Dear IHSS Provider,

This is an important notice of the **eligibility requirements for you to receive and maintain Health and Dental Insurance** provided by In-Home Supportive Services Public Authority of Marin.

To receive Health and Dental Insurance you **must** do the following:

- **Work and be paid for a minimum of 65 hours every month for Kaiser and 85 a month for Dental.**
- **Update your hours worked on line or via telephone twice a month as indicated by IHSS of each month.**

Warning of Insurance Benefits Cancellation

Providers who do not comply with the eligibility requirements for two months will have their Health and Dental Insurance cancelled and a COBRA application sent out to them.

Before being reinstated, you must reimburse IHSS PA for any month you were covered by insurance but were not deducted or did not pay the premium.

If you don't see the deduction on your pay stub for your Health Care Benefits, call me immediately! You may lose or have lost your benefits if you are not being deducted for them. Always check your pay stub information to be sure you are getting deducted for your benefits. It will be on the HEALTH line on your paycheck stub.

If you are working for an In-Home Supportive Services (IHSS) recipient, but not updating your hours worked online on time, you are in danger of losing your Health and Dental Insurance.

If you need more work hours, please contact the Public Authority at (415) 499-1024 and ask for a Registry Specialist.

If you have any questions regarding your eligibility for Insurance through IHSS, please give me a call.

Julia Hansen

Finance Manager

Main: (415) 499-1024 Ext: 102

julia@pamarin.gov

PROVIDER BENEFITS APPLICATION PACKET

Please note:

If applying for health insurance, complete **both forms:** Kaiser and Chubb. Your share of the premium for Kaiser and Chubb insurance is $130.00 per month and it will be deducted from one pay check of each month. You must work 65 hours per month to qualify.

If applying for dental insurance, complete the Delta form. Your share of the premium is $18.62 per month and it will be deducted from one paycheck of each month. You must work 85 hours per month to qualify.

RETURN ONLY THE FILLABLE FORMS. KEEP THE OTHERS FOR YOUR INFORMATION.

Disclosure Form Part One

IHSS: IN-HOME SUPPORT SERVICES
602753 - 0, 7000
Home Region: Northern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.
For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

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

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

Telehealth Visits	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	20% Coinsurance up to a maximum of $50 per procedure after Plan Deductible

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

Emergency Services	You Pay
Emergency department visits	20% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	$150 per trip after Plan Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)

(continues)

Prescription Drug Coverage	**You Pay**
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024-12/31/2024

KAISER PERMANENTE® : DEDUCTIBLE PLAN

Coverage for: Individual/Family | Plan Type: DHMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,000 Individual / $2,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 Individual / $6,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit, deductible does not apply.	Not Covered	None
	Specialist visit	$20 / visit, deductible does not apply.	Not Covered	None
	Preventive care/ screening/ immunization	No Charge, deductible does not apply.	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$10 / encounter	Not Covered	None
	Imaging (CT/PET scans, MRI's)	20% coinsurance up to $50 / procedure	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	Retail: $10 / prescription; Mail order: $20 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Preferred brand drugs (Tier 2)	Retail: $30 / prescription; Mail order: $60 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives, deductible does not apply.
	Non-preferred brand drugs (Tier 2)	Retail: $30 / prescription; Mail order: $60 / prescription, deductible does not apply.	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	$30 / prescription, deductible does not apply.	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	None
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	$150 / trip	$150 / trip	None
	Urgent care	$20 / visit, deductible does not apply.	Not Covered	Non-Plan providers covered when temporarily outside the service area: $20 / visit, deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	None
	Physician/surgeon fee	20% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental / Behavioral Health: $20 / individual visit, deductible does not apply. 20% coinsurance for other outpatient services; Substance Abuse: $20 / individual visit, deductible does not apply. 20% coinsurance up to $5 / day for other outpatient services, deductible does not apply.	Not Covered	Mental / Behavioral Health: $10 / group visit, deductible does not apply; Substance Abuse: $5 / group visit, deductible does not apply.
	Inpatient services	20% coinsurance	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you are pregnant	Office visits	No Charge, deductible does not apply.	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	Not Covered	None
	Childbirth/delivery facility services	20% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge, deductible does not apply.	Not Covered	2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: 20% coinsurance; Outpatient: $20 / visit	Not Covered	None
	Habilitation services	$20 / visit	Not Covered	None
	Skilled nursing care	20% coinsurance	Not Covered	100 day limit / benefit period.
	Durable medical equipment	20% coinsurance, deductible does not apply.	Not Covered	Requires prior authorization.
	Hospice service	No Charge, deductible does not apply.	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam, deductible does not apply.	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (plan provider referred) • Bariatric surgery	• Infertility treatment	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.healthhelp.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 (TTY: 711)

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other (blood work) copayment	$10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$50
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$2,800**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other (blood work) copayment	$10

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$90
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$990**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other (x-ray) copayment	$10

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

The plan would be responsible for the other costs of these EXAMPLE covered services.

HEALTH CARE EMPLOYEES/EMPLOYER DENTAL AND MEDICAL TRUST

P.O. Box 9026
Pleasanton, CA 94566
Tel: 800-824-3316

Kaiser Permanente Enrollment Application

Date Mailed: 2/21/2013

EMPLOYEE/SUBSCRIBER INFORMATION

___ - ___ - ____ Social Security Number | Last Name | First Name | Middle

___ / ___ / ___ Date of Birth | Gender: □ Male □ Female | Marital Status: □ Married □ Single

Preferred Language Spoken | Preferred Language Written | E-mail Address (optional)

Street Address | City | State | Zip Code

( ) Day Phone | ( ) Evening Phone

ACCEPTANCE OF COVERAGE

☐ I understand the cost to me for the Kaiser Permanente/Fidelity Plan is $130 per month. (You must complete both the Kaiser and Fidelity Applications to be enrolled in this plan.)

Kaiser Foundation Health Plan Arbitration Agreement

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

Signature Required for the Kaiser Permanente Plan | Date

DECLINATION OF COVERAGE

☐ I voluntarily choose **not to enroll** in the Health Benefit offered to me by IHSS Public Authority of Marin.

Employee/Subscriber Signature (IF DECLINING COVERAGE) | Date

TO BE COMPLETED BY EMPLOYER (FOR OFFICE USE ONLY)

IHSS Public Authority of Marin | *602753-00* | Effective Date
Company Name | Group Number

Enrollment Reason: □ New Hire □ Loss of Other Coverage □ Open Enrollment □ Other: Reached Top of Waitlist Event Date: _____ Date of Hire: _____

Wait List Number:

Chubb GAP Supplement

Gaps in Medical Coverage May Result in Unexpected Costs...
We've Got You Covered

Need coverage to help pay your Kaiser out-of-pocket costs?!?!?

The rising cost of health care is a real challenge to both employees and employers! Affordable health care coverage often means more risk to employees through increased deductibles and high out-of-pocket expenses.

The Chubb Gap Supplement plan is designed to help you pay for covered out-of-pocket expenses you may incur while you are confined in a hospital or while being treated as an outpatient, due to an illness or injury.

How does the Chubb GAP Supplement work?

- Reimburses 100% of the eligible out-of-pocket costs (deductibles and co-insurance) for in-hospital or outpatient services resulting from an injury or sickness, not paid by your group major medical plan up to the maximum amount stated for each benefit.
- Eligible expenses must be covered by group major medical plan.
- You can submit copies of your bill and the completed Claim Questionnaire to Chubb for payment. If the claim is approved, a check will be mailed to your home.
- You can submit your claim at the time you receive the bill, or you can wait to submit it until the end of the year, but must be filed no later than 12 months from the date of service in order to be eligible for coverage.

Basic Plan Benefits:

Hospital Confinement Benefit

- Up to **$3,000** per Insured Person per Calendar Year
- Includes hospital stays that are 15 consecutive hours or longer and the associated charges (ex: In-patient Hospitalization, Surgeries and Physician's In-Hospital charges)
- Includes Emergency Room treatment for injury.
- Includes Emergency Room treatment for a sickness if it results in a hospital confinement within 24 hours

Outpatient Benefit

- Up to $**1,500** per occurrence subject to a maximum of 4 occurrences per family per calendar year
- Covers out of pocket expenses for outpatient treatment under the regular care and attendance of a physician at a hospital, outpatient surgical or emergency facility, a diagnostic testing facility or similar facility that is licensed to provide outpatient treatment.
- Same or related conditions are considered a new "occurrence" if separated by at least 90 days consecutive treatment-free days

The policy excludes the out-of-pocket expenses related to these services, even if they are covered by your major medical plan:

- Costs associated with treatment in a doctor's office
- Prescription Drugs
- Well-newborn care in hospital
- Wellness or Preventive Care
- Mental and Nervous Conditions
- Ambulance

This is a supplement to health insurance and is not a substitute for major medical coverage.

Arranged/Administered By:
90 Degree Benefits
2810 Premiere Pkwy #400,Duluth, GA 30097
Phone: (800)239-3503 / Fax: (678) 258-8299
Email: claims.t5a@90DegreeDenefits.com
www.90DegreeBenefits.com

For More Information, Please Contact:
Health Care Employees/Employer
Dental and Medical Trust
Tel: (800) 824-3316 / (925) 803-1880

Chubb Gap

DATA COLLECTION FORM

PLAN INFORMATION:

As selected by the Policyholder

In Hospital Benefit Amounts

☒ Plan I:	$3,000.00	In-Hospital Benefit
	$1,500.00	Optional Out-Patient Benefit
	$0	Optional Physician Benefit Rider

APPLICANT INFORMATION:

Name (last, first, middle)				Sex ☐ M ☐ F
Age	Date of Birth (mm/dd/yy)	Social Security Number	Home Phone #	Work Phone #
Street Address			E-Mail	
City		State		Zip Code
Coverage Selected:	☒ Employee Only			

I hereby: ☒ **ENROLL**, or ☐ **CHANGE** as indicated above, for this group insurance coverage for which I am eligible. I authorize my Employer to deduct my contributions, if any, from my salary or wages, and to remit that amount to Chubb Gap Security Life Insurance Company. I request that this authorization remain in effect until such time as I withdraw it by giving written notice prior to the next premium due date. I understand and acknowledge: that no coverage will take effect for any person to be covered who is not also covered by a Major Medical/Comprehensive Policy including Coinsurance and Deductible, in force at the time of my proposed Effective Date for this coverage; that I am either currently covered under a Major Medical/Comprehensive coverage with this Employer or have enrolled for Major Medical/Comprehensive coverage with this Employer; that the coverage for which I am applying may contain Pre-Existing Limitations; that the Master Policy for this coverage is issued to the Health Care Employee/Employer Dental and Medical Trust; and that I will receive a certificate as evidence of my insurance coverage under the policy.

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

Applicant's Signature _____ Date _____

Parent or Legal Guardian if the Applicant is under age 18

Agent's Signature (where applicable by law) _____

TO BE COMPLETED BY EMPLOYER:		
Employer **IHSS PUBLIC AUTHORITY OF MARIN**	Occupation **IHSS Worker**	Date of Hire
Monthly Premium:	Requested Effective of Coverage/Change:	

Policy Holder: Health Care Employees/Employer Dental and Medical Trust

Delta Dental of California
IHSS Public Authority of Marin – 2441/0001

Updated 1/1/2023

Highlights of your Delta Dental PPO Plan	IN-NETWORK	OUT-OF-NETWORK	
	PPO Dentist[1]	DeltaPremier Dentist[2]	Non-Delta Dentist[3]
WHO IS COVERED	Primary enrollee and spouse as well as children to age 26		
DEDUCTIBLES-waived on D&P **BENEFITS MAXIMUM**	**$50 per person** The Maximum benefit paid per calendar year is **$1,000 per person**	**$50 per person** The Maximum benefit paid per calendar year is **$1,000 per person**	**$50 per person** The Maximum benefit paid per calendar year is **$1,000 per person**
DIAGNOSTIC AND PREVENTIVE BENEFITS Oral examinations, cleanings, x-rays, biopsy/tissue examinations, fluoride treatment, space maintainers, specialist consultation	**100%** of a ***PPO*** Dentist fees	**100%** of a ***DeltaPremier*** Dentist fee	**100%** of ***UCR***
BASIC BENEFITS Oral surgery (extractions), fillings, root canals, periodontic (gum) treatment, sealants	**80%** of a ***PPO*** Dentist fees	**80%** of a ***DeltaPremier*** Dentist fee	**80%** of ***UCR***
CROWNS, JACKETS AND CAST RESTORATIONS-12 months wait	**60%** of a ***PPO*** Dentist fees	**50%** of a ***DeltaPremier*** Dentist fee	**50%** of ***UCR***
PROSTHODONTIC BENEFITS – 12 months wait Bridges, partial dentures, full dentures Implant coverage	**60%** of a ***PPO*** Dentist fees	**50%** of a ***DeltaPremier*** Dentist fee	**50%** of ***UCR***
ORTHODONTIC BENEFITS – 12 months wait Lifetime Max - $1000	**50%** of a ***PPO*** Dentist fees	**50%** of a ***DeltaPremier*** Dentist fee	**50%** of ***UCR***

[1]The approved fee for the PPO dentist is based on the PPO fee schedule

[2] The approved fee for DeltaPremier dentist is the filed fee

[3] The non-Delta dentist payment is based on the fee that satisfies the majority of Delta dentists (**UCR**).

*** UCR – Usual, Customary and Reasonable Fee**

- A **Usual** fee is the amount which an individual dentist regularly charges and received for a given service or the fee actually charged, whichever is less
- A **Customary** fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area.
- A **Reasonable** fee schedule is reasonable if it is Usual and Customary.

SERVICES THAT ARE *NOT* COVERED

- Extra-oral grafts
- Cosmetic surgery or dentistry or services to correct congenital malformation
- Services for injuries/conditions covered under Workers' Compensation or Employer's Liability Laws
- Anesthesia (except for general anesthesia for oral surgery)

This Preferred Provider Option program is administered by the **HEALTH CARE EMPLOYEES/EMPLOYER DENTAL TRUST.** If you have specific questions regarding benefit structure, limitations or exclusions, consult the Evidence of Coverage or contact the Customer and Member Services department at (925) 803-1880.

Delta Dental Online at www.deltadentalins.com

DELTA DENTAL ENROLLMENT APPLICATION

DELTA DENTAL ENROLLMENT FORM **Group Name: IHSS Public Authority of Marin**	**Delta Group/Division Number** **2441-0001**

A | Enrollee (Complete this section for new enrollment or change of status)

Name Last First Middle Initial	[redacted]	Social Security Number ___ - ___ - ____ (Member I.D. Number)	Birth date __ / __ / ____ Month / Day / Year	Sex ☐ Male ☐ Female

Mailing Address _____ Telephone Number (____) _____

City _____ State _____ Zip Code _____

[redacted]

B | Change to Existing Enrollment (Complete all sections that apply)

☐ Name Change ☐ Address Change listed above

Reason for change _____ Effective date of change ____ / ___ / ____
Month / Day / Year

C | Signature (Form must be signed to be processed)

I understand that I am required by the employer to pay $18.62 per month for these benefits. (Exception – See COBRA enrollment)
I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

Enrollee Signature _____ Date _____