214
Health Net Seniority Plus	Health Net Medicare Programs. P.O. Box 10198, Van Nuys, CA 91410-0198 For enrollment assistance (new enrollees only) www.healthnet.com	1-800-275-4737 1-800-596-6565
ING	1200 California Street, Suite 108 Redlands, CA 92374 www.ingretirementplans.com/custom/sanbernardino	1-909-748-6468 1-800-584-6001
Optum Health Financial Services (OHFS)	P.O. Box 728, Anoka, MN 55303-0728	1-866-898-4584 1-763-767-4700 Fax
Helpful Resources and Referral Services:		
American Association of Retired Persons	www.aarp.org	1-888-687-2277
American Heart Association	www.heart.org/HEARTORG/	1-800-242-8721
American Cancer Society	www.cancer.org	1-800-227-2345
CMS (for Medicare information)	www.medicare.gov	1-800-633-4227
Social Security Administration (SSA)	www.socialsecurity.gov	1-800-772-1213
Health Insurance Counseling and Advocacy Program (HICAP)	www.aging.ca.gov/information_on/hicap.asp	1-800-434-0222
San Bernardino County Employees' Retirement Association (SBCERA)	348 West Hospitality Lane, Third Floor. San Bernardino, CA 92415-0014 www.sbcera.org	1-909-885-7980 1-877-722-3721

Open Enrollment Meeting Schedule Please note there will be separate meetings for Medicare eligible retirees (meetings listed in green, denoted by “M”) and non-Medicare eligible retirees (meetings listed in black, denoted by “NM”). Take advantage of this opportunity to discover your options. Insurance plan representatives will be at each meeting to answer your questions.

November 2011 Open Enrollment Meetings

Monday	Tuesday	Wednesday	Thursday	Friday
	<p>1</p> <p>Start of Open Enrollment</p> <p>1:00-2:15 pm NM 2:30-3:45 pm M Behavioral Health Resource Center Room F120 850 E. Foothill Blvd., Rialto</p>	<p>2</p> <p>8:00-9:00 am NM 9:15-10:15 am M 11:15 am-12:15 pm NM 12:30-1:30 pm M Government Center Joshua Room 385 N. Arrowhead Ave., San Bernardino</p>	<p>3</p>	<p>4</p>
<p>7</p>	<p>8</p>	<p>9</p> <p>9:00-10:15 am NM 10:30-11:45 am M TAD 2nd Floor Conf. Room A 881 W. Redlands Blvd., Redlands</p>	<p>10</p>	<p>11</p>
<p>14</p> <p>5:30-6:45 pm NM 7:00-8:15 pm M Government Center Joshua Room 385 N. Arrowhead Ave. San Bernardino</p>	<p>15</p> <p>9:00-10:15 am NM 10:30-11:45 am M DAAS Haven Room 9445 Fairway View Place Suite 110, Rancho Cucamonga</p>	<p>16</p> <p>10:00-11:15 am NM 11:30-12:45 pm M Victorville CFS Conference Room 1 15480 Ramona Ave., Victorville</p>	<p>17</p>	<p>18</p>
<p>21</p>	<p>22</p>	<p>23</p>	<p>24</p>	<p>25</p>
<p>28</p> <p>1:30-2:45 pm NM 3:00-4:15 pm M General Services Building Conference Room 777 E. Rialto Ave., San Bernardino</p>	<p>29</p> <p>End of Open Enrollment Deadline to submit all forms</p>	<p>30</p>		

January 1, 2012 is the effective date of new premium rates and any changes you make to your plan elections or coverage levels. If you need help verifying eligibility or with any part of the enrollment process, please call EBSD at (909) 387-5787.

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 pay the cost of coverage and your insurance premium is deducted from your monthly retirement benefit payment.

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

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

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

Please contact EBSD at (909) 387-5787 if you are unsure of your eligibility status.

Dependent Eligibility

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

- ◆ Your legal spouse (a copy of your marriage certificate is required)
- ◆ State-Registered Domestic Partner (copy of the certificate of state registered domestic partnership or equivalent out-of-state certificate is required)
- ◆ Your children* who are:
 - Less than 26 years old and ineligible for other group health plan coverage
 - 26 or more years old, supported primarily by you and incapable of self-sustaining employment by reason of mental or physical disability. A Disabled Dependent Certification Form with proof of physical or mental condition must accompany the Medical and/or Dental Plan Enrollment/Change Form. Please note that it is the medical plan that evaluates and makes the final determination on the disability status.

* Your children include children born to you, legally adopted by you (including those children during any waiting period before the finalization of their adoption), your

Open Enrollment elections are effective January 1, 2012

stepchildren, children for whom you are the legal guardian, and children you support as a result of a valid court order.

(Kaiser Permanente allows coverage for grandchildren if the dependent child was enrolled with Kaiser Permanente prior to giving birth to the grandchild. Coverage for the grandchild may continue as long as the retiree's dependent child is covered.)

Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates and relatives other than those listed above are **not eligible**. If you do not submit all necessary forms and supporting documentation when required, your dependents will not be added to your plan and you will be responsible for any costs incurred.



Enrollment

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

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

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

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

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

Medicare Coordination of Benefits Plans

- ◆ Health Net PPO Medicare Coordination of Benefits (COB)
 - California
 - Out of State

◆ Kaiser Permanente HMO Medicare Coordination of Benefits (COB)*

- California

*Please contact EBSD at (909) 387-5787 for a summary of this plan.

Medicare Integrated Plans (choice of High and Low Options)

- ◆ Health Net Seniority Plus
- ◆ Kaiser Permanente Medicare Advantage

Dental Plans

- ◆ DeltaCare USA (DHMO)
- ◆ Delta Dental PPO

If You Are Enrolling or Making Changes

To enroll or make changes, submit a completed and signed Medical and/or Dental Plan Enrollment/Change Form (with all appropriate documentation such as a marriage or birth certificate, if applicable) to EBSD at 157 W. Fifth Street, First Floor, San Bernardino, CA 92415-0440 by November 30, 2011.

The following 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 changes.
- ◆ **Medical and/or Dental Plan Cancellation Form**

◆ **Disabled Dependent Certification Form** Required for dependents age 26 or older (attach to a Medical and/or Dental Plan Enrollment/Change Form along with medical verification of disability).

◆ **Health Net Seniority Plus Group Enrollment Form**

◆ **Health Net Medicare Program Group Disenrollment Form**

◆ **Health Net COB Prescription Drug Enrollment Form**

◆ **Kaiser Senior Advantage Election Form**

◆ **Kaiser Senior Advantage Disenrollment Form**

◆ **RMT Health Savings Plan Claim for Reimbursement**

If You Are Not Making Changes

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

If You Are Canceling Coverage

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

Note: Requests to cancel a dental plan enrollment are subject to the two-year enrollment commitment provisions of those contracts.

We encourage you to keep this guide the entire year.

Medical and Dental Plan ID Cards

Within 4 to 6 weeks of the effective date of your coverage, you should receive an identification (ID) card from your medical and/or dental plan. You may, however, begin using your medical and/or dental plan before receiving your ID card as of January 1, 2012.

If you do not receive your ID card, or if you need a replacement card, call your plan's member services department (please see page 6 of this Guide for your plan's contact information). You may also request a replacement card online through the plan website. If you have a problem accessing care, call EBSD at (909) 387-5787.

Confirmation Statements

After Open Enrollment ends, you will receive a Confirmation Statement verifying your 2012 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.

Mid-Year Changes

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 following events:

- ◆ You get married
- ◆ You enter into a State Registered Domestic Partnership

- ◆ You get divorced (final decree)
- ◆ You terminate a domestic partnership
- ◆ Your spouse, domestic partner or dependent dies
- ◆ A child is born to you or placed with you for adoption or legal guardianship
- ◆ Your spouse or domestic partner begins or ends employment
- ◆ Your eligible dependent (child) becomes eligible for own insurance
- ◆ Your eligible dependent (child) loses eligibility due to age
- ◆ Your spouse or domestic partner begins or returns from an unpaid leave of absence
- ◆ You relocate into or outside of a network service area
- ◆ You or your dependent becomes entitled to Medicare
- ◆ Your spouse/domestic partner's COBRA or Cal-COBRA coverage ends due to exhaustion of maximum time allowed under COBRA or Cal-COBRA.

Please Note: Because your premiums are paid on an after-tax basis, you may remove dependents from your plan at any time, subject to the terms of the medical and dental plan contracts.

If you experience a qualifying event and you want to request a mid-year change, you must do the following within 60 days of the qualifying event:

- 1 Complete a Medical and/or Dental Plan Enrollment/Change Form (and Medicare forms, if applicable). The forms are included in this Guide, and are also available by contacting EBSD, or by going online at http://www.sbcounty.gov/hr/Benefits_Retire.aspx
- 2 Include supporting documentation with your Enrollment/Change form. Examples of acceptable documentation are:
 - Copies of birth, death, marriage or domestic partner certificates
 - Copies of court papers for divorce or adoption
 - Copy of letter from employer verifying loss or gain of spouse's (or domestic partner's) employment

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

Warning: EBSD must receive your Medical and/or Dental Plan Enrollment/Change Form within 60 days of the qualifying event. If you do not submit the form and supporting documentation within 60 days, you could be denied the opportunity to make plan changes until the next Open Enrollment Period.



Effective Date of Mid-Year Changes

Coverage is effective the first day of the first calendar month following receipt of completed forms and other necessary documentation in the EBSD office. You will be billed for any premiums owed as a result of your enrollment and/or the addition of eligible dependents as a result of the qualifying event. If the qualifying event results in a decrease in premiums, you will receive a refund for the premium overpayment.

NOTE for Newborn and Adopted

Children: Coverage is effective as of the date of the birth, adoption or placement for adoption. For Health Net, newborn children will be covered under the medical group the mother (parent) is assigned to for the first 30 days following birth. For Kaiser members, newborns are covered for the first 31 days including the date of birth. The Retiree/Subscriber **MUST STILL ENROLL** the child under their respective plan through the County within 60 days of the date of birth or adoption. Contact EBSD for more information regarding the newborn enrollment process.

To reduce the time for the adjustment process, you are encouraged to submit your paperwork as soon as possible and not later than the 15th of the month. If you have questions about mid-year changes, please call EBSD at (909) 387-5787.

EBSB Appeals Procedure

General Information

The County of San Bernardino 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 beneficiary believes that a request for a benefit under a health and welfare plan has been improperly denied, he or she may appeal the decision within the parameters set forth in the following procedure.

Appeals for claims that are denied solely by one of the County's benefit carriers must be submitted within the guidelines established by that carrier. 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 beneficiary 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.

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 and long-term care premiums as defined by the Internal Revenue Code (IRC) that are not otherwise covered by insurance.

Eligibility

Eligibility for the RMT is determined by the following criteria:

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

Who Maintains the Funds

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

Optum Health Financial Services (OHFS) is the third party administrator designated by ING to disburse funds for qualifying expenses. RMT funds are used to reimburse a participant for qualifying health-related expenses not covered by the medical/dental plans. This includes medical/dental premiums and copays for prescriptions and doctor visits.

To receive reimbursement for eligible expenses, complete a "Claim for Reimbursement" form and mail it together with verification of the expense to:

Optum Health Financial Services
P.O. Box 728
Anoka, MN 55303-0728

A claim form is enclosed on page 77 of this book. Participants can access their account, see a list of qualifying expenses or obtain additional claim forms via the Optum Health website at www.arcbenefitaccess.com.



Health Club Membership Discounts

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

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

24 Hour Fitness

24 Hour Fitness has 14 facilities in San Bernardino and Riverside Counties, including desert locations and over 60 clubs in Southern California. 24 Hour Fitness offers members:

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

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

Upon initial enrollment, retirees will be responsible for immediate payment of first and last month's dues, plus any add-on fees. Monthly dues are paid thereafter by electronic funds transfer (EFT). Memberships may be canceled at any time with adequate notice as described in the retiree's 24 Hour Fitness membership agreement.

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

LA Fitness

LA Fitness has many facilities in San Bernardino, Riverside, and Los Angeles counties. LA Fitness provides members with the added benefit of knowing, regardless of which facility they use, that the features and amenities are identical. LA Fitness offers members:

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



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

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

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

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



Health Net Elect Open Access

HMO Reliability + specialist self-referral convenience

Health Net Elect Open Access plan is an HMO-style plan with the added benefit of allowing you to go straight to a specialist (within the network, but outside your Medical Group) for examinations and evaluations. You choose between two tiers of benefits – HMO or Open Access – whenever you need care. It works like this:

- ◆ Pick a Participating Physician Group (PPG) and Primary Care Physician (PCP) from within that group. Each member of your family may choose a different PCP.
- ◆ Call your PCP when you need routine or hospital care:
 - Pay a fixed copayment (so there are never any cost surprises)
 - Say goodbye to paperwork – you do not have to deal with claim forms when you use your HMO benefits.
 - Certain services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your PCP in order to be covered by Health Net.
- ◆ See a specialist without a referral, under the Open Access, Tier 2 benefits.
 - Arrange office visits, consultation, evaluation and treatment – only procedures that can be performed in the doctor's office – for a single copayment.
 - Your costs will be higher and you may need claim forms for certain services

- ◆ Go directly to the closest emergency room if you have an emergency. Emergency and urgent care is available worldwide. You don't have to call your PCP first. If you're admitted to a facility, have a family member or hospital staff contact Health Net as soon as possible.

Is Health Net Elect Open AccessSM Right For You?

Yes, if you want:

- ◆ The convenience of having your PCP coordinate services
- ◆ Predictable costs, with fixed 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

More from Health Net

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

Decision PowerSM

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

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

Wellsite — Healthnet.com

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

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

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



Kaiser Permanente HMO

The Kaiser Permanente Plan is a health maintenance organization (HMO). The benefits listed in this Guide are for retirees and their eligible dependents living within the Kaiser Permanente zip code service areas of California. 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.

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

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

Kaiser Permanente Online Services

Wherever they go, members can:

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

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

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

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart on pages 28-47 of this Guide for a list of key covered expenses. Refer to the Kaiser Permanente plan booklet for information about what is not covered under your plan. If you do not have the plan booklet, contact EBSD at (909) 387-5787 for the plan's informational packet.

Helpful Information for New Members – Non Medicare

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

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

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

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

How to Get in Touch with Kaiser Permanente

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

Health Net PPO: The freedom to choose, the support to choose wisely

If freedom of choice is what you want, Health Net PPO is the plan for you. You can go to any doctor or hospital in the Health Net PPO network – there are approximately 4,900 hospitals and 500,000 providers to choose from. Or you can see a provider not in the Health Net network.

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

- ◆ When you choose a participating network provider, you pay:
 - A calendar-year deductible
 - A fixed copayment or coinsurance after you've met your calendar-year deductible (up to the calendar year copayment maximum)
- ◆ When you see a non-participating provider, you pay:
 - A calendar-year deductible
 - A copayment or coinsurance after you've met your calendar-year deductible (up to the calendar-year copayment maximum). Note that the copayment/coinsurance is higher when you go out of network, which means you'll pay more.
 - Charges that exceed allowances for covered services

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

In an emergency, go to the closest emergency facility. If you're admitted, have someone call

Health Net as soon as possible. Emergency care is available worldwide.

Is Health Net PPO Right For You?

Yes, if you want:

- ◆ Freedom of choice, no referrals required
- ◆ Control over how much you spend – your costs are lower when you use our network

- ◆ Broad network access throughout

California. When traveling, we have approximately 4,900 hospitals and 500,000 providers available nationwide through an arrangement with First Health®, a national PPO network.

- ◆ Time savings convenience – no claim forms to file when you use network services

More From Health Net

When you choose Health Net, you get more than health care coverage. You get helpful tools and services to make the most of your health.

Decision PowerSM

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

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



Wellsite — Healthnet.com

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

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

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

Health Net PPO Medicare Coordination of Benefits (COB) Plan

What is a Medicare COB PPO Insurance Plan?

Health Net's 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 Health Net 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 when you use contracted providers in our network. In California, Health Net gives you access to over 61,000 physicians, practitioners and health professionals, and 300 hospitals. Nationwide, we contract with First Health®, a national PPO network that includes approximately 4,900 hospitals and 500,000 providers.

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.

Is Medicare or Health Net the primary payer for plan benefits?

Under the Health Net PPO Medicare COB plan, Medicare is the primary plan and Health Net 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 Health Net. Health Net is responsible for paying the difference between the amount Medicare paid and the Health Net allowed amount for the covered service. The Medicare Summary Notice is a summary of

benefits paid on your behalf by Medicare. You will also receive a copy of the Medicare Summary Notice. Some secondary claims are sent electronically to Health Net by Medicare and do not require that the provider of service submit the claim.

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

2012 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. Effective January 1, 2006, all such County integrated plans incorporated Medicare Part D pharmacy benefits at no additional cost. In order to enroll in a Medicare integrated plan, you must be enrolled in Medicare Parts A and B. When you enroll in a Medicare integrated plan, you assign your Medicare A, B and D benefits to the medical plan. 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)
- ◆ Health Net Seniority Plus (High and Low)

Conditions

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

◆ You must utilize the plan’s Medicare Part D formulary for all of your prescription needs.

◆ You must meet these eligibility requirements:

- You have Medicare Parts A and B
- You live in the medical plan’s service area
- You are free of end stage renal disease
- You are not in a hospice program

◆ It is important to evaluate your benefit needs and the different Medicare integrated plans each year.

◆ If you move out of the service area of your medical plan, you must “disenroll” from the Medicare integrated plan.

◆ To disenroll from a Medicare integrated plan, contact EBSD at (909) 387-9674. Please note that disenrollments from County-sponsored plans and enrollments in other plans may be delayed due to the Center for Medicare & Medicaid Services (CMS) final eligibility determination and processing of your request.

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

For answers to questions regarding Medicare, please contact:

◆ Your local Social Security Administration Office at 1-800-772-1213

◆ The Medicare Program at 1-800-MEDICARE (1-800-633-4227)

◆ The official Medicare website at www.medicare.gov

◆ The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, which offers health insurance counseling for California seniors. Their website is www.aging.ca.gov/information_on/hicap.asp



Health Net Seniority Plus:

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

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

Health Net Seniority Plus:

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

◆ Provides services tailored to Medicare beneficiaries: Health Net is familiar with the conditions most likely to affect you, and the medications you’re most likely to need. The Prescription Drug Plan for Medicare offers coverage for many commonly prescribed

brand name drugs. Even if your physician changes your medications, your new prescription will most likely still be on the list of covered drugs.

- ◆ Makes it easy to use your Part D Prescription Drug benefit: Medical and drug benefits are integrated into one plan with only one ID card.
- ◆ Offers the highest quality care possible: Health Net has a vast network of contracted physicians, hospitals, pharmacies and medical professionals that has been built with precision and care to give you access to the best care we possibly can.

Is Health Net Seniority Plus Right For You?

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

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

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

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

- Integrated medical and 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

More from Health Net

When you choose Health Net, you get more than health care coverage. You get helpful tools and services to make the most of your health.

Decision PowerSM

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

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

For Prospective Health Net Seniority Plus Enrollees

If you are considering enrolling in the Health Net Seniority Plus plan for the first time, you may schedule an in-home appointment with a Health Net representative to obtain enrollment assistance and information about the plan. The telephone number for this service is 1-800-596-6565 and representatives can be reached from 8:00 am to 6:00 p.m. P.S.T. Monday through Friday. Please note: This service is available only to retirees who are not currently enrolled in the Seniority Plus plan. Current Seniority Plus members should call 1-800-275-4737 for any questions they may have.

Health Net Seniority Plus Benefits

Health Net Seniority Plus is a great benefit package which includes a free Health Club Membership, 30 free trips to your doctor, and much more.

Disclaimer for Health Net Seniority Plus:

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



Kaiser Permanente Medicare Advantage

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

- ◆ One broad-based plan, one monthly premium, with benefits that help you thrive in every way.
- ◆ All the perks of Medicare, including Part D prescription drug coverage, and more.
- ◆ 24-hour convenience, and services when you need them.
- ◆ Health and wellness advice and information by phone or online.
- ◆ Over one hundred medical facilities to choose from, and virtually no paperwork.

Explore Kaiser Permanente on kp.org

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

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

Kaiser Permanente Online Services

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

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

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

Helpful Information for New Members – Medicare

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

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

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

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

4000, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m.



DeltaCare USA

DeltaCare USA is an HMO-style dental plan which provides you and your family with quality comprehensive dental benefits at an affordable cost. When you enroll in DeltaCare USA, you must select a contract dentist who will coordinate all of your dental care. Each family member may select their own dentist, up to a maximum of three (3) dentists per family.

How the Plan Works

Retirees enrolling in the DeltaCare USA HMO Plan will be required to participate in the Plan for a consecutive 24-month period.

Network You must utilize your selected provider for all of your dental services. If services are not obtained through the primary care dental office, or if DeltaCare USA has not authorized services elsewhere, the services will not be covered.

Copayments For most basic and preventative services, you pay no copayment. For other covered services, you pay a small fee.

Deductibles There are no deductibles under the DeltaCare USA Plan.

Claim Forms There are no claim forms to file under the DeltaCare USA Plan. Your selected provider completes and submits all claim forms.

Annual Maximum Benefit There is no annual maximum benefit for the DeltaCare USA Plan.

Preexisting Conditions Except for work in progress, there is no exclusion for preexisting conditions.

Out-of-State Dependent Coverage If you have covered dependents living outside of

California, please contact EBSD at (909) 387-5787 for a list of covered states.

Emergency Care If you need emergency services, call your primary care dental office. If your primary care dental office is unavailable, call DeltaCare USA at 1-800-422-4234 and you will be directed to an available DeltaCare USA dentist.

Out-of-Area Care If you need dental care away from home, call DeltaCare USA at 1-800-422-4234 and you will be directed to an available DeltaCare USA dentist. If a DeltaCare USA dentist is not available within a 35-mile radius, obtain care from a nearby licensed dentist and then submit a claim to DeltaCare USA.

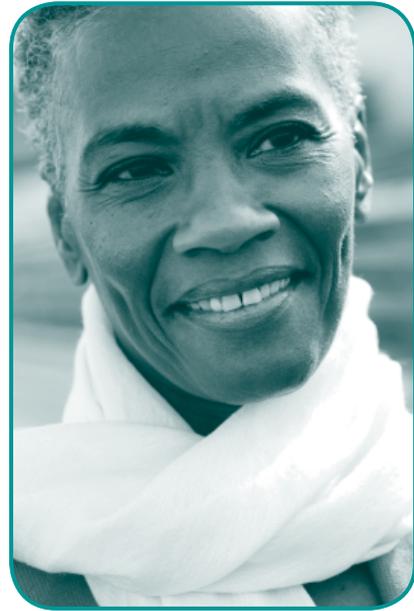
You must submit your claim within 12 months (365 days) of the date you obtained out-of-area (out-of-network) care. You will be reimbursed the cost of treatment less any copays up to the maximum of \$100.

How to get in touch with DeltaCare USA

For information about DeltaCare USA, including if you:

- ◆ Need to select a new DeltaCare USA dentist
- ◆ Have a benefits question
- ◆ Need a provider directory
- ◆ Need a member ID card
- ◆ Have an eligibility question
- ◆ Have a claims question

Call DeltaCare USA at [1-800-422-4234](tel:1-800-422-4234) or visit them online at www.deltadentalins.com.



Delta Dental PPO

Delta Dental PPO is administered by Delta Dental. Delta Dental PPO allows you to choose to receive care from a network provider or from an out-of-network provider. It is your choice. You may change between in- and out-of-network dentists anytime without notifying Delta Dental in advance. Please refer to the Dental Plans Comparison Chart on pages 48-49 for more information on covered services, applicable coinsurance amounts, and annual maximum benefit payments.

How the Plan Works

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

In-Network When you receive your dental care from a Delta Dental PPO network dentist, you will pay a percentage of the dentist's discounted Delta Dental PPO rates (after the annual \$50 per person deductible is met). Enrollees are eligible for crowns, inlays, onlays, cast restorations, and implants only after being continuously enrolled in this plan

for 12 months. This waiting period is waived if the enrollee provides proof of 12 months consecutive dental coverage under another group plan prior to enrollment in this plan. To estimate what your cost will be in advance, you may request a preauthorization by calling Delta Dental at 1-888-335-8227. Please see the Dental Plans Comparison chart on pgs. 48-49 for coinsurance and lifetime maximum benefit information.

Out-of-Network When you receive care from an out-of-network dentist, you will pay a percentage of the dentist's fees plus any charges over Delta Dental's customary allowance (after the annual \$50 per person deductible is met). Your additional share of the cost will be the difference between what the plan covers out-of-network and what your out-of-network dentist is charging you. This cost will vary by provider.

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

Out-of-Area Care If you need dental care away from home, call Delta Dental at 1-888-335-8227. If possible, you will be directed to an available in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit automatically.

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

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

How To Get In Touch With Delta Dental PPO

For information about Delta Dental PPO, including benefits, eligibility, claims, provider directory, or member ID card, call Delta Dental at 1-888-335-8227 or visit Delta's website at www.deltadentalins.com.



Medical Plans Comparison Chart (Non Medicare Eligible)

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

CY = Calendar Year

MAA = Maximum Allowable Amount

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.

PERMANENTE	HEALTH NET PPO PPO MEDICARE COB*		HEALTH NET PPO	
	LOW OPTION	HIGH OPTION In-Network Out-of-Network	LOW OPTION In-Network Out-of-Network	
\$20 copay	20% coinsurance	40% coinsurance after CY deductible	30% coinsurance after CY deductible	50% after CY deductible
\$150/trip after deductible	20% coinsurance after CY deductible	40% coinsurance after CY deductible	30% coinsurance after CY deductible	50% after CY deductible
Not covered	20% coinsurance after deductible up to 30 visits per CY combined with OON	40% coinsurance after CY deductible. Maximum amount payable per visit: \$25. Up to 30 visits combined with PPO	Not covered	Not covered
Kaiser only	CA PPO providers Other areas First Health PPO Providers	Any licensed physician, hospital or other providers of health care who are not part of the PPO Network. Responsible for costs over MAA.	CA PPO providers Other Areas - First Health PPO Providers	Any licensed physician, hospital or other providers of health care who are not part of the PPO Network. Responsible for costs over MAA.
\$500/person, \$1,000/family	\$500/individual, \$1,500/family; Combined with OON	\$500/individual, \$1,500/family	\$1500/individual combined with OON, no family maximum	\$1,500 per member, no family maximum
Deductible applies	\$250 deductible per admit/surgery plus coinsurance	\$250 deductible per admit/surgery plus coinsurance	\$500 per admission, \$500 per outpatient surgery	\$500 per admission, \$500 per outpatient surgery
None	\$250 deductible per admit or visit	\$250 deductible per admit or visit	\$250 deductible plus reduction in coinsurance to 50% applies for each non-certified inpatient hospital admission. \$50 deductible plus reduction in coinsurance to 50% applies for each non-certified outpatient service.	
\$10 per encounter (\$50 MRI, CT, PET) after deductible)	20% coinsurance after deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
20% coinsurance, no deductible	20% coinsurance after deductible; up to \$5,000 per year (CY maximum not applicable to orthotics, diabetic supplies, corrective footwear, nebulizers, face masks and tubing used for the treatment of asthma)	40% coinsurance after deductible plus costs over MAA; up to \$5,000 per year (CY maximum not applicable to orthotics, diabetic supplies, corrective footwear, nebulizers, face masks and tubing used for the treatment of asthma)	30% coinsurance after CY deductible	50% coinsurance after CY deductible

CY = Calendar Year

*For Medicare A+B-Eligible Retirees

MAA = Maximum Allowable Amount

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER	
	HIGH OPTION		LOW OPTION		HIGH OPTION	
	Tier One	Tier Two	Tier One	Tier Two		
Emergency room (Facility)	\$50 copay for facility services. \$0 copay for Professional services. Copay waived if admitted	Not covered	\$250 copay for facility services; \$0 copay for Professional services. Copay waived if admitted	Not covered	\$50; waived if admitted	
Family planning: Infertility services	50% coinsurance; excludes GIFT, ZIFT, IVF	Not covered	Not covered	Not covered	50% coinsurance excludes GIFT, ZIFT and IVF	
Tubal ligation	\$10 copay	Not covered	\$150 copay	Not covered	\$10 copay	
Vasectomy	\$10 copay	Not covered	\$50 copay	Not covered	\$10 copay	
Home health services	No charge	Not covered	\$50 copay	Not covered	No charge if medically necessary up to 100 visits per calendar year	
Hospice	No charge	Not covered	No charge	Not covered	No charge	
Hospital (Facility)	No charge	Not covered	\$1,000 copay per admission	Not covered	No charge, if medically necessary	
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
Maternity care	1st prenatal visit: \$10 copay. Each subsequent prenatal visit and all postnatal visits: No charge	Not covered	\$50 copay per visit	Not covered	\$10 copay for 1st visit; no charge thereafter	
Mental health: Non-severe mental disorders: Inpatient	No charge	Not covered	Not covered	Not covered	No charge	

COMPARISON CHART

CY = Calendar Year

MAA = Maximum Allowable Amount

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.

PERMANENTE	HEALTH NET PPO PPO MEDICARE COB*		HEALTH NET PPO	
	LOW OPTION	HIGH OPTION In-Network Out-of-Network	LOW OPTION In-Network Out-of-Network	
20% coinsurance, after deductible	\$100 deductible per visit plus 20% co-insurance; waived if admitted (Facility and Professional services)	\$100 deductible per visit + 20% coinsurance + costs over MAA; waived if admitted (Facility and Professional services)	\$100 deductible per visit, waived if admitted, plus 30% coinsurance after CY deductible (Facility and Professional services)	\$100 deductible per visit, waived if admitted, plus 30% coinsurance after CY deductible (Facility and Professional services)
50% coinsurance; excludes GIFT, ZIFT, IVF	Not covered	Not covered	Not covered	Not covered
\$20 copay	30% after deductible	50% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
\$20 copay	30% after deductible	50% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
No charge if medically necessary up to 100 visits per calendar year	20% coinsurance after deductible; up to 100 visits per year combined with OON	40% coinsurance after deductible plus costs over MAA; up to 100 visits per year combined with PPO	30% coinsurance after CY deductible up to \$110 maximum payable per day	50% coinsurance after CY deductible up to \$110 maximum payable per day
No charge, no deductible	20% coinsurance after deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% coinsurance after CY deductible
20% coinsurance after deductible	20% coinsurance after \$250 Hospital deductible per confinement	40% coinsurance after \$250 Hospital deductible plus costs over MAA	30% coinsurance after \$500 Hospital deductible per confinement	50% coinsurance after \$500 Hospital deductible per confinement
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
\$20 copay for 1st visit; \$10 copay thereafter	20% after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
20% coinsurance after deductible	20% coinsurance after \$250 Hospital deductible per confinement	40% coinsurance after \$250 Hospital deductible plus costs over MAA	30% coinsurance after \$500 Hospital deductible per confinement	50% coinsurance after \$500 Hospital deductible per confinement

CY = Calendar Year

MAA = Maximum Allowable Amount

OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER	
	HIGH OPTION		LOW OPTION		HIGH OPTION	
	Tier One	Tier Two	Tier One	Tier Two		
Outpatient	\$10 copay	\$30 copay	Not covered	Not covered	\$10 copay individual, \$5 copay group; unlimited visits	
Severe mental disorders: Inpatient	No charge	Not covered	\$1000 copay per confinement	Not covered	No charge; unlimited days	
Outpatient	\$10 copay	\$30 copay	\$30 copay per visit	\$80 copay per visit	\$10 copay; unlimited visits	
Out-of-pocket maximum	\$1,500 member/ \$3,000 family	Not applicable	\$3,000 single/ \$6,000 two party/ \$9,000 family	N/A	\$1,500 member/ \$3,000 family	
Outpatient services: Chemotherapy (Professional)	No charge	Not covered	No charge	Not covered	No charge	
Renal dialysis (Professional)	No charge	Not covered	No charge	Not covered	\$10 copay	
Outpatient surgery (Facility)	No charge	Not covered	\$750 copay per surgery	Not covered	\$10 copay per procedure	
Physician services: Hearing screenings	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay	
Home visits	\$10 copay	Not covered	\$50 copay	Not covered	No charge if medically necessary	
Hospital services	No charge	Not covered	No charge	Not covered	No charge	
Immunizations	\$10 copay	\$30 copay	No charge	\$80 copay applies to allergy testing; office based injectable medications per dose and self-injectable drugs	No charge, including allergy serum and injection services during office visit	

COMPARISON CHART

CY = Calendar Year

MAA = Maximum Allowable Amount

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.

PERMANENTE	HEALTH NET PPO PPO MEDICARE COB*		HEALTH NET PPO	
	LOW OPTION	HIGH OPTION In-Network Out-of-Network	LOW OPTION In-Network Out-of-Network	
\$20 copay individual; \$10 copay group (no deductible)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
20% coinsurance after deductible	20% coinsurance after \$250 Hospital deductible per confinement	40% coinsurance after \$250 Hospital deductible plus costs over MAA	30% coinsurance after \$500 Hospital deductible per confinement	50% coinsurance after \$500 Hospital deductible per confinement
\$20 copay; unlimited visits	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
\$3,000 member/ \$6,000 family	\$2,500 individual/ \$5,000 family	\$5,000 individual/ \$10,000 family	\$6,000 member/ no family maximum	\$12,000 member/ no family maximum
No charge	20% coinsurance after deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
\$20 copay per visit	20% coinsurance after deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
20% coinsurance after deductible	20% coinsurance after \$250 deductible	40% coinsurance after \$250 deductible up to \$350 max per surgery	30% coinsurance after \$500 CY deductible (Facility)	50% coinsurance after \$500 CY deductible (Facility)
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible age 16 and below, age 17 and over not covered	50% coinsurance after CY deductible age 16 and below, age 17 and over not covered
No charge (no deductible)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
No charge	20% coinsurance after CY deductible; \$250 per admit	40% coinsurance after deductible plus costs over MAA; \$250 per admit	30% coinsurance after CY deductible \$500 per admit	50% coinsurance after CY deductible \$500 per admit
No charge, including allergy serum and injection services during office visit (No deductible)	Age 16 and under covered under Preventive Care; age 17 and over not covered	Age 16 and under covered under Preventive Care; age 17 and over not covered	Age 16 and under covered under Preventive Care; age 17 and over not covered	Age 16 and under covered under Preventive Care; age 17 and over not covered

CY = Calendar Year

MAA = Maximum Allowable Amount

OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER	
	HIGH OPTION		LOW OPTION		HIGH OPTION	
	Tier One	Tier Two	Tier One	Tier Two		
Office visits	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay	
Periodic health examinations	\$10 copay	\$30 copay	\$50 copay	\$80 copay	See routine physicals	
Preventive care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	
Routine physicals	\$10 copay	Not covered	Not covered	Not covered	\$10 copay	
Specialists	\$10 copay	\$30 copay	\$70 copay	\$80 copay	\$10 copay	
Surgical services (physician's office)	No charge	No charge	No charge	No charge	\$10 copay	
Well baby/ well child care	\$10 copay	\$30 copay	\$50 copay	\$80 copay	No charge (0-23 months)	
Well woman exam (annual)	\$10 copay	\$30 copay	\$70 copay when performed by OB-GYN; \$50 when performed by PCP	\$80	\$10 copay	
Physical and occupational therapy	\$10 copay when Medically Necessary provided in an inpatient, outpatient or office visit setting	\$30 copay; up to 12 visits per CY when Medically Necessary	\$40 copay when Medically Necessary provided in an inpatient, outpatient or office visit setting	\$80 copay; up to 12 visits per CY when medically necessary. Office visit only	\$10 copay	
Pre-existing condition	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	

COMPARISON CHART

CY = Calendar Year

MAA = Maximum Allowable Amount

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.

PERMANENTE	HEALTH NET PPO PPO MEDICARE COB*		HEALTH NET PPO	
	LOW OPTION	HIGH OPTION In-Network Out-of-Network	LOW OPTION In-Network Out-of-Network	
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
See routine physicals	Not covered. See preventive care	Not covered. See preventive care	Not covered. See preventive care	Not covered. See preventive care
Not applicable	20% coinsurance after CY deductible	40% coinsurance after CY deductible. Up to maximum payable \$20 each exam for children through age 16	30% coinsurance after CY deductible	50% coinsurance
\$20 copay	Not covered	Not covered	Not covered	Not covered
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
20% coinsurance after deductible	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
\$10 copay (0-23 months)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA. \$20 maximum payable per exam	30% coinsurance after CY deductible	50% after CY deductible
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
\$20 copay after deductible	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA; \$25 max payable per visit	30% coinsurance after CY deductible up to 20 visits per CY	50% after CY deductible up to 20 visits per CY
No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions

CY = Calendar Year

MAA = Maximum Allowable Amount

OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER	
	HIGH OPTION		LOW OPTION		HIGH OPTION	
	Tier One	Tier Two	Tier One	Tier Two		
Prescription drugs – Retail Generic	Up to 30-day supply \$5 copay	Up to 30-day supply \$5 copay	Up to 30-day supply \$10 copay	Up to 30-day supply \$10 copay	Up to 100-day supply \$10 copay	
Brand formulary	\$10 copay	\$10 copay	\$100 CY brand name deductible per member plus \$30 copay	\$100 CY brand name deductible per member plus \$30 copay	\$15 copay	
Non-formulary	\$25 copay	\$25 copay	\$100 CY brand name deductible per member plus \$50 copay	\$100 CY brand name deductible per member plus \$50 copay	Not covered	
Prescription drugs – Mail order Generic	Up to 90-day supply \$10 copay	Up to 90-day supply \$10 copay	Up to 90-day supply \$20 copay	Up to 90-day supply \$20 copay	Up to 100-day supply \$10 copay	
Brand formulary	\$20 copay	\$20 copay	\$100 CY brand name deductible per member plus \$60 copay	\$100 CY brand name deductible per member plus \$60 copay	\$15 copay	
Non-formulary	\$50 copay	\$50 copay	\$100 CY brand name deductible per member plus \$100 copay	\$100 CY brand name deductible per member plus \$100 copay	Not covered	
Skilled nursing facility	No charge	Not covered	\$1,000 copay per admit; limited to 100 days per CY	Not covered	No charge; up to 100 days per benefit period	
Speech therapy	\$10 copay when Medically Necessary provided in an inpatient, outpatient or office visit setting	\$30 copay; up to 12 visits per CY when Medically Necessary. Office visit only.	\$40 copay when Medically Necessary provided in an inpatient, outpatient or office visit setting	\$80 copay; up to 12 visits per CY when Medically Necessary. Office visit only	\$10 copay	

CY = Calendar Year

MAA = Maximum Allowable Amount

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.

PERMANENTE	HEALTH NET PPO PPO MEDICARE COB*		HEALTH NET PPO	
	LOW OPTION	HIGH OPTION In-Network Out-of-Network	LOW OPTION In-Network Out-of-Network	LOW OPTION In-Network Out-of-Network
Up to 100-day supply \$10 copay No deductible	Up to 30-day supply \$10 copay CY deductible waived	Up to 30-day supply \$10 copay plus 50% of expense CY deductible waived	Up to 30-day supply \$10 copay CY deductible waived	Up to 30-day supply \$10 copay plus 50% of drug covered expense. CY deductible waived
\$30 copay after \$100 deductible	\$25 copay CY deductible waived	\$25 copay plus 50% of drug covered expense. CY deductible waived	\$25 copay CY deductible waived	\$25 copay plus 50% of drug covered expense. CY deductible waived
Not covered	\$35 copay CY deductible waived	\$35 copay plus 50% of drug covered expense. CY deductible waived	\$35 copay CY deductible waived	\$35 copay plus 50% of drug covered expense. CY deductible waived
Up to 100-day supply \$10 copay No deductible	Up to 90-day supply \$20 copay CY deductible waived	Up to 90-day supply Same vendor as in-network	Up to 90-day supply \$20 copay CY deductible waived	Up to 90-day supply Same vendor as in-network
\$30 copay after \$100 deductible	\$50 copay CY deductible waived	Same vendor as in-network	\$50 copay CY deductible waived	Same vendor as in-network
Not covered	\$70 copay CY deductible waived	Same vendor as in-network	\$70 copay CY deductible waived	Same vendor as in-network
20% coinsurance after deductible; up to 100 days per benefit period	\$250 deductible per confinement plus 20% coinsurance; combined PPO/OON limit of 100 days per CY	\$250 deductible per confinement plus 40% coinsurance; combined PPO/OON limit of 100 days per CY	30% coinsurance after \$500 deductible per confinement	50% coinsurance after \$500 deductible per confinement
\$20 copay after deductible	20% coinsurance after CY deductible	40% coinsurance after deductible up to \$30 max per visit plus costs over MAA	30% coinsurance after CY deductible up to 20 visits per CY	50% coinsurance after CY deductible up to 20 visits per CY

CY = Calendar Year

MAA = Maximum Allowable Amount

OON = Out-of-Network

Medical Plans Comparison Chart (Non Medicare Eligible)

	HEALTH NET EOA				KAISER	
	HIGH OPTION		LOW OPTION		HIGH OPTION	
	Tier One	Tier Two	Tier One	Tier Two		
Substance abuse: Rehab – Inpatient	No charge	Not covered	Not covered	Not covered	No charge. Transitional residential recovery service	
Outpatient	\$10 copay	\$30 copay	Not covered	\$80 copay	\$10 copay individual/ \$5 copay group	
Detox – Inpatient	No charge	Not covered	\$1,000 per confinement	Not covered	No charge	
Outpatient – consultation, therapy, counseling	\$10 copay	\$30 copay	\$80 copay	\$80 copay	\$10 copay individual/ \$5 copay group	
Urgent care (Facility)	\$25 copay Facility services. \$0 copay for Professional services	Not covered	\$100 copay for Facility services; \$0 copay for Professional services	Not covered	\$10 copay	
Vision exams	\$10 copay	\$30 copay	\$50 copay	\$80 copay	\$10 copay	

CY = Calendar Year

MAA = Maximum Allowable Amount

OON = Out-of-Network

COMPARISON CHART

Notes _____

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.

PERMANENTE	HEALTH NET PPO PPO MEDICARE COB*		HEALTH NET PPO	
	LOW OPTION	HIGH OPTION	LOW OPTION	
	In-Network	Out-of-Network	In-Network	Out-of-Network
20% coinsurance after deductible; \$100 transitional residential recovery service	20% coinsurance after \$250 Hospital deductible per confinement	40% coinsurance after \$250 Hospital deductible per confinement plus costs over MAA	30% coinsurance after \$500 Hospital deductible per confinement	50% coinsurance after \$500 Hospital deductible per confinement
\$20 copay individual/ \$5 copay group (no deductible)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
20% coinsurance after deductible	20% coinsurance after \$250 Hospital deductible per confinement	40% coinsurance after \$250 Hospital deductible per confinement plus costs over MAA	30% coinsurance after \$500 Hospital deductible per confinement	50% coinsurance after \$500 Hospital deductible per confinement
\$20 copay individual/ \$5 copay group (no deductible)	20% coinsurance after CY deductible	40% coinsurance after deductible plus costs over MAA	30% coinsurance after CY deductible	50% after CY deductible
\$20 copay	\$35 deductible per visit plus 20% coinsurance (Facility and Professional services)	\$35 deductible per visit plus 20% coinsurance plus costs over MAA (Facility and Professional services)	\$100 deductible per visit plus 30% coinsurance after CY deductible (Facility and Professional services)	\$100 deductible per visit plus 30% coinsurance after CY deductible (Facility and Professional services)
\$20 copay	20% coinsurance after CY deductible	40% coinsurance after deductible	Children thru age 16 only; 30% after CY deductible	Children thru age 16 only; 50% after CY deductible

CY = Calendar Year

MAA = Maximum Allowable Amount

OON = Out-of-Network

Notes

COMPARISON CHART

Medical Plans Comparison Chart (Medicare Eligible)

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

COMPARISON CHART

PCP = Primary Care Physician

PPG = Participating Physician Group

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 MEDICARE ADVANTAGE	
HIGH OPTION	LOW OPTION
\$10 copay	\$25 copay
No charge	\$50 per trip
\$10 copay under ASH plan provider, no referral necessary	\$25 copay under ASH plan provider, no referral necessary
Kaiser only	Kaiser only
None	None
None	None
None	None
No charge; certain imaging and diagnostic procedures \$10 copay	No charge; certain imaging and diagnostic procedures \$25 copay
No charge	20% coinsurance
\$50; waived if admitted	\$50; waived if admitted
\$10 copay per office visit, \$10 copay per procedure; excludes GIFT, ZIFT, and IVF	\$25 copay per office visit, \$25 per procedure; excludes GIFT, ZIFT, and IVF
\$10 copay	\$25 copay
\$10 copay	\$25 copay
No charge	No charge if medically necessary
No charge	No charge
No charge	\$500 per admit

COMPARISON CHART

Medical Plans Comparison Chart (Medicare Eligible)

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	LOW OPTION
Lifetime maximum	Unlimited	Unlimited
Maternity care	Covered same as any other illness	Covered same as any other illness
Mental health: Inpatient	No charge	No charge
Outpatient	\$10 copay	No charge
Severe mental disorders: Inpatient	No charge	No charge
Outpatient	\$10 copay	No charge
Out-of-pocket maximum	\$3,400	\$3,400
Outpatient services: Chemotherapy	No charge (Professional services only)	No charge (Professional services only)
Renal dialysis	No charge (Professional services only)	\$25 copay (Professional services only)
Outpatient surgery	No charge at hospital or ambulatory surgical center. \$10 copay at Physician's office.	No charge
Physician services: Hearing screenings	\$10 copay	No charge
Home visits	\$10 copay	No charge
Hospital services	No charge	No charge
Immunizations/injections	No charge (except for foreign travel/occupation which is covered at 20%)	No charge (except for foreign travel/occupation which is covered at 20%)
Office visits	\$10 copay	No charge
Podiatry	\$10 copay	No charge
Routine physicals	No charge	No charge
Specialists	\$10 copay	No charge

COMPARISON CHART

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

KAISER PERMANENTE MEDICARE ADVANTAGE	
HIGH OPTION	LOW OPTION
Unlimited	Unlimited
\$10 copay	\$5 copay per visit
No charge	\$500 per admit
\$10 copay individuals; \$5 copay group; unlimited visits	\$25 copay individuals; \$12 copay group; unlimited visits
No charge; unlimited days	\$500 per admit
\$10 copay individuals; \$5 copay group; unlimited visits	\$25 copay individuals; \$12 copay group; unlimited visits
\$1,500 member/\$3,000 family	\$1,500 member/\$3,000 family
No charge	No charge
\$10 copay	\$25 copay
\$10 copay per procedure	\$25 copay per procedure
\$10 copay	\$25 copay
No charge	No charge
No charge	No charge
No charge including allergy injections and serum during office visit	No charge including allergy injections and serum during office visit
\$10 copay	\$25 copay
\$10 copay	\$25 copay
No charge	No charge
\$10 copay	\$25 copay

Medical Plans Comparison Chart (Medicare Eligible)

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	LOW OPTION
Surgical services	No charge	No charge
Well baby/well child care	Not covered	Not covered
Well woman exam (annual)	No charge	No charge
Physical and occupational therapy	No charge	No charge
Pre-existing condition	ESRD	ESRD
Prescription drugs – Retail	Up to 30-day supply	Up to 30-day supply
Generic	\$10 copay	\$10 copay
Brand formulary	\$20 copay	\$30 copay
Non-formulary	\$40 copay	\$60 copay
Specialty drugs – Tier 4	25%	33%
Injectable drugs – Tier 5	25%	33%
Prescription drugs – Mail order	Up to 90-day supply	Up to 90-day supply
Generic	\$20 copay	\$20 copay
Brand formulary	\$40 copay	\$60 copay
Non-formulary	\$40 copay	\$150 copay
Specialty drugs – Tier 4	25%	33%
Injectable drugs – Tier 5	25%	33%
Initial coverage limit (ICL)	None	\$3,000 (generics only after ICL)
Skilled nursing facility	No charge (limited to 100 days per benefit period)	Days 1-20; no charge (limited to 100 days per benefit period) Days 21-100; \$75 per day
Speech therapy	No charge	No charge

COMPARISON CHART

ESRD = End Stage Renal Disease

ICL = Initial Coverage Limit

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 MEDICARE ADVANTAGE	
HIGH OPTION	LOW OPTION
\$10 copay	\$25 copay
\$10 copay	\$5 copay
No charge	No charge
Inpatient no copay/outpatient \$10 copay	\$25 copay
No exclusion for pre-existing condition	No exclusion for pre-existing condition
Up to 100-day supply	Up to 30-day supply
\$10 copay	\$10 copay
\$20 copay	\$25 copay
Not covered	Not covered
N/A	N/A
N/A	N/A
Up to 100-day supply	Up to 100-day supply
\$10 copay	\$20 copay
\$20 copay	\$50 copay
Not covered	Not covered
N/A	N/A
N/A	N/A
None	None
No charge up to 100 days per benefit period	No charge up to 100 days per benefit period
\$10 copay	\$25 copay

COMPARISON CHART

Medical Plans Comparison Chart (Medicare Eligible)

	HEALTH NET SENIORITY PLUS	
	HIGH OPTION	LOW OPTION
Substance abuse: Rehab – Inpatient	No charge	No charge
Outpatient	\$10 copay	No charge
Detox – Inpatient	No charge	No charge
Outpatient – consultation therapy, counseling	\$10 copay	No charge
Urgent care	\$20 copay (waived if admitted directly to the hospital)	\$10 copay (waived if admitted directly to the hospital)
Vision exams	\$10 copay	No charge
Other benefits: Bone mass measurements	\$0 copay	\$0 copay
Diabetes self-monitoring training and supplies	\$0 copay	\$0 copay; 20% coinsurance diabetic supplies
Fitness	No charge	No charge
Medical nutrition therapy (for members with diabetes and kidney disease)	\$10 copay	No charge
MHN specialized programs for legal and financial consultations as well as smoking cessation, discounts for weight management and nutrition	No charge	No charge
Silver & Fit	No charge	No charge
Transportation	No charge (30 one-way or 15 round trips per calendar year)	No charge (30 one-way or 15 round trips per calendar year)

COMPARISON CHART

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

KAISER PERMANENTE MEDICARE ADVANTAGE	
HIGH OPTION	LOW OPTION
No charge	\$500 per admit in plan hospital; \$100 per admit for non-medical transitional residential recovery setting
\$10 copay individual/\$5 copay group	\$25 copay individual per visit/\$5 copay group
No charge	\$500 per admit in plan hospital; \$100 per admit for non-medical transitional residential recovery setting
\$10 copay individual/\$5 copay group	\$25 copay individual per visit/\$5 copay group
\$10 copay	\$25 copay
\$10 copay	\$25 copay
Covered if medically necessary, contact Kaiser Permanente for information about Healthy Living Programs	Covered if medically necessary, contact Kaiser Permanente for information about Healthy Living Programs
Covered under Health Education and Durable Medical Equipment	Covered under Health Education and Durable Medical Equipment
Contact Kaiser Permanente for information about Healthy Living Programs	Contact Kaiser Permanente for information about Healthy Living Programs
Contact Kaiser Permanente for information about Healthy Living Programs	Contact Kaiser Permanente for information about Healthy Living Programs
N/A	N/A
N/A	N/A
N/A	N/A

COMPARISON CHART

Dental Plan Comparison Chart Summary

DELTACARE USA HMO DELTA DENTAL PPO

Category	ADA Dental Codes	Description	You pay...	In-Network (You pay...)	Out-of-Network (You pay...plus any costs over Delta Dental Base Allowance)
Preventive Care (NO WAITING PERIOD)	D0120	Periodic oral examination	\$0	0%	30%
	D0210	Full mouth X-ray (panoramic), once in a 5-year period	\$0	0%	30%
	D0270-77	Bitewing, 1 per calendar year or as needed	\$0	0%	30%
	D9110	Emergency, palliative treatment of dental pain	\$5	0%	30%
	D9430	Office visit for observation	\$5	0%	30%
	D0460	Pulp vitality test	\$0	0%	30%
	D1201	Topical Fluoride (child)	\$0	0%	30%
	D1351	Sealant (per tooth)	\$10	20%	40%
	D0470	Diagnostic casts	\$0	0%	30%
	D1110	Prophylaxis (to remove tartar/stains)	\$0	0%	30%
Restorative Dentistry (NO WAITING PERIOD)	D2140	Amalgam on permanent teeth: 1 surface	\$0	20%	40%
	D2150	Amalgam on permanent teeth: 2 surfaces	\$0	20%	40%
	D2160-61	Amalgam on permanent teeth: 3 or 4 surfaces	\$0	20%	40%
	D2330	Composite resin (white), anterior teeth only, 1 surface	\$0	20%	40%
	D2951	Pin retention	\$10	20%	40%
	D1510	Space maintainers	\$25	20%	40%
Periodontics (NO WAITING PERIOD)	D4240	Gingival flap, per quadrant	\$130	20%	40%
	D4341	Periodontal scaling (deep cleaning), per quadrant	\$25	20%	40%
	D4260	Osseous surgery (reshaping bone), per quadrant	\$280	20%	40%
	D4210	Gingivectomy/gingivoplasty (gum surgery), per quadrant	\$130	20%	40%
	D4342	Periodontal Scaling and Root Planing: 1 to 3 teeth per quadrant, limited to 4 quadrants during any 12 consecutive months	\$20	20%	40%
	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis, limited to 1 treatment in any 12 consecutive months	\$25	20%	40%
D4910	Periodontal maintenance procedures	\$55	20%	40%	
Endodontics (NO WAITING PERIOD)	D3110	Pulp capping	\$0	20%	40%
	D3220	Therapeutic pulpotomy	\$0	20%	40%
	D3310	Anterior (front) teeth root canal therapy	\$55	20%	40%
	D3320	Bicuspid root canal therapy	\$120	20%	40%
	D3330	Molar root canal therapy	\$250	20%	40%
	D3920	Hemisection	\$30	20%	40%
	D3450	Root amputation (per root)	\$0	20%	40%
	D3410	Apicoectomy	\$60	20%	40%
	D3426	Periradicular surgery (each additional root)	\$50	20%	40%
	D3430	Retrograde filling (per root)	\$60	20%	40%

<p>Oral Surgery (NO WAITING PERIOD)</p>	<p>D7111 D7220 D7230 D7240 D9215 D9220 D7320 D7310 D7140</p>	<p>Extract, coronal remnants – deciduous tooth Extraction — impacted soft tissue, per tooth Extraction — impacted partially bony, per tooth Extraction — impacted completely bony, per tooth Local anesthesia General anesthesia (first 30 minutes) Alveoplasty (reshape bone) per quad, w/out extraction Alveoplasty (reshape bone) per quad, with extraction Extraction, erupted tooth or exposed root (elevation and/or forceps removal) Incision and drainage of abscess Frenulectomy (includes frenectomy or frenotomy) Vestibuloplasty (ridge extension associated with surgical preparation of ridge for dentures)</p>	<p>\$0 \$50 \$70 \$90 \$0 \$165 \$70 \$50 \$5 \$0 \$0 Not covered</p>	<p>20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%</p>	<p>40% 40% 40% 40% 40% 40% 40% 40% 40% 40% 40% 40%</p>
<p>Crowns and Bridges (WAITING PERIOD FOR PPO ONLY)</p>	<p>D2792 D2780 D2781 D2782 D2752 D2722 D2710 D6930 D2920</p>	<p>Crown — full cast noble metal (silver) Crown — ¾ cast high noble Crown — ¾ cast predominantly base metal Crown — ¾ cast predominantly base metal Crown — porcelain fused to noble metal (silver) Crown — resin with noble metal (silver) Crown — resin (laboratory) Recement fixed partial denture Recement crown</p>	<p>\$150 \$210 \$110 \$150 \$180 \$135 \$50 \$0 \$0</p>	<p>50% 50% 50% 50% 50% 50% 50% 50% 50%</p>	<p>50% 50% 50% 50% 50% 50% 50% 50% 50%</p>
<p>Prosthetics (WAITING PERIOD FOR PPO ONLY)</p>	<p>D5110 D5120 D5211 D5212 D5750-51 D5510 D5410 D5520 D5710-11 D6210 D6720 Various</p>	<p>Complete upper denture Complete lower denture Upper partial denture — resin base Lower partial denture — resin base Reline upper or lower denture, laboratory Repair broken or lower denture, no tooth damage Complete denture adjustment Replace broken tooth on denture Rebase complete maxillary or mandibular denture Denture pontics, cast high noble metal (gold)* Denture crown, resin with high noble metal (gold)* Implants</p>	<p>\$145 \$145 \$120 \$120 \$60 \$20 \$10 \$10 \$55 \$210 \$195 Not covered</p>	<p>50% 50% 50% 50% 50% 50% 50% 50% 50% 50% 50% 50%</p>	<p>50% 50% 50% 50% 50% 50% 50% 50% 50% 50% 50% 50%</p>
<p>Deductible</p>	<p>Deductible is per patient per year</p>	<p>No deductible</p>	<p>\$50</p>	<p>\$50</p>	<p>\$50</p>
<p>Calendar Year Benefit Maximum</p>	<p>No annual or lifetime dollar maximum</p>	<p>\$1,000</p>	<p>\$1,000</p>	<p>\$1,000</p>	<p>\$1,000</p>

COMPARISON CHART

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

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

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

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

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

How to Complete 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 Health Net HMO, you must enter a primary care physician (PCP) and medical group number. If you omit this field, Health Net will assign you to any PCP in your area.
Section E	Medical/Dental	Complete this section if you are not changing plans, but are only adding or deleting dependents. You must enter a PCP and medical group number if you are enrolled in Health Net HMO.
Section F	Medical/Dental	Complete if applicable.
Section G	Medical/Dental	Complete if you have other medical/dental insurance.
Section H	Medical	Complete if anyone to be covered by this medical plan is enrolled in both Medicare Parts A and B.
Section H	Dental	Read, sign and date.
Sections I-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.

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



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

RETIREE
MEDICAL PLAN
ENROLLMENT/CHANGE FORM

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

A NEW RETIREE OPEN ENROLLMENT CHANGE IN STATUS

B I CHOOSE THIS MEDICAL PLAN:
Kaiser Permanente Health Net Elect Open Access HMO
Kaiser Medicare Advantage* Health Net PPO
Kaiser Permanente Medicare COB Health Net PPO Medicare COB
Health Net Seniority Plus*
*Medicare integrated plan. Please complete both the County and the health plan enrollment form.
PREVIOUS MEDICAL PLAN:

Option:
High Option
Low Option
For PPO only
California
Out-of-State

C RETIREE INFORMATION

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

D NEW ENROLLMENT ONLY IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME OR CHANGING PLANS, LIST ALL PERSON(S) TO BE COVERED Health Net HMO & Seniority Plus Enrollees Only

Table with columns: Last Name, First Name, Social Security #, Date of Birth, Relationship, Primary Care Physician's ID No./Group No., Previously Visited?
Rows for Spouse/Domestic Partner and Children.

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

E ENROLLMENT CHANGES ONLY IF YOU ARE ADDING OR DELETING DEPENDENT(S) (BUT NOT CHANGING PLANS), COMPLETE THIS SECTION Health Net HMO & Seniority Plus Enrollees Only

Table with columns: Last Name, First Name, Social Security #, Date of Birth, Relationship, Primary Care Physician's ID No./Group No., Previously Visited?
Rows for adding or deleting Spouse/Domestic Partner and Children.

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

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

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

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

MEDICAL PLAN ENROLLMENT/CHANGE FORM

FORMS

I

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

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

J

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

ACCEPTANCE OF COVERAGE

THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I acknowledge and understand that health care providers may disclose health information about me or my dependents to Health Net Entities, the DBP Entities and/or Fidelity Entities. Health Net Entities, the DBP Entities and/or Fidelity Entities use and may disclose this information for purposes of treatment, payment and health plan operations, including but not limited to, utilization management, quality improvement, disease or case management programs. Health Net's Notice of Privacy Practices is included in the evidence of coverage or certificate of insurance for coverage underwritten by Health Net Entities. I may also obtain a copy of this Notice on the web site at www.healthnet.com or through the Health Net Customer Contact Center.

NOTICE: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the purpose of payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California Law prohibits an HIV test from being used by health insurance companies as a condition of obtaining health insurance coverage.

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

BINDING ARBITRATION AGREEMENT: Subject to their terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the DP Entities and/or the Fidelity Entities, regarding construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the DBP Entities and/or DBP Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the DBP Entities and/or the Fidelity Entities are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the DBP Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

"Plan Contract" refers to the Health Net of California, Inc. and/or Dental Benefit Providers of California, Inc. Group Service Agreement and Evidence of Coverage; "Insurance Policy" refers to Health Net Life Insurance Company, Unimerica Insurance Company, and/or Fidelity Security Life Insurance Company Group Policy and Certificate of Insurance.

K

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

Declining Medical coverage for:

Self Spouse Domestic Partner Dependent(s)

The available coverage has been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s)

By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.

Employee Signature _____ Date _____

L

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

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

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

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

O AGREEMENT

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

I authorize the County of San Bernardino to deduct from my salary or 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 (EBSB)
 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: Delta Dental PPO DeltaCare USA HMO

C **RETIREE INFORMATION**

1. Social Security No.	2. Check One: <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth Month Day Year	4. Check One: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address <input type="checkbox"/>		10. Home Phone () Alternate Phone ()	
11. City	12. State	13. Zip Code	14. DeltaCare USA members must provide the following: Provider Name _____ Provider No. _____

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

Last Name	First Name	Social Security No.	Date of Birth	Relationship
Spouse/Domestic Partner:				
Children:				

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

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

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

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

G **OTHER DENTAL COVERAGE**

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

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

Policy no. _____ Phone number () _____

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

I elect to enroll in (or make the above changes to) the dental plan as shown above and authorize deduction to be made from my 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.

Retiree'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



RETIREE MEDICAL AND/OR DENTAL PLAN CANCELLATION FORM

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

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

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

Medical plan name _____

Dental plan name _____

B RETIREE INFORMATION

1. Social Security No.	2. Check One: <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 () Alternate Phone ()
11. City	12. State	13. Zip Code	

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



DISABLED DEPENDENT CERTIFICATION (Dependent child age 26 or older)

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

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

COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 26 OR OLDER

Dependent Name	Date of Birth	Relationship to Employee
-----------------------	----------------------	---------------------------------

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

Retiree Signature	Telephone ()	Date
--------------------------	--------------------------------	-------------

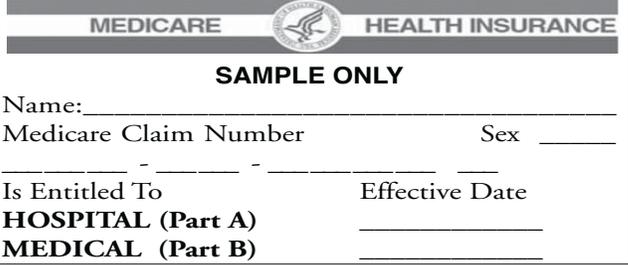
DISTRIBUTION: Original – EBSD-HR (0440)

RETURN FORM TO:

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

HEALTH NET SENIORITY PLUS EMPLOYER (HMO) ENROLLMENT REQUEST FORM

Please contact Health Net Seniority Plus Employer (HMO) if you need information in another language or format (Braille).

To Enroll in Health Net Seniority Plus Employer (HMO), 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: ()	
Permanent Residence Street Address (P.O. Box is not allowed):			
City:		State:	ZIP Code:
Mailing Address (only if different from your Permanent Residence Address):			
Street Address:		City:	State: ZIP Code:
Please Provide Your Medicare Insurance Information			
<p>Please take out your Medicare card to complete this section.</p> <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card - OR - Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board. <p>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</p>			
Please read and answer these important questions			
<p>1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, retirement date (month/day/year): _____ If no, name of retiree: _____</p>		<p>2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse: _____ Name of dependents: _____</p>	
<p>3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>4. Do you have End Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have had a successful kidney transplant and/or you don't need regular dialysis any more, 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.</p>			
<p>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 <u>prescription</u> drug coverage in addition to Health Net Seniority Plus Employer (HMO)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for Coverage: _____</p>			
<p>6. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" please provide the following information: Name of Institution: _____ Address & Phone Number of Institution (number and street): _____</p>			
<p>7. Do you receive Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide your Medicaid number: _____</p>			
<p>8. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare drug coverage since you became eligible to join a Medicare drug program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Please Choose a Primary Care Physician (PCP), clinic or health center:			
<p>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: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Braille, audio tape or large print Please contact Health Net Seniority Plus Employer (HMO) Member Services at 1-800-275-4737 if you need information in another format or language than what is listed above. Our office hours are 8:00 a.m. – 8:00 p.m., 7 days a week. TTY users should dial 1-800-929-9955.</p>			

Please Read and Sign Below

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

Health Net Seniority Plus Employer (HMO) 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. 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. 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 (Example: Annual Enrollment Period from October 15 – December 7), or under certain special circumstances.

Health Net Seniority Plus Employer (HMO) serves specific service area. If I move out of the area that Health Net Seniority Plus Employer (HMO) serves, I need to notify the plan so that I can disenroll and find a new plan in my new area. Once I am a member of Health Net Seniority Plus Employer (HMO), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net Seniority Plus Employer (HMO) 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 the limited coverage near the U.S. border.

I understand that beginning on the date Health Net Seniority Plus Employer (HMO) coverage begins, I must get all of my health care from Health Net Seniority Plus Employer (HMO), except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Health Net Seniority Plus Employer (HMO) and other services contained in my Health Net Seniority Plus Employer (HMO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR HEALTH NET SENIORITY PLUS EMPLOYER (HMO) 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 Health Net Seniority Plus Employer (HMO), he/she may be paid based on my enrollment in Health Net Seniority Plus Employer (HMO).

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net Seniority Plus Employer (HMO) 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): _____	Rep ID: _____	
Plan ID #: _____		
Group #: _____	ICEP/IEP: _____	[OEP: _____]
Effective Date of Coverage: _____	AEP: _____	SEP (type): _____
Not Eligible: _____		



HEALTH NET MEDICARE PROGRAMS GROUP DISENROLLMENT FORM

If you request disenrollment, you must continue to receive all medical care from Health Net Medicare Programs until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of the Health Net Medicare Programs network. We will notify you of your effective date after we have received this form from you.

Last Name	First Name	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Subscriber / R #			
Group # (please refer to ID card)			
Birth date:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone Number: ()	

Effective ____/____/____ (must be the 1st day of the month)

Reason: Premium too high Claims payment unsatisfactory Customer service unsatisfactory
(optional) Moving out of a Health Net Medicare Programs' service area Date of move: _____
 Other reason: _____

Are you transitioning from one Health Net Medicare Programs Plan to another Health Net Medicare Programs Plan?

<input type="checkbox"/> Yes, I am transferring to a Health Net Medicare Advantage HMO Plan.
<input type="checkbox"/> Yes, I am transferring to a Health Net Medicare COB/PDP Plan.
<input type="checkbox"/> Yes, I am transferring to a Health Net Medicare Individual Plan.
<input type="checkbox"/> No

Please allow 7-10 business days for processing. To check the status of the cancellation please call the appropriate Medicare Member Services number below:

Health Net Medicare Advantage HMO Plans
1-800-275-4737 (TTY dial 711), 8:00 a.m.- 8:00 p.m., 7 days a week

Health Net Medicare COB/PDP Plans
1-800-806-8811 (TTY dial 711), 8:00 a.m.- 8:00 p.m., 7 days a week

Health Net Medicare PFFS Plans
1-800-977-8221 (TTY dial 711), 8:00 a.m.- 8:00 p.m., 7 days a week

If your spouse is currently enrolled in a Health Net Medicare plan and wishes to disenroll, a separate disenrollment must be completed.

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

On the effective date of enrollment in another Medicare Advantage or Medicare Prescription Drug Plan, I understand Medicare will automatically cancel my current membership in Health Net Medicare Programs. 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 do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

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

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 Health Net Medicare Programs or by Medicare.

If you are the authorized representative, 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



Main Subscriber ID Effective Date

--	--

EMPLOYER GROUP MEDICAL AND MEDICARE COORDINATION OF BENEFITS AND/OR PART D PRESCRIPTION DRUG ENROLLMENT REQUEST FORM

To enroll in Health Net's Coordination of Benefits (COB) and/or Part D Prescription Drug Plan (PDP) please provide the following information:																												
Employer or union name:		Group #:																										
Last name:	First name:	MI:	<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 #: ()																									
Permanent residence – Street address:		Apt #:	City:	State: ZIP:																								
Mailing address (only if different from above):		Apt #:	City:	State: ZIP:																								
Please provide your Medicare insurance information																												
Please take out your Medicare card to complete this section. <ul style="list-style-type: none"> Please fill in these blanks so they match your red, white and blue Medicare card. - OR - <ul style="list-style-type: none"> 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 to join a Medicare prescription drug plan.		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 5px;">MEDICARE</td> <td style="text-align: center; padding: 5px;"></td> <td style="text-align: center; padding: 5px;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="3" style="text-align: center; padding: 5px;">SAMPLE ONLY</td> </tr> <tr> <td colspan="3" style="padding: 5px;">Name: _____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Medicare Claim Number _____</td> <td style="padding: 5px;">Sex _____</td> </tr> <tr> <td colspan="3" style="padding: 5px;">_____ - _____ - _____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Is Entitled To</td> <td style="padding: 5px;">Effective Date</td> </tr> <tr> <td colspan="2" style="padding: 5px;">HOSPITAL (Part A)</td> <td style="padding: 5px;">_____</td> </tr> <tr> <td colspan="2" style="padding: 5px;">MEDICAL (Part B)</td> <td style="padding: 5px;">_____</td> </tr> </table>			MEDICARE		HEALTH INSURANCE	SAMPLE ONLY			Name: _____			Medicare Claim Number _____		Sex _____	_____ - _____ - _____			Is Entitled To		Effective Date	HOSPITAL (Part A)		_____	MEDICAL (Part B)		_____
MEDICARE		HEALTH INSURANCE																										
SAMPLE ONLY																												
Name: _____																												
Medicare Claim Number _____		Sex _____																										
_____ - _____ - _____																												
Is Entitled To		Effective Date																										
HOSPITAL (Part A)		_____																										
MEDICAL (Part B)		_____																										
Provider selection	Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	Participating physician group (PPG): _____ PPG ID#: _____	Primary care physician (PCP) name: _____ PCP ID #: _____ <input type="checkbox"/> Prior patient																									
Please read and answer these important questions. NOTE: Medicare eligible spouse or dependent(s) must fill out separate forms. Please contact your employer group administrator.																												
1. Are you the retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," retirement date (mm/dd/yyyy): _____ If "No," name of retiree: _____		2. Are you covering a spouse or dependents under this employer or union plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," name of spouse: _____ Name of dependents: _____																										
3. Do you or your spouse work? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
4. Do you receive Medicaid benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide your Medicaid number: _____																												
5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Worker's Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Health Net? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID # for coverage: _____																												
6. Are you a resident in a long-term care facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the following information: Name of institution: _____ Address and phone number of institution: _____																												
7. Have you had Medicare prescription drug coverage or other drug coverage that was at least as good as standard Medicare drug coverage since you became eligible to join a Medicare drug plan? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
Please check the box below if you would prefer us to send you information in a language other than English or in another format: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Braille, large print format, others																												
Please contact Health Net Member Services at 1-800-806-8811 (TTY users should dial 1-800-929-9955) if you need information in another format or language other than what is listed above. Our office hours are 8:00 a.m.– 8:00 p.m., seven days a week.																												

The information on this page applies to enrollment in group **medical benefits**.

Group information

Check the desired plan as offered by your employer: Medical plan: (Write the plan number next to the product)			Reason for application:
<input type="checkbox"/> HMO: _____	<input type="checkbox"/> Flex Net (Indemnity): _____	<input type="checkbox"/> Select (POS): _____	<input type="checkbox"/> Retiree
<input type="checkbox"/> HMO Variable Copay: _____	<input type="checkbox"/> PPO: _____	<input type="checkbox"/> Select 3-tier POS: _____	<input type="checkbox"/> Open Enrollment
<input type="checkbox"/> HMO Silver Network: _____	<input type="checkbox"/> HSA PPO: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Loss of prior coverage date: _____
<input type="checkbox"/> Elect Open Access SM : _____	<input type="checkbox"/> Out-of-State PPO (OOS PPO): _____		<input type="checkbox"/> COBRA effective date: _____
<input type="checkbox"/> Elect (POS): _____	<input type="checkbox"/> Salud con Health Net: _____		<input type="checkbox"/> Add dependent qualifying event: _____
<input type="checkbox"/> EPO: _____			<input type="checkbox"/> Qualifying event date: _____

Provider selection

Participating physician group/ PPG #	Health Net primary care physician/PCP #	Physician name (First, Last)	Is this your current M.D.?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have other health coverage? If "Yes," please complete this section. Please fill out the following information to receive proper credit for PREVIOUS COVERAGE, if immediately prior to becoming eligible for this plan, you were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal laws, your employer for FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name		Name and address of other insurance carrier			Prior coverage start date	
					MM/DD/YYYY 	
Prior coverage end date	Reason for ending coverage	Group #/ Policy ID #	Is this your primary coverage?	Does it cover?	Medicare	Over-age dependent type
MM/DD/YY 			<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D	<input type="checkbox"/> Disabled

Declination of Coverage (Complete this section if any coverage is to be declined by you.)

Declining medical coverage Reason: Other group coverage Individual coverage Other: _____
 Other group coverage by another group (i.e., spouse's employer)

The available coverages have been explained to me by my employer. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s). **By declining coverage, I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.**

Note: If you decline coverage for yourself or an eligible dependent because of coverage under other health insurance, you may be eligible for special enrollment rights if you or your dependent lose eligibility for that coverage. Also, if you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you and your dependent may be eligible for special enrollment rights. You must request special enrollment within 30 days of the loss of coverage or acquisition of a new dependent.

Employee signature: _____ Date: _____

(ONLY IF DECLINING COVERAGE: If signed in error, please cross out and initial.)

Please read the reverse side and sign below.

Your signature:	Today's date:
If you are the authorized representative, you must sign above and provide the following information:	
Name:	Relationship to enrollee:
Address:	Phone number:

Office use only

Name of staff member/agent/broker (if assisted in enrollment):		Rep ID:
Plan ID #:		
Group #:	ICEP/IEP:	OEP:
Effective date of coverage:	AEP:	SEP (type):
		Not eligible:

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

Health Net. A stand-alone prescription drug plan with a Medicare contract. 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 Health Net PDP 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 a time – if I am currently in a Medicare Prescription Drug Plan, my enrollment in Health Net PDP 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, generally during the Annual Enrollment Period (October 15–December 7), unless I qualify for certain special circumstances.

Health Net PDP serves a specific service area. If I move out of the area that Health Net PDP 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 Health Net PDP network pharmacies. Once I am a member of Health Net PDP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Health Net PDP 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.

I understand that if I am getting assistance from a sales agent, broker or other individual employed by or contracted with Health Net PDP, he or she may be paid based on my enrollment in Health Net PDP. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Health Net PDP will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Health Net PDP 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 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:** _____

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®

Kaiser Permanente Senior Advantage (HMO) ELECTION FORM

Northern California Region or Southern California Region Group Plan

IMPORTANT INFO – Read *all* pages before signing this form

Complete and return this form to become a Kaiser Permanente Senior Advantage (HMO) member. If you and your spouse are both applying, you'll each need to complete a separate form. For help completing this form, call **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

- You're entering into an important agreement, governed by specific Medicare and Kaiser Permanente rules, explained further on. Your signature on this election form signifies that you've read, understand, and agree to these provisions. Kaiser Permanente is a health plan with a Medicare contract.
- You must be enrolled in Medicare Part B. You must live inside our Senior Advantage service area to enroll. Check the ZIP codes/counties listed in the *Evidence of Coverage* to be sure you qualify for enrollment.
- If you have end-stage renal (kidney) disease (ESRD), you may not become a member of Senior Advantage unless one of the following is also true:
 - You were diagnosed with ESRD while you were already a Kaiser Permanente member in the Northern California region or the Southern California region, and you are enrolling during an allowable election period. To be eligible, there must be no break in coverage between your current Kaiser Permanente coverage and the start of your coverage in our Senior Advantage plan.
 - You were in a Medicare Advantage (or Medicare+Choice) plan that left the Medicare program or stopped providing coverage in your area on or after December 31, 1998, and you have not yet used your one-time enrollment exception to enroll in a Medicare health plan.
 - You've had a successful kidney transplant and you attach a note or records from your doctor showing that you've had a kidney transplant and no longer need regular dialysis.
 - You belong to an employer group or union/trust fund plan who terminated their contract with another insurer and selected Kaiser Permanente as a plan option for their employees.

ABOUT THE ELECTION PROCESS - Submitting your form

- After completing pages 1-3, read the sections titled "Release of Information" and "Conditions of Election" at the end of this form. Then sign and date page 3.
 - We'll review your form for completeness and required signatures and then contact you by mail that we have received it.
 - We'll notify Medicare that you've applied to join Senior Advantage.
 - Within 10 calendar days after Medicare confirms your eligibility, we'll confirm the effective date of your coverage. We'll send you a Kaiser Permanente ID card and information for new members.

ELECTION FORM

COMPLETE THE REQUIRED FIELDS BELOW

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

MEDICARE HEALTH INSURANCE CARD (REQUIRED INFO)

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

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

You must have Medicare 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)			_____	

ELECTION FORM

Page 2 of 3 for applicant to complete

Last Name: _____ First Name: _____

ADDITIONAL REQUIRED INFORMATION

1. Are you a current or former member of any Kaiser Permanente health plan? Yes No
If yes: Current Former Kaiser Permanente Medical Record Number _____
2. Do you currently have end-stage renal (kidney) disease? Yes No
If yes, provide: Diagnosis date (mm/dd/yyyy) ____ / ____ / ____
Transplant date ____ / ____ / ____
See the section titled "Important info" on the cover page for more information about enrolling with ESRD.
3. Are you a resident in a long-term care facility, such as a nursing home? Yes No
If yes, provide: Date of admission ____ / ____ / ____
Name of institution _____ Phone _____
Address _____ City _____ State ____ ZIP _____
- 4a. Are you actively working for an employer with 20 or more employees who provides employee group health insurance coverage for you? Yes No
If no, are you retired? Yes Retirement date ____ / ____ / ____
- 4b. Is your spouse actively working for an employer with 20 or more employees who provides employee group health insurance for you? Yes No
If yes, provide name of spouse's employer _____
5. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, Workers' Compensation, VA benefits, or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to Senior Advantage? Yes No
If yes, list other coverage and ID number(s) for this coverage:
Name of other coverage _____
ID# for this coverage _____ Group # for this coverage _____
6. Requested effective date (subject to CMS approval) ____ / ____ / ____

 Check here if you prefer to receive info in Spanish

This information is available in a different format or in Spanish by calling **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, 8 a.m. to 8 p.m.

Puede obtener esta información en un formato diferente o en español llamando al **1-800-443-0815** (TTY **1-800-777-1370**), los siete días de la semana, de 8 a.m. a 8 p.m.

If you currently have Kaiser Permanente coverage through more than one employer or union/trust fund, you must choose one coverage option for your Senior Advantage plan and complete the information below.

Employer Group/Union/Trust Fund Name _____

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

Requested effective date (subject to CMS approval) ____ / ____ / ____

ELECTION FORM

Page 3 of 3 for applicant to complete

Last Name: _____ First Name: _____

KAISER FOUNDATION HEALTH PLAN ARBITRATION AGREEMENT

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 1560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up 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*.

RELEASE OF INFORMATION

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

READ "CONDITIONS OF ELECTION" BEFORE SIGNING AND DATING BELOW (REQUIRED INFO)

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

Signature of applicant or
signature of authorized representative _____ Date ____ / ____ / ____Authorized representative name _____ Relationship _____
(please print)

Address _____ Phone _____

Signature of any person who
assisted in completing this form _____ Date ____ / ____ / ____**INTERNAL USE ONLY**

Date _____ Lang Pref _____

Rep _____ IEP ICEP AEP SEP

CONDITIONS OF ELECTION – By completing this form, I agree to the following:

1. I will read the Senior Advantage *Evidence of Coverage (EOC)* when I get it to know which rules I must follow in order to get coverage in this Medicare Advantage plan. If I don't receive a copy of the *EOC*, I may call Kaiser Permanente at **1-800-443-0815 (TTY 1-800-777-1370)**, seven days a week, 8 a.m. to 8 p.m.
2. I understand that Kaiser Permanente is a health plan with a Medicare contract.
3. I must maintain my enrollment in Medicare Part B.
4. I can be in only one Medicare Advantage plan or Medicare Advantage Prescription Drug Plan at a time. By enrolling in Senior Advantage, I will automatically be disenrolled from any other Medicare Advantage plan or Prescription Drug Plan in which I am currently a member.
5. 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 trust funds to understand the coverage that I am entitled to before I make a decision about which employer's or trust fund's plan to select for my Senior Advantage plan.
6. It's my responsibility to inform you of any prescription drug coverage that I have or may get in the future.
7. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.
8. I understand that I must enroll in the Senior Advantage service area in which I reside. I understand that it's my obligation to notify Kaiser Permanente if I permanently move or leave the service area for more than six months in a row.
9. 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.
10. I understand that starting on the effective date of my coverage, I must receive all of my covered health care from Kaiser Permanente, except for emergency care, out-of-area urgent care when our network is not available, dialysis care while temporarily outside the service area, or authorized referrals. If I obtain routine care from non-Plan providers, neither Kaiser Permanente nor Medicare will be responsible for the costs. I will refer to the Senior Advantage *EOC* for more information about covered benefits and services. 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. Services authorized by Kaiser Permanente and other services contained in my Kaiser Permanente 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.**
11. Once I become a member of Senior Advantage, I have the right to appeal plan decisions about payment/services.
12. 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.
13. Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options as well as medical assistance through the state Medicaid program and the Medicare Savings Program.
14. If I am a Kaiser Permanente Medicare Cost member enrolling in Senior Advantage, I understand that the Medicare Cost plan is closed to new enrollment and I cannot re-enroll.

If you currently have health coverage from an employer or union/trust fund, joining Senior Advantage could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Senior Advantage. Read the communications your employer or union/trust fund sends you. If you have questions, visit their website or contact the office listed in their communications. If there isn't any info on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please read carefully before you sign this form.

RETURN FORM TO:

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



SENIOR ADVANTAGE DISENROLLMENT FORM

This form is to be completed for each member of your family who wishes to discontinue membership in the Kaiser Permanente Senior Advantage program. **If you join another Medicare Advantage or Medicare Prescription Drug Plan, you do not need to complete this form. Once you enroll in another Medicare Advantage/Medicare Prescription Drug Plan, your current membership in Senior Advantage will be terminated automatically. If you wish to enroll in a Medicare Supplement Plan/Medigap Plan, you must complete this disenrollment form.** If you have any questions, please call the Kaiser Permanente Member Service Call Center toll free at **1-800-443-0815** (TTY **1-800-777-1370**), seven days a week, from 8 a.m. to 8 p.m. Please return this form to the address below.

If you request disenrollment, you must continue to receive all medical care as usual through Kaiser Permanente, until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Kaiser Permanente's network.

When enrolled in the Kaiser Permanente Senior Advantage plan, you can make plan changes only 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. We will notify you of your effective date of disenrollment in writing after we have received this form from you.

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK

KAISER PERMANENTE MEDICAL RECORD #	LAST NAME	FIRST NAME	MI
	STREET ADDRESS		
MEDICARE #	CITY	STATE	ZIP
BIRTH DATE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	HOME PHONE NUMBER	

Please read carefully before signing and dating this disenrollment form.

For Individual Plan members only: I understand that my disenrollment from Senior Advantage terminates all coverage through Kaiser Permanente, including Advantage Plus if applicable, effective the date of disenrollment. I understand that my current membership in Senior Advantage will be terminated automatically on the effective date of enrollment in another Medicare Health Plan/Medicare Prescription Drug Plan.

For Employer Group/Trust Fund members only: I understand that my disenrollment from Senior Advantage may affect my employer group or trust fund coverage, and I must also contact my Group Benefits Office to complete the termination process. I understand that my current membership in Senior Advantage will be terminated automatically on the effective date of enrollment in another Medicare Health Plan (or a Medicare Prescription Drug Plan if your Senior Advantage plan includes Part D coverage).

For all members: 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 do not enroll in such coverage at this time, I may have to pay a higher premium for this coverage in the future.

Your signature* _____ Date _____

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. 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 form and (2) documentation of this authority is available upon request by Kaiser Permanente or by Medicare.

Authorized representative must provide the following information:

Name _____ Phone _____

Address _____

Relationship to Enrollee _____

H0524_2806000702 (02/27/2008)
SKU # 3306-0002-07

RETURN FORM TO:

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

CLAIM FOR REIMBURSEMENT

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

UNREIMBURSED MEDICAL EXPENSE CLAIMS

A	B	C	D	E	F
Line	Date Expense Incurred (Date of Service)	Expense Amount Claimed	Detailed Description of Expense	Person for Whom Expense Incurred (self, spouse, etc.)	Name of Service Provider
1		\$			
2		\$			
3		\$			
4		\$			
5		\$			
6		\$			
7		\$			
8		\$			
Total Medical Expense Claim		\$			

DEPENDENT DAY CARE EXPENSE CLAIMS (if Applicable)

A	B	C	D	E	F	G
Line	Period Covered (mo/day/yr.) From To	Expense Amount Claimed	Name of Daycare Provider	Dependent Who Received Service (self, spouse, etc.) Age Name	Provider Certification Amount Signature	Tax ID# of Provider
1		\$			\$	
2		\$			\$	
Total Daycare Expense Claim		\$				

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered by the Company's Plan with respect to such expenses and that the expenses have not been reimbursed, or are not reimbursable, from any other source. By signing this form, I certify that the expenses claimed for medical expense reimbursement or payment are eligible for reimbursement under the Plan, and were incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. I also certify that I have obtained a Form W-10 (or shown due diligence obtaining the dependent care provider's TIN or social security number) from any dependent care providers and I intend to file Form 2441 with the Internal Revenue Service with respect to any dependent care expense reimbursements, if any. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, and that if an expense for which payment or reimbursement is claimed is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes, including federal, state, or local income tax, on amounts paid from the Plan which relate to such expense. Note: Reimbursements from the medical expense reimbursement account are limited if you are covered under a Health Savings Account (HSA) to dental or vision expenses, expenses related to preventative care, and expenses that exceed the health plan deductible.

Employee's Signature _____

Date _____

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

Mail, fax, or email claim to: OHFS, P.O. Box 728, Anoka, MN 55303-0728 • FAX (763) 767-4700 • EMAIL flexclaims@arcadministration.com • PHONE (763) 772-1380 OR (866) 898-4584

PLAN CLAIM REIMBURSEMENT INFORMATION

Cafeteria, HRA and/or VEBA plans enable you to save taxes and increase your spendable income by converting a portion of your compensation from cash to benefits. Under these plans, you use pre-tax dollars to pay for unreimbursed medical and/or dependent care expenses. Otherwise, you would pay your share of benefit costs with after-tax dollars.

Your election to participate in the plan is made on a plan year basis. However, the IRS allows election changes under certain circumstances, referred to as family status changes. Examples of changes to family status include: marriage, divorce, birth or adoption of a child, death of a spouse or dependent, significant changes in health coverage due to your spouse's employment, the termination or commencement of employment by your spouse. For more detailed information about the relationship of family status changes to this plan, please refer to your Summary Plan Description and your human resources representative.

SUBMITTING CLAIMS

To claim benefits under the plan, complete the claim for reimbursement form, attach appropriate documentation of expenses and forward to OptumHealth Financial Services, PO Box 728, Anoka, MN 55303-0728. **Claims may be faxed to OHFS with documentation to the following fax number - (763) 767-4700.** They may also be emailed to us (with scanned in documentation attached) at flexclaims@arcadministration.com. Faxed or emailed claims that are received by OHFS after 1:00 PM Central Time will be processed on the next business day. Whether you submit claims and documentation by mail, fax, or email it is important that you make sure that the documentation that you submit to OHFS is legible. If OHFS is unable to read any of the following items because of the quality of the copy or the fax, the claim will be denied pending resubmission of legible documentation. The documentation must *clearly* identify -

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

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

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

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

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

MEDICAL EXPENSE CLAIMS

To be eligible for reimbursement under the plan, you must provide proof the expenses were incurred. Please attach a copy of an itemized statement from the provider. Expenses are only eligible if they are incurred while you are participating in the plan. Expenses may be incurred by you, your spouse or other individuals who qualify as eligible dependents under federal rules governing cafeteria plans. **Note: Reimbursements from the medical expense reimbursement account are limited if you are covered under a Health Savings Account (HSA) to dental or vision expenses, expenses related to preventative care, and expenses that exceed the health plan deductible.**

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

DEPENDENT DAY CARE CLAIMS

Eligible dependents include your children under age 13, or if older, the person receiving care must be physically or mentally incapable of self care. See your SPD for additional information on Qualifying Individuals and certain benefit maximums which apply. Reimbursement for dependent care expenses are eligible if these amounts are paid to permit you to work. If you are married, dependent care expenses are only eligible if your spouse is also working for pay, attending school, or seeking employment while you are at work.

To request reimbursement, complete the dependent care section of the claim form and attach proof the dependent care services were provided by attaching an itemized statement or by having your dependent care provider complete the Provider Certification (Section F) of the form.

According to federal law, you must report the name, address and taxpayer identification number of the dependent care provider when you file your tax return.

To access your account information, log on to www.arcbenefitaccess.com and click on the *FSA/HRA/VEBA Participant Login button*.

OHFS050709UNIVERSAL

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

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

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

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

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

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

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

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

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

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

When you enroll in a medical plan or make changes to your coverage, you should check your retirement 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.

5 May I switch medical plans when I retire?

At the time of retirement, you may select the retiree plan of your choice. However, if you elect COBRA continuation coverage, you may not switch plans unless you move out of your

plan's service area (see question 10). You may change to another medical plan **ONLY** during Open Enrollment.

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

You may enroll your eligible dependents (i.e., newborn, newly adopted child, new spouse, or stepchild) within 60 days of a qualifying event (birth, marriage, custody, etc.). To enroll your eligible dependents, you must submit a Medical and/or Dental Plan Enrollment/Change Form (with any required attachments and verifications) within 60 calendar days. You may add dependents only during Open Enrollment unless you experience a qualifying event. New dependent coverage is effective the first day of the month following the event. Exceptions: See page 14 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 old or becomes eligible for other group health plan coverage, i.e. through an employer or spouse.

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

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

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

Yes. If you move outside the service area of your plan, you will be required to enroll in another County medical plan within 60 calendar days after the move or cancel your coverage. Until you change or cancel your enrollment, you will only be covered under the "Out-of-Area Emergency" provision of your current HMO for 90 days.

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

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

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

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 Optum Health?**

Since the program is a reimbursement program and not a prepayment program, expenses must be incurred before you can receive payment for them. Optum Health 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.





County of San Bernardino
Human Resources Department
EMPLOYEE BENEFITS AND SERVICES DIVISION
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440