Welcome to the City of Reedley's 2017 Open Enrollment
Under Age 65 Retirees – Tier I
(Including grandfathered Tier II retirees who retired on or before 12/31/2016)

The **City of Reedley's** 2017 open enrollment is November 7th – December 6th with benefits beginning January 1, 2017. *If you are planning to change your health insurance plan, please submit your open enrollment change forms as soon as practicable to ensure a smooth transition to your new plan.*

For the 2017 plan year, SJVIA Anthem Blue Cross HMO premium increased by 15.29%; SJVIA Anthem Blue Cross PPO increased by 25.60%; and Kaiser increased by 8.79%. We are pleased to inform you that the retiree contribution for the Anthem HMO 1-party plan will be $0.00 for the 2017 plan year. The new rates and retiree contribution details are provided with the enclosed open enrollment packet. The new retiree and retiree dependent deduction amounts will continue to be administered and collected by Administrative Solutions Inc. (ASI).

2017 Benefit Modifications – There were no benefit changes for the 2017 plan year.

Open Enrollment is the time to change plans or drop eligible family members, subject to the regulations set forth in the current Retiree Health Benefits Resolution. Outside of this open enrollment period, the only opportunity to make changes to your enrollment is if you or your dependent(s) become Medicare eligible.

Your open enrollment packet is enclosed with this memo. You may also access this packet on the City of Reedley's web site and click on the applicable link. The packet has the Summary of Benefits for Anthem Blue Cross HMO & PPO, Kaiser Benefit Summary, the retiree and retiree dependent contribution sheet and all forms necessary to make changes.

Your Responsibility – Must be completed by December 6, 2016

- If you do not want to make any changes **no paperwork is needed.**
- To change insurance companies, you will need to complete the applicable enrollment form and check the open enrollment box for the insurance plan to which you want to change.
- If you want to drop your coverage or your dependents' coverage:
  - Anthem Blue Cross members please complete the personal information (name & address) and the waiver section of the enrollment/change form.
  - Kaiser members please complete the waiver form.

Questions:

- Questions regarding enrollment – Please contact Darla Bello at (559) 637-4200 extension 240 or Julie Capistran at extension 216; Fax number (866) 331-1187
- Benefit and/or insurance plan questions please contact Kathy Sunday or Susan Smithson at Horstmann Financial & Insurance Services at (559) 447-3965.

CITY OF REEDLEY

SJVIA MONTHLY PREMIUM RATES & RETIREE/CITY CONTRIBUTIONS

EFFECTIVE JANUARY 1, 2017

Tier I - Retirees under age 65

Total Monthly Cost	Retiree Only	Retiree + 1	Retiree + 2 or more
SJVIA PPO	$732.66	$1,464.33	$1,903.54
SJVIA HMO	$669.79	$1,338.59	$1,740.07
SJVIA Kaiser	$759.55	$1,492.15	$1,931.91
City's Monthly Contribution	**Retiree Only**	**Retiree + 1**	**Retiree + 2 or more**
Blended PPO & HMO ($500 cap for dependents)	**$701.23**	**$1,201.23**	**$1,201.23**
Retiree Monthly Contribution	**Retiree Only**	**Retiree + 1**	**Retiree + 2 or more**
SJVIA PPO	**$31.43**	**$263.10**	**$702.31**
SJVIA HMO	**$0.00**	**$137.36**	**$538.84**
SJVIA Kaiser	**$58.32**	**$290.92**	**$730.68**

Anthem Blue Cross Enrollment Form

Effective date	Group no.

Anthem BlueCross

Purpose: ☐ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

SECTION 1: TYPE OF COVERAGE — Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:

- ☐ HMO (CaliforniaCare)[1]
- ☐ Preferred HMO (CaliforniaCare PLUS)[1]
- ☐ Advantage HMO[1]
- ☐ Priority Select HMO[1]
- ☐ Select HMO[1]
- ☐ Vivity HMO[1]
- ☐ Elements Choice EQ HMO[1]
- ☐ Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ PPO (Prudent Buyer)
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)[1]
- ☐ Elements Choice EQ PPO
- ☐ Medicare
- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO (non-California resident)
- ☐ Lumenos® (select one of the following)
  - ☐ H.S.A.[2] ☐ H.R.A.
  - ☐ H.I.A. ☐ H.I.A. Plus
- ☐ Elements Choice EQ HSA

1 Indicate Medical Group/IPA No. in the ***Employee and Family Information*** section.
2 Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Dental

Anthem Blue Cross plans:

- ☐ Dental Net HMO[3]
- ☐ Choice Dental (select one of the following)
  - ☐ Dental Net HMO[3] ☐ PPO Dental
- ☐ Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

3 Indicate Dental Office No. in the ***Employee and Family Information*** section.

☐ UniAccount (Flexible Spending account)[4] (Indicate payroll deductions)
I authorize payroll deductions on the following:
- ☐ Health Care Account $_____
- ☐ Dependent Care $_____

4 Anthem Blue Cross PPO, drug and dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another health plan. Reminder: Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

Vision ☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life Insurance All the coverages listed may not be offered under your plan. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the ***Life Insurance Beneficiary Designation Information*** section. **Annual salary** $

Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount
☐ Basic Life (AD&D)	$_____	☐ Optional Life - Employee	$_____	☐ Optional AD&D - Employee	$_____
☐ Dependent Life - Spouse	$_____	☐ Optional Dependent Life/Spouse	$_____	☐ Optional AD&D - Spouse	$_____
☐ Dependent Life - Child	$_____	☐ Optional Dependent Life/Child	$_____	☐ Optional AD&D - Child	$_____
		☐ Short Term Disability	$_____	☐ Voluntary Short Term Disability	$_____
		☐ Long Term Disability	$_____	☐ Voluntary Long Term Disability	$_____

LANGUAGE CHOICE (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

SECTION 2: APPLICANT'S PERSONAL INFORMATION

Social Security numbers are required under CMS Regulations and by the IRS.

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or ID no.[5] (required)
Mailing address		Apt. no.	# of dependents including spouse	Spouse/DP Social Security or ID no.[5] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date	Employer name	Job title	Class	Dept. no.	Email address

SECTION 3: EMPLOYEE AND FAMILY INFORMATION — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YYYY)	Social Security or ID no.[5] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below	HMO & POS ONLY IPA/Primary Care Physician Code	Current MD?	Dental Net ONLY Office No.
☐ M ☐ F	Employee								☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP						IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.
5 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

SECTION 4: DECLINATION — To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

B. Dental coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

C. Vision coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

D. Life insurance coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage — check one
☐ Covered by spouse's group coverage. Carrier name and ID no.: _____
☐ Covered by Anthem Blue Cross Individual policy
☐ Spouse covered by employer's group medical coverage. Carrier name: _____
☐ Enrolled in Tricare
☐ Enrolled in any other insurance carrier plan. Carrier name: _____
☐ Medicare
☐ Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)
X

Date

~~SECTION 5: COBRA/CAL-COBRA COVERAGE INFORMATION — Complete only if enrolling in COBRA/Cal-COBRA.~~

~~Reason for COBRA/Cal-COBRA coverage~~

~~Federal COBRA qualifying event date~~	~~Federal COBRA coverage begin date~~	~~Federal COBRA coverage end date~~
~~Cal-COBRA qualifying event date~~	~~Cal-COBRA coverage begin date~~	~~Cal-COBRA coverage end date~~

SECTION 6: OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS — All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person: _____ Insurance company: _____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Date coverage began: _____ Date ended: _____

~~C. Does any person applying for coverage currently have **dental** insurance coverage?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If yes, applicant/family member name(s):~~ _____
~~Type of continuous coverage:~~ ☐ ~~Group~~ ☐ ~~Individual~~ ☐ ~~Other:~~ _____
~~Insurance company:~~ _____ ~~Date coverage began:~~ _____ ~~Date ended:~~ _____

~~D. Does any person applying for coverage currently have **vision** insurance coverage?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If yes, applicant/family member name(s):~~ _____
~~Type of continuous coverage:~~ ☐ ~~Group~~ ☐ ~~Individual~~ ☐ ~~Other:~~ _____
~~Insurance company:~~ _____ ~~Date coverage began:~~ _____ ~~Date ended:~~ _____

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No
Note: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SECTION 7: MEDICARE SECTION — Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim No.

SECTION 8: PRIOR COVERAGE FOR PPO PLANS ONLY — Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **NOTE**: If this section is left blank, there may be delays in the processing of claims for these dependents.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Child				
Child				
Child				

1 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

~~SECTION 9: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION~~

~~Note: Dependent Life payments are always paid to the employee.~~

~~Primary Beneficiary — First to receive payment (required)~~ ~~If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.~~

~~Name~~	~~Birthdate~~	~~Social Security no.~~	~~Relationship~~	~~%~~
~~Street address~~		~~City~~	~~State~~	~~ZIP code~~
~~Name~~	~~Birthdate~~	~~Social Security no.~~	~~Relationship~~	~~%~~
~~Street address~~		~~City~~	~~State~~	~~ZIP code~~

SECTION 10: PLEASE READ CAREFULLY — Signature required.

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

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

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

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: ***It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.**

Signature (Required)

Applicant X	Date

1 Anthem is required by the Internal Revenue Service to collect this information.

Your Summary of Benefits

SJVIA

Anthem Blue Cross

Custom Premier HMO 15

January 1, 2017

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $1,000; Family $2,000

The following copay does not apply to the annual copay maximum: for infertility treatment. After an annual copay maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses infertility treatment.

Covered Services	Per Member Copay
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing)*, and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay
Smoking Cessation Program	No copay
Physician Medical Services	
∘ Office & home visits	$15/visit
∘ Specialists	$15/visit
∘ Skilled nursing facility visits	No copay
∘ Hospital visits	No copay
∘ Injectable medications in physician's office *(excluding allergy serum and immunization)*	No copay
∘ Surgeon & Surgical assistant	No copay
∘ Anesthesiologist or anesthetist	No copay
Acupuncture	$15/visit

Covered Services	Per Member Copay
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
∘ Outpatient surgery & supplies	No copay
∘ Advanced Imaging	No copay
∘ All other X-ray & laboratory tests (*including genetic testing*)	No copay
∘ Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
∘ Other Outpatient Medical Services including:	No copay
Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	
General Medical Services (*when performed in non-hospital-based facility*)	
∘ Advanced Imaging	No copay
∘ All other X-ray & laboratory tests (*including genetic testing*)	No copay
∘ Allergy testing & treatment *(including serums)*	No copay
∘ Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
∘ Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$15/visit
Emergency Care	
∘ Physician & medical services	No copay
∘ Outpatient hospital emergency room services	$100/visit (*waived if admitted inpatient*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	No copay
Urgent Care *(out of service area)*	$15/visit *(copay waived if admitted inpatient or outpatient ER. For in area, contact your PCP or medical group)*
Skilled Nursing Facility (*limited to 100 days/calendar year ; limit does not apply to mental health and substance abuse*)	
∘ All necessary services & supplies (*excluding take-home drugs*)	No copay
Ambulance Services	
∘ Transportation when medically necessary	No copay
Ambulatory Surgical Center	
∘ Outpatient surgery & supplies	No copay

Covered Services	Per Member Copay
Pregnancy and Maternity Care Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Abortions** *(including prescription drug for abortion, mifepristone)*	No copay No copay
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment • Rental and Purchase of DME *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge)*	No copay
Family Planning and Infertility Services • Infertility studies & tests • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization • Counseling & consultation	 $15/visit No copay $15/visit $15/visit
Mental or Nervous Disorders and Substance Abuse • Inpatient facility care *(subject to utilization review; waived for emergency admissions*) • Inpatient physician visits • Outpatient facility care • Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	 No copay No copay No copay $15/visit *(for non-preventive visits)*
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$15/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	 No copay $15/visit $15/visit

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions link provided here. Please see your EOC for full details on your covered benefits

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

SJVIA
Modified Chiropractic Care and Acupuncture Rider Plan 10/40

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit to a Chiropractor or Acupuncturist	$10/visit
Maximum Benefits	
Office visits to a Chiropractor or Acupuncturist	40 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	$50 per calendar year

Covered Services

Chiropractor Services: Member has up to 40 visits, combined with visits for acupuncture services, in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- Chiropractic Appliances: Up to $50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
  - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
  - cervical collars or cervical pillows;
  - ankle braces, knee braces, or wrist braces;
  - heel lifts;
  - hot or cold packs;
  - lumbar cushions;
  - rib belts or orthotics; and
  - home traction units for treatment of the cervical or lumbar regions.

Acupuncture Services. Member has up to 40 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans acupuncturist.

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, incluing, without limitation, asthma or addictions such as nicotine addiction.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;
- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors or non-ASH Plans Acupuncturists: Services and supplies provided by a chiropractor or an acupuncturists who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplement. Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC..

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO plan to obtain emergency or out-of-area care.

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

SJVIA
San Joaquin Valley Insurance Authority

usscript

Prescription Drug Copays

30 Day Supply:		**Mail**	
Generic	$10	Generic	$20
Formulary	$20	Formulary	$40
Non-Formulary	$35	Non-Formulary	$60
DAW 1 - No Cost Differential		DAW 1 - No Cost Differential	
DAW 2 - Non-Formulary + Cost Difference		DAW 2 - Non-Formulary + Cost Difference	
90 Day Supply:		**Specialty Medication Copay:**	
Generic	$20	30% ($100.00 max.)	
Formulary	$40		
Non-Formulary	$60	** Specialty medications are covered at a 30-day	
DAW 1 - No Cost Differential		Supply only.**	
DAW 2 - Non-Formulary + Cost Difference			
Annual Out-of-Pocket Maximum			
Individual	$2,000		
Family	$4,000		

Exclusions

Hair Treatments
Pigmenting/Depigmenting
Anti-wrinkle
Fluoride Preps
Misc. Medical Supplies
OTC Medications
Miscellaneous Injectables
Toradol (excluded at mail)
Zyvox (excluded at mail)

This is not a complete summary of benefits. Additional limitations and exclusions may apply.

Anthem Blue Cross Enrollment Form

Effective date	Group no.

Anthem BlueCross

Purpose: ☐ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

SECTION 1: TYPE OF COVERAGE — Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:

- ☐ HMO (CaliforniaCare)[1]
- ☐ Preferred HMO (CaliforniaCare PLUS)[1]
- ☐ Advantage HMO[1]
- ☐ Priority Select HMO[1]
- ☐ Other: _____
- ☐ Select HMO[1]
- ☐ Vivity HMO[1]
- ☐ Elements Choice EQ HMO[1]

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ PPO (Prudent Buyer)
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)[1]
- ☐ Elements Choice EQ PPO
- ☐ Medicare
- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO (non-California resident)
- ☐ Lumenos® (select one of the following)
  - ☐ H.S.A.[2] ☐ H.R.A.
  - ☐ H.I.A. ☐ H.I.A. Plus
- ☐ Elements Choice EQ HSA

1 Indicate Medical Group/IPA No. in the ***Employee and Family Information*** section.
2 Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Dental

Anthem Blue Cross plans:

- ☐ Dental Net HMO[3]
- ☐ **Choice Dental** (select one of the following)
  - ☐ Dental Net HMO[3] ☐ PPO Dental
- ☐ Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

3 Indicate Dental Office No. in the ***Employee and Family Information*** section.

☐ UniAccount (Flexible Spending account)[4] (Indicate payroll deductions)
I authorize payroll deductions on the following:
- ☐ Health Care Account $_____
- ☐ Dependent Care $_____

4 Anthem Blue Cross PPO, drug and dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another health plan. Reminder: Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

Vision ☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life Insurance All the coverages listed may not be offered under your plan. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the ***Life Insurance Beneficiary Designation Information*** section. **Annual salary** $

Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount
☐ Basic Life (AD&D)	$_____	☐ Optional Life - Employee	$_____	☐ Optional AD&D - Employee	$_____
☐ Dependent Life - Spouse	$_____	☐ Optional Dependent Life/Spouse	$_____	☐ Optional AD&D - Spouse	$_____
☐ Dependent Life - Child	$_____	☐ Optional Dependent Life/Child	$_____	☐ Optional AD&D - Child	$_____
		☐ Short Term Disability	$_____	☐ Voluntary Short Term Disability	$_____
		☐ Long Term Disability	$_____	☐ Voluntary Long Term Disability	$_____

LANGUAGE CHOICE (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

SECTION 2: APPLICANT'S PERSONAL INFORMATION

Social Security numbers are required under CMS Regulations and by the IRS.

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or ID no.[5] (required)
Mailing address		Apt. no.	# of dependents including spouse	Spouse/DP Social Security or ID no.[5] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date	Employer name	Job title	Class	Dept. no.	Email address

SECTION 3: EMPLOYEE AND FAMILY INFORMATION — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YYYY)	Social Security or ID no.[5] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below	HMO & POS ONLY IPA/Primary Care Physician Code	Current MD?	Dental Net ONLY Office No.
☐ M ☐ F	Employee								☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP						IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.
5 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

SECTION 4: DECLINATION — To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

B. Dental coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

C. Vision coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

D. Life insurance coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage — check one
☐ Covered by spouse's group coverage. Carrier name and ID no.: _____
☐ Covered by Anthem Blue Cross Individual policy
☐ Spouse covered by employer's group medical coverage. Carrier name: _____
☐ Enrolled in Tricare
☐ Enrolled in any other insurance carrier plan. Carrier name: _____
☐ Medicare
☐ Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)
X

Date

~~SECTION 5: COBRA/CAL-COBRA COVERAGE INFORMATION — Complete only if enrolling in COBRA/Cal-COBRA.~~

~~Reason for COBRA/Cal-COBRA coverage~~

~~Federal COBRA qualifying event date~~	~~Federal COBRA coverage begin date~~	~~Federal COBRA coverage end date~~
~~Cal-COBRA qualifying event date~~	~~Cal-COBRA coverage begin date~~	~~Cal-COBRA coverage end date~~

SECTION 6: OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS — All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person: _____ Insurance company: _____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Date coverage began: _____ Date ended: _____

~~C. Does any person applying for coverage currently have **dental** insurance coverage?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If yes, applicant/family member name(s):~~ _____
~~Type of continuous coverage:~~ ☐ ~~Group~~ ☐ ~~Individual~~ ☐ ~~Other:~~ _____
~~Insurance company:~~ _____ ~~Date coverage began:~~ _____ ~~Date ended:~~ _____

~~D. Does any person applying for coverage currently have **vision** insurance coverage?~~ ☐ ~~Yes~~ ☐ ~~No~~
~~If yes, applicant/family member name(s):~~ _____
~~Type of continuous coverage:~~ ☐ ~~Group~~ ☐ ~~Individual~~ ☐ ~~Other:~~ _____
~~Insurance company:~~ _____ ~~Date coverage began:~~ _____ ~~Date ended:~~ _____

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No
Note: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SECTION 7: MEDICARE SECTION — Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim No.

SECTION 8: PRIOR COVERAGE FOR PPO PLANS ONLY — Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **NOTE**: If this section is left blank, there may be delays in the processing of claims for these dependents.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Child				
Child				
Child				

1 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

~~SECTION 9: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION~~

~~Note: Dependent Life payments are always paid to the employee.~~

~~Primary Beneficiary — First to receive payment (required)~~ ~~If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.~~

~~Name~~	~~Birthdate~~	~~Social Security no.~~	~~Relationship~~	~~%~~
~~Street address~~		~~City~~	~~State~~	~~ZIP code~~
~~Name~~	~~Birthdate~~	~~Social Security no.~~	~~Relationship~~	~~%~~
~~Street address~~		~~City~~	~~State~~	~~ZIP code~~

SECTION 10: PLEASE READ CAREFULLY — Signature required.

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

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

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

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: ***It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.**

Signature (Required)

Applicant X	Date

1 Anthem is required by the Internal Revenue Service to collect this information.

SJVIA PPO 500
Custom PPO 500/35/80/60

Anthem believes this plan is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance. Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-Participating Providers & Other Health Care Providers- (includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$500/member; $1,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$250/admission *(waived for emergency admission)*	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums (*no cross application*)		
PPO Providers & Other Health Care Providers	$3,000/member/year; $6,000/family/year	
Non-PPO Providers	$10,000/member/year; $20,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense		
Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$125/surgery + 20%	40% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. [2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$35/visit[2] *(deductible waived)*	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
➢ Drugs administered by a medical provider (*certain drugs are subject to utilization review)*	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	No copay	40%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	40%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	40%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$35/visit *(deductible waived)*	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	40%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$35/visit[2] *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Female Sterilization (*including tubal ligation and counseling/consultation)*	*No copay*	Not covered
➢ Male Sterilization	20%	Not covered
➢ Family Planning counseling	$35/visit *(deductible waived)*	Not covered

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2]The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	$250/admission + 20%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE (recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	$250/admission + 20%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME (member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$35/visit *(deductible waived)*	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	20%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$250/admission + 20%	$250/admission + 20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$35/visit[3] *(deductible waived)*	40%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[3] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

SJVIA
San Joaquin Valley Insurance Authority

usscript

Prescription Drug Copays

30 Day Supply:		**Mail**	
Generic	$10	Generic	$20
Formulary	$20	Formulary	$40
Non-Formulary	$35	Non-Formulary	$60
DAW 1 - No Cost Differential		DAW 1 - No Cost Differential	
DAW 2 - Non-Formulary + Cost Difference		DAW 2 - Non-Formulary + Cost Difference	
90 Day Supply:		**Specialty Medication Copay:**	
Generic	$20	30% ($100.00 max.)	
Formulary	$40		
Non-Formulary	$60	** Specialty medications are covered at a 30-day	
DAW 1 - No Cost Differential		Supply only.**	
DAW 2 - Non-Formulary + Cost Difference			
Annual Out-of-Pocket Maximum			
Individual	$2,000		
Family	$4,000		

Exclusions

Hair Treatments
Pigmenting/Depigmenting
Anti-wrinkle
Fluoride Preps
Misc. Medical Supplies
OTC Medications
Miscellaneous Injectables
Toradol (excluded at mail)
Zyvox (excluded at mail)

This is not a complete summary of benefits. Additional limitations and exclusions may apply.

California Region Group Enrollment/Change Form

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

TO BE COMPLETED BY EMPLOYER		
Company name **City of Reedley**		Hire date (mm/dd/yyyy)
Group number **604207**	Enrollment unit	Effective enrollment/ change date (mm/dd/yyyy)

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

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

Health Plan *(Check one)* ☑ HMO Plan ❑ Deductible Plan ❑ Other _____

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

❑ Name Change *(complete sections A, B, C, D)* From: **City of Reedley** To: _____

Event Date (mm/dd/yyyy) _____

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

City of Reedley
Medical Record No. *(if known)*

Social Security No.

Name (Last, First, MI)

Birth Date (mm/dd/yyyy)

Gender ❑ M ❑ F

City of Reedley
Home Address

City of Reedley
City

City of Reedley
State

ZIP

City of Reedley
Work Phone

Home Phone

City of Reedley
Email

Ethnicity

City of Reedley
Preferred Language

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

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

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

Name (Last, First, MI): Address:

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

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance*.

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

*

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

Date

KAISER PERMANENTE®

Disclosure Form

604207 SJVIA-City Of Reedley

Principal benefits for Kaiser Permanente Traditional Plan

(1/1/16—12/31/16)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Accumulation Period

The Accumulation Period for this plan is 1/1/16 through 12/31/16 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year

Plan Deductible	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialty Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Hearing exams	No charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

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

Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit

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

Ambulance Services	**You Pay**
Ambulance Services	No charge

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$5 for up to a 30-day supply
Most generic refills through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items in accord with our DME formulary guidelines	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge

(continues)

Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$15 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices	No charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No charge

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

KAISER PERMANENTE®

Small Business

DECLINATION OF COVERAGE

Employers: Keep a copy of this form for your records.

COMPANY INFORMATION

Company name	Customer ID (if assigned)

REASON FOR DECLINING

I have been offered Kaiser Permanente group health coverage by my employer. I voluntarily choose not to enroll myself and my dependents in a Kaiser Permanente plan at this time. I understand that the next opportunity to enroll will be during the annual open enrollment period.

Reason for declining (check one):

- ☐ I am covered by another employer's health plan through my spouse/domestic partner/parent.
  Name of carrier:
- ☐ I am covered by another plan offered by my employer.
  Name of carrier:
- ☐ I am covered by an individual health plan.
  Name of carrier:
- ☐ I am covered by Medicare, Medi-Cal, or Tricare.
- ☐ Other reason for declining:

SIGNATURE

Employee name (please print)	Social Security number (last 4 digits)
Signature X	Date

You may be eligible to enroll yourself and your dependents before the next open enrollment period if a qualifying event, such as losing other coverage, occurs. If your situation changes, please contact your employer immediately for more information.