DATE: **OCTOBER 31, 2017**

TO: **CITY OF SANTA ROSA UNIT 8 EMPLOYEES**

FROM: **DOMINIQUE KURIHARA, RISK MANAGER**

SUBJECT: **COBRA DENTAL COVERAGE CHANGE & BUY-UP OPTION**

During bargaining negotiations earlier this year, your collective bargaining unit, Unit 8, bargained to increase the amount of dental coverage offered to Unit 8 employees effective January 1, 2018.

As a result of these agreements, all Unit 8 employees will be transferred to the new core plan (Group #03066- 09001) effective January 1, 2018. All Unit 8 employees have the option of enrolling in the higher coverage plan, called the Buy-up Plan (Group #03066-09002).

Enclosed are the following documents for your information and use:

- Delta Dental PPO Unit 8 Core Summary Plan Sheet;
- Delta Dental PPO Unit 8 Buy-up Summary Plan Sheet;
- 2018 COBRA Rates;
- An Enrollment Form to complete, date, sign and return should you choose to enroll in the Buy-up option.

Should you choose to change from the core plan to the buy-up option, the enclosed enrollment form will need to be completed and returned to Human Resources no later than November 20, 2017. If you do not wish to enroll in the Buy-up Option, you do not need to turn in any additional forms.

Please note, all Unit 8 employees should update their group plan number accordingly with their providers beginning in January of 2018 as the old group plan number will no longer work.

For additional questions, please contact Michelle Capella at (707) 543-3062.

Encls.

DELTA DENTAL

Keep Smiling

Delta Dental PPO℠

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at **deltadentalins.com**. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[4] You can find this date by logging in to Online Services.

Newly covered?

Visit **deltadentalins.com/welcome**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO.. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

HL_PPO #104383D (rev. 3/17)

Plan Benefit Highlights for: City of Santa Rosa, Unit 8 - Transit (Core Plan)

Group No: 03066-01001, 09001 **Effective Date:** 01/01/2018

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Maximums	PPO dentists: $2,100 per person each calendar year Non-PPO dentists: $2,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions, posterior composite restorations and sealants	80 %	80 %
Endodontics (root canals)	80 %	80 %
Periodontics (gum treatment)	80 %	80 %
Oral Surgery	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges, dentures and implants	80 %	80 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$2,000 Lifetime	$2,000 Lifetime

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

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

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

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

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[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO.. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

HL_PPO #104383D (rev. 3/17)

Plan Benefit Highlights for: City of Santa Rosa, Unit 8 - Transit (Buy-Up Plan)

Group No: 03066-01002, 09002 **Effective Date:** 01/01/2018

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Maximums	PPO dentists: $3,500 per person each calendar year Non-PPO dentists: $3,400 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions, posterior composite restorations and sealants	80 %	80 %
Endodontics (root canals)	80 %	80 %
Periodontics (gum treatment)	80 %	80 %
Oral Surgery	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges, dentures and implants	80 %	80 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$2,000 Lifetime	$2,000 Lifetime

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

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

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

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2018 COBRA Rates

Health Premium	CITY - PPO
Single	$773.16
Double	$1,567.74
Family	$2,200.14
Health Premium	**CITY EPO**
Single	$889.44
Double	$1,810.50
Family	$2,528.58
Health Premium	**Kaiser**
Single	$736.44
Double	$1,492.26
Family	$2,081.82
Dental Premium	**Misc & Safety Units**
Single	$70.38
Double	$121.38
Family	$170.34
Dental Premium CORE	**UNIT 8 TRANSIT ONLY**
Single	$77.52
Double	$133.62
Family	$187.68
Dental Premium BUY-UP	**UNIT 8 TRANSIT ONLY**
Single	$96.90
Double	$166.26
Family	$233.58
Vision Premium	**Misc & Safety Units**
Single	$9.50
Double	$14.77
Family	$22.15

UNIVERSAL BENEFITS ENROLLMENT OR CHANGE WORKSHEET

City of Santa Rosa

Reason for changing benefits (circle all that apply): **Event Date:**
New Hire / Add Dependent / Delete Dependent / Open Enrollment / Retirement / Other
Please explain:

EMPLOYEE INFORMATION – COMPLETE IN FULL

Employee Name (Last, First, Middle Initial)		Gender: M / F	Employee Type:	Social Security No.
Employee Street Address			City, State	Zip Code
Employee Mailing Address (if different)			City, State	Zip Code
Job Title:	Date of Hire:	Department:		Unit:

Marital Status (circle one): Single Married State Domestic Partner Legally Separated Divorced

LIST ALL DEPENDENTS TO BE ENROLLED IN COVERAGE (All eligible dependent children under 26 years of age may be enrolled in medical, dental and vision coverage)

Last Name, First Name, M.	Gender	Birth Date	Social Security No.	Relationship (circle one):	Coverage / Action	
	M / F			Self	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Spouse / Domestic Partner	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change
	M / F			Natural Child Step Child Legal Child Domestic Partner Child	Medical Add Delete No Change	Dental & Vision Add Delete No Change

MEDICAL ELECTION (MISCELLANEOUS EMPLOYEES ONLY) - PLEASE CHECK ONLY ONE APPLICABLE BOX(ES)	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE + FAMILY	WAIVE
Health Plan: City EPO				(If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)
Health Plan: City PPO				(If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)
Health Plan: Kaiser Permanente Traditional HMO Plan: Active (GP# 8961-0000) Retiree (GP# 8961- 0002)				(If waiving health insurance coverage, please complete Additional Health/Dental Coverage on Page 2)

DENTAL & VISION ELECTIONS - PLEASE CHECK APPLICABLE BOX(ES)	EMPLOYEE ONLY	EMPLOYEE +1	EMPLOYEE + FAMILY	WAIVE
Dental & Vision - All Units EXCEPT UNIT 8 (Dental = Delta Dental PPO Group #3066-0015 / Vision = VSP)				
Dental & Vision - UNIT 8 CORE ONLY (Dental = Delta Dental PPO Group #3066-01001 / Vision = VSP)				
Dental & Vision - UNIT 8 CORE & BUY-UP OPTION (Dental = Delta Dental PPO Group #3066-01002 / Vision = VSP)				

UNIVERSAL BENEFITS ENROLLMENT OR CHANGE WORKSHEET

ENROLLMENT DECLINATIONS	ADDITIONAL HEALTH/DENTAL COVERAGE
Coverage is declined for the following people: **Self OR Spouse Only OR Spouse & Child(ren) OR Child(ren) only because:** **the individuals are insured by:** **Insurance Carrier:** _____: **OR Other reasons:**_____ _____	**Secondary/primary health and/or dental coverage exists for:** **Self Spouse Only Spouse &Child(ren) Child(ren) only** **Health Carrier:**_____ **Policy #/Effective Date:** _____ **Dental Carrier:** _____ **Policy #/Effective Date:**_____

Authorization to Obtain OR Release Medical Information Explanation: The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the ***Confidentiality of Medical Information Act*** , effective January 1, 1980, Section 56 et. Seq., of the ***California Civil Code*** . Your cooperation is being requested.
Authorization to Obtain OR Release Medical Information: I hereby authorize my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim. **Initial**_____

Arbitration Agreement: I agree and understand that any and all disputes, including claims relating to the delivery of services under the selected medical plan and claims of medical malpractice, (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered,) except for claims subject to ***ERISA*** , or any dispute that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or) any enrolled family member including heirs and assigns) and the insurance company providing my medical insurance (its parents, subsidiaries, or affiliates) through the above elected plan, or any Participating Physician Group/Independent Physician Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.
Initial if you have selected the City EPO or the City PPO_____

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**

(All Plans-EPO, PPO, Kaiser Permanente) X	Signature of witness (only required if employee signature is "X")	Date:

HUMAN RESOURCES USE ONLY				OLD LEVEL (circle one)			EFFECTIVE DATE:
Medical Plan Level Change?	YES	NO		EE ONLY	EE +1	EE + FAMILY	
Dental Level Change?	YES	NO		EE ONLY	EE +1	EE + FAMILY	
Vision Plan Level Change?	YES	NO		EE ONLY	EE +1	EE + FAMILY	

Office Use Only **Confirmation Sent to PY:** _____ **Received HR** _____ **By:** **on:**	**Entered EBS**_____ **By:**_____	**COPY Received PY** _____ **By:**