**BELMONT-REDWOOD SHORES SCHOOL DISTRICT**

**MEMORANDUM**

TO: All BRSSD Benefit-Eligible Employees

FROM: Craig A. Goldman, Chief Business Official
Genevieve Randolph, Assistant Superintendent of HR & Administrative Services

DATE: October 13, 2017

RE: **2018 Open Enrollment for Medical Benefits**

**OPEN ENROLLMENT**

*Begins*: Wednesday, November 1, 2017
*Ends*: Thursday,, November 30, 2017
*Changes Effective*: Monday, January 1, 2018

"**Open Enrollment**" is the annual opportunity for you to make any of the following changes to your current medical care coverage:

- Select a different plan provider, i.e., switch from Kaiser to Anthem Blue Cross or from Anthem Blue Cross to Kaiser,
- Select a different plan with the current provider, e.g., switch from Kaiser Mid Plan to Kaiser High (Traditional) Plan
- Add or delete dependents.

Open Enrollment also provides an opportunity for employees to add or delete their dependents to the District's vision and dental plans. (**Note**: An employee who elects to drop a dependent from dental coverage cannot re-enroll that dependent in the dental program for three (3) years.)

There are several things for you to consider during the Open Enrollment period:

- ***All BRSSD employees who are eligible for benefits must participate in the District's dental plan.*** This requirement is a condition of the District's participation in the San Mateo County Schools Insurance Group. It applies to you as a BRSSD employee, but not to your dependents.
- The premiums charged by Kaiser and Anthem Blue Cross (ABC) have changed. Kaiser will increase its premiums by 11.37%, and ABC will increase its premiums by 9.0%.
- As of January 1, 2018, the District will increase its health care contributions based upon 50% of the premium increase for the Kaiser Single Mid Plan. For most employees, this will increase the District contribution by approximately $359 per year.
- Beginning in 2018, employees will have an additional ABC "PPO $30" option. This option has lower premium costs than the ABC "EPO $30" option, but whether it is actually a less expensive option will depend upon utilization by the employee and his or her dependents. Representatives from Anthem Blue Cross will be at the District Office on Wednesday, November 1 at 3:45pm, to share information about the different coverages and costs associated with the ABC PPO $30 and the ABC EPO $30 plans. (**Note**: We have learned that Anthem Blue Cross is planning to eliminate its EPO $30 plan in 2020.)
- The 2018 health premium rates and the District's new contribution rates for each employee group are reflected on the attached rate sheets.
- District health care benefit premiums are based upon the calendar year (January - December).

Please review the attached rate sheets and plan summaries to determine the right provider (Kaiser or ABC) and plan (ABC EPO $30 or PPO $30 or Kaiser High, Mid, or Low) for you.

Also, please be aware of the following:

- All changes made during Open Enrollment will be effective as of January 1, 2018. You should expect to see changes reflected in your January 31 pay warrant.
- The District offers a variety of employee benefits in addition to medical, dental, and vision coverage. These include the following:
  - *Section 125 Flexible Spending Accounts* for eligible medical reimbursements and dependent daycare expenses through American Fidelity Assurance (AFA). AFA also offers a wide variety of financial and insurance products that can be paid for through payroll deductions. These must be reviewed and renewed annually.
  - *Section 403(b) and 457 Deferred Compensation Plans* through Employee Benefit Services & Advisors.
  - *Commuter Benefits* through My Commuter Check.
  - *Employee Assistance Program* through OPTUM

  Please see the attached Employee Benefits Summary for additional information.
- **Considerations for ten- and eleven-month employees**: Ten- and eleven-month employees are responsible for their share of July and August health care premiums. How this is handled varies depending upon whether an individual will continue as a District employee in the following school year, leaves District employment at the end of the school year, or leaves District employment in July or August. For additional information regarding summer health care premium contributions, please contact Jan Fraga at jfraga@brssd.org or ext. 1016.

Representatives from American Fidelity Assurance (AFA) will be at school sites and the District Office on select dates between November 20 through December 5. You can sign up for an appointment to ensure that you use pre-tax deductions for (1) your share of health care premiums and (2) flexible spending accounts. AFA will pay for a roving substitute teacher to cover teacher appointments at each school site that has at least seven teacher appointments. AFA is currently scheduled as follows:

| School Site | Date | Time |
|---|---|---|
| Central Elementary | Monday, November 27 | 8am – 4pm |
| Cipriani Elementary | Tuesday,, November 28 | 8am – 4pm |
| Fox Elementary | Wednesday, November 29 | 8am – 4pm |
| Nesbit Elementary | Thursday, November 30 | 8am – 4pm |
| Redwood Shores Elementary | Monday, December 4 | 8am – 4pm |
| Sandpiper Elementary | Friday, December 1 | 8am – 4pm |
| Ralston Middle School | Monday/Tuesday, November 20/21 | 8am – 4pm |
| District Office - Last Chance Day! | Tuesday, December 5 | 8am – 4pm |

**If you wish to make any changes to your current medical, dental, or vision coverage, please complete the appropriate attached form and deliver it to Jan Fraga at the District Office. If you have questions or need assistance, please contact Jan at jfraga@brssd.org or ext. 1016.**

Belmont-Redwood Shores School District

**Employee Benefits Summary**

Qualified employees of the Belmont-Redwood Shores School District have access to a variety of employee benefits as summarized below.

Health Benefits

The District contributes toward health care benefits of qualified certificated and classified employees. The amount the District contributes varies based upon the employee's bargaining unit, the employee's full-time equivalency, i.e., portion of a full-time assignment, and the number of dependents.

- *Medical Benefits*: Beginning January 1, 2018, the District will offer five medical plan options to employees and their dependents. This includes an EPO plan and a PPO plan through Anthem Blue Cross and three HMO plans (high, mid, and low) through Kaiser. Each plan provides for different coverages, co-payments, and other out-of-pocket costs. Before selecting a plan, each employee should consider which plan best meets his or her individual needs.
- *Dental Benefits*: All benefit-eligible employees must participate in the District's Delta dental plan. They may also enroll their dependents. Employees may use the District's health plan contributions toward the cost of the premiums.
- *Vision Benefits*: Employees may enroll themselves and their dependents in the District's VSP vision plan. Employees may use the District's health plan contributions toward the cost of the premiums.
- *Post-retirement Health Benefits*: Employees who have met certain requirements with respect to years of service with the District may be entitled to a period of District contributions toward health benefit premiums. The requirements, coverage, and District contributions vary by employee group, so employees are encouraged to consult their respective collective bargaining agreements.

Section 125 Plan Benefits

- *Premium Deductions*: Employee health insurance premium contributions, if any, can be deducted from the employee's payroll on a pre-tax basis.
- *Health Flexible Spending Account*: Employees can set aside part of their pay, on a pre-tax basis, to reimburse themselves for eligible medical expenses for themselves, their spouses, and other qualifying individuals.
- *Dependent Day Care Flexible Spending Account*: Employees can set aside part of their pay, on a pre-tax basis, to reimburse themselves for eligible dependent care expenses.

Employee Assistance Plan

The District's Employee Assistance Plan (EAP) is designed to provide employees and their dependents with confidential support for everyday challenges or more serious problems. The EAP offers counseling

and assistance for numerous concerns and issues, including depression, anxiety, and stress; substance abuse; workplace problems or conflicts; and parenting and family issues. The EAP is offered to all employees by the San Mateo County Schools Insurance Group without cost. The benefit provider is United Behavioral Health, operating under the brand "Optum." For assistance or additional information, contact Optum at (866) 248-4094 or log on to www.liveandworkwell.com (access code: smcsig).

Retirement Plans

- *403(b) Tax-Sheltered Annuities*: A 403(b) tax-sheltered annuity (TSA) plan is a type of deferred-compensation retirement savings plan available for public education organizations. It has tax treatment similar to a 401(k) plan. Employee salary deferrals into a 403(b) plan are made before income tax is paid and allowed to grow tax-deferred until the money is taxed as income when withdrawn from the plan.
- *Roth 403(b) Plan*: Unlike a traditional, deferred-compensation 403(b) TSA, a Roth 403(b) plan allows employees to contribute after-tax dollars and then withdraw tax-free dollars from their accounts when they retire.
- *457 Plan*: A 457 plan is a deferred-compensation retirement plan that is available for governmental employees. Employees defer compensation on a pre-tax basis. For the most part, the plan operates similarly to a 401(k) or 403(b). The key difference is that there is no 10% penalty for withdrawal before the age of 59½ (although the withdrawal is subject to ordinary income taxation).

Commuter Benefits

- Internal Revenue Code Section 132(f) allows employees the opportunity to set aside a portion of their salary to pay for certain transportation expenses through *My Commuter Check*. Employees are not taxed on amounts set aside and used for qualified expenses (that is, pre-tax dollars are used to pay the commuting expenses). Transportation expenses generally include payments for the use of mass transportation (for example, train, subway, bus fares) and qualified parking expenses.

District Partners

- *American Fidelity Assurance Company (American Fidelity)* serves as the District's Section 125 Plan Administrator for the purpose of signing up employees to pay their share of health premiums or to contribute to Health Flexible Spending Accounts, Dependent Day Care Flexible Spending Accounts, and/or Commuter Benefits on a pre-tax basis. In addition to providing Section 125 Plan support, American Fidelity offers additional products such as disability income insurance, accident insurance, cancer insurance, annuities, and life insurance. Employees can contact American Fidelity's representative, Amanda Dillon, by phone at 408-421-2896 or by email at amanda.dillon@americanfidelity.com.
- *Employee Benefit Services & Advisors, Inc. (EBS)* serves as the District's 403(b) and 457 Plan Administrator responsible for administration, compliance, and remittance of employee contributions. The District's plan administrator representative is David Kuga, who can be reached by phone at 408-978-1000 x2872 or by email at dkuga@ebenefitservices.net.

- *Employee Benefit Services Group* represents EBS in supporting 403(b) and 457 plan participation and provides investment assistance.
- *San Mateo County Schools Insurance Group (SMCSIG)* implements, operates, and maintains a variety of insurance programs on behalf of participating districts. Our District participates in SMCSIG's Kaiser HMO medical plans, VSP vision plan, and Delta dental plan..
- *Monterey County Schools Insurance Group (MCSIG)* implements, operates, and maintains a variety of insurance programs on behalf of participating districts. Our District participates in MCSIG's Anthem Blue Cross EPO medical insurance program.

Other Benefits and Resources

- The California State Teachers' Retirement System (CalSTRS) provides retirement, disability and survivor benefits for certificated teachers and administrators. Both the District and employees make monthly contributions in support those benefits. For more information about CalSTRS, see www.calstrs.com.
- The California Public Employees' Retirement System (CalPERS) manages retirement, disability and survivor benefits for classified staff and management. Both the District and employees make monthly contributions in support of those benefits. For more information about CalPERS, see www.calpers.ca.gov.
- The Association of California School Administrators (ACSA), the California Teachers Association (CTA), and the California School Employees Association (CSEA) offer insurance and other benefits to their members. For more information, see their respective websites: ACSA - www.acsa.org, CTA - www.cta.org, and CSEA - www.csea.com.

# Belmont Redwood Shores School District

## SECTION 125 BENEFIT ENROLLMENT
***Plan Year: 1/1/2017 to 12/31/2017***

# *Enrollment Schedule*

***An American Fidelity Representative will be at your site:***

| School Site | Date | Time |
|---|---|---|
| Central Elementary | November 28th | 9 AM – 4 PM |
| Cipriani Elementary | November 28th | 9 AM – 4 PM |
| Fox Elementary | November 29th | 9 AM – 4 PM |
| Nesbit Elementary | November 30th | 9 AM – 4 PM |
| Redwood Elementary | December 1st | 9 AM – 4 PM |
| Sandpiper Elementary | December 2nd | 9 AM – 4 PM |
| Ralston Middle School | November 21st | 9 AM – 4 PM |
| District Office | November 22nd | 9 AM – 4 PM |

**PLEASE READ:**
Please meet with your American Fidelity Representative to learn more about all your benefits offered through payroll deductions.

IMPORTANT: For those employees who wish to enroll, continue or make changes to your Medical Reimbursement or Dependent Day Care Account for the next plan year, *you must meet with your American Fidelity Representative.*

**Please see your site secretary to schedule your individual appointment today!**

Northern California Branch Office
9355 E. Stockton Blvd., Ste. 110
Elk Grove, CA 95624
1-800-365-8306 • 916-683-8306

## BELMONT-REDWOOD SHORES SCHOOL DISTRICT

2018 HEALTH CARE PLAN RATES AND CONTRIBUTIONS

**CERTIFICATED (BRSFA) EMPLOYEES**

| Medical Plans | Provider | Co-pay Doctor's Visit | Co-pay Generic Rx | Monthly Single Rate | Monthly Couple Rate | Monthly Family Rate |
|---|---|---|---|---|---|---|
| | Anthem Blue Cross EPO | $30 | $7 | $1,037.00 | $2,073.00 | $2,695.00 |
| | Anthem Blue Cross PPO $30 | $30 | $10 | $761.00 | $1,518.00 | $1,973.00 |
| | Kaiser Permanente HMO High Plan | $20 | $10 | $681.24 | $1,362.48 | $1,927.91 |
| | Kaiser Permanente HMO Mid Plan | $20 | $10-$30 | $586.58 | $1,173.15 | $1,660.01 |
| | Kaiser Permanente HMO Low Plan | $40 | $10-$30 | $533.71 | $1,067.42 | $1,510.40 |

| Dental Plan | Provider | | | Monthly Single Rate | Monthly Couple Rate | Monthly Family Rate |
|---|---|---|---|---|---|---|
| | Delta Dental | | | $66.90 | $133.80 | $199.36 |

| Vision Plan | Provider | | | Monthly Single Rate | Monthly Couple Rate | Monthly Family Rate |
|---|---|---|---|---|---|---|
| | VSP | | | $9.33 | $19.48 | $27.96 |

| District Contribution | *Based upon Medical Plan election. If no Medical Plan elected, contribution based upon Kaiser Single Medical contribution.* | | | Monthly Contribution based upon Single Medical Election | Monthly Contribution based upon Couple Medical Election | Monthly Contribution based upon Family Medical Election |
|---|---|---|---|---|---|---|
| | Anthem Blue Cross Plans | | | $710.46 | $1,135.46 | $1,427.12 |
| | Kaiser Permanente HMO Plans | | | $633.01 | $935.46 | $1,202.12 |

Note: District contributions stated above are based upon full-time employment. District contributions for part-time employees will be prorated. For example, a 0.75 FTE employee electing a Kaiser Couple plan will receive a monthly District contribution of $701.60 (0.75 times $935.46).

| **Calculating Monthly Employee Contribution** | | | | |
|---|---|---|---|---|
| Medical Plan Rate | $ | **Example:** | Medical Plan Rate (Kaiser Mid Plan Couple) | $1,173.15 |
| Dental Plan Rate | $ | | Dental Plan Rate (Single) | $66.90 |
| Vision Plan Rate | $ | | Vision Plan Rate (Family) | $27.96 |
| Total Health Plan Rate (Medical + Dental + Vision) | $ | | Total Health Plan Rate (Medical + Dental + Vision) | $1,268.01 |
| District Contribution (based upon Medical Plan elected) | $ | | District Contribution (based upon Couple Medical - Kaiser) | $935.46 |
| **Employee Monthly Contribution** (Total Health Plan Rate minus District Contribution). If negative, enter 0. | $ | | **Employee Monthly Contribution** (Based upon Medical Couple) | $332.55 |

**Important**: If you wish to make any changes to your current medical, dental, or vision coverage, please contact Jan Fraga, Administrative Assistant (Payroll & Benefits), at jfraga@brssd.org or ext. 1016. Any change from your 2017 elections must be made using a provider Enrollment/Change Form. All Enrollment/Change Forms must be submitted to and received by Jan Fraga at the District Office no later than 4:00 pm on Thursday, November 30.

rev. 9/28/2017

## BELMONT-REDWOOD SHORES SCHOOL DISTRICT

2018 HEALTH CARE PLAN RATES AND CONTRIBUTIONS

**CLASSIFIED (CSEA) EMPLOYEES**

| **Medical Plans** | **Provider** | **Co-pay Doctor's Visit** | **Co-pay Generic Rx** | **Monthly Single Rate** | **Monthly Couple Rate** | **Monthly Family Rate** |
|---|---|---|---|---|---|---|
| | Anthem Blue Cross EPO | $30 | $7 | $1,037.00 | $2,073.00 | $2,695.00 |
| | Anthem Blue Cross PPO $30 | $30 | $10 | $761.00 | $1,518.00 | $1,973.00 |
| | Kaiser Permanente HMO High Plan | $20 | $10 | $681.24 | $1,362.48 | $1,927.91 |
| | Kaiser Permanente HMO Mid Plan | $20 | $10-$30 | $586.58 | $1,173.15 | $1,660.01 |
| | Kaiser Permanente HMO Low Plan | $40 | $10-$30 | $533.71 | $1,067.42 | $1,510.40 |

| **Dental Plan** | **Provider** | | | **Monthly Single Rate** | **Monthly Couple Rate** | **Monthly Family Rate** |
|---|---|---|---|---|---|---|
| | Delta Dental | | | $66.90 | $133.80 | $199.36 |

| **Vision Plan** | **Provider** | | | **Monthly Single Rate** | **Monthly Couple Rate** | **Monthly Family Rate** |
|---|---|---|---|---|---|---|
| | VSP | | | $9.33 | $19.48 | $27.96 |

| **District Contribution** | *Based upon Medical Plan election. If no Medical Plan elected, contribution based upon Kaiser Single Medical contribution.* | | | **Monthly Contribution based upon Single Medical Election** | **Monthly Contribution based upon Couple Medical Election** | **Monthly Contribution based upon Family Medical Election** |
|---|---|---|---|---|---|---|
| | Anthem Blue Cross Plans | | | $1,029.20 | $1,029.20 | $1,029.20 |
| | Kaiser Permanente HMO Plans | | | $1,029.20 | $1,029.20 | $1,029.20 |

Note: District contributions stated above are based upon full-time employment. District contributions for part-time employees will be prorated. For example, a 0.75 FTE employee will receive a monthly District contribution of $771.90 (0.75 times $1029.20). See example below for a 0.75 FTE employee taking Kaiser Mid Plan Couple, Dental Single, and Vision Family. See next page for District contributions for other FTEs.

| **Calculating Monthly Employee Contribution** | | | | |
|---|---|---|---|---|
| Medical Plan Rate | $ | **Example:** | Medical Plan Rate (Kaiser Mid Plan Couple) | $1,173.15 |
| Dental Plan Rate | $ | | Dental Plan Rate (Single) | $66.90 |
| Vision Plan Rate | $ | | Vision Plan Rate (Family) | $27.96 |
| Total Health Plan Rate (Medical + Dental + Vision) | $ | | Total Health Plan Rate (Medical + Dental + Vision) | $1,268.01 |
| District Contribution (based upon Medical Plan elected) and FTE | $ | | District Contribution (based upon 0.75 FTE) | $771.90 |
| **Employee Monthly Contribution** (Total Health Plan Rate minus District Contribution). If negative, enter 0. | $ | | **Employee Monthly Contribution** (Based upon Medical Couple) | $496.11 |

**Important:** If you wish to make any changes to your current medical, dental, or vision coverage, please contact Jan Fraga, Administrative Assistant (Payroll & Benefits), at jfraga@brssd.org or ext. 1016. Any change from your 2017 elections must be made using a provider Enrollment/Change Form. All Enrollment/Change Forms must be submitted to and received by Jan Fraga at the District Office no later than 4:00 pm on Thursday, November 30.

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## BELMONT-REDWOOD SHORES SCHOOL DISTRICT

2018 HEALTH CARE PLAN RATES AND CONTRIBUTIONS

**CLASSIFIED (CSEA) EMPLOYEES**

| Employee FTE | Annual District Contribution | Monthly District Contribution |
|---|---|---|
| 0.125 | $1,543.80 | $128.65 |
| 0.225 | $2,778.84 | $231.57 |
| 0.25 | $3,087.60 | $257.30 |
| 0.375 | $4,631.40 | $385.95 |
| 0.5 | $6,175.20 | $514.60 |
| 0.6 | $7,410.24 | $617.52 |
| 0.625 | $7,719.00 | $643.25 |
| 0.675 | $8,336.52 | $694.71 |
| 0.6875 | $8,490.90 | $707.58 |
| 0.75 | $9,262.80 | $771.90 |
| 0.8038 | $9,927.25 | $827.27 |
| 0.8125 | $10,034.70 | $836.23 |
| 1.0 | $12,350.40 | $1,029.20 |

Add up which benefits you wish to take. Look at your FTE to get your monthly contribution amount. Take your total monthly contribution minus the cost of your premiums. If there is a negative difference, then that is your out-of-pocket costs. If there is a positive difference, then the District is paying the full cost of your benefits.

**Note to New Hires: 10-Month or 11-Month**

The portion you owe for next July and August benefits will be deducted from your September 2018 through June 2019 paychecks.

**Delta Dental** - your coverage is at 70% the first year, 80% the second year, 90% the third year and 100% thereafter. To move from one level to the next, you must do at least one cleaning per year. If you are coming from another district be sure you do not have a lapse in coverage; otherwise your coverage will revert back to 70%.

rev. 9/28/2017

## BELMONT-REDWOOD SHORES SCHOOL DISTRICT

2018 HEALTH CARE PLAN RATES AND CONTRIBUTIONS

### CLASSIFIED AND CERTIFICATED MANAGEMENT, CLASSIFIED SUPERVISORY, AND CLASSIFIED CONFIDENTIAL EMPLOYEES

| Medical Plans | Provider | Co-pay Doctor's Visit | Co-pay Generic Rx | Monthly Single Rate | Monthly Couple Rate | Monthly Family Rate |
|---|---|---|---|---|---|---|
| | Anthem Blue Cross EPO | $30 | $7 | $1,037.00 | $2,073.00 | $2,695.00 |
| | Anthem Blue Cross PPO $30 | $30 | $10 | $761.00 | $1,518.00 | $1,973.00 |
| | Kaiser Permanente HMO High Plan | $20 | $10 | $681.24 | $1,362.48 | $1,927.91 |
| | Kaiser Permanente HMO Mid Plan | $20 | $10-$30 | $586.58 | $1,173.15 | $1,660.01 |
| | Kaiser Permanente HMO Low Plan | $40 | $10-$30 | $533.71 | $1,067.42 | $1,510.40 |

| Dental Plan | Provider | | | Monthly Single Rate | Monthly Couple Rate | Monthly Family Rate |
|---|---|---|---|---|---|---|
| | Delta Dental | | | $66.90 | $133.80 | $199.36 |

| Vision Plan | Provider | | | Monthly Single Rate | Monthly Couple Rate | Monthly Family Rate |
|---|---|---|---|---|---|---|
| | VSP | | | $9.33 | $19.48 | $27.96 |

| District Contribution | *Based upon Medical Plan election. If no Medical Plan elected, contribution based upon Kaiser Single Medical contribution.* | | | Monthly Contribution based upon Single Medical Election | Monthly Contribution based upon Couple Medical Election | Monthly Contribution based upon Family Medical Election |
|---|---|---|---|---|---|---|
| | Anthem Blue Cross Plans | | | $633.01 | $633.01 | $633.01 |
| | Kaiser Permanente HMO Plans | | | $633.01 | $633.01 | $633.01 |

Note: District contributions stated above are based upon full-time employment. District contributions for part-time employees will be prorated. For example, a 0.75 FTE employee will receive a monthly District contribution of $474.76 (0.75 times $633.01).

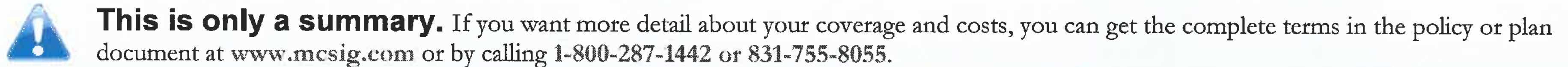
| Calculating Monthly Employee Contribution | | | | | |
|---|---|---|---|---|---|
| | Medical Plan Rate | $ | Example: | Medical Plan Rate (Kaiser Mid Plan Couple) | $1,173.15 |
| | Dental Plan Rate | $ | | Dental Plan Rate (Single) | $66.90 |
| | Vision Plan Rate | $ | | Vision Plan Rate (Family) | $27.96 |
| | Total Health Plan Rate (Medical + Dental + Vision) | $ | | Total Health Plan Rate (Medical + Dental + Vision) | $1,268.01 |
| | District Contribution (based upon Medical Plan elected) | $ | | District Contribution (based upon Couple Medical) | $633.01 |
| | **Employee Monthly Contribution** (Total Health Plan Rate minus District Contribution). If negative, enter 0. | $ | | **Employee Monthly Contribution** (Based upon Medical Couple) | $635.00 |

**Important**: If you wish to make any changes to your current medical, dental, or vision coverage, please contact Jan Fraga, Administrative Assistant (Payroll & Benefits), at jfraga@brssd.org or ext. 1016. Any change from your 2017 elections must be made using a provider Enrollment/Change Form. All Enrollment/Change Forms must be submitted to and received by Jan Fraga at the District Office no later than 4:00 pm on Thursday, November 30.

rev. 9/20/2017

# Municipalities, Colleges, Schools Insurance Group: EPO $30 No Ded
## Coverage Period Beginning on/after 01/01/2018

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: EPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mcsig.com or by calling 1-800-287-1442 or 831-755-8055.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$ 0** | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For participating providers **$2,000** person / **$4,000** family. There is no out-of-pocket limit for non-participating provider services unless otherwise noted. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services (co-insurance). This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, non-participating charges, co-payments, penalties, and health care this plan doesn't cover | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.anthem.com/ca or **call 1-800-287-1442** for a list of participating providers. No Monterey County hospitals in this plan's network. | If you use a participating doctor or other health care provider this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services. |

**Questions:** Call 1-800-287-1442 or visit us at www.mcsig.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mcsig.com or call 1-800-287-1442 to request a copy.



OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 co-pay/visit | Not covered. | |
| | Specialist visit | $30 co-pay/visit | Not covered. | |
| | Other practitioner office visit | $10 co-pay/visit for Chiropractor. | Not covered. | Plan utilizes Chiropractic Health Plan of California. Number of visits limited to CHPC authorized treatment plan. |
| | | $30/visit for Acupuncture. | Not covered. | 30 visit limit per plan year. |
| | Preventive care/screening/immunization | No charge. | Not covered. | Benefit limited to the recommended services and guidelines found at http://www.HealthCare.gov/center/regulations/prevention.html (the list). |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge. | Not covered. | |
| | Imaging (CT/PET scans, MRIs) | No charge. | | Advanced imaging requires pre-authorization. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.mcsig.com. | Generic drugs | $0/mail order; $7/retail; $9.50 retail maintenance. | 20% co-ins. + balance billing. | Outpatient drug coverage provided through Express Scripts. No outpatient drug coverage through Anthem network.<br><br>Mail order is 90 day supply; retail and retail maintenance are 30 day supply.<br><br>Specialty drug coverage provided exclusively through CuraScript. |
| | Preferred brand drugs | $20/retail; $29 retail maintenance; $40 mail order. | | |
| | Non-preferred brand drugs | $35 retail; $44 retail maintenance; $70 mail order. | | |
| | Specialty drugs | $21/generic; $60 brand; $100 non-preferred brand. | No coverage. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $100 co-pay. | Not covered. | |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room services | $100/admit co-pay. | $100/admit co-pay. No coverage if not emergency. | Co-pay may be reimbursable, see EOC. Non-participating ER physician services provided in a Participating facility covered as Participating. |
| | Emergency medical transportation | $100 co-pay. | 20% co-ins. based on R&C plus balance billing. 20% co-ins. based on billed charges if true emergency. | |
| | Urgent care | $30 co-pay/visit. | Not covered. | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200 co-pay. | Not covered. | |
| | Physician/surgeon fee | | | |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15 co-pay/visit. | 40% co-insurance + balance billing. | Mental, Behavioral health & substance abuse coverage provided through MHN. No coverage under Anthem network. Participating provider services not subject to deductible. |
| | Mental/Behavioral health inpatient services | $0 | | |
| | Substance use disorder outpatient services | $15 co-pay/visit. | | |
| | Substance use disorder inpatient services | $0 | | |
| **If you are pregnant** | Prenatal and postnatal care | $30/visit. | Not covered. | |
| | Delivery and all inpatient services | No charge. | | |
| **If you need help recovering or have other special health needs** | Home health care | $30/ visit. | Not covered. | 120 day limit per illness. |
| | Rehabilitation services | $30/ visit. | Not covered. | Visit limits may apply. See Evidence of Coverage document. |
| | Habilitation services | | | |
| | Skilled nursing care | No charge. | Not covered. | 365 day lifetime limit. |
| | Durable medical equipment | 20% co-insurance. | Not covered. | Items costing $2,000 or more require pre-authorization. |
| | Hospice service | No charge. | | $15,000 lifetime benefit maximum. |
| **If your child needs dental or eye care** | Eye exam | No coverage. | | Separate coverage through VSP. |
| | Glasses | No coverage. | | |
| | Dental check-up | No coverage. | | Separate coverage through Delta Dental. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic Surgery
- Dental care
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine vision care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric Surgery (if performed at an Anthem Center of Excellence). Requires pre-authorization.
- Chiropractic Care (only when utilizing a Chiropractic Health Plan of California participating provider).
- Non-emergency care when traveling outside the U.S. See www.mcsig.com
- Routine foot care

## Your Rights to Continue Coverage:

If you lose coverage under the plan then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-287-1442. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054; 1-800-627-8797.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,980
- **Patient pays** $ 560

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care (12 office visits) | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays (assumes 12 office visits) (assumes 90 day generics at mail order for Rx) | $560 |
| Co-insurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$560** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $ 3,530
- **Patient pays** $ 570

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $1,500 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $730 |
| Education | $290 |
| Laboratory tests | $140 |
| Vaccines, other preventive | $140 |
| **Total** | **$4,100** |

**Patient pays:**

| | |
|---|---|
| Deductibles (in-office procedures subject to deductible) | $0 |
| Co-pays (assumes 4 office visits in a year) ($30 per office visit co-pay applies) (assumes 90 day generics at mail order for Rx) | $120 |
| Co-insurance | $260 |
| Limits or exclusions (Education benefit limited to $100) | $190 |
| **Total** | **$570** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

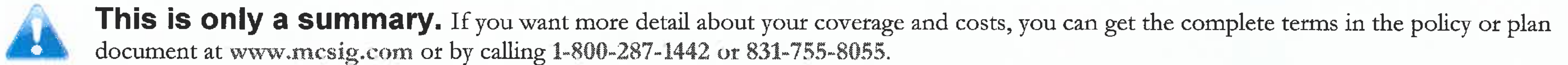
## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# Municipalities, Colleges, Schools Insurance Group: PPO $30

## Coverage Period Beginning on/after 01/01/2018

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for: Individual + Family | Plan Type: PPO**



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mcsig.com or by calling 1-800-287-1442 or 831-755-8055.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$ 0** | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | Yes. **$1,000** person **/ $2,000** family, cumulative annual for all hospital services and all medical and diagnostic procedures. | You must pay all of the costs for these services up to the specific cumulative annual deductible amount before this plan begins to pay for these services unless otherwise noted. All non-participating services are subject to this deductible unless otherwise noted. There are other services subject to this cumulative deductible. See Evidence of Coverage booklet. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For participating providers **$5,500** person **/ $11,000** family. For non-participating providers **$11,000** person **/ $22,000** family. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services (co-insurance). This limit helps you plan for health care expenses. Amounts you pay over Reasonable & Customary (balance billing) for non-participating provider care does not accrue toward the out-of-pocket limits. |
| **What is not included in the out–of–pocket limit?** | Premiums, non-participating balance billed charges, co-payments, penalties, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.anthem.com/ca or **call 1-800-287-1442** for a list of participating providers. | If you use a participating doctor or other health care provider this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services. |

**Questions:** Call 1-800-287-1442 or visit us at **www.mcsig.com.**
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.mcsig.com or call 1-800-287-1442 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 co-pay/visit | 50% co-ins. + balance billing | Participating exam/consults not subject to deductible. Medical *procedures* and all non-participating services subject to deductible. |
| | Specialist visit | $40 co-pay/visit | 50% co-ins. + balance billing | |
| | Other practitioner office visit | $10 co-pay/visit for Chiropractor.<br><br>All amounts over $65/visit for Acupuncture. | Not covered.<br><br>All amounts over $65/visit for Acupuncture. | Plan utilizes Chiropractic Health Plan of California network. Number of visits limited to CHPC authorized treatment plan. No deductible.<br><br>30 visit limit per plan year. No deductible. |
| | Preventive care/screening/immunization | Nothing. | 50% co-ins. + balance billing | Benefit limited to the recommended services and guidelines found at http://www.HealthCare.gov/center/regulations/prevention.html (the list). |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% co-ins/visit. | 50% co-ins. + balance billing | Non-participating subject to deductible. |
| | Imaging (CT/PET scans, MRIs) | 30% co-ins/visit. | | Advanced imaging requires pre-authorization. |

| Common Medical Event | Services You May Need | Your cost if you use a Participating Provider | Your cost if you use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.mcsig.com. | Generic drugs | $0/mail order; $10/retail; $13 retail maintenance. | 20% co-ins. + balance billing. | Outpatient drug coverage provided through Express Scripts. No outpatient drug coverage through Anthem network.<br><br>Mail order is 90 day supply; retail and retail maintenance are 30 day supply.<br><br>Specialty drug coverage provided exclusively through CuraScript. |
| | Preferred brand drugs | $25/retail; $35 retail maintenance; $40 mail order. | | |
| | Non-preferred brand drugs | $40 retail; $50 retail maintenance; $80 mail order. | | |
| | Specialty drugs | $21/generic; $60 brand; $100 non-preferred brand. | No coverage | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% co-insurance | 50% co-ins. + balance billing | All procedures subject to deductible. |
| | Physician/surgeon fees | | | |
| **If you need immediate medical attention** | Emergency room (ER) services | $250 co-pay. 30% co-insurance. | $250 co-pay. 30% co-insurance + balance billing. | Co-pay may be reimbursable, see EOC. Deductible applies. Non-participating ER physician services in Participating facility covered as Participating. |
| | Emergency medical transportation | 30% co-insurance. | 50% co-ins. based on R&C + balance billing. 50% co-ins. based on billed charges if true emergency | Deductible applies. |
| | Urgent care | $30 co-pay/visit. No deductible. | 50% co-ins. + balance billing | Medical *procedures* and non-participating svcs subject to deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% co-insurance. | 50% co-ins. + balance billing | All hospitalizations subject to deductible. |
| | Physician/surgeon fee | | | |

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| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | Participating Provider | Non-Participating Provider | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15 co-pay/visit. | 40% co-ins. + balance billing | Mental, Behavioral health & substance abuse coverage provided through MHN. No coverage under Anthem network. Participating provider services not subject to deductible. All non-participating provider services subject to deductible. |
| | Mental/Behavioral health inpatient services | $0 | | |
| | Substance use disorder outpatient services | $15 co-pay/visit. | | |
| | Substance use disorder inpatient services | $0 | | |
| **If you are pregnant** | Prenatal and postnatal care | 30% co-insurance. | 50% co-ins. + balance billing | All Maternity services subject to deductible. |
| | Delivery and all inpatient services | 30% co-insurance. | | |
| **If you need help recovering or have other special health needs** | Home health care | 30% co-insurance. | 50% co-insurance + balance billing. | Subject to deductible. 120 day limit per illness. |
| | Rehabilitation services | 30% co-insurance. | 50% co-ins. + balance billing | Subject to deductible. Visit limits may apply. See Evidence of Coverage document. |
| | Habilitation services | | | |
| | Skilled nursing care | 30% co-insurance. | 50% co-ins. + balance billing. | Subject to deductible. 365 day lifetime limit. |
| | Durable medical equipment | 30% co-insurance. | 50% co-ins. + balance billing | Items costing $2,000 or more require pre-authorization. All services subject to deductible. |
| | Hospice service | Nothing, after deductible. | | Subject to deductible. |
| **If your child needs dental or eye care** | Eye exam | No coverage. | | Separate coverage through VSP. |
| | Glasses | No coverage. | | |
| | Dental check-up | No coverage. | | Separate coverage through Delta Dental. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic Surgery
- Dental care
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine vision care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric Surgery (if performed at an Anthem Center of Excellence). Requires pre-authorization.
- Chiropractic Care (only when utilizing a Chiropractic Health Plan of California participating provider).
- Non-emergency care when traveling outside the U.S. See www.mcsig.com
- Routine foot care

## Your Rights to Continue Coverage:

If you lose coverage under the plan then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 54159, Los Angeles, CA 90054; 1-800-627-8797.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $4,650**
- **Patient pays $ 2,890**

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Co-pays (assumes 90 day generics at mail order for Rx) | $ |
| Co-insurance | $1,890 |
| Limits or exclusions | $ |
| **Total** | **$2,890** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $4,100**
- **Plan pays $2,447**
- **Patient pays $1,653**

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $1,500 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $730 |
| Education | $290 |
| Laboratory tests | $140 |
| Vaccines, other preventive | $140 |
| **Total** | **$4,100** |

**Patient pays:**

| | |
|---|---|
| Deductibles (in-office procedures subject to deductible) | $1,000 |
| Co-pays (assumes 4 office visits in a year) ($30 per office visit co-pay applies) (assumes 90 day generics at mail order for Rx) | $160 |
| Co-insurance | $303 |
| Limits or exclusions (Education benefit limited to $100) | $190 |
| **Total** | **$1,653** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

38320 SAN MATEO COUNTY SCHOOLS INSURANCE GROUP – Belmont (High Plan)

## Principal Benefits for High Kaiser Permanente Traditional Plan (1/1/18—12/31/18)

### Accumulation Period

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (calendar year).

### Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

| Amounts Per Accumulation Period | Self-Only Coverage (a Family of one Member) | Family Coverage Each Member in a Family of two or more Members | Family Coverage Entire Family of two or more Members |
|---|---|---|---|
| Plan Out-of-Pocket Maximum | $1,500 | $1,500 | $3,000 |
| Plan Deductible | None | None | None |
| Drug Deductible | None | None | None |

| Professional Services (Plan Provider office visits) | You Pay |
|---|---|
| Most Primary Care Visits and most Non-Physician Specialist Visits | $20 per visit |
| Most Physician Specialist Visits | $20 per visit |
| Routine physical maintenance exams, including well-woman exams | No charge |
| Well-child preventive exams (through age 23 months) | No charge |
| Family planning counseling and consultations | No charge |
| Scheduled prenatal care exams | No charge |
| Routine eye exams with a Plan Optometrist | No charge |
| Urgent care consultations, evaluations, and treatment | $20 per visit |
| Most physical, occupational, and speech therapy | $20 per visit |

| Outpatient Services | You Pay |
|---|---|
| Outpatient surgery and certain other outpatient procedures | $20 per procedure |
| Allergy injections (including allergy serum) | $5 per visit |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | No charge |
| Covered individual health education counseling | No charge |
| Covered health education programs | No charge |

| Hospitalization Services | You Pay |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | No charge |

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | $50 per visit |

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

| Ambulance Services | You Pay |
|---|---|
| Ambulance Services | $50 per trip |

| Prescription Drug Coverage | You Pay |
|---|---|
| Covered outpatient items in accord with our drug formulary guidelines: | |
| Most generic items at a Plan Pharmacy or through our mail-order service | $10 for up to a 100-day supply |
| Most brand-name items at a Plan Pharmacy or through our mail-order service | $10 for up to a 100-day supply |
| Most specialty items at a Plan Pharmacy | $10 for up to a 30-day supply |

| Durable Medical Equipment (DME) | You Pay |
|---|---|
| DME items in accord with our DME formulary guidelines | 20% Coinsurance |

| Mental Health Services | You Pay |
|---|---|
| Inpatient psychiatric hospitalization | No charge |
| Individual outpatient mental health evaluation and treatment | $20 per visit |
| Group outpatient mental health treatment | $10 per visit |

| Chemical Dependency Services | You Pay |
|---|---|
| Inpatient detoxification | No charge |

| | |
|---|---|
| Individual outpatient chemical dependency evaluation and treatment | $20 per visit |
| Group outpatient chemical dependency treatment | $5 per visit |

| Home Health Services | You Pay |
|---|---|
| Home health care (up to 100 visits per Accumulation Period) | No charge |

| Other | You Pay |
|---|---|
| Skilled nursing facility care (up to 100 days per benefit period) | No charge |
| Prosthetic and orthotic devices | No charge |
| Hospice care | No charge |

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

38320 SAN MATEO COUNTY SCHOOLS INSURANCE GROUP – Belmont (Mid Plan)

## Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/18—12/31/18)

**Accumulation Period**

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (calendar year).

**Out-of-Pocket Maximum(s) and Deductible(s)**

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

| Amounts Per Accumulation Period | Self-Only Coverage (a Family of one Member) | Family Coverage Each Member in a Family of two or more Members | Family Coverage Entire Family of two or more Members |
|---|---|---|---|
| Plan Out-of-Pocket Maximum | $3,000 | $3,000 | $6,000 |
| Plan Deductible | $1,000 | $1,000 | $2,000 |
| Drug Deductible | None | None | None |

| Professional Services (Plan Provider office visits) | You Pay |
|---|---|
| Most Primary Care Visits and most Non-Physician Specialist Visits | $20 per visit (Plan Deductible doesn't apply) |
| Most Physician Specialist Visits | $20 per visit (Plan Deductible doesn't apply) |
| Routine physical maintenance exams, including well-woman exams | No charge (Plan Deductible doesn't apply) |
| Well-child preventive exams (through age 23 months) | No charge (Plan Deductible doesn't apply) |
| Family planning counseling and consultations | No charge (Plan Deductible doesn't apply) |
| Scheduled prenatal care exams | No charge (Plan Deductible doesn't apply) |
| Routine eye exams with a Plan Optometrist | No charge (Plan Deductible doesn't apply) |
| Urgent care consultations, evaluations, and treatment | $20 per visit (Plan Deductible doesn't apply) |
| Most physical, occupational, and speech therapy | $20 per visit (Plan Deductible doesn't apply) |

| Outpatient Services | You Pay |
|---|---|
| Outpatient surgery and certain other outpatient procedures | 20% Coinsurance after Plan Deductible |
| Allergy injections (including allergy serum) | No charge (Plan Deductible doesn't apply) |
| Most immunizations (including the vaccine) | No charge (Plan Deductible doesn't apply) |
| Most X-rays and laboratory tests | $10 per encounter (Plan Deductible doesn't apply) |
| Preventive X-rays, screenings, and laboratory tests as described in the *EOC* | No charge (Plan Deductible doesn't apply) |
| MRI, most CT, and PET scans | $50 per procedure (Plan Deductible doesn't apply) |
| Covered individual health education counseling | No charge (Plan Deductible doesn't apply) |
| Covered health education programs | No charge (Plan Deductible doesn't apply) |

| Hospitalization Services | You Pay |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | 20% Coinsurance after Plan Deductible |

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | 20% Coinsurance after Plan Deductible |

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

| Ambulance Services | You Pay |
|---|---|
| Ambulance Services | $150 per trip (Plan Deductible doesn't apply) |

| Prescription Drug Coverage | You Pay |
|---|---|
| Covered outpatient items in accord with our drug formulary guidelines: | |
| Most generic items at a Plan Pharmacy | $10 for up to a 30-day supply (Plan Deductible doesn't apply) |
| Most generic refills through our mail-order service | $20 for up to a 100-day supply (Plan Deductible doesn't apply) |
| Most brand-name items at a Plan Pharmacy | $30 for up to a 30-day supply (Plan Deductible doesn't apply) |
| Most brand-name refills through our mail-order service | $60 for up to a 100-day supply (Plan Deductible doesn't apply) |



*(continues)*

| | |
|---|---|
| Most specialty items at a Plan Pharmacy | $30 for up to a 30-day supply (Plan Deductible doesn't apply) |
| **Durable Medical Equipment (DME)** | **You Pay** |
| DME items in accord with our DME formulary guidelines | 20% Coinsurance (Plan Deductible doesn't apply) |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | 20% Coinsurance after Plan Deductible |
| Individual outpatient mental health evaluation and treatment | $20 per visit (Plan Deductible doesn't apply) |
| Group outpatient mental health treatment | $10 per visit (Plan Deductible doesn't apply) |
| **Chemical Dependency Services** | **You Pay** |
| Inpatient detoxification | 20% Coinsurance after Plan Deductible |
| Individual outpatient chemical dependency evaluation and treatment | $20 per visit (Plan Deductible doesn't apply) |
| Group outpatient chemical dependency treatment | $5 per visit (Plan Deductible doesn't apply) |
| **Home Health Services** | **You Pay** |
| Home health care (up to 100 visits per Accumulation Period) | No charge (Plan Deductible doesn't apply) |
| **Other** | **You Pay** |
| Skilled nursing facility care (up to 100 days per benefit period) | 20% Coinsurance (Plan Deductible doesn't apply) |
| Prosthetic and orthotic devices | No charge (Plan Deductible doesn't apply) |
| All Services related to covered infertility treatment | 50% Coinsurance (Plan Deductible doesn't apply) |
| Hospice care | No charge (Plan Deductible doesn't apply) |

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

38320 SAN MATEO COUNTY SCHOOLS INSURANCE GROUP – Belmont (Low Plan)

# Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/18—12/31/18)

## Accumulation Period

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (calendar year).

## Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

| Amounts Per Accumulation Period | Self-Only Coverage (a Family of one Member) | Family Coverage Each Member in a Family of two or more Members | Family Coverage Entire Family of two or more Members |
|---|---|---|---|
| Plan Out-of-Pocket Maximum | $6,000 | $6,000 | $12,000 |
| Plan Deductible | $3,000 | $3,000 | $6,000 |
| Drug Deductible | None | None | None |

| Professional Services (Plan Provider office visits) | You Pay |
|---|---|
| Most Primary Care Visits and most Non-Physician Specialist Visits | $40 per visit (Plan Deductible doesn't apply) |
| Most Physician Specialist Visits | $40 per visit (Plan Deductible doesn't apply) |
| Routine physical maintenance exams, including well-woman exams | No charge (Plan Deductible doesn't apply) |
| Well-child preventive exams (through age 23 months) | No charge (Plan Deductible doesn't apply) |
| Family planning counseling and consultations | No charge (Plan Deductible doesn't apply) |
| Scheduled prenatal care exams | No charge (Plan Deductible doesn't apply) |
| Routine eye exams with a Plan Optometrist | No charge (Plan Deductible doesn't apply) |
| Urgent care consultations, evaluations, and treatment | $40 per visit (Plan Deductible doesn't apply) |
| Most physical, occupational, and speech therapy | $40 per visit (Plan Deductible doesn't apply) |

| Outpatient Services | You Pay |
|---|---|
| Outpatient surgery and certain other outpatient procedures | 30% Coinsurance after Plan Deductible |
| Allergy injections (including allergy serum) | No charge (Plan Deductible doesn't apply) |
| Most immunizations (including the vaccine) | No charge (Plan Deductible doesn't apply) |
| Most X-rays and laboratory tests | $10 per encounter (Plan Deductible doesn't apply) |
| Preventive X-rays, screenings, and laboratory tests as described in the *EOC* | No charge (Plan Deductible doesn't apply) |
| MRI, most CT, and PET scans | $50 per procedure (Plan Deductible doesn't apply) |
| Covered individual health education counseling | No charge (Plan Deductible doesn't apply) |
| Covered health education programs | No charge (Plan Deductible doesn't apply) |

| Hospitalization Services | You Pay |
|---|---|
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | 30% Coinsurance after Plan Deductible |

| Emergency Health Coverage | You Pay |
|---|---|
| Emergency Department visits | 30% Coinsurance after Plan Deductible |

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

| Ambulance Services | You Pay |
|---|---|
| Ambulance Services | $150 per trip (Plan Deductible doesn't apply) |

| Prescription Drug Coverage | You Pay |
|---|---|
| Covered outpatient items in accord with our drug formulary guidelines: | |
| Most generic items at a Plan Pharmacy | $10 for up to a 30-day supply (Plan Deductible doesn't apply) |
| Most generic refills through our mail-order service | $20 for up to a 100-day supply (Plan Deductible doesn't apply) |
| Most brand-name items at a Plan Pharmacy | $30 for up to a 30-day supply (Plan Deductible doesn't apply) |
| Most brand-name refills through our mail-order service | $60 for up to a 100-day supply (Plan Deductible doesn't apply) |



*(continues)*

| | |
|---|---|
| Most specialty items at a Plan Pharmacy | $30 for up to a 30-day supply (Plan Deductible doesn't apply) |
| **Durable Medical Equipment (DME)** | **You Pay** |
| DME items in accord with our DME formulary guidelines | 20% Coinsurance (Plan Deductible doesn't apply) |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | 30% Coinsurance after Plan Deductible |
| Individual outpatient mental health evaluation and treatment | $40 per visit (Plan Deductible doesn't apply) |
| Group outpatient mental health treatment | $20 per visit (Plan Deductible doesn't apply) |
| **Chemical Dependency Services** | **You Pay** |
| Inpatient detoxification | 30% Coinsurance after Plan Deductible |
| Individual outpatient chemical dependency evaluation and treatment | $40 per visit (Plan Deductible doesn't apply) |
| Group outpatient chemical dependency treatment | $5 per visit (Plan Deductible doesn't apply) |
| **Home Health Services** | **You Pay** |
| Home health care (up to 100 visits per Accumulation Period) | No charge (Plan Deductible doesn't apply) |
| **Other** | **You Pay** |
| Skilled nursing facility care (up to 100 days per benefit period) | 30% Coinsurance (Plan Deductible doesn't apply) |
| Prosthetic and orthotic devices | No charge (Plan Deductible doesn't apply) |
| All Services related to covered infertility treatment | 50% Coinsurance (Plan Deductible doesn't apply) |
| Hospice care | No charge (Plan Deductible doesn't apply) |

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

**Plan Benefit Highlights for:** Plan D
**Group No:** 15997

DELTA DENTAL PPO[SM]
BENEFIT HIGHLIGHTS

Under the incentive plan, Delta Dental pays 70% of the Non-Delta Dental PPO dentists' contract allowance for covered diagnostic, preventive and basic services and 70% of the Non-Delta Dental PPO dentists' contract allowance for major services during the first year of eligibility. The coinsurance percentage will increase by 10% each year (to a maximum of 100%) for each enrollee if that person visits the dentist at least once during the year. If an enrollee does not use the plan during the calendar year, the percentage remains at the level attained the previous year. If an enrollee becomes ineligible for benefits and later regains eligibility, the percentage will drop back to 70%.

| | |
|---|---|
| **Eligibility** | Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 26 |
| **Maximums** | In-network: $2,200 per person each calendar year<br>Out-of-network: $2,000 per person each calendar year |

| **Benefits and Covered Services*** | **Delta Dental PPO dentists**** | **Non-Delta Dental PPO dentists** Incentive Plan** (Delta Dental Premier® & Non-Delta Dental Dentists) |
|---|---|---|
| **Diagnostic & Preventive Services (D & P)** Exams, three cleanings, x-rays and sealants | 100 % | 70-100 % |
| **Basic Services** Fillings and simple tooth extractions | 100 % | 70-100 % |
| **Endodontics** (root canals) Covered Under Basic Services | 100 % | 70-100 % |
| **Periodontics** (gum treatment) Covered Under Basic Services | 100 % | 70-100 % |
| **Oral Surgery** Covered Under Basic Services | 100 % | 70-100 % |
| **Major Services** Crowns, inlays, onlays and cast restorations | 100 % | 70-100 % |
| **Prosthodontics** Bridges and dentures | 50 % | 50 % |
| **Dental Accident Benefits** | 100 % (separate $1,000 maximum per person each calendar year) | 100 % (separate $1,000 maximum per person each calendar year) |

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

| Delta Dental of California | Customer Service | Claims Address |
|---|---|---|
| 100 First St. | 866-499-3001 | P.O. Box 997330 |
| San Francisco, CA 94105 | | Sacramento, CA 95899-7330 |

**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

# Your Vision Benefits Summary

Get the best in eye care and eyewear with Belmont Redwood Shores School District and VSP® Vision Care.

## Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP provider.

## Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

## Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a Premier Program location who carries these brands.

## Plan Information

**VSP Provider Network:** VSP Signature

Belmont Redwood Shored School District and VSP provide you with an affordable eyecare plan.

| Benefit | Description | Copay |
|---|---|---|
| | **Your Coverage with a VSP Provider** | |
| **WellVision Exam** | • Focuses on your eyes and overall wellness<br>• Every 12 months | $10 for exam and glasses |
| **Prescription Glasses** | | |
| **Frame** | • $130 allowance for a wide selection of frames<br>• $150 allowance for featured frame brands<br>• 20% savings on the amount over your allowance<br>• $70 Costco® frame allowance<br>• Every 24 months | Combined with exam |
| **Lenses** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children<br>• Every 12 months | Combined with exam |
| **Lens Enhancements** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 35-40% on other lens enhancements<br>• Every 12 months | $50<br>$80 - $90<br>$120 - $160 |
| **Contacts (instead of glasses)** | • $120 allowance for contacts and contact lens exam (fitting and evaluation)<br>• 15% savings on a contact lens exam (fitting and evaluation)<br>• Every 12 months | $0 |
| **Primary Eyecare** | • Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.<br>• As needed | $5 |
| **Extra Savings** | **Glasses and Sunglasses**<br>• Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.<br>• 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.<br>**Retinal Screening**<br>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam<br>**Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities<br>• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor | |
| | **Your Coverage with Out-of-Network Providers** | |

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam ............ up to $45
Frame ............ up to $50
Single Vision Lenses ............ up to $45
Lined Bifocal Lenses ............ up to $65
Lined Trifocal Lenses ............ up to $85
Progressive Lenses ............ up to $85
Contacts ............ up to $105

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

[1]Brands/Promotion subject to change.

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# San Mateo County Schools Insurance Group
# Medical Enrollment Form

| DISTRICT USE | |
|---|---|
| **Group #** (4-digit District ID) | **Subgroup #** (3-digit employee class) |
| | |

## I. EMPLOYEE INFORMATION

| *Social Security Number* | *First Name* | *MI* | *Last Name* | *Mailing Address* | *City* | *State* | *Zip Code* |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| *Date of Birth* | *Gender* | *Marital status* | *Are you married to a MCSIG covered employee?* | *Email* | *Home Phone* |
|---|---|---|---|---|---|
| | ❑ M ❑ F | ❑ *Single* ❑ *Married* | ❑ *Yes* ❑ *No*<br>*If Yes, provide Spouse Work Location:* ______ | | |

## II. MCSIG PLAN SELECTION

| ❑ New Enrollment | | M = MEDICAL PLAN OPTIONS | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Effective Date* | Coverage Options | PPO $30 | EPO $30 No Ded | | | | | | | | | | | | | | | |
| *Date of Hire* | Employee Only | ❑ | ❑ | | | | | | | | | | | | | | | |
| | Employee + One | ❑ | ❑ | | | | | | | | | | | | | | | |
| | Employee + Family | ❑ | ❑ | | | | | | | | | | | | | | | |

## III. DEPENDENT ENROLLMENT INFORMATION (Please list all dependents to be enrolled (Attach additional sheets if necessary.) Documentation required: Marriage License, Birth Certificate, etc.... See reverse

| | | | Relation | Effective Date | Last Name | First Name | MI | Social Security Number (Required) | Has other health plan? | Birth Date | Age | Totally Disabled? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | ☐ *Spouse*<br>☐ *Domestic Partner*<br>☐ *M* ☐ *F* | | | | | | ☐Y ☐N<br>☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N<br>☐Y ☐N |
| | | | ☐ *Son*<br>☐ *Daughter* | | | | | | ☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N |
| | | | ☐ *Son*<br>☐ *Daughter* | | | | | | ☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N |
| | | | ☐ *Son*<br>☐ *Daughter* | | | | | | ☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N |
| | | | ☐ *Son*<br>☐ *Daughter* | | | | | | ☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N |
| | | | ☐ *Son*<br>☐ *Daughter* | | | | | | ☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N |
| | | | ☐ *Son*<br>☐ *Daughter* | | | | | | ☐Y ☐N<br>☐Y ☐N | | | ☐Y ☐N<br>☐Y ☐N |

***(complete the reverse side)***

## PLEASE READ CAREFULLY—SIGNATURE REQUIRED

I attest by signing bellow that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions and misstatements.

**DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required contribution.

**NON-PARTICIPATION PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**ELIGIBILITY:** I understand that eligible dependents must be enrolled within 30 days of a qualifying event. If a dependent is no longer eligible for coverage (i.e. divorce, overage child. Etc.) I will notify MCSIG of the change within 30 days.

**EFFECTIVE DATE:** The effective date of coverage is subject to the eligibility guidelines of the employer and MCSIG.

**REQUIREMENT FOR BINDING ARBITRATION:**
I UNDERSTAND THAT MCSIG REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES, AS DESCRIBED IN THE MEDICAL PLAN HANDBOOK. (Available @ www.MCSIG.com)

**AUTHORIZATION:**
I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent of MCSIG any and all records related to medical history, services rendered, or treatment given to anyone enrolled in my health plan for purpose of review, investigation, or analysis of any application or claim.

I also authorize MCSIG or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical information obtained if such disclosure is necessary if such processing is necessary to allow the processing of any claim.

This authorization shall become effective immediately and shall remain in effect as is necessary to enable MCSIG to process claims.

**Summary of Benefits and Coverage** (SBC) summarizes important information about any health care option in a standard format and is available on the web at www.MCSIG.com. A paper copy of the SBC and Plan Handbook is also available, free of charge, by calling 1(800) 287-1442 (toll free).

The information you are asked to provide on this enrollment form is used only for technical and administration purposes and is not shared with anyone outside of the confines of administering your health care coverage.

Employee Signature: X ______________________________ Date: ________________

**Documentation that is required*. Please attach copies of:**

- Certified Marriage Certificate
- Domestic Partner State Registration Certificate (Same sex partners or over 62 opposite sex partners)
- Birth Certificates (for ALL dependent children)
- Adoption (Adoption Placement Papers)
- Legal Guardianship (final paperwork showing effective date)
- Proof of enrollment in other medical coverage, for employee to opt-out of medical plan
- MCSIG Disabled Dependent Form

***Any required documentation that is not included with the enrollment form will delay the enrollment process.**

## DECLINATION OF COVERAGE FORM

I was provided with and am signing acknowledgment of review and receipt of coverage and enrollment information for the insurance coverages provided through MCSIG. I hereby decline the indicated coverages offered for the following persons:

| SELF | | SSN |
|---|---|---|

*Check applicable coverages:*

☐ Medical * ☐ ☐

*MUST provide proof of other other medical coverage

| SPOUSE | | SSN |
|---|---|---|

*Check applicable coverages:*

☐ Medical ☐ ☐

Check reason: ☐ covered under another plan ☐ not covered, but do not choose to enroll at this time

| CHILD | | SSN |
|---|---|---|
| CHILD | | SSN |
| CHILD | | SSN |

Check applicable coverages:

☐ Medical ☐ ☐

Check reason: ☐ covered under another plan ☐ not covered, but do not choose to enroll at this time

I, the undersigned, understand that if I decline medical coverage at this time, I waive my right to re-enroll in the medical plan until the next annual open enrollment.* ________ Initial

*ACTIVE EMPLOYEES are eligible to participate in the Annual Open Enrollment.

*RETIREES are not subject to the Annual Open Enrollment.

Employee Name (print or type) ______________________ Employee Signature ______________________

Employer ______________________ Employer Representative &Title ______________________

Date signed ______________________

***RETURN YOUR COMPLETED FORM TO YOUR EMPLOYER BENEFIT REPRESENTATIVE FOR PROCESSING. PLEASE RETAIN A COPY FOR YOUR RECORDS.***

# California Region Group Enrollment/Change Form

**Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.**

| TO BE COMPLETED BY EMPLOYER | | |
|---|---|---|
| Company name | | Hire date (mm/dd/yyyy) |
| Group number | Enrollment unit | Effective enrollment/ change date (mm/dd/yyyy) |

**A. ENROLLMENT/CHANGE REASON** *(see Change Table for assistance)* New group: ❑ Yes ❑ No

❑ New Hire *(complete sections A, B, C, D)* ❑ Open Enrollment *(complete sections A, B, C, D)*

Health Plan *(Check one)* ❑ HMO Plan ❑ Deductible Plan ❑ Other ______

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify)* ______

❑ Name Change *(complete sections A, B, C, D)* From: ______ To: ______

Event Date (mm/dd/yyyy) ______

**B. EMPLOYEE** Have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

Medical Record No. *(if known)* ______ Social Security No. ______

Name (Last, First, MI) ______ Birth Date (mm/dd/yyyy) ______ Gender ❑ M ❑ F

Home Address ______ City ______ State ______ ZIP ______

Work Phone ______ Home Phone ______ Email ______

Ethnicity ______ Preferred Language ______

**C. FAMILY** For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

| | | |
|---|---|---|
| ❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner<br>Spouse/domestic partner name:<br>Former last name *(if any)*: | Gender ❑ M ❑ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ❑ Add ❑ Delete ❑ Child ❑ Student<br>Dependent name:<br>Relationship: | Gender ❑ M ❑ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ❑ Add ❑ Delete ❑ Child ❑ Student<br>Dependent name:<br>Relationship: | Gender ❑ M ❑ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |
| ❑ Add ❑ Delete ❑ Child ❑ Student<br>Dependent name:<br>Relationship: | Gender ❑ M ❑ F | Social Security No.<br>Birth Date (mm/dd/yyyy)<br>Medical Record No. |

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:

Name (Last, First, MI): Address:

**D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement***

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

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2), the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3), the KPIC Dental Plans.

______

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) Date

# California Region Group Enrollment/Change Form

## General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A and B. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

## Instructions for completing employer and new enrollment sections and sections A through D:

**To be completed by employer:** The employer must complete all fields to ensure we have correct account and enrollment information.

**Section A:** The subscriber must complete this section.

**Section B:** The subscriber must always complete this section. Use the Change Table (below) for assistance.

**Section C:** The subscriber must indicate the requested change to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* form may be required.

**Section D:** The subscriber must sign and date this section.

## Change Table

| Add dependent | Event date |
|---|---|
| Acquired student status* | Student status date |
| Family adoption* | Adoption date |
| Loss of coverage | Coverage loss date |
| New spouse (marriage) | Marriage date |
| Moved into service area | Move date |
| Newborn addition | Birth date |
| Open enrollment | Open enrollment effective date |

| Delete dependent | Event date |
|---|---|
| Loss of student status | Status change date |
| Divorce | Divorce date |
| Member deceased* | Death date |
| Delete dependent(s) | Dependent termination date |
| Open enrollment | Open enrollment effective date |

| Demographic Change | Event date |
|---|---|
| Address change, telephone number change | Status change date |
| Demographic (name, birthdate, social security number) change | Status change date |

*Additional documentation may be required.

KAISER PERMANENTE®

# ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

**VERY IMPORTANT - Please Print Legibly**

## FOR GROUP USE ONLY

| Group No. | Division | State |
|---|---|---|
| Effective Date / / | Hire Date / / | |
| Name of Employer | | |
| Location | Pay Code | Benefit Package |

## Enrollee/Change Information

- ❑ New Enrollment
- ❑ Marital Status Change
- ❑ Terminate Enrollee Coverage
- ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- ❑ Add/Delete Dependent
- ❑ Address Change
- ❑ Other ______________

## Enrollee Classification

- ❑ Full-Time ❑ Hourly ❑ Certified
- ❑ Part-Time ❑ Salaried ❑ Classified
- ❑ Retired ❑ Member/Other ______________

## Primary Enrollee Information

| Social Security Number | Enrollee ID Number (if applicable) | Date of Birth / / | Gender ❑ Male ❑ Female | Marital Status ❑ Single ❑ Married |
|---|---|---|---|---|
| First Name | Last Name | | | Middle Initial |
| Mailing Address (Street) | City | State | Zip Code | |
| E-mail Address (internal use only) | Phone Number ( ) - | Phone Type Cell ❑ Work ❑ Home ❑ | | |
| Name of Other Dental Carrier | Policy Holder Name (first/last) | Date of Birth / / | | |
| Effective Date of Other Policy / / | Policy Holder Street Address | City | State | Zip Code |

## COBRA (if applicable)

- ❑ Termination
- ❑ Reduction in Hours
- ❑ Divorce/Legal Separation*
- ❑ Widowed/Surviving Dependent*
- ❑ Dependent Child No Longer Eligible*

Indicate qualifying date: ____/____/____

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.**

## Dependent Information

| Relationship | Dependent First Name (Last only if different from enrollee) | Add / Term | Social Security Number | Date of Birth | Male / Female | Student / Disabled** | Name of School (overage student)** |
|---|---|---|---|---|---|---|---|
| Spouse/Partner | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | |
| Dependent | | ❑ ❑ | | / / | ❑ ❑ | ❑ ❑ | |

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Signature of Enrollee ______________________________ Date ____/____/____

**VISION SERVICE PLAN**
**MEMBERSHIP ENROLLMENT FORM**

Name of Group _____ Department _____ Effective Date _____

| | | | |
|---|---|---|---|
| 1 | Social Security No. | Last Name / First Name / MI | Date of Birth |

| | | | |
|---|---|---|---|
| 2 | Do you have dependent children - Y ☐ N ☐<br>Are you enrolling your dependents in the VSP Plan? Y ☐ N ☐ | 3 | Does your spouse have coverage with VSP? ☐<br>If Yes, who is covered? |

## 4 Coverage Level and Rates

| (√) | | Monthly Rates | |
|---|---|---|---|
| | | Plan | Plan |
| ☐ | Employee Only | $ | $ |
| ☐ | Employee + Spouse | $ | $ |
| ☐ | Employee + Child(en) | $ | $ |
| ☐ | Employee + Family | $ | $ |

**PLEASE LIST ALL OF YOUR DEPENDENTS THAT WILL BE ENROLLED IN THE PROGRAM**

| 5 | Last Name / First Name / MI | Social Security No. | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Please Return To Your Human Resources Department. Do Not Return To VSP**

**Signature**______________________ **Date**______________