SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services



RETIREE BENEFITS & ENROLLMENT GUIDE 2027

Open Enrollment Dates: Nov 2 – 30, 2026

BENEFITS | SECURITY | WELLNESS | PEACE OF MIND

Supporting your health. Securing your Future.

Photo: Chino Hills State Park

Open Enrollment *Tips*

- ✔ Review this guide and visit **link.sbcounty.gov/Retiree-Benefits** to learn more about your retiree health plan options
- ✔ Review What's New for Plan Year 2027 (page 5)
- ✔ Check important dates for open enrollment (page 4)
- ✔ Prepare for your transition from COBRA to retiree health benefits
- ✔ Prepare for your transition from traditional to Medicare benefits
- ✔ Enroll and make changes by 5:00 p.m. November 30, 2026
- ✔ Submit any required dependent documentation to Employee Benefits and Services Division (EBSD) by December 4, 2026

Contact Employee Benefits at:

EBSD: 909-387-5787
EBSD Toll-Free: 888-743-1474
EBSD Email: ebsd@hr.sbcounty.gov Attn: Retiree Desk

Open enrollment is November 2 through November 30, 2026

https://link.sbcounty.gov/RetireeOE

You are encouraged to keep this guide throughout the year.



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Welcome to the 2027 Retiree Benefits & Enrollment Guide

This Guide is designed to help you understand your health benefit options during open enrollment and throughout the year. Information in this guide includes:

- ✔ Medical and dental plan options
- ✔ Monthly premiums
- ✔ Enrollment, change, and cancellation forms
- ✔ Answers to frequently asked questions

Open Enrollment 2027

Open enrollment provides you an opportunity to evaluate your current medical and dental coverage and to elect the benefit plans that best fit your needs. During open enrollment you may:

- ✔ Enroll in a plan
- ✔ Change plans
- ✔ Terminate coverage
- ✔ Add or remove dependents

Elections and changes made during this open enrollment period will be effective January 1, 2027.

2027 Retiree Open Enrollment Important Dates	
◆ **Nov. 2, 2026**	First day of open enrollment
◆ **Nov. 9, 2026**	First open enrollment webinar
◆ **Nov. 11, 2026**	Employee Benefits office closed (Veteran's Day)
◆ **Nov. 26–27, 2026**	Employee Benefits office closed (Thanksgiving)
◆ **Nov. 30, 2026**	Last day of open enrollment
◆ **Dec. 4, 2026**	Last day to submit proof of dependency and/or dependent disability
◆ **Jan. 1, 2027**	Effective date of new premium rates and new elections/changes

Please contact Employee Benefits at **909-387-5787** or via email at **ebsd@hr.sbcounty.gov** should you have any questions about your retiree health benefit options during open enrollment or throughout the year.

What's New for Plan Year 2027?

Go Green. Go Paperless.

Go paperless this year. Review your Open Enrollment materials online at **https://link.sbcounty.gov/RetireeOE** to reduce paper waste, access the most up-to-date information, and view everything from any device.

2027 Retiree Medical and Dental Premium Rates

The Blue Shield Medicare and non-Medicare plans will have an approximate 6.90% rate increase. Kaiser Senior Advantage plans will have an approximate 1.40% rate reduction and the non-Medicare plans will have an approximate 5.99% increase. Dental PPO/HMO plans will have no rate changes.

2027 Retiree Health Plan Options

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

2027 Medical Plans	
Blue Shield of California	**Kaiser Permanente**
Non-Medicare Plans (Choice of High & Low Options)	
◆ Blue Shield Signature HMO ◆ Blue Shield Trio HMO ◆ Blue Shield PPO • California • Out of State	◆ Kaiser Permanente High Deductible Health Plan HMO (CA) ◆ Kaiser Permanente HMO • Colorado (selected zip codes) • Oregon/Washington (selected zip codes)
Medicare Integrated Plans (Choice of High and Low Options)	
◆ Blue Shield 65 Plus (HMO)	◆ Kaiser Permanente Senior Advantage • Colorado (selected zip codes) • Oregon/Washington (selected zip codes)
Medicare Coordination of Benefits Plans	
◆ Blue Shield PPO Medicare Coordination of Benefits (COB) • California • Out of State	
Dental Plans	
◆ DeltaCare USA DHMO ◆ Delta Dental PPO (Choice of High and Low Options)	

CONTACT INFORMATION

Employee Benefits and Services Division

175 West Fifth Street, First Floor 909-387-5787
San Bernardino, CA 92415
https://link.sbcounty.gov/RetireeOE

All Retiree Medical and Dental Plans . 909-387-9674
link.sbcounty.gov/Retiree-Benefits
https://link.sbcounty.gov/RetireeOE

COBRA 909-387-5552

PROVIDERS:

Blue Shield 65 Plus (HMO)
www.blueshieldca.com

Blue Shield 65 Plus (HMO) Member Services
. 800-776-4466
PO Box 927, Woodland Hills, CA 91365.9856

Blue Shield PPO and Non.Medicare
www.blueshieldca.com

Blue Shield of California 855-829-3566
PO Box 272540, Chico, CA 95927.2540

Blue Shield Signature
www.blueshieldca.com

PO Box 272540, Chico, CA 95927.2540
. 855-829-3566

DeltaCare USA DHMO
www.deltadentalins.com

PO Box 1803, Alpharetta, GA 30023
. 855-244-7323

Delta Dental PPO
www.deltadentalins.com

PO Box 997330 Sacramento, CA 95899
. 855-244-7323

Kaiser Permanente
https://my.kp.org/sbcounty

Kaiser Permanente Foundation Health Plan, Inc
. 800-464-4000
PO Box 7141, Pasadena, CA 91109.7141

Kaiser Permanente Senior Advantage
https://my.kp.org/sbcounty

Kaiser Permanente – Medicare Unit
. 800-443-0815
(for membership enroll/disenroll)
PO Box 232400, San Diego, CA 92193.2400

CONTACT INFORMATION

Voya
https://cosb.beready2retire.com
1030 Nevada Street, Suite 203 909-748-6468
Redlands, CA 92374 800-452-5842

Voya Health Account Solution
www.voya.com/ws/myHRA
PO Box 1168, Minneapolis, MN 55440
. 1-833-232-4673
. . . . . Fax 1-855-370-0670
. . . . . HASinfo@voya.com

HELPFUL RESOURCES AND REFERRAL SERVICES:

American Association of Retired Persons (AARP) 888-687-2277
www.aarp.org

American Cancer Society (ACS) 800-227-2345
www.cancer.org

American Heart Association (AHA) 800-242-8721
www.heart.org

Centers for Medicare & Medicaid Services
(CMS for Medicare information) 800-633-4227
www.cms.gov
www.medicare.gov

Covered California (State of California Health Care Exchange) 800-300-1506
www.coveredca.com

Health Insurance Counseling and Advocacy Program (HICAP) /
California's State Health Insurance Assistance Program 800-434-0222
https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/

Social Security Administration (SSA) 800-772-1213
www.socialsecurity.gov

San Bernardino County Employees' Retirement Association (SBCERA) . . 909-885-7980
348 West Hospitality Lane, Third Floor San Bernardino, CA 92415-0440 . . 877-722-3721
www.sbcera.org

Frequently Asked Questions & Answers

1 What are the next steps when I retire?

You will want to contact Employee Benefits at **909-387-5787** for information on your health plan options such as COBRA continuation coverage, retiree health benefit options and/or Medicare plan options.

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

No. As a retiree, your participation in a retiree medical plan is completely voluntary. You may continue your coverage as a dependent under your spouse's (or domestic partner's) County coverage. If your spouse (or domestic partner) loses medical coverage under a County-sponsored medical plan because of a reduction in work hours, termination of employment, or retirement, you and your spouse (or domestic partner) might be eligible to continue group coverage through COBRA. Also, if your covered spouse (or domestic partner) retires, your spouse (or domestic partner) will have 60 days to elect coverage as a retiree. Your spouse (or domestic partner) may then enroll you as a covered dependent.

3 How do I pay for my retiree health insurance premium(s)?

Your insurance premium(s) will be deducted from your monthly retirement benefit payment (SBCERA pension check). If you are a new retiree and not yet receiving a retirement benefit payment, you will need to submit payment directly to Employee Benefits by mail or in person payment. We accept cash, check and money order.

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

You pay the full monthly insurance premium for medical and dental coverage. If eligible for Medicare, your advantage insurance premium is in addition to the regular MediCare Part B monthly premium.

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

When you enroll in a medical plan or make changes to your coverage, you should check your retirement benefit payment carefully to verify that the proper deduction is being taken. If the deduction is not being taken or is incorrect, contact Employee Benefits immediately to correct the discrepancy.

6 May I switch medical plans when I retire?

At the time of retirement, you may select the retiree plan of your choice. However, if you elect COBRA continuation coverage, you may not switch plans unless you move out of your plan's service area (see question 12). You may change to another medical plan ONLY during open enrollment.

7 Is there a vision plan for retirees?

San Bernardino County does not offer a retiree vision plan. View the Medical Comparison chart for additional information on covered vision exams. If you are newly retired, you may continue your EyeMed vision coverage for up to 18 months by electing COBRA. In addition, you may be able to obtain vision coverage with VSP from the Retired Employees of San Bernardino County (RESBC)/Pacific Group Agencies or the Teamsters Local 1932 if you are a member. For information about these plans, contact Pacific Group Agencies, the Benefit Plans Administrator, at **800-511-9065** or Teamsters Local 1932 at **909-889-8377 x 234**.

8 When may I add new eligible dependents to my coverage?

You may add dependents only during open enrollment unless you experience a qualifying event. You may enroll your eligible dependents (i.e., newborn newly adopted child, new spouse, or stepchild) within 60 days of a qualifying event (birth, marriage, custody, etc.). To enroll your eligible dependents, you must submit a Medical and/or Dental Plan Enrollment/Change Form (with any required attachments and/or verifications) within 60 days. New dependent coverage is effective the first day of the month following the event. *Exceptions:* See page 17 for coverage information regarding newborns and adopted children.

9 What happens to my dependents' health coverage if I become deceased?

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

10 When does a dependent lose eligibility?

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

- Your non-disabled, covered child turns 26 years of age
- The final divorce decree is granted
- Dissolution of a domestic partnership

Your former spouse must be removed from your medical and dental plans within 60 days of the event date even if the divorce settlement requires you to provide coverage.

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

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

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

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

Frequently Asked Questions & Answers

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

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

- Call the Social Security office at **1-800-772-1213** or CMS at **1-800-633-4227** regarding enrollment for Medicare insurance benefits
- Apply for Medicare online at **https://www.ssa.gov/benefits/medicare**
- Call Employee Benefits at **909-387-5787** for your medical insurance options

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

Yes. When you sign and date the COBRA Medical Plan Enrollment/Change Form or the COBRA Dental Plan Enrollment/Change Form you authorize the San Bernardino County to deduct the monthly COBRA payments from your monthly retiree benefit payment once you have paid the initial premium in full.

15 How can I initiate a reimbursements for my premiums from my Retirement Medical Trust Fund?

You can file a reimbursement online at www.voya.com/ws/myHRA.

16 My dependent loss coverage but I'm not currently enrolled in a retiree medical/dental plan. Can I still enroll my dependent on a retiree medical/dental plan?

No. A retiree must be enrolled as the subscriber on a retiree medical/dental plan in order to add a dependent.

17 Do I have to notify Employee Benefits when I enroll in a Medicare plan?

If you are enrolled in a retiree medical plan with the County and decide to enroll in an individual Medicare plan, you will be required to cancel your retiree medical plan with the County. Contact Employee Benefits immediately to cancel your plan and recurring SBCERA deductions.

18 Who may I call for additional information?

See the Contact Information section on pages 6 and 7 of this Guide for telephone numbers and web site addresses.

2027 Retiree Medical and Dental Premium Rates

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

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

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

Retiree: Blue Shield 65 Plus – Retiree only, over 65, with Medicare A and B (High Option) $283.71

Dependent: Blue Shield Signature – 1 Dependent, under 65, no Medicare (High Option) $1,283.17

Total Monthly Premium: $1,566.88

Monthly Medical Plan Rates

Effective January 1, 2027 Plan and Coverage Level	2027 Rates		
Blue Shield Signature (HMO)	**High**	**Low**	**TRIO**
Retiree only, under 65, no Medicare	$1,120.89	$921.50	$842.06
1 Dependent, under 65, no Medicare	$1,283.17	$1,053.96	$962.67
2 Dependents, under 65, no Medicare	$2,176.21	$1,787.49	$1,632.67
Retiree only, over 65, no Medicare	$1,120.89	n/a	n/a
1 Dependent, over 65, no Medicare	$1,283.17	n/a	n/a
2 Dependents, over 65, no Medicare	$2,176.21	n/a	n/a

Blue Shield 65 Plus (HMO) Medicare Advantage	High	Low
Retiree only, over 65, with Medicare A and B	$283.71	$117.36
1 Dependent, over 65, with Medicare A and B	$279.35	$113.00
2 Dependents, over 65, with Medicare A and B	$558.70	$226.00
Blue Shield PPO Medicare COB – California and Out of State	**High**	**Low**
Retiree only, over 65, with Medicare A and B	$845.85	n/a
1 Dependent, over 65, with Medicare A and B	$841.51	n/a
2 Dependents, over 65, with Medicare A and B	$1,682.99	n/a

Monthly Medical Plan Rates (continued)

Effective January 1, 2027 Plan and Coverage Level	2027 Rates		
Blue Shield PPO – California and Out of State	**High**	**Low**	
Retiree only, under 65, no Medicare	$1,836.48	$1,437.91	
1 Dependent, under 65, no Medicare	$1,881.03	$1,471.80	
2 Dependents, under 65, no Medicare	$3,915.91	$3,045.16	
Kaiser Permanente (HMO)	**High**	**Low**	**HDHP**
Retiree only, under 65, no Medicare	$1,609.92	$1,224.24	$980.26
1 Dependent, under 65, no Medicare	$1,605.56	$1,219.88	$975.90
2 Dependents, under 65, no Medicare	$2,938.17	$2,232.38	$1,785.90
Retiree only, over 65, no Medicare	$1,609.92	$1,224.24	$980.26
1 Dependent, over 65, no Medicare	$1,605.56	$1,219.88	$975.90
2 Dependents, over 65, no Medicare	$3,211.12	$2,439.76	$1,951.80
Kaiser Permanente Senior Advantage	**High**	**Low**	
Retiree only, over 65, with Medicare A and B	$232.17	$141.31	
1 Dependent, over 65, with Medicare A and B	$227.81	$136.95	
2 Dependents, over 65, with Medicare A and B	$455.62	$273.90	

Monthly Dental Plan Rates

	DeltaCare USA HMO	Delta Dental PPO Low Option	Delta Dental PPO High Option
Retiree only	$20.03	$45.33	$63.69
Retiree + 1	$31.01	$83.41	$118.34
Retiree + 2 or more	$44.21	$143.29	$204.27

Contact Employee Benefits for information if your specific plan is not listed in the rates table.
Phone: 909-387-5787 | 888-743-1474
Email: ebsd@hr.sbcounty.gov Attn: Retiree Desk

Eligibility

To participate in a County-sponsored retiree plan, you must be a San Bernardino County Employees' Retirement Association (SBCERA) retiree or eligible dependent. You or your eligible dependent pay the cost of coverage and your insurance premium may be deducted from your monthly retirement benefit payment. If you do not receive a monthly retiree benefits payment, you will need to submit payments directly to Employee Benefits.

If you are a surviving spouse or child of a County employee (eligible dependent), you may be eligible to enroll in County-sponsored retiree health benefits. If you are unsure of your eligibility status, contact Employee Benefits at **909-387-5787** or **ebsd@hr.sbcounty.gov**.

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

- You retire;
- You lose employer sponsored coverage;
- Your COBRA or Cal-COBRA coverage ends due to exhaustion of the maximum time allowed;
- You relocate into or out of a plan's network service area;
- You are covered under your spouse or domestic partner's plan and she/he loses coverage;
- You become eligible for Medicare;
- You are covered under your spouse or domestic partner's plan, and you get divorced or you terminate the domestic partnership.

Note: It is important that you notify our office within **60** days of the qualifying event date.

Dependent Eligibility

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

- Your legal spouse (a copy of your marriage certificate is required)
- State-Registered Domestic Partner (copy of the certificate of state registered domestic partnership or equivalent out-of-state certificate is required)
- Your children* who are:
  - Under age 26
  - Over age 26, supported primarily by you and incapable of self- sustaining employment by reason of mental or physical disability. A Disabled Dependent Certification Form with proof of physical or mental condition from your health care provider must accompany the Medical and/or Dental Plan Enrollment/ Change Form. Please note that it is the medical plan that evaluates and makes the final determination on the disability status. Contact Employee Benefits at **909-387-5787** for detailed information.

* Your children include children born to you, legally adopted by you, your step-children, children of your state-registered domestic partner, children for whom you are the legal guardian, and children you support as a result of a valid order.

Kaiser Permanente allows coverage for grandchildren only if the grandchild's parent (your dependent child) was enrolled on the County's Kaiser Permanente plan prior to the birth of the grandchild. Grandchildren may remain enrolled as long as they have no break in coverage and meet the following criteria:

1) the dependent child is covered;

2) the grandchild permanently resides with you or your spouse; and

3) the grandchild receives all financial support and maintenance from you or your spouse.

Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates and relatives other than those listed above are **not eligible**.

NOTE: If you do not submit all necessary forms and supporting documentation when required, your dependents will not be added to your plan and you will be responsible for any costs incurred.

Your last day to submit proof of dependency and the Disabled Dependent Certification form is **December 4, 2026**.

Enrollment

During open enrollment, you may cancel your medical and/or dental plan coverage (subject to contractual enrollment commitment requirements), change medical plans, and add/delete eligible dependents to/from your coverage. Before making changes, be sure to read your enrollment materials carefully. The enrollment options you elect during the 2027 open enrollment period will remain in effect for the entire plan year and you must wait until the next open enrollment period to make changes, unless you experience a qualifying life event (see page 18).

If You Are Enrolling or Making Changes

To enroll or make changes, submit a completed and signed Medical and/or Dental Plan Enrollment/Change Form (with all appropriate documentation, such as a marriage or birth certificate, if applicable) to Employee Benefits at **175 W. Fifth Street, First Floor, San Bernardino, CA 92415-0440** or by email at **ebsd@hr.sbcounty.gov**.

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

- Medical Plan Enrollment/Change Form (pg. 95)
- Dental Plan Enrollment/Change Form (pg. 99)
- Disabled Dependent Certification Form (pg. 103)

If newly enrolling in a Medicare Plan, you will need to complete the following forms:

- Medical Plan/Enrollment Change Form (required, on pg. 95)
- Blue Shield 65 Plus (HMO) Group Enrollment Form (add as applicable, on pg. 105)
- Blue Shield of California Medicare Rx Plan (PDP) Form (add as applicable, on pg. 109)
- Kaiser Senior Advantage Election Form (add as applicable, on pg. 121)

IMPORTANT INFORMATION for New Enrollees in Blue Shield and/or DeltaCare USA HMO Plans:

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

For Blue Shield provider information, you may visit their website at **blueshieldca.com** or call **855-829-3566** for non-Medicare plans or **800-776-4466** for Medicare plans. Information for Delta Dental providers can be found at **www.deltadentalins.com** or by calling **855-244-7323**.

Important Information for Medicare-Eligible Enrollees:

For those newly enrolling in a Medicare Plan, the Centers for Medicare and Medicaid Services (CMS) requires a signed Medicare plan enrollment form in order to process coverage under the plan. Medicare plan enrollment forms for Kaiser and Blue Shield can be found in the back of this guide. If a signed enrollment form is not received by **November 30, 2026,** you will not be enrolled in medical coverage through the County. Your next opportunity to enroll in County-sponsored coverage will be during the next open enrollment period in November 2027 or if you experience a mid-year qualifying life event.

If You Are Canceling Coverage

You may cancel coverage at any time during the year. To cancel coverage, complete the Medical and/or Dental Plan Cancellation Form and submit it to Employee Benefits at **175 W. Fifth Street, First Floor, San Bernardino, CA 92415-0440**. If you are enrolled in a Medicare plan, you will also need to complete and submit the appropriate Medicare disenrollment form.

The following cancellation forms are contained in this guide:

- Medical and/or Dental Plan Cancellation Form (required, on pg. 101)
- Blue Shield Medicare Program Group Disenrollment Form (add as applicable, on pg. 113)
- Kaiser Senior Advantage Disenrollment Form (add as applicable, on pg. 127)

NOTE: Requests to cancel dental plan enrollments are subject to the two-year enrollment provision of the Delta Dental Contract. Please contact Employee Benefits to see if you have met this minimum requirement prior to canceling your dental coverage.

Medical and Dental Plan ID Cards

You will receive an identification (ID) card from your medical and/or dental plan within 4 to 6 weeks of the effective date of your new coverage. You may, however, begin using your medical and/or dental plan on the effective date of your coverage. Your provider can verify your eligibility by your social security number and date of birth.

New elections made during the 2027 open enrollment period will be effective January 1, 2027. Any enrollments made outside of open enrollment will be effective the first day of the calendar month following the election.

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

Confirmation Statements

After open enrollment, you will receive a confirmation statement verifying your 2027 elections.

The confirmation notice will be mailed to your mailing address and will list the plan(s) you elected, dependents covered, and the effective date of your coverage.

Please be sure to review your confirmation statements carefully. Contact Employee Benefits if there is a concern or question about the information contained in your statement.

Mid-Year Enrollments & Changes

The enrollment options you elect during the 2027 open enrollment period will remain in effect for the entire plan year. You must wait until the next open enrollment period to make changes, UNLESS you experience a qualifying life event as noted in the Life Events chart on the following page.

The two exceptions to mid-year changes are removing dependents and cancelling coverage. As your premiums are paid on an after-tax basis, you may revoke your election and/or remove your dependents from your plan at any time, subject to the terms of the medical and dental plan contracts.

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

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

Effective Date of Mid-Year Changes

All elections made during the plan year will become effective the first calendar day of the month following the date that the completed enrollment forms and documentation are received by Employee Benefits. You will be billed for any premiums owed as a result of the plan election changes. If your plan election change results in an increase or decrease in premium, your deduction will be increased or you will receive a refund consistent with the change.

Newborn and Adopted Children

Under Blue Shield, newborn children will be covered under the same medical group in which the natural mother is enrolled for the first 60 days. If the natural mother of the newborn is not enrolled as a member or if the child has been placed with the subscriber for adoption, the personal physician selected must be a physician in the same medical group or Individual Practice Association (IPA) as the subscriber.

Under Kaiser, newborn children are covered for the first 31 days. Newly adopted children or child placed with you for adoption are eligible for coverage the first date in which you or your spouse or domestic partner gain the legal right to control the child's health care.

Retiree subscribers must still enroll the newborn under their respective plan through the County. Contact Employee Benefits to complete the newborn's enrollment.



Qualifying Life Events Chart

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

Qualifying Life Event	Medical / Dental	Documentation Required (All documentation must be submitted within 60 days of the event)
Loss of coverage	Retiree may enroll self if coverage is lost and may enroll eligible dependents	• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable) (enrollment) • Retiree Dental Enrollment/Change Form • Proof of spouse's employment and benefit plan loss
Self or dependent(s) gain or loses eligibility for Medicare or Medicaid	Retiree may cancel medical plan enrollment or enroll self/dependent(s) in Medicare Advantage plan/non-Medicare plan	• Retiree Medical Cancellation Form (Please note, dental cannot be cancelled for this event) • Retiree Medical Enrollment/Change Form • Proof of gain or loss of Medicare or Medicaid
Relocate into or out of a plan's network service area	Retiree may enroll/ change or cancel plans.	• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable) • Retiree Dental Enrollment/Change Form • Proof of loss of coverage or address change
Gain Dependent • Marriage • Domestic Partnership • Birth/Adoption/ Placement for Adoption/Legal Guardianship	Retiree may enroll newly eligible dependent(s)	• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable) • Retiree Dental Enrollment/Change Form • Marriage Certificate, Domestic Partner Certificate and/or Birth Certificate(s) or Court Documentation

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

Life Events Chart (continued)

Qualifying Life Event	Medical / Dental	Documentation Required (All documentation must be submitted within 60 days of the event)
Dependent Ceases to Satisfy Plan Eligibility Requirements (e.g., over age dependent)	Retiree must remove dependent	• Retiree Medical Enrollment/Change Form • Retiree Dental Enrollment/Change Form
Dependent reaches age 26 (OAD) and relies on you for support and is permanently mentally or physically disabled	Retiree may elect to keep dependent enrolled	To keep dependent enrolled in health benefits, you must submit the Disabled Dependent Certification (within 60 days of event)
Over Age Dependent (OAD) loses coverage under other parent's employer-sponsored plan.	Retiree may elect to enroll OAD if supported by you and incapable of self-sustaining (mental or physical disability)	• Retiree Medical Enrollment/Change Form (and Medicare forms, if applicable) • Retiree Dental Enrollment/Change Form • Marriage Certificate, Domestic Partner Certificate, and/or Birth Certificate(s) or Court Documentation • Disabled Dependent Certification • Proof of Loss of Coverage
Removal of Dependent(s)	Retiree may remove dependent(s) anytime during plan year as premium is paid on after-tax basis	• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable) • Retiree Dental Enrollment/Change Form
Spouse/Domestic Partner's COBRA or Cal-COBRA coverage ends due to exhaustion of benefit	Retiree may enroll self and eligible dependent(s)	• Retiree Medical Enrollment/Change Form (and Medicare forms if applicable) • Retiree Dental Enrollment/Change Form • Marriage Certificate, State Registered Domestic Partner Certificate and/or Birth Certificate(s) • Proof of loss of COBRA coverage

Over Age Dependent (OAD)

<table>
<tr><th>Dependent Relationship to Subscriber</th><th>Blue Shield *</th><th>Kaiser *</th></tr>
<tr><td rowspan="2">Disabled Dependent over the age of 26 is defined as:
Unmarried, dependent child who is permanently and totally disabled and unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment and provides physician's certification annually for as long as the disability continues.</td><td colspan="2">May enroll a disabled dependent within 60 days from the disabled date.
Subject to receipt and approval of Physician's certification and carrier approval.</td></tr>
<tr><td>Continued Enrollment:
Disabled dependents must be enrolled in the plan upon attaining the age of 26 in order to continue enrollment. If the disabled dependent discontinues enrollment at any time after attaining age 26, they will not be allowed to re-enroll for coverage (e.g. there must be no break in coverage).</td><td>Continued Enrollment:
No prior enrollment requirement.
Subject to receipt and approval of Physician's certification</td></tr>
</table>

*Subject to carrier approval



Continuation of Coverage (COBRA) for Retiree Plans

San Bernardino County, as required under provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), offers employees/retirees and their covered family members the opportunity to elect a temporary extension of coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage would otherwise end due to certain qualifying events. You are also eligible for an additional 18 months of medical coverage under Cal-COBRA. Vision and dental coverage are not available under Cal-COBRA.

Length of Continuous Coverage

Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination of employment (other than for reasons of gross misconduct)	Employee Spouse, Dependent Child	18 months
Reduction in work hours	Employee Spouse, Dependent Child	18 months
Death of the employee	Spouse, Dependent Child	36 months
Divorce or legal separation	Spouse, Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

(Detailed definitions of qualifying events are contained in the law itself – click here for more information).

A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under San Bernardino County's group health and welfare plans maintained by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of a covered employee.

Retirees who voluntarily cancel their retiree medical coverage are not entitled to COBRA coverage (e.g., due to non-payment). On the other hand, dependents of retirees may lose their eligibility for retiree health benefits due to a qualifying event. Eligible dependents who are enrolled in a County-sponsored retiree health plan on the day before a "qualifying event" are considered to be "Qualified Beneficiaries" who are entitled to COBRA continuation coverage. Each qualified beneficiary has independent election rights to COBRA.

To elect COBRA, you must notify Employee Benefits of your qualifying event within 60 days of the event date. You will not be enrolled in COBRA continuation coverage until you make a COBRA election and all premiums are paid. Once an election is made and premiums are paid, your coverage will be retroactively reinstated back to your loss of coverage date.

The qualified beneficiary is responsible for the full premium plus a 2% administration fee.

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

Employee Benefits Appeals Procedure

General Information

Employee Benefits maintains and provides documents that explain the policies, requirements, and limits of coverage for all retiree benefit programs. In the event that a retiree or eligible dependent believes that a request for a benefit under a health plan has been improperly denied, he or she may appeal the decision within the parameters set forth in the following procedure.

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

Denied Benefits Appeals Process

If you or your beneficiary's request or claim for benefits is denied you have the right to file an appeal in writing directly to the Employee Benefits Appeals Unit. Submissions can be sent directly to the Employee Benefits email box at ebsd@hr.sbcounty.gov.

- ✔ Appeals must be submitted within 30 calendar days of the notice of denial or adverse decision.
- ✔ Within 15 calendar days of the date the appeal is received, the Employee Benefits Appeals Unit will review the facts and respond in writing with its findings.
- ✔ A review period may be extended by an additional 15 days if special circumstances and/or insufficient information require an extension of time for a decision to be made. You will be notified and required to send additional information within 15 calendar days from the date of the notice to provide the specified information. Should the requested information not be received within the specific time, the Employee Benefits Appeals Unit will make a decision without it, in which case, the decision is final and not eligible for a second appeal.

NOTE: All approvals are subject to carrier contract limitations.

Blue Shield Signature HMO

HMO Reliability + Specialist Self-Referral Convenience

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

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

- Designate your Primary Care Physician (PCP) and Medical Group from within the Shield Signature network. Each member of your family may choose a different PCP.
- Your PCP coordinates your care to include referrals to specialist within the Level 1 HMO benefit.
- Call your PCP when you need routine or hospital care:
  - Pay a fixed copayment (so there are never any cost surprises)
  - Say goodbye to paperwork – you do not have to deal with claim forms when you use your HMO benefits.
  - Certain services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your PCP in order to be covered under the plan.
- Accessing Level 2 benefits – Seeing a specialist without a referral.
  - Arrange office visits, consultation, evaluation and treatment—only procedures that can be performed in the doctor's office will be covered under this benefit.
  - Your copayments will be slightly higher and you may need claim forms for certain services.
- Go directly to the closest emergency room if you have an emergency. Emergency and urgent care are available worldwide. You don't have to call your PCP first. If you're admitted to a facility, have a family member or hospital staff contact Blue Shield as soon as possible.

Is Blue Shield Signature HMO Right For You?

Yes, if you want:

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

Claim Forms

Under the Blue Shield Signature HMO (Level 1) component you do not have to file claim forms.

Blue Shield Trio HMO

Trio HMO is a network designed to deliver a coordinated, effective, and efficient care experience. It is made up of a subset of Independent Practice Association (IPAs), medical groups, and affiliated physicians from the Access+ HMO.

What is the Trio HMO plan?

With the Trio HMO plan, you get access to a quality network of doctors, hospitals, and other providers at an affordable price. The Trio HMO keeps your costs down because Blue Shield partners with an accountable care organization (ACO) that consists of doctors, hospitals, and other health care providers that share information about your care and coordinate it to give you better treatment and keep your costs down.

How does the Trio HMO plan work?

- A lower premium contribution. The Trio HMO plan will cost you less in monthly premiums.
- Under the Trio HMO plan option, you pay no deductible and your out-of-pocket annual expenses are limited to $3,000 per member or $9,000 per family.
- A select network that focuses on coordinating your care. Trio's lower premium is made possible because Trio network providers team up to coordinate your care to help keep you healthy – and reduce your costs.
- You must select a PCP in the Trio network. PCPs perform preventive care and treat medical conditions. They also coordinate other health care, including referrals to specialists and hospitals within their medical group/Independent Practice Association (IPA). Each member of your family can choose a different physician and medical group/IPA.

Medical Transition of Care Benefit

If you are currently receiving care — for planned surgeries, pregnancy and newborn care, acute and serious chronic conditions, or a terminal illness — from a provider that is not in the Trio network, please call your Shield Concierge team to see if continuation of care is available to you during your transition to the Trio HMO plan. If you have been scheduled for treatment that required authorization from your former doctor who is not in the Trio network, you will need new authorization from a doctor who is in the Trio network. If you have questions, please call your Shield Concierge team.

Pharmacy

Drug tiers: Drugs in a formulary are typically grouped into tiers based on defined categories such as generic drugs, preferred brand-name drugs, nonpreferred brand-

name drugs, and specialty drugs. The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers. You can find information about what you pay by drug tier on the Medical Plan Comparison Chart. To verify that your prescription drug is on Blue Shield's specialty drug list, visit **blueshieldca.com/pharmacy**, or call your Shield Concierge team.

The Meal Delivery Program

With the LifeSpring meal delivery program, qualified patients recovering from serious illness can get ready-to-heat meals that fit their dietary needs delivered right to their door. Through the Call the Car service, they can also get medical transportation from their home to medical appointments, dialysis centers, and other healthcare facilities as needed.

A Blue Shield Case Manager will determine if you are eligible for these programs and, if so, will authorize meal delivery service and transportation for you.

To find out if you are eligible for these services, or to get more information, contact your dedicated Shield Concierge team.

Blue Shield PPO

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

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

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

Is the Blue Shield PPO Right For You?

Yes, if you want:

- Freedom of choice

- Control over how much you spend – your costs are lower when you use our network
- Broad network access throughout California and Nationwide
- Time savings convenience – no claim forms to file when you use network services
- Access to Heal - schedule in-person healthcare visits with Heal doctors wherever you are—at home, in the office, or even a hotel.

Blue Shield PPO Medicare Coordination of Benefits (COB) Plan

What is a Medicare COB PPO Insurance Plan?

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

How does the plan work?

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

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

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

- Your provider submits claims to the Medicare intermediary for determination and payment of allowable amounts.
- The Medicare intermediary then sends a Medicare Summary Notice to both you and the provider of service. Medicare electronically sends the claim to Blue Shield once they have processed their payment. Blue Shield automatically processes the remainder of the claim, pays their portion, and sends an explanation of benefits to both the member and provider. Blue Shield is responsible for paying the difference between the amount Medicare paid and the Blue Shield allowed amount for the covered service. You will receive a copy of the Medicare Summary Notice showing a summary of benefits paid on your behalf by Medicare. Some secondary claims are sent electronically to Blue Shield by Medicare and do not require that the provider of service submit a claim.

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

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

Blue Shield 65 Plus HMO (Medicare Eligible Retirees)

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

Blue Shield 65 Plus (HMO):

- With a large network of physicians and hospitals, chances are your doctor is in the Blue Shield 65 Plus (HMO) network, you won't have to worry about finding a new doctor to learn about you and your conditions.
- Provides services tailored to Medicare beneficiaries: Blue Shield is familiar with the conditions most likely to affect you, and the medications you're most likely to need. The Prescription Drug Plan for Medicare offers coverage for many commonly prescribed brand name drugs. Even if your physician changes your medications, your new prescription will most likely still be on the list of covered drugs.
- Makes it easy to use your Part D Prescription Drug benefit: Medical and drug benefits are integrated into one plan with only one ID card.
- Offers the highest quality care possible: Blue Shield offers a vast network of contracted physicians, hospitals, pharmacies and medical professionals to give you access to the best possible care.

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

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

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

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

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

FEATURES A user friendly Medicare plan that offers:

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

SilverSneakers

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

- Members have access to more than 10,000 participating locations across the country, including 24 Hour Fitness, Anytime Fitness, Fitness 19, YMCAs and many others. Women-only locations, including Curves®, are also available nationwide.

- SilverSneakers is available online at **www.silversneakers.com** where members have a comprehensive, easy-to-use wellness resource in the member pages.
- SilverSneakers Steps is a personalized fitness program that fits the lifestyle of members who don't have convenient access to a Silver-Sneakers location (a location is 15 miles or more from their home). Steps members receive a kit with the wellness tools they need to get fit. Please contact Blue Shield 65 Plus at **888-423-4632**.

Additional Blue Shield Member Services

Short-Term Out-of-Area Care

OUTSIDE OF CALIFORNIA: The Blue Shield Signature HMO provides coverage for you and your family for your Urgent Service needs when you or your family are temporarily traveling outside of California. You can receive urgent care services from any provider; however, using the BlueCard® Program, described below, can be more cost effective and eliminate the need for you to pay for the services when they are rendered and submit a claim for reimbursement.

NOTE: *Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.*

Out-of-Area Follow-up Care is covered and services may be received through the BlueCard® Program participating provider network or from any provider. However, authorization by Blue Shield is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield may direct the patient to receive the additional follow-up services from the PCP.

WITHIN CALIFORNIA: If you need urgent medical care but are outside of your PCP Service Area, if possible you should call Blue Shield Member Services. You may also locate a Plan Provider by visiting our web site at **www.blueshieldca.com/findaprovider**. However, you are not required to use a Blue Shield of California Plan Provider to receive Urgent Services. You may use any provider.

NOTE: *Authorization by Blue Shield is required for care that involves a surgical or other procedure or inpatient stay.*

Follow-up care is also covered through a Blue Shield of California Plan Provider and may also be received from any provider. However, when outside your PCP Service Area, authorization by Blue Shield HMO is required for more than two Out-of-Area Follow-up Care outpatient visits. Blue Shield HMO may direct the patient to receive the additional follow-up services from the PCP. If services are not received from a Blue Shield of California Plan Provider, you may be required to pay the provider for the entire cost of the service and submit a claim to Blue Shield HMO. Claims for Urgent Services obtained outside of your PCP Service Area within California will be reviewed retrospectively for coverage. When you receive covered Urgent Services outside your PCP Service Area within California, the amount you pay, if not subject to a flat dollar copayment, is calculated based upon Blue Shield's Allowed Charges.

Long-Term Out-of-Area Care

The County's HMO plans offer coverage in select states for members that either reside or travel outside the state of California for an extended period of time. Students, long-term travelers, and families living apart can rely on access to routine care, urgent care, and emergency services in select states with the Away From Home Care® program. Note that a 30-day notification is required prior to participation in the Away From Home Care® program. You may call **800-622-9402** to coordinate use of this benefit or for more information about availability and state-specific coverage.

Coverage while traveling outside California or the United States

BLUECARD® PROGRAM: Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs. When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/ or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. Please obtain full details on the BlueCard® Program from the current Blue Shield EOC or by calling Blue Shield's Customer Service at **855-256-9404**. To find a provider in the United States, visit **provider.bcbs.com**, or call **800-810-2583**. To find a provider outside the country, visit **bcbsglobalcore.com**, or call **804-673-1177** collect.

Medical Transition of Care Benefit

As a new member, you are entitled to a medical review that may allow you to continue your current treatment plan due to a specific diagnosis for a specified time frame with your prior provider. Some examples of circumstances for you or a family member are:

- You are scheduled for surgery within 3 weeks after your effective date of coverage.
- You have documented follow-up care for surgery that was completed within 6 weeks prior to your effective date of coverage.
- You have complications resulting from surgery performed within the month prior to your effective date of coverage.
- You are presently undergoing a course of chemotherapy or radiation therapy.
- You are approved for or on a waiting list for a transplant.
- You have an acute or serious chronic condition.
- You are currently receiving outpatient mental health treatment or you are currently in a chemical dependency treatment program.

If you have a transition of care issue, please contact Blue Shield's Customer Service at **855-829-3566** for non-Medicare plan members and **800-776-4466** for Medicare plan

members and ask for assistance with transition of care. Blue Shield will assign you a case manager to guide and assist you with your specific transition of care needs.

Teladoc

Teladoc provides board-certified doctors and pediatricians and mental health professionals that you can speak with 24/7 by phone or video at no extra cost. These doctors can treat nonemergency medical and behavioral health issues and prescribe medications when needed. Before you can use Teladoc, you'll need to register and complete your medical history. This gives Teladoc doctors the information they need to make an accurate diagnosis. You can set up your Teladoc account at **teladoc.com/bsc**.

Contacting Blue Shield

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

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

If you need information, call Blue Shield at **855-829-3566**, or go to Blue Shield's website at **www.blueshieldca.com**.

Kaiser Permanente HMO (Non-Medicare Retirees)

The Kaiser Permanente Plan is a health maintenance organization (HMO). The benefits listed in this Guide are for retirees and their eligible dependents living within the Kaiser Permanente zip code service areas of California. If you would like to determine if your zip code* is eligible for enrollment or if you would like a Kaiser Permanente Member Handbook, please call Employee Benefits at **909-387-5787.**



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

How the Plan Works

Kaiser Permanente offers three benefit plans for Non-Medicare retirees: HMO High Option, HMO Low Option and a High Deductible HSA Option.

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente facilities. You have access to virtually full-service, unlimited medical care. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers.

The County has contracted to cover durable medical equipment. See the durable medical equipment insert located in your Kaiser Permanente materials for specific benefit information.

What's Covered and Not Covered

Refer to the Medical Plans Comparison Chart on pages 38–73 of this Guide for a list of key covered expenses. Refer to the Kaiser Permanente Evidence of Coverage (EOC) for information about what is not covered under your plan.

Please see your evidence of coverage for more details on your coverage and benefits. You can access the Kaiser HMO EOCs on the County website **link.sbcounty.gov/Retiree-Benefits**.

Out-of-Area Care

If you need medical care and cannot get to a Kaiser Permanente facility, or if you have any questions regarding our Care Away from Home, please contact (951)268-3900 or kp.org/travel.

Claim Forms

No claim form filing is required; however, you may have to file claim forms for out-of-area urgent or emergency care.



Kaiser Permanente HMO High Deductible Health Plan (HDHP)

What is the HDHP HMO Plan?

With this plan, you'll need to pay the full cost for most covered services until you reach a set amount known as your deductible. After you reach your deductible, you'll start paying less for the rest of the year—just a copay or a coinsurance (which is a percentage of the total cost). And most preventive care services (like routine physical exams, mammograms, and cholesterol screenings) are covered at no cost or just a copay—even before you reach your deductible.

Also, with this plan, if eligible, you can set up an individual health savings account (HSA) with your banking institution. You will not have to pay federal taxes on the money in this account and you can access these funds anytime to pay for care—including copays, coinsurances, and deductible payments.

How do deductible plans work?

With a deductible plan, you get all the quality care and resources people expect from Kaiser Permanente. The main difference is how you pay for care.

- You'll need to pay the full cost for covered services until you reach a set amount known as your deductible. For example, a $1,500 deductible means you'll pay the full cost of your care and services up to $1,500.
- After you reach your deductible, you'll start paying less for the rest of the year — just a copay or a coinsurance.
- Most preventive care services are covered at no cost or just a copay, even before you reach your deductible.

Your plan also has an out-of-pocket maximum that helps limit how much you'll pay for care. If you reach it, you won't have to pay for covered services for the rest of the year. This can help protect you financially if you ever have a serious illness or injury.

- Payments for most covered services count toward your out-of-pocket maximum.
- Copays and coinsurances don't count towards your deductible, but they do help you reach your out-of-pocket maximum.
- After you reach your out-of-pocket maximum, Kaiser Permanente will pay for all covered services for the rest of the year.
- For more information, visit **kp.org/deductibleplans**

Kaiser Permanente Senior Advantage HMO, Group Plans (Medicare-eligible Retirees)

Kaiser Permanente's Senior Advantage plan combines your Medicare coverage with Kaiser Permanente's 70 years of health care experience, quality, and convenience.

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

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

Additional Kaiser Member Services

Helpful Information for New Members

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

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

For Southern California members, contact the New Member Entry Department, toll free, Monday through Friday from 7am to 7pm. Kaiser non-Medicare members call **888-956-1616** and Kaiser Medicare members call **800-443-0815**.

Online Services

Wherever they go, members can access **www.kp.org** to:

- E-mail their doctor's office or pharmacy
- Schedule, view and cancel appointments
- Order prescription refills
- Use valuable online health calculators, information, and resources

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

With a single click, members can check immunization records, details of past office visits, vital signs, certain test results, and diagnosed health conditions. By utilizing Kaiser's online services, staying connected to your health is now quick, easy and convenient.

Emergency Care

If you think you have an emergency medical condition and cannot safely go to a plan hospital, call 911 or go to the nearest hospital. Kaiser Permanente covers emergency care from providers anywhere in the world. Please see your Evidence Of Coverage (EOC) for more details on your coverage and benefits. You can access the Kaiser HMO EOCs on the County website at **link.sbcounty.gov/Retiree-Benefits**.

Telemedicine

Members can request a telephone or video appointment and have prescriptions sent to the pharmacy for minor health conditions such as allergies, colds, coughs and even some follow-up appointments. Usually scheduled phone and video visits cost less than in-person visits. However, costs for services will vary depending on the Kaiser medical plan you are enrolled in. Please see your Evidence Of Coverage (EOC) for more details on your coverage and benefits. For more information about phone and video visits or to schedule an appointment call us at **833-KP4CARE (833-574-2273)** or **711** (TTY), Monday through Friday, 7a.m. to 7p.m. You can also schedule some appointments online at **kp.org/getcare** or with the Kaiser Permanente mobile app.

Continuity of Care Program

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

Contacting Kaiser

You can email your doctor's office with nonurgent questions anytime or call a licensed care provider day or night for advice, referrals, prescription requests, and more—all at no cost.

If you have any questions or need information, call Kaiser Permanente's Member Service Contact Center at **800-464-4000**, 24 hours a day, 7 days a week (closed holidays). For TTY, call **711**. You can also visit Kaiser Permanente's website at: **my.kp.org/sbcounty**.

Medicare Prescription Drug Coverage — Important Notice

2027 Certificate of Creditable Medicare Prescription Drug Coverage

San Bernardino County has determined that the prescription drug coverage offered by the County's Retiree Health Plan Participants is, on average expected to pay out as much as standard Medicare prescription drug coverage will pay in 2027 and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium if you later decide to join a Medicare prescription drug plan.

If you have any questions about this benefit, please call Employee Benefits at **909-387-5787**. You will be informed should any County plan ever lose creditable coverage status.

Medicare Integrated Plans — Important Information

A Medicare integrated plan combines your Medicare coverage with the benefits of an insured medical plan. All County integrated plans incorporate Medicare Part D pharmacy benefits at no additional cost. In order to enroll in a Medicare integrated plan, you must be enrolled in Medicare Parts A and B. When you enroll in a Medicare integrated plan, you assign your Medicare A and benefits to the medical plan that includes Part D. You must pay the Medicare Part B premium. As such, you do not need to enroll in a separate Medicare Part D pharmacy plan and most members do not pay a separate Part D premium. However, if your income is above a certain limit ($106,000 if you file individually or $212,000 if you're married and file jointly), you may have to pay a Part D Income Related Monthly Adjustment Amount (IRMAA) paid directly to the federal government, in addition to your Medicare integrated plan premiums under the County.

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

Your Medicare benefits will not be available to you outside the Medicare integrated plan network except for emergency and urgent care. As a County retiree or eligible dependent, you have four County-sponsored Medicare integrated plans available to you:

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

Conditions

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

- You must utilize the plan's Medicare Part D formulary for all of your prescription needs.
- You must meet these eligibility requirements:
  - You have Medicare Parts A and B
  - You live in the medical plan's service area
  - You are not in a hospice program

It is important to evaluate your benefit needs and the different Medicare integrated plans each year. If you move out of the service area of your medical plan, you must "disenroll" from the Medicare integrated plan. To disenroll from a Medicare integrated plan, contact Employee Benefits at **909-387-5787**. Please note that dis-enrollments from County sponsored plans and enrollments in other plans may be delayed due to the Center for Medicare & Medicaid Services (CMS) final eligibility determination and processing of your request.

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

For answers to questions regarding Medicare, please contact:

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



Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Allergy Testing	$10 copay	$30 copay	No charge	$80 copay	$0 copay
Ambulance	No charge if medically necessary	Refer to Level 1 benefit	$300 per transport	Refer to Level 1 benefit	$250 per transport
Chiropractic	Not covered	Not covered	Not covered	Not covered	Not covered
Choice of Providers	Signature Level I HMO Plan Providers	Signature Level II Preferred Providers	Signature Level I HMO Plan Providers	Signature Level I Preferred Providers	TRIO Network Only

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$20 copay	20% coinsurance after plan deductible	20% coinsurance– CY deductible waived	40% coinsurance after CY deductible Allergy Testing & Allergy Serum	30% coinsurance Allergy Testing & Allergy Serum deductible waived for testing & serum	50% coinsurance Allergy Testing & Allergy Serum
No charge if medically necessary	$150 per trip after deductible	20% coinsurance after plan deductible	20% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance
Not covered	Not covered	Not covered	20% coinsurance CY, preferred and non-pref providers combined	40% up to 30 visits per CY, preferred and non-pref providers combined	$25 copay per visit	50% coinsurance
Kaiser Permanente Providers only	Kaiser Permanente Providers only	Kaiser Permanente Providers only	Preferred Providers Out of state – Blue Card	Non Preferred Providers	Preferred Providers Out of state – Blue Card	Non Preferred Providers

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	**Level 1**	**Level 2**	**Level 1**	**Level 2**	**Trio Network**
Deductibles: Calendar Year	None	None	None	None	None
Hospital / Ambulatory Surgical	No Charge	No Charge	No Charge	No Charge	No Charge
Prior Authorization	All services require prior authorization and/or referral by your Personal Physician or the same IPA/Medical Group as the Personal Physician HMO				
Diagnostic X-Ray/Lab	No charge	No charge in Physician's Office only Not covered: MRI, MUGA, PET, SPECT	No charge	No charge in Physician's Office only Not covered: MRI, MUGA, PET, SPECT	No charge

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
None	$500 per member/ $1,000 per family	$1,700 per member/ $3,400 per family	$500 per member/$1,000 per family, combined In-Network & Out-of-Network		$1,500 per member/No Family Maximum, combined In-Network & Out-of-Network	
No Charge	20% coinsurance after plan deductible	20% coinsurance after plan deductible	$250 per admission copay semiprivate room or ICU	40% coinsurance	$500 per admission copay semiprivate room or ICU	50% coinsurance Outpatient & Inpatient hospital/ Ambulatory Surgical Center
N/A	N/A	N/A	Prior Authorization required for selected inpatient admissions and outpatient services		Prior Authorization required for selected inpatient admissions and outpatient services	
No charge	$10 per encounter after deductible ($50 per MRI, CT, PET after deductible)	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	**Level 1**	**Level 2**	**Level 1**	**Level 2**	**Trio Network**
Durable Medical Equipment	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge
Emergency Room	$50 copay for facility; No charge for Professional Services Copay waived if admitted	Refer to Level 1 benefit	$250 copay for facility; No charge for Professional Services Copay waived if admitted	$250 copay for facility; No charge for Professional Services Copay waived if admitted	$250 copay for facility; No charge for Professional Services Copay waived if admitted
Home Health Services	No charge Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits/day, 2 hrs/visit (8 hrs total) up to 100 visits per CY	Refer to Level 1 benefit	$50 copay Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits per day, 2 hours per visit (8 hours total) up to the visit limit per calendar year	Refer to Level 1 benefit	$50 copay Intermittent and part-time home visits by a home health care agency to provide skilled services up to 4 visits per day, 2 hours per visit (8 hours total) up to the visit limit per calendar year

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge	20% coinsurance No deductible	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$50 copay Waived if admitted	20% coinsurance after deductible	20% coinsurance after plan deductible	Facility: $100/visit + 20% Professional Services: 20% Covered the same PPO/OON if not admitted, if admitted follows PPO inpatient hospital benefits		Facility: $100/visit + 30% Applies to both Facility & Professional Services. Waived if admitted	
No charge if medically necessary Limit of 100 visits per CY	No charge if medically necessary Limit of 100 visits per CY	No charge after plan deductible	20% coinsurance	Must be pre-authorized. When these services are pre-authorized, In-Network copayment is applicable	30% coinsurance	Must be preauthorized When these services are preauthorized, In-Network copayment is applicable

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Hospice	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge
Hospital (Facility)	No charge	Refer to Level 1 benefit	Inpatient Hospital: $1,000 per admission	Refer to Level 1 benefit	Inpatient Hospital: $1,000 per admission
Mental Health and Substance Abuse Disorders Inpatient Hospital Services	No charge	Refer to Level 1 benefit	$1,000 per admission	Refer to Level 1 benefit	$1,000 per admission

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge	No charge	No charge	24-hour continuous home care: 20% coinsurance General respite care: 20% coinsurance Routine home care: No charge In-patient respite care: No charge	Must be preauthorized When these services are preauthorized, In-Network copayment is applicable	24-hour continuous home care: 30% coinsurance General respite care: 30% coinsurance Routine home care: No charge In-patient respite care: No charge	Must be preauthorized When these services are preauthorized, In-Network copayment is applicable
No charge	20% coinsurance after plan deductible	20% coinsurance after plan deductible	$250 hospital deductible per confinement + 20%	40% coinsurance	$500 hospital deductible per confinement + 20% coinsurance	50% coinsurance
No charge	20% co-insurance after deductible	20% coinsurance after plan deductible	$250 per admission + 20% coinsurance	40% coinsurance	$500 per admission + 20% coinsurance	50% coinsurance

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	**Level 1**	**Level 2**	**Level 1**	**Level 2**	**Trio Network**
Residential Care	No charge	Refer to Level 1 benefit	$1,000 per admission	Refer to Level 1 benefit	$1,000 per admission
Physician Inpatient Services	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge
Office Visit	No charge up to 3 visits. $10 per visit thereafter	No charge up to 3 visits. $10 per visit thereafter	No charge up to 3 visits. $30 per visit thereafter	No charge up to 3 visits. $30 per visit thereafter	$50/visit
Out-of-Pocket Maximum	$1,500 per member $3,000 per family	None	$3,000 Per member $6,000 Two members $9,000 Three or more members	None	$3,000 Per member $6,000 Two members $9,000 Three or more members
Outpatient Services Chemotherapy (Professional)	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge
Renal Dialysis (Professional)	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge	20% coinsurance subject to the plan deductible	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	20% coinsurance	50% coinsurance
No charge	20% co-insurance after deductible	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$10 copay individual / $5 group copay	$20 copay individual / $10 group copay	20% coinsurance after plan deductible	No charge up to 3 visits. 20% per visit thereafter	40% coinsurance	No charge up to 3 visits. 30% per visit thereafter	50% coinsurance
$1,500 per member $3,000 per family	$3,000 per member $6,000 per family	$4,100 per member $8,200 per family	$2,500 per member PPO $5,000 per family PPO	$5,000 each member OON $10,000 family OON	$6,000 each member PPO No family maximum	$10,000 per member
$10 copay	20% co-insurance after deductible	No charge after plan deductible	20% Professional Services	40% Professional Services	30% Professional Services	50% Professional Services
$10 copay	$20 copay	No charge after plan deductible	20% Professional Services	40% Professional Services	30% Professional Services	50% coinsurance

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Outpatient Surgery (Facility)	No charge	Refer to Level 1 benefit	$750 copay per surgery performed at outpatient hospital facility or ambulatory surgical center $50 copay when performed in PCP office visit	Refer to Level 1 benefit	$750 copay per surgery performed at outpatient hospital facility or ambulatory surgical center
Physician Services Hearing Screening	No charge (preventive care)	$30 copay	No charge (preventive care)	$80 copay	No charge (preventive care)
Home Visits	$10 copay	Refer to Level 1 benefit	$50 copay	Refer to Level 1 benefit	$50 copay
Hospital Services	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	20% coinsurance after deductible	20% coinsurance after plan deductible	$250 deductible + 20% coinsurance	40% coinsurance	Ambulatory Surgery: 20% coinsurance Outpatient Hospital: $250 per surgery + 20% coinsurance	50% coinsurance
$10 copay	$20 copay	No charge (preventive care) 20% coinsurance after plan deductible	No charge	40% coinsurance	No charge	50% coinsurance
$0 copay if medically necessary	$0 copay if medically necessary	$0 copay if medically necessary	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge	20% coinsurance after deductible	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Immunizations	Immunizations: No charge – part of preventive care office visit; Other: $10 copay per prescription	$30 copay.	Immunizations: No charge – part of preventive care office visit. Other: $50 copay per prescription	$80 copay – Applies to allergy testing; office based Injectable meds per dose No charge – applies to allergy serum; allergy injection svcs; immunizations for occupational or foreign travel and other immunizations; Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency See Pharmacy benefits	Immunizations: No charge – part of preventive care office visit in accordance with immunization schedule Other: $50 copay per prescription

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
No charge Includes allergy serum and injection services during office visits	No charge Includes allergy serum and injection services during office visits No deductible	No charge Allergy injections (including allergy serum)	Covered under Preventative Care; Injections covered at 20% co-insurance; Immunizations for Foreign Travel are not covered See Pharmacy benefits	Covered under Preventative Care; Injections covered at 40% coinsurance; Immunizations for Foreign Travel are not covered Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency See Pharmacy benefits	Covered under Preventative Care; Injections covered at 20% coinsurance; Immunizations for Foreign Travel are not covered See Pharmacy benefits	Covered under Preventative Care; Injections covered at 40% coinsurance; Immunizations for Foreign Travel are not covered See Pharmacy benefits

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Office Visits	$10 copay	$30 copay	$50 copay	$80 copay	$50 copay
Preventive Care	No charge	$30 copay	No charge	$80 copay	No charge
Specialists	$10 copay	$30 copay	$70 copay	$80 copay	$50 with referral, $55 if self-referred
Surgical Services (Physician's Office)	No charge	No charge	No charge	No charge	No charge
Telemedicine Appointments	No charge	No charge	No charge	No charge	No charge
Well Baby/ Well Child	No charge (preventive care)	$30 copay	No charge (preventive care)	$80 copay	No charge (preventive care)
Well Woman Exam (Annual)	No charge (preventive care)	$30 copay	No charge (preventive care)	$80 copay	No charge (preventive care)

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$20 copay	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge	No charge	No charge	No charge	40% coinsurance	No charge	50% coinsurance
$10 copay	$20 copay	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
$10 copay	20% coinsurance after deductible	20% coinsurance after plan deductible	20% coinsurance	40% coinsurance	30% coinsurance	50% coinsurance
No charge	No charge	No charge after plan deductible	No charge	No charge	No charge	No charge
No charge (0–23 months)	No charge (0–23 months)	No charge (0–23 months)	No charge (preventive care)	40% coinsurance	No charge (preventive care)	50% coinsurance
No charge	No charge	No charge	No charge (preventive care)	40% coinsurance	No charge (preventive care)	50% coinsurance

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	**Level 1**	**Level 2**	**Level 1**	**Level 2**	**Trio Network**
Physical and Occupational Therapy	$10 per visit applies to physical, speech, occupational and respiratory therapy when performed in an outpatient or office visit setting	$30 copay; up to 12 visits per CY year when Medically Necessary	$40 per visit applies to physical, speech, occupational and respiratory therapy when performed in an outpatient or office visit setting	$80 copay; up to 12 visits per CY office visit only when Medically necessary	$40 per visit applies to physical, speech, occupational and respiratory therapy when performed in an outpatient or office visit setting
Pre-Existing Conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions	No exclusion for pre-existing conditions
Prescription Drug – Retail	Up to 30-day supply	Refer to Level 1 benefit	Up to 30-day supply	Refer to Level 1 benefit	Up to 30-day supply
Generic	$5 copay	Refer to Level 1 benefit	$10 copay	Refer to Level 1 benefit	Tier 1 – $10 copay
Brand Formulary	$10 copay	Refer to Level 1 benefit	$30 copay	Refer to Level 1 benefit	Tier 2 – $30

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

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

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	**Level 1**	**Level 2**	**Level 1**	**Level 2**	**Trio Network**
Prescription Drug – Non-Formulary	$25 copay	Refer to Level 1 benefit	$50 copay	Refer to Level 1 benefit	Tier 3 – $50
Lancets	No charge	Refer to Level 1 benefit	No charge	Refer to Level 1 benefit	No charge
Specialty Drugs	Blue Shield's formulary applies. Specialty drugs are covered when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs obtained from a Non-Specialty Pharmacy Network are not covered, unless Medically Necessary for a covered emergency.				
	30 days supply applicable retail copay applies	Refer to Level 1 benefit	30 days supply applicable retail copay applies	Refer to Level 1 benefit	$50 – Tier 4
Prescription Drug – Mail Order	Up to 90-day supply	Refer to Level 1 benefit	Up to 90-day supply	Refer to Level 1 benefit	Up to 90-day supply

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

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	**Level 1**	**Level 2**	**Level 1**	**Level 2**	**Trio Network**
Prescription Drug Generic	$10 copay	Refer to Level 1 benefit	$20 copay	Refer to Level 1 benefit	$20 – Tier 1
Brand Formulary	$20 copay	Refer to Level 1 benefit	$60 copay	Refer to Level 1 benefit	$60 – Tier 2
Non-Formulary	$50 copay	Refer to Level 1 benefit	$100 copay	Refer to Level 1 benefit	$100 – Tier 3
Skilled Nursing Facility	No charge Limited to 100 days per CY	Refer to Level 1 benefit	$1,000 per confinement Limited to 100 days per CY	Refer to Level 1 benefit	$400 per confinement Limited to 100 days per CY

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$10 copay No deductible	$10 after plan deductible	$20 copay	Not covered	$20 copay	Not covered
$15 copay	$30 copay after $100 deductible	$30 after plan deductible	$50 copay	Not covered	$50 copay	Not covered
$15 copay when prescribed by a plan physician in accordance with formulary guidelines	$30 copay when prescribed by a plan physician in accordance with formulary guidelines	$30 after plan deductible when prescribed by a plan physician in accordance with formulary guidelines	$70 copay	Not covered	$70 copay	Not covered
No charge up to 100 days per benefit period	20% coinsurance after deductible up to 100 days per benefit period	20% coinsurance after plan deductible up to 100 days per benefit period	Freestanding Nursing Facility: 20% coinsurance Hospital Unit Skilled Nursing: 20% coinsurance Limit of 100 days per CY combined In & Out of Network	Freestanding Facility: 20% coinsurance w/ prior authorization Hospital Unit Skilled Nursing: 40% Limit of 100 days per CY combined on In & Out of Network	Freestanding Nursing Facility: 20% coinsurance Hospital Unit Skilled Nursing: 20% coinsurance Limit of 100 days per CY combined In & Out of Network	Freestanding Facility: 20% coinsurance w/ prior authorization Hospital Unit Skilled Nursing: 50% Limit of 100 days per CY combined on In & Out of Network

Medical Plans Comparison Chart (Non Medicare Eligible)

CY = Calendar Year

OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Speech Therapy	$10 per visit copayment for office setting. When medically necessary. Inpatient and outpatient services : No charge	$30 copay Up to 12 visits per CY when medically necessary. Office visit only.	$40 per visit copayment for office setting. When medically necessary. Inpatient and outpatient services : No charge	$80 copay Up to 12 visits per CY when medically necessary. Office Visit Only.	$40 per visit
Urgent Care (Facility)	$10 copay	$10 copay	$10 copay	Refer to Level 1 benefit	$50 copay

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
$10 copay	$20 copay after deductible	20% Coinsurance after Plan Deductible	20% coinsurance	Speech Therapy provided by a speech therapist will be 20% coinsurance (same as in-network) Speech therapy by any other provider than a speech therapist 40% coinsurance	30% coinsurance	Speech Therapy provided by a speech therapist will be 30% coinsurance (same as in-network) Speech therapy by any other provider than a speech therapist 50% coinsurance
$10 copay	$20 copay	20% coinsurance after plan deductible	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.	See applicable benefit (services covered at applicable benefit copay) Out-of-state emergency, non-emergency care and urgent care utilized through BlueCard Program.

Medical Plans Comparison Chart (Non Medicare Eligible)

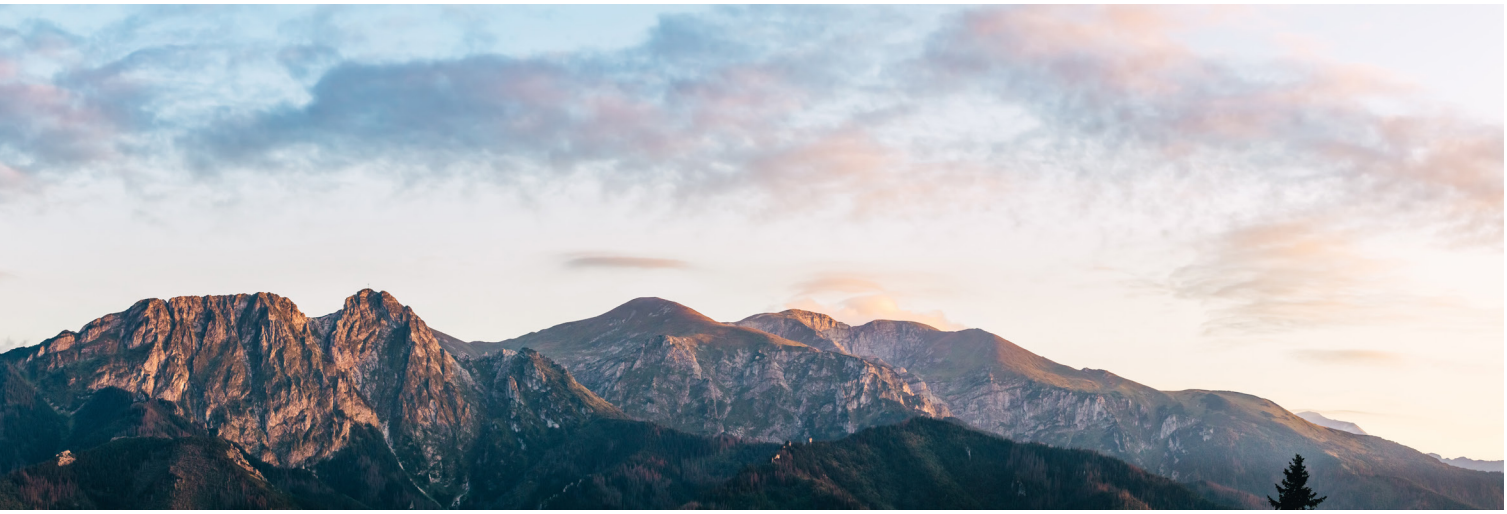
CY = Calendar Year OON = Out-of-Network

	BLUE SHIELD SIGNATURE HMO				
	High Option		Low Option		Trio Option
Services	Level 1	Level 2	Level 1	Level 2	Trio Network
Vision Exams	$10 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	For visits to non-participating providers, the maximum per member per calendar year reimbursement is $60 for an ophthalmologic exam and $50 for an optometric exam	$10 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	For visits to non-participating providers, the maximum per member per calendar year reimbursement is $60 for an ophthalmologic exam and $50 for an optometric exam	Not covered



Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

KAISER PERMANENTE			BLUE SHIELD PPO & MEDICARE COB PPO HIGH OPTION		BLUE SHIELD PPO LOW OPTION	
High Option	**Low Option**	**High Deductible Health Plan Option**	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount	**In-Network**	**Out-of-Network** Member pays coinsurance plus charges over max allowable amount
Routine eye exam with a plan optom-etrist – No charge	Routine eye exam with a plan optometrist – No charge	10% coinsurance	$10 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	Reimbursed at rate of $50 for ophthal-mologic and $60 for optometric exam (one visit [no age limit] every 12 months).	$10 per visit for services provided by contracted vision provider (one visit [no age limit] every 12 months)	Reimbursed at rate of $50 for ophthal-mologic and $60 for optometric exam (one visit [no age limit] every 12 months)



Medical Plans Comparison Chart (Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	KAISER PERMANENTE SENIOR ADVANTAGE PLAN	
Services	**High Option**	**Low Option**
Allergy Testing	No charge	No charge
Ambulance	No charge	$50 per trip
Chiropractic	$10 copay under ASH plan provider, no referral necessary	$20 copay under ASH plan provider, no referral necessary
Choice of Providers	Kaiser Permanente Providers only	Kaiser Permanente Providers only
Deductibles Calendar Year	None	None
Hospital/Ambulatory Surgical	None	$500 per admit
Non-Certification	None	None
Diagnostic X-Ray/Lab	No charge. Certain procedures subject to $10 copay	No charge. Certain procedures subject to $25 copay
Durable Medical Equipment	No charge	20% coinsurance
Emergency Room	$50 copay. Waived if admitted	$50 copay. Waived if admitted
Home Health Services	No charge	No charge
Hospice	Coverage from Medicare	Coverage from Medicare
Hospital	No charge	$500 per admit
Mental Health Inpatient	No charge Unlimited days	$500 per admit Unlimited days

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

BLUE SHIELD 65 PLUS (HMO) MEDICARE ADVANTAGE	
High Option	**Low Option**
No charge	No charge
No charge for emergency or non-emergency transportation. Non-emergency transportation requires a PCP referral and medical group approval before services are rendered.	$125 copay for emergency and non-emergency transportation. Non-emergency transportation requires a PCP referral and medical group approval before services are rendered.
$10 copay Limited to the Medicare Allowed Benefit	No charge Limited to the Medicare Allowed Benefit
Blue Shield Providers	Blue Shield Providers
None	None
None	None
All services require prior authorization and/or referral by the Physician	All services require prior authorization and/or referral by the Physician
No charge	$0 to $250 based on Medicare Allowable Cost (X-ray no charge)
No charge	20% coinsurance
$20 copay. Waived if admitted	$50 Facility and Professional Services. Waived if admitted
No charge	No charge
Reimbursed directly by Medicare when enrolled in a Medicare-certified hospice	Reimbursed directly by Medicare when enrolled in a Medicare-certified hospice
No charge	No charge
No charge for days 1–150 per admission	No charge for days 1–150 per admission

Medical Plans Comparison Chart (Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	KAISER PERMANENTE SENIOR ADVANTAGE PLAN	
Services	**High Option**	**Low Option**
Mental Health Outpatient	$10 copay for individual; $5 copay group; unlimited visits	$25 copay individual; $12 copay group; unlimited visits
Out-Of-Pocket Maximum	$1,000 per Member	$1,000 per Member
Outpatient Services Chemotherapy (Professional)	No charge	No charge
Renal Dialysis (Professional)	No charge	No charge
Outpatient Surgery (Facility)	$10 copay per procedure	$25 copay per procedure
Physician Services Hearing Screening	$10 copay	$25 copay
Home Visits	$0 copay if medically necessary	$0 copay if medically necessary
Hospital Services	No charge	No charge
Immunizations/ Injections	No charge; includes allergy serum and injection services during office visits	No charge; includes allergy serum and injection services during office visits
Office Visits	$10 copay	$25 copay
Podiatry	$10 copay	$25 copay
Routine Physicals	No charge	No charge
Specialists	$10 copay	$25 copay
Surgical Services (Physician's Office)	$10 copay	$25 copay

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

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

Medical Plans Comparison Chart (Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

	KAISER PERMANENTE SENIOR ADVANTAGE PLAN	
Services	**High Option**	**Low Option**
Physical and Occupational Therapy	$10 copay	$25 copay
Pre-Existing Conditions	End Stage Renal Disease (ESRD)	End Stage Renal Disease (ESRD)
Prescription Drug - Retail Generic	Up to 100-day supply $10 copay	Up to 30-day supply $10 copay
Brand Formulary	$20 copay	$25 copay
Non-Formulary	$20 copay when prescribed by a plan physician in accordance with formulary guidelines	$25 copay when prescribed by a plan physician in accordance with formulary guidelines
Specialty Drugs	30-day supply - 20% up to $100 max	30-day supply - 20% up to $100 max
Injectable Drugs	See applicable prescription drug copay	See applicable prescription drug copay
Prescription Drug – Mail Order Generic	Up to 100-day supply $10 copay	Up to 100-day supply $20 copay
Brand Formulary	$20 copay	$50 copay

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

BLUE SHIELD 65 PLUS (HMO) MEDICARE ADVANTAGE	
High Option	**Low Option**
No charge	No charge
End Stage Renal Disease (ESRD)	End Stage Renal Disease (ESRD)
Up to 30-day supply Retail 30-day, Preferred PPO pharm $10 Retail 90-day, Preferred PPO pharm $20 Retail 90-day, Other PPO pharm $30 Long-term care, 34 day supply $10	Up to 30-day supply Retail 30-day, Preferred PPO pharm $10 Retail 90-day, Preferred PPO pharm $20 Retail 90-day, Other PPO pharm $30 Long-term care, 34 day supply $10
Retail 30-day, Preferred PPO pharm $20 Retail 90-day, Preferred PPO pharm $40 Retail 90-day, Other PPO pharm $60 Long-term care, 34 day supply $20	Retail 30-day, Preferred PPO pharm $30 Retail 90-day, Preferred PPO pharm $60 Retail 90-day, Other PPO pharm $90 Long-term care, 34 day supply $30
Retail 30-days, Preferred PPO pharm $40 Retail 90-day, Preferred PPO pharm $80 Retail 90-day, Other PPO pharm $120 Long-term care, 34 day supply, $40	Retail 30-days, Preferred PPO pharm $60 Retail 90-day, Preferred PPO pharm $120 Retail 90-day, Other PPO pharm $180 Long-term care, 34 day supply, $60
Retail 30-day supply/Preferred PPO or Other PPO pharmacy, 20% up to $100 max Retail 90-day supply/Preferred or Other PPO or Non-PPO pharmacy, 20% up to $300 max	Retail 30-day supply/Preferred or Other PPO pharmacy, 20% up to $100 max Retail 90-day supply/Preferred or Other PPO pharmacy, 20% up to $300 max Mail-Order 90-day supply, 20% up to $300 max
Retail 30-day supply/Preferred PPO or Other PPO pharmacy, 20% up to $100 max Retail 90-day supply/Preferred or Other PPO or Non-PPO pharmacy, 20% up to $300 max	Retail 30-day supply/Preferred or Other PPO pharmacy, 20% up to $100 max Retail 90-day supply/Preferred or Other PPO pharmacy, 20% up to $300 max Mail-Order 90-day supply, 20% up to $300 max
Up to 90-day supply $20 copay	Up to 90-day supply $20 copay
$40 copay	$60 copay

Medical Plans Comparison Chart (Medicare Eligible)

CY = Calendar Year OON = Out-of-Network

Services	KAISER PERMANENTE SENIOR ADVANTAGE PLAN	
	High Option	Low Option
Prescription Drug – Mail Order Non-Formulary	$20 copay when prescribed by a plan physician in accordance with formulary guidelines	$25 copay when prescribed by a plan physician in accordance with formulary guidelines
Specialty Drugs	20% coinsurance (not to exceed $100) for up to a 100-day supply	20% coinsurance (not to exceed $100) for up to a 100-day supply
Injectable Drugs	No charge	No charge
Catastrophic Coverage Limit	See EOC	See EOC
Skilled Nursing Facility	No charge up to 100 days per benefit period	No charge up to 100 days per benefit period
Speech Therapy	$10 copay	$25 copay
Substance Use Disorder Rehab – Inpatient	No charge	$500 per admit in plan hospital $100 per admit for non-medical transitional residential recovery setting. Unlimited days
Rehab – Outpatient	$10 copay individual $5 copay group	$25 copay individual; $5 copay group
Detox – Inpatient	No charge	$500 per admit in plan hospital $100 per admit for non-medical transitional residential recovery setting. Unlimited days
Detox – Outpatient (consultation, therapy, counseling)	$10 copay individual $5 copay group	$25 copay individual; $5 copay group
Telemedicine Appointments	No charge	No charge
Urgent Care (Facility)	$10 copay	$25 copay

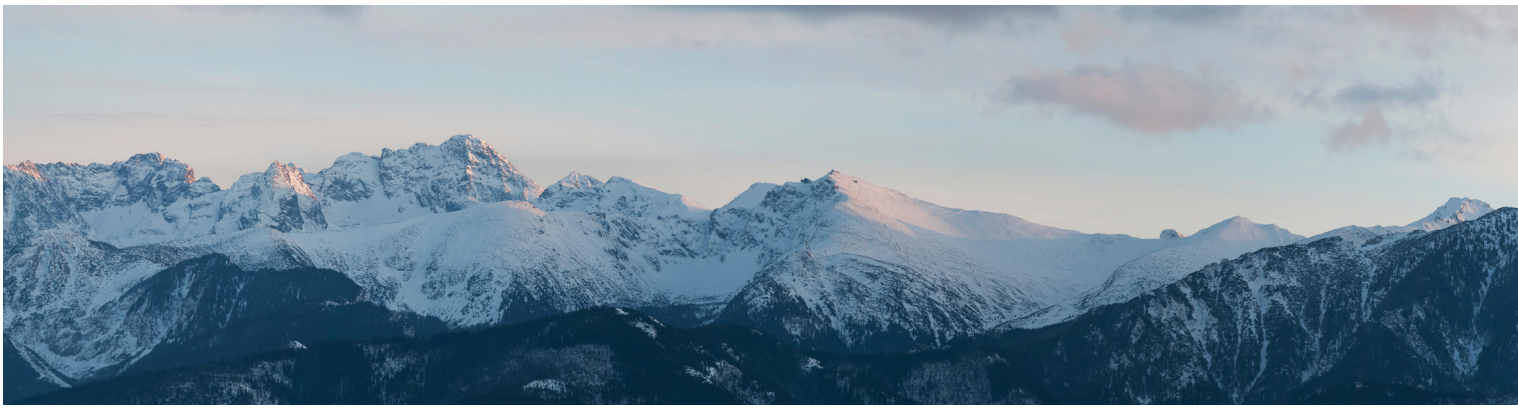
Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

BLUE SHIELD 65 PLUS (HMO) MEDICARE ADVANTAGE	
High Option	**Low Option**
$80 copay	$120 copay
20% up to $300 max	20% up to $300 max
20% up to $300 max	20% up to $300 max
Once out-of-pocket expenses for a CY reach $4,550, payment is limited to the lesser of 5% or applicable copay for the drug	Once out-of-pocket expenses for a CY reach $4,550, payment is limited to the lesser of 5% or applicable copay for the drug
No charge up to 100 days per benefit period	Days 1-20, no charge (limited to 100 days per benefit period). Days 21-100, $75 per day
No charge	No charge
Refer to Mental Health	Refer to Mental Health
Refer to Mental Health	Refer to Mental Health
N/A	N/A
$20 copay waived if admitted	$10 copay waived if admitted

Medical Plans Comparison Chart (Medicare Eligible)

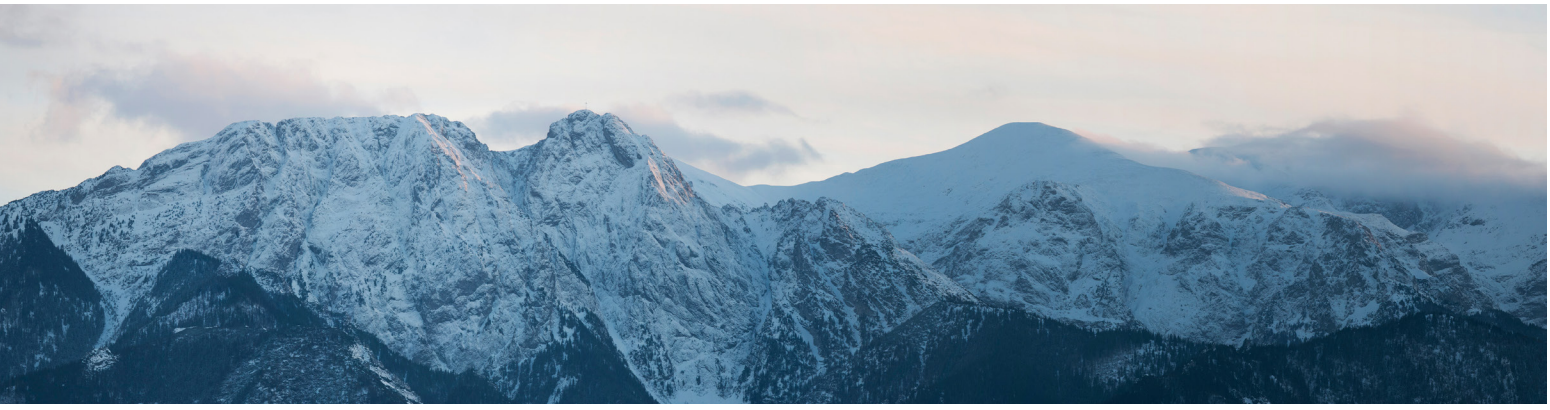
CY = Calendar Year OON = Out-of-Network

	KAISER PERMANENTE SENIOR ADVANTAGE PLAN	
Services	**High Option**	**Low Option**
Vision Exams	$10 copay. Includes eyewear (purchased at plan offices) allowance of $150 every 24 months.	$10 copay. Includes eyewear (purchased at plan offices) allowance of $150 every 24 months.
Other Benefits Bone Mass Measurements	No charge if medically necessary and approved by a plan physician	No charge if medically necessary and approved by a plan physician
Diabetes self-monitoring training and supplies	Insulin & Syringes: covered same as other prescriptions; chem. strips & lancets 100% covered in accordance with DME formulary guidelines.	Insulin & Syringes: covered same as other prescriptions; chem. strips & lancets 100% covered in accordance with DME formulary guidelines
Fitness	Contact Kaiser Permanente for more information on their Healthy Lifestyle Programs	Contact Kaiser Permanente for more information on their Healthy Lifestyle Programs
Medical Nutrition Therapy (for members with diabetes and kidney disease)	Contact Kaiser Permanente for more information on their Healthy Lifestyle Programs	Contact Kaiser Permanente for more information on their Healthy Lifestyle Programs



Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

BLUE SHIELD 65 PLUS (HMO) MEDICARE ADVANTAGE	
High Option	**Low Option**
$10 copay	No charge
No charge	No charge
No charge	No charge, patient education 20% coinsurance, diabetic supplies
Contact Blue Shield for more information on their SilverSneakers Program	Contact Blue Shield for more information on their SilverSneakers Program
$10 copay	No charge



DeltaCare USA DHMO

DeltaCare USA is a prepaid "HMO-style" dental plan (DHMO) which provides you and your family with quality comprehensive dental benefits at an affordable cost. The information below is a general summary of DeltaCare USA DHMO Plan benefits.

Please refer to the Dental Plans Comparison Chart on pages 81–89 for a listing of the most highly utilized procedures and applicable co-pay amounts. For a complete listing of benefits, please refer to your plan's Evidence of Coverage (EOC) and Patient Charge Schedule (PCS) which can be found on-line **link.sbcounty.gov/Retiree-Benefits**.

How the Plan Works

When you enroll in DeltaCare USA, you must select a primary care dentist for yourself and your covered dependents. You and your dependents may choose your own primary dentist near your home or work. You may elect to change your primary dentist for any reason.

You must utilize the selected primary care dentist for all of your dental services. If services are not obtained through the primary care dental office, or if DeltaCare USA has not authorized the services, those services will not be covered. If you require specialty care, your primary care dentist will refer you to a network specialist. You should request a treatment plan, which outlines your out-of-pocket costs, from your dentist before proceeding with any recommended services.

What's Covered

While covered under the DeltaCare USA Plan, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to plan exclusions and limitations. Please refer to the Dental Plans Comparison Chart in this guide for a sample of covered expenses. For a comprehensive explanation of benefits, please refer to the plan's evidence of coverage document (EOC) at **link.sbcounty.gov/Retiree-Benefits**.

Orthodontia Coverage

You and your covered dependents may obtain comprehensive and/or limited orthodontic care from any DeltaCare USA DHMO orthodontist.

Annual Maximum Benefit

There is no annual maximum benefit for the DeltaCare USA DHMO Plan.

PLEASE NOTE: Retirees who enroll in the DeltaCare USA DHMO or PPO Low Plan are required to participate for a minimum of 24 consecutive months. You can change between the DHMO and Low Plan at Open Enrollment.

Retirees who enroll in the Delta Dental PPO-High Plan are required to participate in the High Plan for a minimum of 24 consecutive months.

Copayments

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

Deductibles

There are no deductibles under the DeltaCare USA DHMO Plan.

Claim Forms

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

Out-of-State Coverage

If you or your covered dependents are living outside of California, benefits are available in the following states:

AR – Arkansas	FL – Florida	MI – Michigan	NV – Nevada	TX – Texas
AZ – Arizona	GA – Georgia	MO – Missouri	OK – Oklahoma	WA – Washington
CA – California	ID – Idaho	MT – Montana	OR – Oregon	

Please Note: Even if a state is listed, there may be some areas within the state that are not covered.

Emergency Care

Emergency services are limited to relieving sudden and severe pain, controlling excessive bleeding, or eliminating serious and sudden ("acute") infections. Routine restorative procedures or definitive treatments (e.g., root canal) are not considered emergency care.

If you need emergency services, call your primary care dental office first. If your primary care dental office is unavailable, call Delta Dental customer service at **855-244-7323** to speak with a representative between the hours of 5:00am to 6:00pm PST, Monday through Friday. After hour inquiries will be directed to our Customer Automated Link Line seven days a week between 4:30am and 9:30pm PST.

Emergency Care Away from Home or After Hours

If you need dental care away from home, call Delta Dental member services for a listing of network dentists. Out-of-area dental emergency coverage up to $100, per emergency for each member.

Be aware that you will be responsible for all applicable copayments including an additional charge for services received after regularly scheduled office hours if applicable.

What's Not Covered

It is extremely important that you read your EOC before you obtain services in order to know what DeltaCare USA will and will not cover. Exclusions and Limitations are subject to change, please refer to the DeltaCare USA EOC and PCS or contact DeltaCare USA Member

Services at **855-244-7323** for additional information. Generally, root canals, dentures, crowns and bridges that are in-progress are not covered for new plan members. In addition, placement, repair, maintenance or removal of dental implants are not covered.

Out-of-Network Providers

An out-of-network provider is a dentist that is not contracted with DeltaCare USA. Any services obtained from an out-of-network provider will not be covered.

Delta Dental PPO (High & Low Options)

Delta Dental PPO allows you to seek services from an in-network provider (Delta Dental PPO), or an out-of-network provider (Delta Dental Premier and non-contracted providers). You may change dentists anytime without notifying Delta Dental. It is your choice; however, it is important to note that your co-pays may be higher for select services if you choose to go to an out-of-network or to a Delta Dental Premier provider.

There are two PPO plan options referred to as the Low Plan and the High Plan. Please refer to the Dental Plans Comparison Chart on pages 81–89 for a list of the most utilized procedures, applicable coinsurance amounts, and annual maximum benefit payments. For a complete listing of benefits, please refer to your plan's EOC and/or PCS which can be found on-line at **link.sbcounty.gov/Retiree-Benefits**.

How the Plan Works

The amount you pay for services will depend on whether you visit a Delta Dental PPO, a Delta Dental Premier, or an out of network dentist.

In-Network Providers

When you receive your dental care from a Delta Dental PPO contracted dentist, you will pay a percentage of the dentist's discounted contracted fee schedule.

Delta Dental has a large network of PPO providers for you to choose from. In the Delta Dental PPO plan, individual dentists are contracted as Delta Dental PPO providers, not entire groups. It is important to ask whether or not your dentist is contracted with the Delta Dental PPO Network to determine if he or she is an in-network provider. To find an in-network Delta Dental PPO provider in your area call Delta Dental Member Services at **855-244-7323** or go to **www.deltadentalins.com.**

Out-of-Network Providers & Delta Dental Premier Providers

The Delta Dental PPO plan allows you to seek services from an out-of-network provider, either Delta Dental Premier contracted or non-contracted; however, you will incur a higher copayment for select services. Delta Dental Premier contracted providers agree to accept the Delta Dental Premier fee as payment in full, and members cannot be balance billed beyond the Premier contracted fee. If you visit a non-contracted dentist, you will be responsible for the difference between the payment dental providers receive from Delta Dental and their usual fees. This cost will vary by provider.

EXAMPLE: The cost-comparison below demonstrates the cost difference between obtaining a service from an in-network versus an out-of-network provider. (Note: the numbers cited are for example purposes only. They may not be the actual rates associated with this procedure.)

In-network vs Out-of-network Cost-comparison Example		
Procedure: Root Planning Delta Dental's maximum allowance payable for the procedure: $100		
Network	**Network Fee**	**Patient's Responsibility**
In-network: If the procedure is performed by an in-network (Delta Dental PPO) dentist	In-network fee (flat amount based on contracted fee): $85	In-network copayment (patient's responsibility): 20% of in-network fee. $85 x 20% = $17 **Patient Pays $17**
Out-of-network: If the procedure is performed by an out-of-network (Delta Dental Premier or non-contracted) dentist	Out-of-network fee (will vary by provider): $100 for Delta Dental Premier or $125 for out-of-network provider	Out-of-network copayment (patient's responsibility): 40% of either: • Delta Dental Premier: Premier contracted fee with no balance billing. $100 x 40% = $40 **Patient pays $40** • Out of network: maximum allowance plus the difference between the out-of-network fee and the maximum allowance. ($100 x 40% = $40) plus ($125 - $100 = $25) = $65 **Patient pays $65**

Annual Maximum Benefit

The High PPO has a calendar year maximum of $1,700. The Low PPO plan has a calendar year annual maximum of $1,000 per person. Once you reach the annual maximum, you will be responsible for 100% of the cost for services received until the end of the calendar year. On January 1st, each member will receive a new annual maximum (either $1,700 or $1,000).

Deductibles

The Delta Dental High and Low DPPO plans have a $50 per person or $150 per family calendar year annual deductible. However, the deductible does not apply to preventive services such as routine cleanings and exams.

Copayments

For most preventive and restorative services, you pay nothing out-of-pocket when you obtain services from an in- network provider. For other services, you pay a copayment as described in your evidence of coverage. As previously noted, copayments will be higher when you receive services from an out-of-network dentist

Claim Forms

Under the Delta Dental DPPO, in-network dentists will submit a claim form directly to Delta Dental. If your dentist is not contracted (out-of-network) with Delta Dental, you may have to file your own claims. It is your responsibility to pay your dentist for services rendered and to submit all necessary claim forms.

Predetermination of Covered Benefits

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

To predetermine treatment, your dentist sends Delta Dental a proposed treatment plan, along with x-rays relevant to the case. Delta Dental then checks to be sure the services are covered by your dental program. Delta Dental also calculates how any coinsurance and dollar maximum limits might affect your share of the cost. Your dentist then receives an estimate of the amount Delta Dental will pay for approved services. Please call Delta Dental Member Services at **855-244-7323** if you or your dentist has questions about predetermination of benefits.

What's Covered

The Delta Dental PPO Plan provides you with comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan and are subject to plan exclusions and limitations as defined in the Delta Dental DPPO Plan Evidence of Coverage (EOC).

Please Note: If more than one covered service will treat a dental condition, payment is limited to the least costly treatment, provided it is a professionally accepted, necessary and appropriate treatment. If you accept or request a more costly covered service, you will be responsible for expenses that exceed the amount covered for the least costly service. This practice is called the **Alternate Benefit Provision** and is described in the plan's EOC. The Alternate Benefit Provision typically applies to crowns, bridges, and dentures. For this reason, a Predetermination of Covered

Benefits and prescribed treatment plan issued by your dental provider prior to receiving treatment is highly recommended.

Diagnostic and Preventive (D&P) Services

D&P services will no longer accrue against the annual calendar year benefit! This enhancement provides the member receiving their annual cleanings, x-rays and exams an additional benefit valued at up to $500 annually.

Out-of-State Dependent Coverage

Dependents are eligible for services out of state.

Emergency Care

If you need emergency services, call your dental office. If your office is unavailable, call Delta Dental Member Services at **855-244-7323** and you will be directed to an available Delta Dental PPO, Delta Dental Premier or non-contracted provider of choice.

Additional Delta Member Services

Delta Dental Wellness Benefits

Gum disease is associated with a number of systemic conditions, and people with certain chronic conditions may benefit from additional periodontal (gum) cleanings and maintenance. That's why, in addition to your standard coverage, Delta Dental's Wellness Benefits offers expanded coverage for pregnant woman and those diagnosed with diabetes, heart disease, HIV/AIDS, rheumatoid arthritis or stroke.

Eligible participants can receive:

- DHMO Members: Waived frequency limitations and copayments (D1110, D1120, D4910) when services are needed more frequently due to medical necessity as determined by the Contract Dentist. Simply mention your medical condition to your dental office and they will waive the frequency limitation as medically necessary.
- DPPO Members: 100% coverage for one periodontal scaling and root planning procedure, per quadrant (D4341 or D4342) every 12 months (versus 24 months). A combination of any 4 routine cleanings or perio maintenance covered at 100% (D1110, D1120, D4346, D4910).

To enroll, simply log in to online services at **www.deltadentalins.com** or call Member Services at **855-244-7323**, Monday through Friday 5am to 5pm PST.

Contact Delta Dental

Contact Delta Dental Member Services at **855-244-7323**, available Monday through Friday, 5:00am through 6:00pm PST to assist you with questions related to your benefit plan, locating/changing a provider, ID card requests, and/or claims information.

For your convenience DeltaCare USA members can also access information related to their benefits and eligibility, locate/change their provider, print ID cards and view claims information online at **www.deltadentalins.com**.



Dental Plans Comparison Chart

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

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

** This procedure may be subject to additional costs based on materials used and/or location of the tooth/teeth within the mouth (e.g., See Alternate Benefit Provision on page 80).

This comparison chart contains a listing of highly utilized services only and is not inclusive of all your plan benefits. For a detailed description of covered benefits, including all of the limitations and exclusions, refer to your Evidence of Coverage and/or Patient Charge Schedule. Official plan and insurance documents govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official documents, the official plan documents will prevail.

DeltaCare USA (DHMO)	Delta Dental Low PPO		Delta Dental High PPO	
In Network Only (DeltaCare USA)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)
Calendar Year Maximum Benefit (certain Diagnostic and Preventive services do not accrue to your calendar year maximum benefit)				
Not Applicable	$1,000 per person		$1,700 per person	
Calendar Year Deductible (waived Diagnostic and Preventive services)				
Not Applicable	$50 per person/$150 per family		$50 per person/$150 per family	



Dental Plans Comparison Chart

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

Category	Code	Description
Preventive Care	D0120	Periodic oral evaluation (2 per calendar year)
	D0210	Full mouth X-ray (see frequency limitations)
	D9110	Emergency, palliative treatment of dental pain
	D1110 (Adult)	Prophylaxis (cleanings) (limitations apply)
	D1351	Sealant (per tooth) limitations may apply
	D1352	Preventive resin restoration – permanent tooth
Adjunctive General Services*	D9975	External bleaching – self-treatment with bleaching tray & gel
	D9943	Occlusal guard adjustments.
	D9944	Occlusal guards – hard appliance – full arch
	D9945	Occlusal guards – soft appliance – full arch
	D9946	Occlusal guards – hard appliance – partial arch
	D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Restorative Dentistry	D2140 (1) D2150 (2) D2160 (3) D2161 (4)	Amalgam (“silver” fillings) on primary or permanent teeth: 1, 2, 3 or 4 surfaces
	D2330 (1) D2331 (2) D2332 (3) D2335 (4)	Resin composite (white fillings), anterior (front) teeth: 1, 2, 3 or 4 surfaces
	D2391 (1) D2392 (2) D2393 (3) D2394 (4)	Resin Composite (white fillings), posterior (molars): 1, 2, 3 or 4 surfaces

DeltaCare USA (DHMO)	Delta Dental Low PPO		Delta Dental High PPO	
In Network Only (DeltaCare USA)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)
You Pay	**You Pay**	**You Pay** (plus costs over maximum allowance)	**You Pay**	**You Pay** (plus costs over maximum allowance)
No charge	No charge	30%	No charge	No charge
No charge	No charge	30%	No charge	No charge
$2.00	No charge	30%	No charge	No charge
No charge	No charge	30%	No charge	No charge
$3.00	No charge	30%	No charge	No charge
$3.00	No charge	30%	No charge	No charge
$125.00 per arch	Not covered	Not covered	Not covered	Not covered
$10.00	20%	40%	No charge	10%
$90.00	50%	50%	25%	30%
$90.00	50%	50%	25%	30%
$90.00	50%	50%	25%	30%
$40.00	Benefit covered through Medical Plan/Delta Dental pays as secondary to medical	Benefit covered through Medical Plan/Delta Dental pays as secondary to medical	Benefit covered through Medical Plan/Delta Dental pays as secondary to medical	Benefit covered through Medical Plan/Delta Dental pays as secondary to medical
No charge	20%	40%	No charge	10%
No charge	20%	40%	No charge	10%
$35.00 $45.00 $50.00 $55.00	20%	40%	No charge	10%

Dental Plans Comparison Chart

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

Category	Code	Description
Restorative Dentistry	D2510 (1) D2520 (2) D2530 (3+)	Metallic Inlay – Up to 3+ surfaces
	D2650 (1) D2651 (2) D2652 (3+)	Composite resin inlay (white) – Up to 3+ surfaces
	D2610 (1) D2620 (2) D2630 (3+)	Porcelain/ceramic inlay – Up to 3+ surfaces
Periodontics*	D4241 (1-3) D4240 (4+) (# of teeth)	Gingival flap, per quadrant
	D4263	Bone replacement graft – first site in quadrant
	D4264	Bone replacement graft – each additional site in quadrant
	D4211 (1-3) D4210 (4+) (# of teeth)	Gingivectomy/ gingivoplasty (gum surgery), per quadrant
Endodontics*	D3220	Pulpotomy
	D3222	Partial pulpotomy for apexogenesis – permanent tooth
	D3310	Root canal – Anterior (front) teeth
	D3320	Root canal – Bicuspid
	D3330	Root canal – Molar

DeltaCare USA (DHMO)	Delta Dental Low PPO		Delta Dental High PPO	
In Network Only (DeltaCare USA)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)
You Pay	**You Pay**	**You Pay** (plus costs over maximum allowance)	**You Pay**	**You Pay** (plus costs over maximum allowance)
$100.00 each	50%** upon review, pre-determination recommended	50%** upon review, pre-determination recommended	25%** upon review, pre-determination recommended	30%** upon review, pre-determination recommended
$100.00 each	50%** upon review, pre-determination recommended	50%** upon review, pre-determination recommended	25%** upon review, pre-determination recommended	30%** upon review, pre-determination recommended
$100.00 each	50%** Optional services, plan pays for amalgam, pre-determination recommended	50%** Optional services, plan pays for amalgam, pre-determination recommended	25%** Optional services, plan pays for amalgam, pre-determination recommended	30%** Optional services, plan pays for amalgam, pre-determination recommended
$90.00 $120.00	20%	40%	No charge	10%
$160.00	20%	40%	No charge	10%
$80.00	20%	40%	No charge	10%
$45.00 $70.00	20%	40%	No charge	10%
$3.00	20%	40%	No charge	10%
$17.00	20%	40%	No charge	10%
$50.00	20%	40%	No charge	10%
$70.00	20%	40%	No charge	10%
$135.00	20%	40%	No charge	10%

Dental Plans Comparison Chart

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

Category	Code	Description
Oral Surgery*	D7286	Biopsy of soft oral tissue
	D7140	Uncomplicated extraction, single tooth
	D7220	Extraction – impacted soft tissue, per tooth
	D7230	Extraction – impacted partially bony, per tooth
Oral Surgery*	D7240	Extraction – impacted completely bony, per tooth
	D9215	Local anesthesia
	D9223	General anesthesia – each additional 15 minutes (only with oral surgery)
	D7450/ D7451	Removal of benign odontogenic cyst or tumor
Crowns and Bridges	D2790	Crown – full cast high noble metal (gold)
	D6721	Crown – resin with predominantly base metal
	D6740	Crown – porcelain/ceramic substrate
	D6722	Crown – resin with noble metal
	D6930	Recement fixed partial denture
	D2920	Recement crown
	D6241	Pontic – porcelain fused to predominantly base metal (front teeth or molars)
	D6980	Fixed prosthodontic

DeltaCare USA (DHMO)	Delta Dental Low PPO		Delta Dental High PPO	
In Network Only (DeltaCare USA)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)
You Pay	**You Pay**	**You Pay** (plus costs over maximum allowance)	**You Pay**	**You Pay** (plus costs over maximum allowance)
No charge	20%	40%	No charge	10%
$2.00	20%	40%	No charge	10%
$25.00	20%	40%	No charge	10%
$45.00	20%	40%	No charge	10%
$70.00	20%	40%	No charge	10%
No charge	No charge	No charge	No charge	No charge
$78.00	20%	40%	No charge	10%
No charge	Benefit covered through Medical Plan/Delta Dental pays as secondary coverage under basic benefits	Benefit covered through Medical Plan/Delta Dental pays as secondary coverage under basic benefits	Benefit covered through Medical Plan/Delta Dental pays as secondary coverage under basic benefits	Benefit covered through Medical Plan/Delta Dental pays as secondary coverage under basic benefits
$100.00	50%	50%	25%	30%
$100.00	50%	50%	25%	30%
$100.00	50%	50%	25%	30%
$100.00	50%	50%	25%	30%
No charge	20%	40%	No charge	10%
No charge	20%	40%	No charge	10%
$100.00	50%	50%	25%	30%
Not covered	50%	50%	25%	30%

Dental Plans Comparison Chart

Please Note: This comparison chart only highlights benefits. The evidence of coverage document (EOC) and official plan documents contain comprehensive benefit details and govern your rights and benefits under each plan. If any discrepancy exists between this comparison chart and the official plan documents, the official plan documents will prevail.

Category	Code	Description
Prosthetics	D5110 (Upper) D5120 (Lower)	Complete upper or lower denture
	D5211 (Upper) D5212 (Lower)	Upper or lower partial denture – resin base
	D5670 (Upper) D5671 (Lower)	Replace all teeth (upper or lower) on cast metal framework
Prosthetics	D5511	Repair broken Denture Base
	D5410 (Upper) D5411 (Lower)	Complete denture adjustment
	D5520	Replace broken tooth on denture
	D6010 D6012 D6040 D6050	Implants
Ortho-dontics	D8660	Pre ortho visit
	D8999	Ortho Treatment Plan and Records
	D8080/8090	Banding (placement of brackets and wires)
	D8670 (child)	Periodic Orthodontic Treatment Visit
	D8670 (adult)	Periodic Orthodontic Treatment Visit
	D8680	Retention

DeltaCare USA (DHMO)	Delta Dental Low PPO		Delta Dental High PPO	
In Network Only (DeltaCare USA)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)	In Network (Delta Dental PPO)	Out-of-Network (Delta Dental Premier and Non Contracted)
You Pay	**You Pay**	**You Pay** (plus costs over maximum allowance)	**You Pay**	**You Pay** (plus costs over maximum allowance)
$120.00 for either upper or lower	50%	50%	25%	30%
$120.00 for either upper or lower	50%	50%	25%	30%
$145.00 for either upper or lower	20%	40%	No charge	10%
$17.00	20%	40%	No charge	10%
$3.00 for either upper or lower	20%	40%	No charge	10%
$17.00 per tooth	20%	40%	No charge	10%
Not covered	Not covered	Not covered	25%	30%
$80.00	Not covered	Not covered	50% of treatment cost + any cost over $1,700 (max lifetime benefit $1,700)"	
$400.00	Not covered	Not covered		
$1,000 /$1,500	Not covered	Not covered		
No charge	Not covered	Not covered		
No charge	Not covered	Not covered		
$220.00	Not covered	Not covered		

Retirement Medical Trust Fund

The Retirement Medical Trust (RMT) Fund Plan was implemented by San Bernardino County to assist eligible retirees and their dependents with the high cost of health related expenses. It provides a method for eligible participants to pay, on a nontaxable basis, for qualified expenses including medical, dental, and long-term care premiums (as defined in IRC Section 213) that are not otherwise reimbursed by insurance.

Eligibility

Eligibility for the RMT is determined by the following criteria:

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

Who Maintains the Funds

The funds are placed into an individual account in your name. The funds are automatically transferred to this account from San Bernardino County upon termination from the County. You have the option to re-allocate the funds to a variety of available investment options. Investment choices in the RMT plan are identical to those found in the County's 457(b) Deferred Compensation Plan, with the exception of the Voya Fixed Account.

Your account is maintained by Voya Health Account Solution. Voya will maintain your RMT account, provide online and toll free access to your account and access to a menu of investment options.

For more information on the administration of the RMT Plan or your individual account, please contact Voya Health Account Solutions at **1-833-232-4673**. To receive assistance from a Voya representative regarding investment options, you can contact our local Voya office at **909-748-6468**, toll free at **800-452-5842**, or visit the Voya custom webpage at **https://cosb.beready2retire.com**.

Access to the Funds

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

Voya is the administrator designated to disburse funds for qualifying expenses. RMT funds are used to reimburse a participant for qualifying health-related expenses not covered by an insurance plan. This includes medical/dental/vision premiums and copays for prescriptions and doctor visits. To receive reimbursement for eligible expenses, file a

claim online at **https//www.voya.com/ws/myHRA** or complete a "Reimbursement Request Form" and mail it together with verification of the expense to:

Voya, P.O. Box 1168, Minneapolis, MN 55440

A claim form is enclosed on page 129 of this guide. To receive assistance from a Voya representative, call **1-833-232-4673**. Participants can access their account, see a list of qualifying expenses, or obtain additional claim forms via the Voya website at: **https//www.voya.com/ws/myHRA**.

Important Reminder: Be sure to update your recurring premium amount to reflect changes in premiums effective 1/1/2027 using the "Recurring Individual Premium Reimbursement Request." Contact Employee Benefits at **909-387-5802** or at **salarysavings@hr.sbcounty.gov** to request copies of the Voya forms or visit **https://www.voya.com/ws/myHRA**



Health Club Membership Discounts

County retirees and/or their family members are also eligible for discounted gym memberships through our Employee Discount Program.

Fitness Your Way for Blue Shield Subscribers

Get healthy and feel good on your own terms with Fitness Your Way™, the gym membership program that offers you the flexibility to work out at any of the 10,000+ network fitness locations for $25 a month (plus a one-time $25 enrollment fee). Meet your lifestyle needs by working out anytime, anywhere, and as often as you need while tracking progress of your goals online.

Learn more or access these services by visiting **https://fitnessyourway.tivityhealth.com/bsc** or calling **833-283-8387** Monday–Friday, 5 a.m.–5 p.m. Pacific Time.

24 Hour Fitness

To enroll in a 24 Hour Fitness health club membership at the County's discounted rate, retirees may enroll by taking one of the following steps:

- Visit any 24 Hour Fitness club and enroll onsite, or
- Visit online at **www.24hourfitness.com/corporate** and enter ID: 14418CORP to initiate the enrollment process.

Upon initial enrollment, retirees will be responsible for immediate payment of first and last months' dues. Monthly dues are paid thereafter by Electronic Funds Transfer (EFT).

For more information, contact any 24 Hour Fitness facility or Employee Benefits via email at **mhm@hr.sbcounty.gov** or phone at **909-387-5831**.

		INITIATION FEE	ALL-CLUB SPORT ACCESS	ALL-CLUB SUPER SPORT ACCESS	ALL-CLUB ULTRA SPORT ACCESS
1 Year Commitment	Employee Only	$0	$28.99 dues/ month	$38.99 dues/ month	$48.99 dues/ month
No Commitment	Employee Only	$0	$29.99 dues/ month	$39.99 dues/ month	$49.99 dues/ month
	Each Additional Member	$0	$28.99 dues/ month	$38.99 dues/ month	$48.99 dues/ month

When to Complete Forms

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

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

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

How to Complete Enrollment/Change Forms

Section A Medical/Dental	Check the box for the appropriate reason you are completing the form.
Section B Medical/Dental	Check the box for the plan and the option you are electing. For PPO please select California or Out-of-State. Enter your previous plan.
Section C Medical/Dental	Complete all fields.
Section D Medical/Dental	Complete this section only if you are enrolling for the first time or changing plans. List all dependents you want to covered. For Blue Shield Signature HMO, you must enter a primary care physician (PCP) and medical group number. If you omit this field, Blue Shield will assign you to any PCP in your area. For DeltaCare USA DHMO, you must designate your dentist on the enrollment form by providing the applicable provider number. If you omit this information, Delta Dental will also assign you to a Dentist in your area.
Section E Medical/Dental	Complete this section if you are not changing plans (outside of open enrollment), but are only adding or removing dependents. You must enter a PCP and medical group number if you are enrolled in Blue Shield HMO. For Dental DHMO enrollment, you will need to provide the Dentist provider number.
Section F Medical/Dental	Complete if applicable.
Section G Medical/Dental	Complete if you have other medical/dental insurance.

Section H Medical	Complete if anyone to be covered by this medical plan is enrolled in both Medicare Parts A and B.
Section H Dental	Read, sign and date.
Sections I-O Medical	Read, sign and date pages 2 and 3 of the enrollment/change form.

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



175 West Fifth Street, San Bernardino, CA 92415-0440 | Phone: 909.387.5787 • Fax: 909.387.5566
www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

For Office Use Only		
Effective Month Date	Day	Year
KP Group ID #	KP Sub EU #	KP Dep EU #
Blue Shield Group #		
Blue Shield Plan ID #	Blue Shield Class ID #	
Emp ID #		

Retiree Medical Plan Enrollment/Change Form

County of San Bernardino—Retirees

A. ◯ New Enrollment ◯ Open Enrollment ◯ Change in Status

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

◯ Kaiser Permanente Traditional HMO Plan
◯ Kaiser Senior Advantage *
◯ Blue Shield Signature HMO
◯ Blue Shield PPO
◯ Blue Shield PPO COB
◯ Blue Shield 65 Plus (HMO) *

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

Previous Medical Plan: _____

Option:
◯ High Option
◯ Low Option
◯ BS TRIO / KP HDHP

For PPO Only:
◯ California
◯ Out of State

C. RETIREE INFORMATION OR RETIREE'S ELIGIBLE SURVIVOR INFORMATION

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

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

Mailing Address	☐ Check Here If New Address	Primary Phone ( ) Alternate Phone ( )	Email Address

City	State	Zip Code	Blue Shield Signature HMO and 65 Plus HMO Primary Care Physician ID No./Group ID No.	Previously Visited?
				◯ Yes ◯ No

Residential Address (if different from mailing address)

D. NEW ENROLLMENT ONLY — IF YOU ARE ENROLLING IN THIS MEDICAL PLAN FOR THE FIRST TIME, LIST ALL DEPENDENTS TO BE COVERED

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

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

E. ENROLLMENT CHANGES ONLY — IF YOU ARE ADDING OR DROPPING DEPENDENTS, LIST DEPENDENTS AND INDICATE EFFECTIVE DATE: Month Day Year

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

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

☐ Domestic Partnership ☐ Dissolution
☐ Marriage ☐ Divorce ☐ Death

PLEASE READ THE FOLLOWING DISCLOSURES AND SIGN YOUR AGREEMENT ON THE LAST PAGE OF THIS FORM
NOTE: KAISER MEMBERS ALSO NEED TO SIGN THE KAISER ARBITRATION AGREEMENT (SECTION I) ON THE FOLLOWING PAGE

Rev. 09.30.2025

G. OTHER MEDICAL COVERAGE	H. MEDICARE COVERAGE
Are you or any other member of your family covered by other group medical insurance? ○ Yes ○ No *If Yes, provide information below* Insurance Company_____ Policy No._____ Spouse's Employer_____ Phone Number_____	List all family members enrolled in both Parts A & B of Medicare: Name (First, Middle, Last) _____ ID No. _____Date of Birth (Month, Day, Year) _____/_____/_____ Name (First, Middle, Last) _____ ID No. _____Date of Birth (Month, Day, Year) _____/_____/_____

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

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

_____ _____
Signature Required for Kaiser Permanente Plan **Date**

J. BLUE SHIELD OF CALIFORNIA MEMBERS ONLY
(THIS SECTION APPLIES IF ENROLLING IN A BLUE SHIELD PLAN)

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

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

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

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

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

K. DEPENDENT AFFIDAVIT

I understand and agree to each of the following:

My enrolled dependent(s) meet the definition of an "eligible dependent" as defined in the Retiree Benefits Guide and plan eligibility requirements by carrier. *A complete list of dependent eligibility criteria may be found on the Human Resources Department - Employee Benefits and Services Division (HR-EBSD) internet site.*

- If I falsify dependent eligibility information to enroll an ineligible dependent, my dependent's coverage will be terminated in accordance with the provisions of the benefit plan contract. Any inconsistences discovered with respect to enrollment and eligibility will be investigated and appropriate action will be taken.
- The County reserves the right to request adequate documentation to assess a dependent's eligibility. Failure to submit requested information may result in immediate termination of the dependent's coverage from the County's group plans.
- It is my responsibility to:
  - Notify HR-EBSD within 60 days of the family status change date that would make one or more of my dependents ineligible for group health coverage.
  - Provide supporting documentation upon request of HR-EBSD.
  - I am responsible for any applicable cost incurred for obtaining supporting documentation.

- The effective date of my dependent's loss of coverage will be based on the date of the actual qualifying event. Based on the notification date, coverage effective dates may be established retroactively.
- If it is found that I am covering or have covered a dependent that is not eligible, I will be financially responsible for the cost of incurred claims paid by the carrier on my ineligible dependent's behalf.
- Failure to notify HR – EBSD of dependent eligibility changes in a timely manner (within 60 days of event date), may result in premiums paid to the carrier for coverage for which your dependent was ineligible. Any refunds owed for such premiums are at the discretion of the carrier. The County is not liable for any premiums paid in which the carrier has determined are ineligible for refund. Additionally, the County does not assume any liability resulting from terminating coverage of ineligible dependent(s).

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

L. DISABLED DEPENDENTS

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

_____ _____

_____ _____

M. QUALIFIED CHANGE IN STATUS EVENT

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

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

To add or delete dependents, I understand that I must submit a new Medical Plan Enrollment/Change Form within sixty (60) days of a Qualifying Change in Status Event. If I do not submit a Medical Plan Enrollment/Change Form within sixty (60) days, my request may be denied. All requests must be consistent with the stated qualifying event.

N. SELECTION OF A LOW OPTION HEALTH PLAN

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

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

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

O. AGREEMENT

I hereby elect the medical plan as designated on this enrollment form. I have also listed eligible dependents added to the medical plan, or to be deleted from the plan.

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

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

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

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

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

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

Subscriber's Signature _____ **Date**_____

RETURN FORM TO:

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

175 West Fifth Street, San Bernardino, CA 92415-0440 | Phone: 909.387.5787 • Fax: 909.387.5566
www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

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

Retiree Dental Plan Enrollment/Change Form

A ☐ NEW ENROLLMENT ☐ OPEN ENROLLMENT ☐ CHANGE IN STATUS

B I ELECT THIS DENTAL PLAN: ☐ Delta Dental PPO – Low* ☐ Delta Dental DPPO - High* ☐ DeltaCare USA HMO

C **RETIREE INFORMATION OR RETIREE'S ELIGIBLE SURVIVOR INFORMATION**

1. Social Security No.	2. Check One: ◯ Male ◯ Female	3. Date of Birth Month Day Year	4. Check One: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Domestic Partner
5. Last Name	6. First Name	7. MI	8. For Name Change, List Former Name Here
9. Mailing Address Check Here If New Address		10. Primary Phone: ( ) Alternate Phone: ( )	11. Email
12. City	13. State	14. Zip Code	15. DeltaCare HMO members must provide the following: Provider Name_____ Provider No._____

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

Last Name	First Name	Sex	Social Security No.	Date of Birth	Relationship
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			
		☐ M ☐ F			

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

E **ENROLLMENT CHANGES ONLY** IF YOU ARE ADDING OR DROPPING DEPENDENTS, LIST DEPENDENTS AND INDICATE EFFECTIVE DATE MONTH DAY YEAR / /

Name of family member(s) to be added or deleted:	Sex	Social Security No.	Date of Birth	Relationship
☐ Add Spouse/Domestic Partner: ☐ Remove	☐ M ☐ F			
☐ Add Children: ☐ Remove	☐ M ☐ F			
☐ Add Children: ☐ Remove	☐ M ☐ F			
☐ Add Children: ☐ Remove	☐ M ☐ F			
☐ Add Children: ☐ Remove	☐ M ☐ F			

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

G **OTHER DENTAL COVERAGE**

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

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

Policy no. _____ Phone number ( )

Please read and sign the back of this form

Rev. 10/20/2026

H **Employee Authorization:**

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

Dependent Affidavit:

I understand and agree to each of the following:

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

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

By signing below:

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

Retiree's Signature _____ Date _____

Rev. 10/20/2026

RETURN FORM TO:

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

SAN BERNARDINO COUNTY

Human Resources
Employee Benefits and Services

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

For Office Use Only		
Effective Month Date	Day	Year
Group #		
Plan/Class ID # (Blue Shield Only)		
Emp ID #		

RETIREE MEDICAL AND/OR DENTAL PLAN CANCELLATION FORM

A I CHOOSE TO CANCEL THE FOLLOWING MEDICAL AND/OR DENTAL COVERAGE

Plan Name	Effective Date of Cancellation (must be 1st of the month)		
	Month	Day	Year
Medical:		1	
Dental:		1	

B RETIREE INFORMATION

Social Security No.	Check One ❑ Male ❑ Female	Date Of Birth Month Day Year	Check One ❍ Married ❍ Widowed ❍ Single ❍ Divorced ❍ Domestic Partner

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

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

City	State	Zip Code	Email Address

C DEPENDENT INFORMATION (enrolled in a retiree plan)

Last Name, First Name	Social Security #	Date of Birth	Enrolled in Dental	Enrolled in Medical—Plan name if different from above	
Spouse/Domestic Partner:			❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:			❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:			❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:			❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:			❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:
Children:			❑ Yes ❑ No	❑ Yes ❑ No	Plan Name:

Subscriber's Signature _____ **Date**_____

Rev. 09.30.2025

RETURN FORM TO:

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

2027 Enrollment Request Form for Blue Shield 65 Plus (HMO)

To enroll in Blue Shield 65 Plus, please provide the following information:

Plan Sponsor name:		
Group or union number (leave blank if not provided by your Plan Sponsor):		
Last name:	First name:	Middle initial:
Birth date (MM/DD/YYYY):		Sex: ☐ Male ☐ Female
Home phone number:	Phone Type: ☐ Landline ☐ Mobile	
Permanent residence street address: (P.O. box is not allowed) Street address:		
City:	State:	ZIP code:
Mailing address, only if different from your permanent address: Street address:		
City:	State:	ZIP code:

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Please contact Customer Service at **(800) 776-4466 (TTY: 711)** if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m. to 8 p.m. PT, seven days a week.

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of the required materials. You can change your preference for delivery at any time.

Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

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

Name (as it appears on your Medicare card):

Medicare number:

Is entitled to: Effective date:

Hospital (Part A) _____

Medical (Part B) _____

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

Please read and answer these important questions

*1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (MM/DD/YYYY): _____

If no, name of retiree: _____

*2. Are you covering a spouse or dependents under this Plan Sponsor? ☐ Yes ☐ No

If yes, name of spouse: _____

Name(s) of dependent(s): _____

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

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

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

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

Name of other coverage: _____

ID # for coverage: _____

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

If yes, please provide the following information:

Name of institution: _____

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

_____

* For informational purposes only. This does not enroll anyone into the plan besides the applicant.

Please choose a primary care physician (PCP), clinic, or health center. If you do not select a primary care physician (PCP), one will be assigned to you:

Physician name or affiliated medical group:

Physician ID #:

Physician group name:

Current patient? ☐ Yes ☐ No

Please read and sign below

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

Blue Shield 65 Plus is a Medicare Advantage plan and has a contract with the federal government. will need to keep my Medicare Part A and B coverage. I can only be in one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year.

Blue Shield 65 Plus serves a specific service area. If I move out of the area that Blue Shield 65 Plus serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Blue Shield 65 Plus, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* (EOC) document from Blue Shield 65 Plus when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

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

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Blue Shield 65 Plus will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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

Signature:	**Today's date (MM/DD/YYYY):**

If you're the authorized representative, sign previous page, and fill out the fields below:

Name:

Street address:

City: State: ZIP code:

Phone number:

Relationship to enrollee:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. SHIP counselors, family members, or other third parties) helping the enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

Please return your completed enrollment form to your Benefits Administrator or send to:

Email: GroupMAPD@blueshieldca.com

Mail: Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856

Fax: (877) 251-3660

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

Blue Shield of California is an independent member of the Blue Shield Association MG00001-GRP-FF_0426

4 of 4

RETURN FORM TO:

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

2027 Enrollment Request Form for Blue Shield of California Medicare Rx Plan (PDP)

To enroll in Blue Shield of California Medicare Rx Plan, please provide the following information:

Plan Sponsor name:		
Group no. (leave blank if not provided by your Plan Sponsor):		
Last name:	First name:	Middle initial:
Birth date (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	
Home phone number:	Phone type: ☐ Landline ☐ Mobile	
Permanent residence street address: (P.O. box not allowed) Street address:		
City:	State:	ZIP code:
Mailing address, only if different from your permanent address: Street address:		
City:	State:	ZIP code:

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Select one if you want us to send you information in a language other than English.
☐ Spanish

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

If you have questions, please contact Blue Shield of California Medicare Rx Plan at **(888) 239-6469 (TTY: 711)**. Our office hours are 8 a.m. to 8 p.m. PT, seven days a week.

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications (for example: Explanation of Benefits or the Annual Notice of Changes) are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. You can change your preference for delivery at any time.

Please provide your Medicare insurance information

Please take out your red, white, and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

– OR –

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

Name (as it appears on your Medicare card):

Medicare number:

Is entitled to: Effective date:

Hospital (Part A) _____

Medical (Part B) _____

Please read and answer these important questions

*1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (MM/DD/YYYY): _____

If no, name of retiree: _____

*2. Are you covering a spouse or dependents under this Plan Sponsor? ☐ Yes ☐ No

If yes, name of spouse: _____

Name(s) of dependent(s): _____

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

4. Some individuals may have other drug coverage, including other private insurance, worker's compensation, VA benefits, or state pharmaceutical assistance programs.

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

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

Name of other coverage: _____

ID # for coverage: _____

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

If yes, please provide the following information:

Name of institution: _____

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

*For informational purposes only. This does not enroll anyone into the plan besides the applicant.

Please read this important information

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

Please read and sign below

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

Blue Shield of California Medicare Rx Plan is a Medicare Prescription Drug Plan and has a contract with the federal government. I understand that although Medicare only requires that I have Medicare Part A or Part B to enroll in this Prescription Drug Plan, my Plan Sponsor may have other requirements for eligibility. Failure to meet the requirements may affect my eligibility for plan-sponsored retiree coverage.

Enrollment in this plan is generally for the entire year.

Blue Shield of California Medicare Rx Plan serves a specific service area. If I move out of the area that Blue Shield of California Medicare Rx Plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of the Blue Shield of California Medicare Rx Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* (EOC) document from Blue Shield of California Medicare Rx Plan when I get it to know which rules I must follow to get coverage with this Medicare Prescription Drug Plan.

I understand that beginning on the date my Blue Shield of California Medicare Rx Plan coverage begins, I must get all of my prescription drug services from Blue Shield of California Medicare Rx Plan. Prescription drugs authorized by Blue Shield of California Medicare Rx Plan and contained in my Blue Shield of California Medicare Rx Plan *Evidence of Coverage* (EOC) document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BLUE SHIELD OF CALIFORNIA MEDICARE Rx PLAN WILL PAY FOR THE SERVICES**.

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

Release of information:

By joining this Medicare Prescription Drug Plan, I acknowledge that Blue Shield of California Medicare Rx Plan will release my information to Medicare or other plans as is necessary for treatment, payment, and healthcare operations. I also acknowledge that Blue Shield of California Medicare Rx Plan will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

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

Signature:	**Today's date (MM/DD/YYYY):**

If you're the authorized representative, sign the previous page, and fill out these fields:

Name:

Street address:

City: State: ZIP code:

Phone number:

Relationship to enrollee:

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., SHIP counselors, family members, or other third parties) helping the enrollee fill out this form.

Name: _____ Relationship to enrollee: _____

Signature: _____

Please return your completed enrollment form to your Benefits Administrator or send to:

Email: **GroupMAPD@blueshieldca.com**
Mail: Blue Shield of California
P.O. Box 948
Woodland Hills, CA 91365-9856
Fax: (877) 251-3896

Blue Shield of California is a PDP plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.

Blue Shield of California is an independent member of the Blue Shield Association

PDP00045-GPDP-FF_0426

4 of 4

RETURN FORM TO:

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

blue california

Blue Shield Medicare Advantage Disenrollment Form

Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Plan 2 (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Inspire (HMO), Blue Shield Vital (HMO), Blue Shield Inspire (PPO), Blue Shield Medicare (PPO), Blue Shield AdvantageOptimum Plan (HMO), Blue Shield AdvantageOptimum Plan 1 (HMO), Blue Shield AdvantageOptimum Plan 2 (HMO), Blue Shield TotalDual Plan (HMO D-SNP), Blue Shield Inspire (HMO D-SNP), and Blue Shield Coordinated Choice Plan (HMO)

If you request disenrollment, you must continue to get all medical care from your Blue Shield Medicare Advantage Plan on the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of Blue Shield Medicare Advantage Plan network. We will notify you of your effective date after we get this form from you.

Last Name	☐ Mr. ☐ Mrs. ☐ Ms.
First Name	Middle Initial
Medicare # ____-____-____	Birth Date ____/____/____ (M M D D Y Y Y Y)
Home phone number ____-____-____	Alternative phone number ____-____-____

Sex ☐ M ☐ F

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

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

Your Signature*:	**Today's Date** ____/____/____

* Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that:

1) This person is authorized under State law to complete this disenrollment and
2) Documentation of this authority is available upon request by Blue Shield of California or by Medicare.

Last Name ☐ Mr. ☐ Mrs. ☐ Ms.

First Name Middle Initial

Street Address

City State ZIP code

Relationship to Enrollee

Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).

__ __ / __ __ / __ __ __ __

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date).

__ __ / __ __ / __ __ __ __

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date).

__ __ / __ __ / __ __ __ __

☐ I am joining a PACE program on (insert date).

__ __ / __ __ / __ __ __ __

☐ I am joining employer or union coverage on (insert date).

		/			/				

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date).

		/			/				

If none of these statements applies to you or you're not sure, please contact Blue Shield of California Medicare Advantage Plan Customer Care at **(800) 776-4466** (TTY users should call **711**) to see if you are eligible to disenroll. We are open 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday) from April 1 through September 30.

RETURN FORM TO:

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

Blue Shield of California is an independent member of the Blue Shield Association MR14132-MA_10-20

blue california

Blue Shield Rx Plus (PDP) and Blue Shield Rx Enhanced (PDP) Disenrollment Form

Please fill out and carefully read all the information below before signing and dating this disenrollment form. We will notify you of your effective date after we get this form from you.

Instead of sending a disenrollment request to Blue Shield Medicare prescription drug plans, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, to disenroll by telephone. TTY users should call 1-877-486-2048.

Last Name	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Ms.
First Name	Middle Initial
Medicare # ____-____-____	Birth Date ____/____/____ (M M D D Y Y Y Y)
Sex ☐ M ☐ F	
Home phone number ____-____-____	Alternative phone number ____-____-____

By completing this disenrollment request, I agree to the following:
Blue Shield Rx Plus or Blue Shield Rx Enhanced will notify me of my disenrollment date after they get this form. I understand that until my disenrollment is effective, I must continue to fill my prescriptions at Blue Shield Rx Plus or Blue Shield Rx Enhanced network pharmacies to get coverage. I understand that there are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances. I understand that I am disenrolling from my Medicare Prescription Drug Plan and, if I don't have other coverage as good as Medicare, I may have to pay a late enrollment penalty for this coverage in the future.

Your Signature*: **Date:**

* Or the signature of the person authorized to act on your behalf under the laws of the State where you live. If signed by an authorized individual (as described above), this signature certifies that:

1) This person is authorized under State law to complete this disenrollment and
2) documentation of this authority is available upon request by Blue Shield of California or by Medicare.

Blue Shield of California is an independent member of the Blue Shield Association PDP00013-PDP (10/19)

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

Last Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Ms.

First Name Middle Initial

Street Address

City State ZIP code

Relationship to Enrollee

Information to include on or with Disenrollment Form – Attestation of Eligibility for an Election Period

Typically, you may disenroll from a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year or during the Medicare Advantage Open Enrollment Period from January 1 through March 31 of each year. There are exceptions that may allow you to disenroll from a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Election Period.

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date).

__ __ / __ __ / __ __ __ __

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date).

__ __ / __ __ / __ __ __ __

☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for Medicare prescription drug coverage, but I haven't had a change.

☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date).

__ __ / __ __ / __ __ __ __

☐ I am joining a PACE program on (insert date).

__ __ / __ __ / __ __ __ __

☐ I am joining employer or union coverage on (insert date).

		/			/				

☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date).

		/			/				

If none of these statements applies to you or you're not sure, please contact Blue Shield Rx Plus or Blue Shield Rx Enhanced Member Services at **(888) 239-6469** (TTY users should call **711**) to see if you are eligible to disenroll. We are open 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m., Saturday and Sunday) from April 1 through September 30.

RETURN FORM TO:

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

KAISER PERMANENTE®

Group Plan

Kaiser Permanente Senior Advantage (HMO)

Group Medicare Election Form – California

Filling out and returning this form is your first step to becoming a Kaiser Permanente Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing this form, call Kaiser Permanente at **1-800-443-0815**, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

   Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400

   You can also fax or email your completed form to:
   FAX: **1-855-355-5334**
   EMAIL: **KPMedicareEnrollments@kp.org**
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit **kp.org/medicare/applicationstatus**.

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

4470978282 (10/2026)

Senior Advantage – Group – California

Employer Group Use Only
Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

To Enroll in Kaiser Permanente Senior Advantage, Please Provide the Following Information

Employer or Union Name: _____ Group #: _____

LAST Name: _____

FIRST Name: _____ Middle Initial: _____ Sex: ☐ Male ☐ Female

Primary Phone Number: _____ Secondary Phone Number: _____ Birth Date: (mm/dd/yyyy) _____

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number: _____

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.): _____

City: _____

County: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address)

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Senior Advantage – Group – California

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

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

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A

2. Are you the retiree? ☐ Yes ☐ No
   If "yes", retirement date (mm/dd/yyyy):
   If "no", name of retiree:

3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If "yes", name of spouse:
   Name(s) of dependent(s):

4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information:
   Name of institution:
   Address of institution (number and street): Phone Number:

4470978282 (10/2026)

Senior Advantage – Group – California

Last Name _____ First Name _____

6. Requested effective date of enrollment into this plan (subject to CMS approval): _____

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

☐ Spanish ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact Kaiser Permanente at **1-800-443-0815** if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

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

Employer Group/Union/Trust Fund Name:

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

Requested effective date of enrollment into this plan (subject to CMS approval):

Senior Advantage – Group – California

Last Name _____ First Name _____

Please Read and Sign Below

KAISER FOUNDATION HEALTH PLAN, INC. ARBITRATION AGREEMENT

By completing this enrollment application, I agree to the following:
Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however most employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

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

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

I understand that beginning on the date Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my Senior Advantage **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

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

Senior Advantage – Group – California

Last Name | First Name

Release of Information:

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

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

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Enrollee or Authorized Representative Signature:

Today's Date:

If you are the authorized representative of the enrollee, meaning you attest that you are legally authorized to complete this enrollment request on their behalf under State law (Power of Attorney, court-ordered legal guardianship, etc.), please sign above and provide your information below:

Name:

Address:

Phone Number: **Relationship to Enrollee:**

For future membership-related inquiries or requests, please feel free to send a copy of the authorized representative document to: Kaiser Permanente – Medicare Unit P.O. Box 232400 San Diego, CA 92193-2400 or FAX: **1-855-355-5334** or EMAIL: **KPMedicareEnrollments@kp.org**. A copy of the authorized representative document is not required for completing this enrollment request.

4470978282 (10/2026)

Senior Advantage - Group - California

Last Name _____ First Name _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. Do not complete this section if you are the enrollee or their legal/authorized representative.

Name: _____

Relationship to Enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

Office Use Only:

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

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ SEP (type): _____

RETURN FORM TO:

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

4470978282 (10/2026)

KAISER PERMANENTE®

Group Plan

Kaiser Permanente Medicare Advantage/Senior Advantage (HMO)

Group Medicare Enrollment Form

Filling out and returning this form is your first step to becoming a Kaiser Permanente Medicare Advantage/Senior Advantage member. If you and your spouse are both applying, you'll each need to fill out a separate form. For help completing this form, call Kaiser Permanente at the phone number listed below for your region, 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

Colorado Region	**1-800-476-2167**
Georgia Region	**1-800-232-4404**
Mid-Atlantic States Region	**1-888-777-5536**
Nevada	**1-888-775-7003**
Northwest Region (NW Oregon, SW Washington, and Lane County, OR)	**1-877-221-8221**

Washington Region (Counties: Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Spokane, Thurston, Whatcom, Grays Harbor (ZIP codes: 98541, 98557, 98559, 98568), and Mason (ZIP codes: 98524, 98528, 98546, 98548, 98555, 98584, 98588, 98592)) **1-888-901-4600.**

How to fill out this form

1. Answer all questions and print your answers using black or blue ink. Fill in check boxes with an X.
2. Sign and date the form. **Make sure you've read all the pages before you sign.**
3. Mail the original, signed form to:

   Kaiser Permanente – Medicare Unit
   P.O. Box 232400
   San Diego, CA 92193-2400

   You can also fax or email your completed form to:
   FAX: **1-855-355-5334**
   EMAIL: **KPMedicareEnrollments@kp.org**
4. Make a copy for your records. If required, submit a copy to your employer group, union or trust fund.

Next steps

- We'll review your form to make sure it's complete. Then we'll let you know by mail that we've received it.
- We'll let Medicare know that you've applied for Medicare Advantage/Senior Advantage.
- Within 10 calendar days after Medicare confirms your enrollment, we'll first let you know the start date for your coverage. Next, we will send you a Kaiser Permanente ID card and your new member package within 10 days of your start date.
- To check on the status of your application, please visit **kp.org/medicare/applicationstatus.**

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

4471062903 (10/2026)

Medicare Advantage/Senior Advantage – Group

Employer Group Use Only
Please provide receipt date of form in this section when submitting on behalf of employee/retiree.

Employer Group #: _____ Employer Receipt Date: _____

Authorized Rep: _____

To Enroll in Kaiser Permanente Medicare Advantage/Senior Advantage, Please Provide the Following Information

Please indicate which Kaiser Permanente **region** you reside in and wish to enroll:

☐ **COLORADO** ☐ **GEORGIA** ☐ **MID-ATLANTIC STATES** ☐ **NEVADA** ☐ **NORTHWEST** ☐ **WASHINGTON**

Employer or Union Name: San Bernardino County

Group #:

LAST Name:

FIRST Name:

Middle Initial:

Sex: ☐ Male ☐ Female

Primary Phone Number:

Secondary Phone Number:

Birth Date: (mm/dd/yyyy)

Are you a current or former member of any Kaiser Permanente health plan? ☐ Yes ☐ No If yes: ☐ Current ☐ Former

Kaiser Permanente Medical/Health Record Number:

Permanent Residence Street Address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):

City:

County:

State:

ZIP Code:

Mailing Address (only if different from your Permanent Residence Address)

Street Address:

City:

State:

ZIP Code:

Email Address:

4471062903 (10/2026)

Medicare Advantage/Senior Advantage – Group

Last Name _____ First Name _____

Please Provide Your Medicare Insurance Information

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

- OR -

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

Name (as it appears on your Medicare card):

Medicare Number:

Is Entitled To: Effective Date:

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part B, however most employer groups require both Parts A and B to join a Medicare Advantage plan.

Please Read and Answer These Important Questions

1. Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No ☐ N/A
2. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date (mm/dd/yyyy):
   If no, name of retiree:
3. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse:
   Name(s) of dependent(s):
4. Will you have other prescription drug coverage (like VA, TRICARE) in addition to Kaiser Permanente? ☐ Yes ☐ No
   If "yes", please list your other coverage and your identification (ID) number(s) for that coverage.
   Name of other coverage: ID # for other coverage:
5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes", please provide the following information:
   Name of institution:
   Address of institution (number and street): Phone Number:
6. Requested effective date of enrollment into this plan (subject to CMS approval)

4471062903 (10/2026)

Medicare Advantage/Senior Advantage – Group

Last Name _____ First Name _____

The fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

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

☐ Spanish ☐ Braille ☐ Large Print ☐ Audio CD ☐ Data CD

Please contact your Kaiser Permanente region at the phone number listed on the instruction page if you need information in an accessible format or language other than what is listed above. Our office hours are 7 days a week, 8 a.m. to 8 p.m. TTY users should call **711.**

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

Employer Group/Union/Trust Fund Name:

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

Requested effective date of enrollment into this plan (subject to CMS approval):

Medicare Advantage/Senior Advantage – Group

Last Name _____ First Name _____

Please Read and Sign Below

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

Kaiser Permanente is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Part B, however most employer groups require both Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I may leave this plan at any time during the year as allowed by my group by sending a request to Kaiser Permanente. However, before I request disenrollment, I will check with my group or union/trust fund to determine if I am able to continue my group membership.

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

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

I understand that beginning on the date Medicare Advantage/Senior Advantage coverage begins, I must get all of my health care from Kaiser Permanente, except for emergency or urgently needed services or out-of-area dialysis services.

Services authorized by Kaiser Permanente and other services contained in my Medicare Advantage/Senior Advantage **Evidence of Coverage** document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KAISER PERMANENTE WILL PAY FOR THE SERVICES.**

For Northwest region only: Any services received under the Outside Service Area Benefit (if applicable) do not need to be authorized or provided by Kaiser Permanente.

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

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Medicare Advantage/Senior Advantage – Group

Last Name _____ First Name _____

Release of Information:

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

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

Enrollee or Authorized Representative Signature:

_____

Today's Date: _____

If you are the authorized representative of the enrollee, meaning you attest that you are legally authorized to complete this enrollment request on their behalf under State law (Power of Attorney, court-ordered legal guardianship, etc.), please sign above and provide your information below:

Name: _____

Address: _____

Phone Number: _____ **Relationship to Enrollee:** _____

For future membership-related inquiries or requests, please feel free to send a copy of the authorized representative document to: Kaiser Permanente – Medicare Unit P.O. Box 232400 San Diego, CA 92193-2400 or FAX: **1-855-355-5334** or EMAIL: **KPMedicareEnrollments@kp.org**. A copy of the authorized representative document is not required for completing this enrollment request.

Medicare Advantage/Senior Advantage – Group

Last Name _____ First Name _____

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. Do not complete this section if you are the enrollee or their legal/authorized representative.

Name: _____

Relationship to Enrollee: _____

Signature: _____

National Producer Number (Agents/Brokers only): _____

For CO, GA, NW, NV, & WA regions – Office Use Only:

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

Plan ID #: _____ Effective Date of Coverage: _____

ICEP/IEP: _____ OEP: _____ SEP (type): _____

For MAS region – Office Use Only:

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

Plan ID #: _____ Effective Date of Coverage: _____

PBP#: ☐ H2172-801 ☐ H2172-803 ☐ H2172-804 ☐ H2172-805

Group Number: _____ Subgroup Number: _____

Employer Subsidy Group: ☐ Yes ☐ No Part D Group: ☐ Yes ☐ No

ICEP/IEP: _____ OEP: _____ SEP (type): _____

RETURN FORM TO:

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

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

Disabled Dependent Certification
(Dependent child age 26 or older)

Must print in Black or Blue ink ONLY

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

COMPLETE ONE FORM FOR EACH DEPENDENT CHILD AGE 26 OR OLDER

Dependent Name	Date of Birth	Relationship to Employee

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

Please provide the following:

Type of disability:	☐Permanent	☐Temporary	**If temporary, provide end date:**
Name of Provider:			
Provider Address:			
License No.:		**Telephone:**	
Provider Signature			**Date:**

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

Employee (Print & Sign)	Date:

Payroll Specialist (Print & Sign)	Telephone:	Date:

DISTRIBUTION: Original - EBSD-HR (0440)

Office Use Only

Reviewed by (Employee ID)	Date

REV. HR 06/11/2014

Disabled Dependent Certification

RETURN FORM TO:

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

QUALIFIED PREMIUM RECURRING BASIS REIMBURSEMENT REQUEST

Voya Benefits Company, LLC
Voya BC, LLC
A member of the Voya® family of companies
Health Account Solutions: PO Box 1168, Minneapolis, MN 55440
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASinfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

SUBMITTING A RECURRING BASIS PREMIUM REIMBURSEMENT REQUEST

1. Complete **Employee Information** section below
2. Enter monthly premium amount(s) in the **Premium Provider Information** section.
3. Ensure you are prepared to provide documentation showing the:
    1. dates of coverage
    2. amount of premiums you will be required to pay for the coverage period (generally a 12 month plan year)
4. Fax or e-mail this form to Voya Health Account Services at:

    Fax: 855-370-0670

    Email: HASinfo@voya.com.

Once submitted and processed, you should expect to receive a reimbursement monthly for your expense via check or direct deposit. You can verify payments made to you by logging into your account at https://www.voya.com/ws/myHRA.

EMPLOYEE INFORMATION

Employee Name *(Required) (First)* _____ *(Last)* _____

Primary Phone *(Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Employer _____ Email _____

PREMIUM PROVIDER INFORMATION

Monthly Premium Amount	Start Date of Coverage *(mm/dd/yyyy)*	End Date of Coverage *(mm/dd/yyyy)*	Provider Name

CLAIMANT'S STATEMENT

I understand that this certification is submitted to verify certain expenses incurred by me for reimbursement under my employer's Health Reimbursement Account. I agree to notify my employer immediately of any change or modification of any of the information contained herein.

Employee's Signature _____ Date _____

Employee's Name *(Please print.)* _____

Note: Must be submitted with Proof of Expense to be approved and processed.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM

Voya Benefits Company, LLC
Voya BC, LLC
Members of the Voya® family of companies
Health Account Solutions: PO Box 1168, Minneapolis, MN 55440
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASinfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

FILING INFORMATION

- File your claim online or through our Voya Health Solutions mobile app
- For information on our mobile app, visit iOS or Google Play
- Sign up for direct deposit online

Receipts must include:

- Date the expense was incurred
- Description of the expense(s)
  - Deductible and/or Coinsurances
  - Prescription
  - Inpatient or Outpatient Services
  - Other
- Doctor or name of provider
- Dollar amount of the expense(s)

EMPLOYEE INFORMATION

Employee Name *(Required) (First)* _____ *(Last)* _____

Employer Name *(Required)* _____

Daytime Phone *(Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Email is required to receive important account notifications such as claim confirmations, payment notifications and denial letters.

Email _____

HRA EXPENSES

Amount Incurred	Service Dates	Description Please refer to your plan description, available through your online portal to determine what expenses are eligible for reimbursement under this plan.	Person Receiving Product/Service
$			
$			
$			
$			
$			
$ 0.00	Total Expenses Requested:		

SIGNATURE

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for IRS eligible expenses incurred by my legal dependents or myself (Domestic/Civil Union Partners are not IRS eligible dependents in most cases.) I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction. By submitting this form, I certify the above.

Employee's Signature *(Required)* _____ Date *(Required)* _____

DIRECT DEPOSIT AUTHORIZATION FORM

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 1168, Minneapolis, MN 55440
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASInfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

EMPLOYEE INFORMATION

Employee / Member Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Social Security Number (SSN) (*Required*) _____

Phone _____ Email (*Required*) _____

Employer Name _____

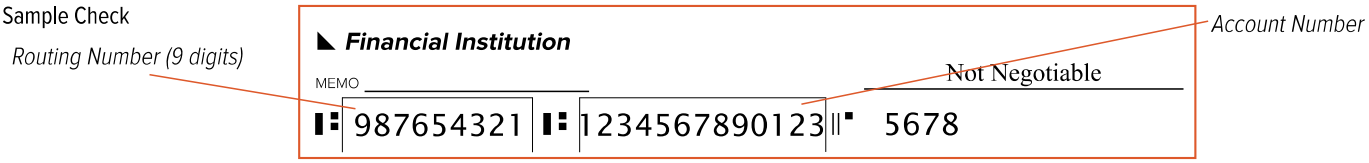
DIRECT DEPOSIT AUTHORIZATION

Please confirm receipt of your direct deposit prior to using funds. Voya Benefits Company, LLC will not be responsible for overdraft fees on your account. *All fields are required.*

Bank Name _____ Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number *(9 digits)* _____ Bank Account Number _____

Sample Check



Note: This account will be on hold until you activate the account online. A deposit will be made to your account in the next 3 business days. Once you confirm the deposited amount, the account will be activated and available for use. You can confirm the deposited amount by visiting your Consumer Portal. After logging in, click on the link under the Action Required section of the Home Page. The link will read "One or more bank accounts require activation". Follow the instructions on the site to activate the account.

AUTHORIZATION AND SIGNATURE

I authorize Voya Benefits Company, LLC and the financial institution listed above to initiate credit entries, and if necessary, debit entries and adjustments for any credit entries made in error to the account shown. This authorization will remain in effect until one of the following occurs: Voya Benefits Company, LLC receives written termination notification of direct deposit or are given direction from your employer to update.

Employee Signature _____ Date _____

Order #214068 02/22/2024



Human Resources
Employee Benefits and Services