EL DORADO UNION HIGH SCHOOL DISTRICT

CLASSIFIED EMPLOYEES

2020-2021 OPEN ENROLLMENT

September 1 – September 30, 2020 – CVT

(CVT Dental/Vision Changes Take Effect on October 1, 2020)

September 21 – October 16, 2020 – CalPERS

(CalPERS Health Coverage Changes Take Effect on January 1, 2021)

IMPORTANT – PLEASE READ

Its open enrollment time again. Enclosed is important information regarding your medical, dental and vision plans, as well as detailed information on participation in the District's in-lieu program and your responsibility.

California's Valued Trust Dental and Vision Only

You can begin making changes to your dental and vision plans online at mycvt.cvtrust.org beginning on September 1, 2020.

All changes must be submitted on-line no later than September 30, 2020.

CalPERS for Medical Enrollment

To enroll in a health plan or to change your health plan, complete the Health Benefits Plan Enrollment Form (HBD-12) and send it to the Payroll Department at the District Office.

Changes to medical plans will be effective January 1, 2021.
Your December payroll pays for January coverage.
All health enrollment changes must be submitted by October 16, 2020.

American Fidelity

Sign up for coverage, or make changes to existing coverages by scheduling an appointment with an American Fidelity representative. Policies that you currently have in place will continue with the exception of Dependent Care and Medical Expense Reimbursement accounts, which will automatically stop on October 1, 2020.

If you wish to continue your Dependent Care and/or Medical Expense Reimbursement policies, you need to meet with an American Fidelity representative to set them up again.

Check with your site secretary for appointment availability. If you are not able to schedule an appointment with a representative at your site, you can contact an American Fidelity representative via email at Tangee.Franco@americanfidelity.com.

All plans/policies will remain as they were unless you make a change.

OPEN ENROLLMENT CHECKLIST

Find the statement that best describes your situation and complete the items listed.

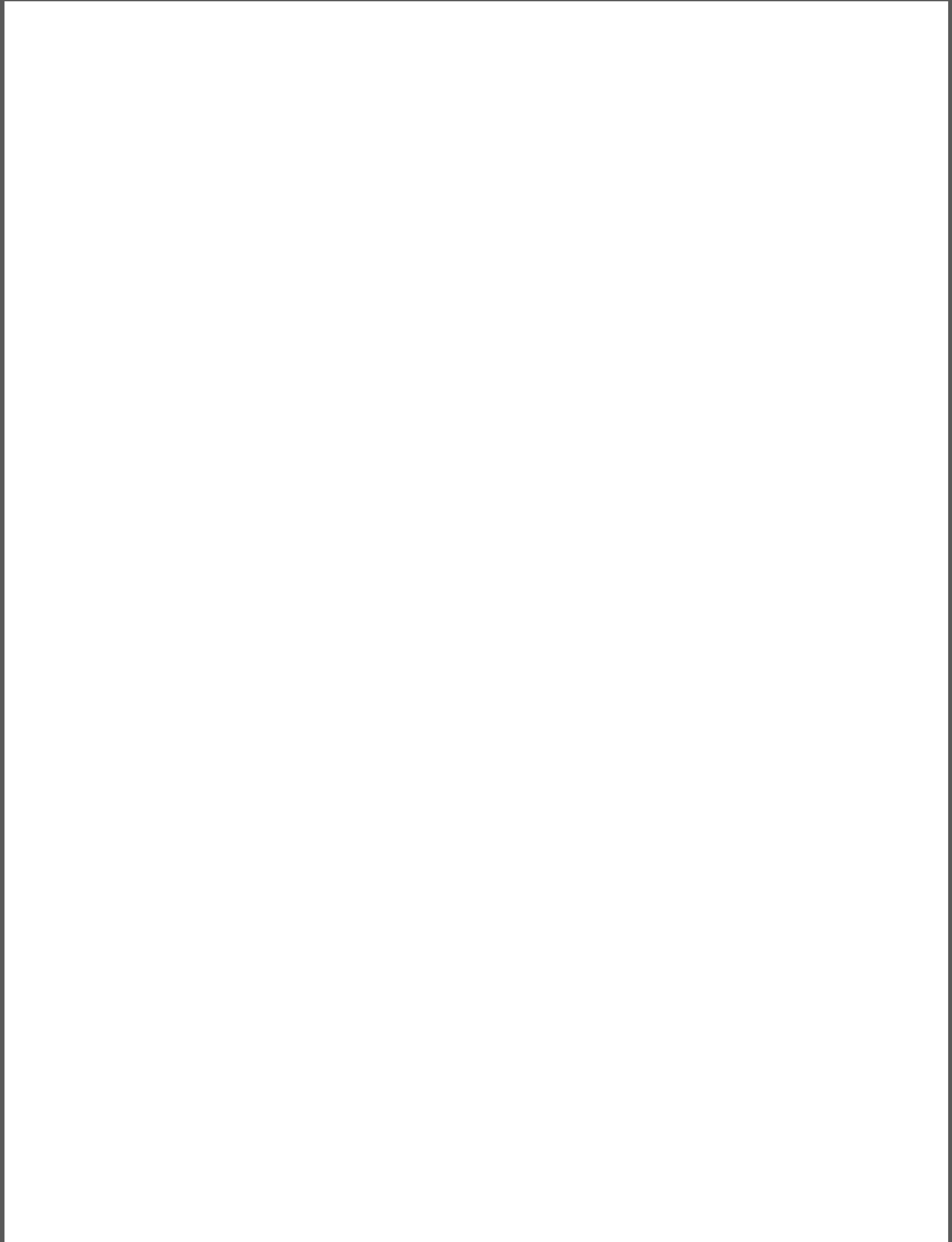
- I am currently enrolled in District sponsored health insurance coverage and **do not** wish to make any changes.
  - ☐ EDUHSD Declaration of Health Coverage (MANDATORY) – Send to Payroll

- I am currently enrolled in District sponsored health insurance coverage and wish to make changes.
  - ☐ MEDICAL – Health Benefits Plan Enrollment Active Employees (HBD-12)
  - ☐ DENTAL & VISION – All changes must completed online at my|CVT
  - ☐ EDUHSD Declaration of Health Coverage (MANDATORY) – Send to Payroll

- I am currently enrolled in the Cash-in-Lieu program and wish to remain in the program for the 2020-2021 Plan Year.
  - ☐ EDUHSD Declaration of Health Coverage (MANDATORY) – Send to Payroll
  - ☐ Annual Proof of Medical Coverage (MANDATORY) – Send to Payroll

- I am currently enrolled in the Cash-in-Lieu program but need to enroll in to the District sponsored health insurance coverage.
  - ☐ MEDICAL – Health Benefits Plan Enrollment Active Employees (HBD-12)
  - ☐ DENTAL & VISION – All changes must completed online at my|CVT
  - ☐ EDUHSD Declaration of Health Coverage (MANDATORY) – Send to Payroll

- I am currently enrolled in the District sponsored health insurance coverage but need to enroll in to the Cash-in-Lieu program.
  - ☐ MEDICAL – Health Benefits Plan Enrollment Active Employees (HBD-12)
  - ☐ DENTAL & VISION – All changes must completed online at my|CVT
  - ☐ EDUHSD Declaration of Health Coverage (MANDATORY) – Send to Payroll
  - ☐ Annual Proof of Medical Coverage (MANDATORY) – Send to Payroll



2020-2021 PREMIUM RATES - CLASSIFIED EMPLOYEES

CAPPED AMOUNT: $ 9,472.65

CalPERS (Plan Year: 1/1/2021 - 12/31/2021)

12 Month Premium

	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditonal HMO	Blue Shield Access+ HMO	Blue Shield Trio HMO	Health Net SmartCare HMO	Kaiser Permanente HMO	PERS Choice (PPO 80/20)	PERS Select (PPO 80/20)	PERS Care (PPO 90/10)	United Healthcare HMO	Western Health Advantage HMO	Full Time Monthly Cap Amount
Single	$ 927.82	$ 1,311.00	$ 1,172.89	$ 882.61	$ 1,122.90	$ 815.59	$ 938.09	$ 568.03	$ 1,297.80	$ 943.43	$ 758.84	
Single+1	$ 1,855.64	$ 2,622.00	$ 2,345.78	$ 1,765.23	$ 2,245.80	$ 1,631.19	$ 1,876.17	$ 1,136.06	$ 2,595.59	$ 1,886.86	$ 1,517.67	
Family	$ 2,412.34	$ 3,408.60	$ 3,049.51	$ 2,294.79	$ 2,919.54	$ 2,120.54	$ 2,439.02	$ 1,476.88	$ 3,374.27	$ 2,452.91	$ 1,972.97	$ 789.39

10 Month Premium

	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditonal HMO	Blue Shield Access+ HMO	Blue Shield Trio HMO	Health Net SmartCare HMO	Kaiser Permanente HMO	PERS Choice (PPO 80/20)	PERS Select (PPO 80/20)	PERS Care (PPO 90/10)	United Healthcare HMO	Western Health Advantage HMO	Full Time Monthly Cap Amount
Single	$ 1,113.39	$ 1,573.20	$ 1,407.47	$ 1,059.14	$ 1,347.48	$ 978.71	$ 1,125.70	$ 681.64	$ 1,557.36	$ 1,132.11	$ 910.60	
Single+1	$ 2,226.77	$ 3,146.40	$ 2,814.93	$ 2,118.27	$ 2,694.96	$ 1,957.42	$ 2,251.41	$ 1,363.27	$ 3,114.71	$ 2,264.23	$ 1,821.21	
Family	$ 2,894.80	$ 4,090.32	$ 3,659.41	$ 2,753.75	$ 3,503.45	$ 2,544.64	$ 2,926.82	$ 1,772.25	$ 4,049.12	$ 2,943.50	$ 2,367.57	$ 947.27

2020-2021 DENTAL and VISION PREMIUM RATES - CLASSIFIED EMPLOYEES

CAPPED AMOUNT: $ 9,472.65

CVT (Plan Year: 10/1/2020 - 9/30/2021)

12 Month Premium

	Delta Dental	Delta Dental 70/30	Vision Services	Full Time Monthly Cap Amount
Single	$ 112.60	$ 62.42	$ 22.08	
Single+1	$ 112.60	$ 62.42	$ 22.08	
Family	$ 112.60	$ 62.42	$ 22.08	$ 789.39

10 Month Premium

	Delta Dental	Delta Dental 70/30	Vision Services	Full Time Monthly Cap Amount
Single	$ 135.12	$ 74.90	$ 26.50	
Single+1	$ 135.12	$ 74.90	$ 26.50	
Family	$ 135.12	$ 74.90	$ 26.50	$ 947.27

MyCVT Online Member Enrollment

Quick steps to apply for insurance coverage

MyCVT is a web-based site where you can enroll as a new member of California's Valued Trust (CVT), choose a plan from several options that have been selected by your district or unit and make changes to your plan such as adding dependents or a change of address.

Before you can enroll online, you must first create your account.

Getting started

1. To access the site directly from your browser, type: https://mycvt.cvtrust.org.
2. You may also access the portal from www.cvtrust.org. Click on the MyCVT logo in the upper, right-hand corner of the page to open up the main portal page.
3. You will need the following information to create your account:
   - Unique email address (you cannot use a shared or group email)
   - Social Security number (do not use dashes in the form)
   - Your district name and classification
   - Password (six-digits minimum)
   - Date of Birth

Creating your account

1. From the MyCVT portal page, select "Create new account." Complete the requested information and submit.
2. Verify your date of birth.
3. A registration link will be sent to the unique email you submitted.
4. **Click on the link in the email** to complete the registration process.

New member enrollment

1. Login to your MyCVT account at https://mycvt.cvtrust.org.
2. Click the "Apply for Insurance Coverage" link
3. Complete the personal information section, choose "Next" to save and continue.

Add dependents

1. You can add or remove dependents. Add dependents by clicking on the blue "Add Dependent" button. Click the "Terminate" button next to any dependent you wish to remove form coverage.
2. If adding a dependent, enter all the required dependent information and click "Save" after each dependent has been added.
3. If you need to change any information, the forms can be opened again and edited by clicking the blue link of the dependent's name you want to update on the "Dependent Information" page. Always save every edit.

Choose your plan

1. The next step is to select your plans from the plan choice page. The plan selection will include those bargained benefits available to your unit.

2. Click "Show Plans" next to the coverage types (Health, Dental, Vision, Life) to see a grid of drop down menus that contain the plans available to you. You can compare up to four different plans by clicking the drop down menus and selecting the plans you want to compare. Once you have decided which plan you are going to choose, click the blue "Select this plan" button above the drop down menu to select that plan for that coverage. If you are unsure about which plans to choose, consult your district office for a summary of plans and the options/costs. You can also call CVT Member Services for assistance.
3. If your district does not offer plans for a particular coverage type, the words "No plans available" will appear next to that coverage type.
4. Once you have completed selecting your plans for all of the available coverage types, click "I'm Ready to Review My Application" to continue.

Submit your completed enrollment

1. If you have completed all the information and are ready to submit your forms, click the "I'm Ready to Review My Application" button located in the lower left side of the "Plans" page.
2. The Review page gives a summary of the plans selected and displays any dependents you have added. Click on the blue "Submit" button to submit your application.
3. Once your application has been submitted, any documents that are required will be listed. If you have the documents in a digital version available to upload, use the "Browse" and "Upload" buttons to upload the documents. When the document has been successfully uploaded, that document section will appear as green.
4. If you do not have the documents available at that time, you can login at a later time to upload them. There will be a count of documents required in the submitted enrollment section when you login.
5. You can print your enrollment form for your records by clicking the "Print your enrollment button" located on the bottom portion of the page.
6. Your submitted application and documents will be reviewed by your district and then submitted to CVT for review and approval.

Questions

If you have any questions about how to create your account, help is only a phone call away. Contact your district office or CVT Member Services at 800-288-9870

520 East Herndon Avenue
Fresno, CA 93720
(800) 288-9870
www.cvtrust.org

March 2015

DECLARATION OF HEALTH COVERAGE

CLASSIFIED EMPLOYEES

First Name ____________ Middle ____ Last Name ____________

(INSTRUCTIONS ON REVERSE)

OPTION A: ☐ I elect to enroll myself and **all** eligible dependents in district offered health insurance coverage.	
OPTION B-1: ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage. If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90-day waiting period or the Open Enrollment effective date.
OPTION B-2: ☐ I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.	
OPTION C-1: ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
OPTION C-2: ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having other health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after your request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first the month following the 90 day waiting period or the Open Enrollment effective date.
OPTION D: ☐ I am covered under my spouse's coverage, who is a District Employee.	Name of spouse:

Dental and Vision Coverage Certification (Check one box only)
Under penalty of perjury, I certify that one (1) of the following be true: ☐ a) I am currently enrolled in the district sponsored dental and vision coverage. ☐ b) I am currently enrolled in a non-district sponsored dental and vision coverage. ☐ c) I am currently **not** enrolled in any dental and vision coverage.

If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See Payroll or Human Resources for applicable time limits.

If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See Payroll or Human Resources for applicable time limits.

Further in order to participate in the in-lieu benefit option, you must:

1) **Complete the Declaration of Health Coverage form, and**
2) **Provide the District with proof of current health coverage annually within the specified time limits of the District Open Enrollment period.**

Signature of Employee ____________ Date ____________

INSTRUCTIONS – DECLARATION OF HEALTH COVERAGE

Please contact your Payroll Specialist if you have any questions regarding the Declaration of Health Coverage form.	
Employee Information	Complete by entering your legal name.
OPTION A:	Mark this box if you are: a) Enrolling in CalPERS Health benefits and have no dependents, or b) Enrolling yourself and ALL eligible dependents in CalPERS Health benefits.
OPTION B-1: OPTION B-2:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage. Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have other health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
OPTION C-1: OPTION C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health coverage. Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.
OPTION D:	Mark this box if your spouse is: a) A current employee of El Dorado Union High School District, and b) Has you listed as a dependent on her District-sponsored health insurance coverage.

MONTHLY MEDICAL PREMIUMS ONLY
-AMERICAN FIDELITY ASSURANCE COMPANY
SECTION 125 BENEFIT ELECTION FORM/SALARY REDUCTION AGREEMENT

Name of Employer **EDUHSD**	
Name of Employee	
Social Security Number:	Plan Year

SECTION 125 BENEFIT ELECTION

Please indicate which benefits you wish to select:

BENEFIT	COMPANY PLAN	SECTION 125 BEFORE TAX	EMPLOYER-PAID
☐ Medical Insurance			
☐ Dental			
☐ Vision			
TOTALS			

Terms and Conditions

I hereby authorize the above payroll reductions as my contribution to my Employer's Section 125 Cafeteria Plan.

I understand that:

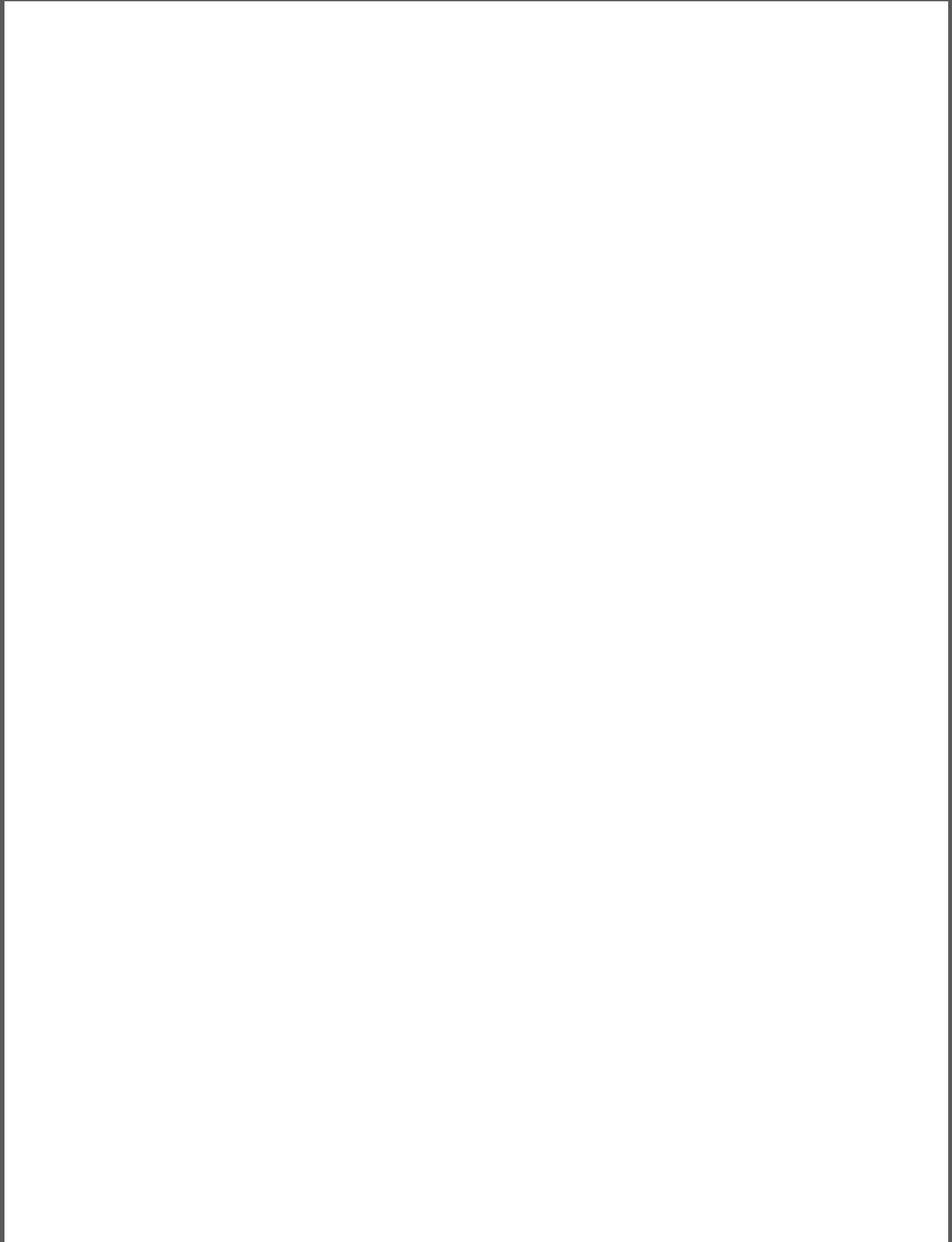
- Changes in the cafeteria plan elections can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status; change in number of dependents; termination or commencement of employment; change in work schedule; dependent satisfies or ceases to satisfy dependent eligibility under the IRC 125 regulations. Participation in this plan will automatically cease upon termination of employment. In most cases NO change may be made in the Medical Expense Reimbursement Account except for termination of participation due to termination of employment. For special rules affecting your plan, please contact your employer. FICA taxes are not paid on section 125 salary reductions. Therefore, your social security benefits at retirement may be reduced.
- Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage; in most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the insurance carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.

This authorization replaces any previous authorization I have made.

Signature of Employee ______________________ Date

PARTICIPATION WAIVED- sign this section ONLY if you wish to waive participation in Section 125

Signature of Employee ______________________ Date



Health Benefits Plan Enrollment for Active Employees (HBD-12)

Health Account Management Division
P.O. BOX 942715
Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | TTY (877) 249-7442
FAX (800) 959-6545
www.calpers.ca.gov

SECTION A: Applicant Information

1. **Employee Name:** *(First)* *(M.I.)* *(Last)*
2. **Hire Date:** *(mm/dd/yyyy)*
3. **CalPERS ID or Social Security Number:**
4. **Date of Birth:** *(mm/dd/yyyy)*
5. **Gender:** ☐ Male ☐ Female ☐ Nonbinary
6. **Physical Address:** *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
7. **Mailing Address** (If different): *(Street)* *(City)* *(State)* *(ZIP)* *(County)*
8. **Use Work ZIP Code for Health Eligibility**: ☐ Yes ☐ No *If yes, enter zip code here: (ZIP)*
9. **E-mail Address:**
10. **Primary Phone:** **Alternate:**

SECTION B: Type of Action

11. ☐ Enroll in a Health Plan ☐ Add/Delete Dependents ☐ Change Health Plan ☐ Cancel All Coverage ☐ Decline Coverage

SECTION C: Type of Permitting Event

12. ☐ New Employee ☐ New Contracting Agency ☐ Marriage or Domestic Partnership Date *(mm/dd/yyyy)*: ☐ Open Enrollment ☐ Move
☐ Delete Dependent Due to Death ☐ Divorce or Domestic Partnership Termination ☐ Birth/ Adoption ☐ Other:

13. **Permitting Event Date**: (mm/dd/yyyy)
14. **Name of Health Plan**: (If changing health plans, list new plan name)

SECTION D: Subscriber and Dependent Information (List yourself and all of your dependents)

15.

Name (First, M.I., Last)	Relationship Code *1	Gender	Date of Birth (mm/dd/yyyy)	CalPERS ID or Social Security Number	Action	Primary Care Physician
	SELF	☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	
		☐ M ☐ F ☐ Nonbinary			☐ Add ☐ Delete	

*1 Relationship Codes: **S** - Spouse **DP** - Domestic Partner **NC** - Natural Child **SC** - Step Child **AC** - Adopted Child **DPC** - Domestic Partner Child **PCR** - Parent Child Relationship

SECTION E: Enrollment

16. **To enroll, carefully review the information in this section and check the box:**

☐ **I ELECT TO ENROLL** in (or **MAKE CHANGES TO**) a health benefits plan as indicated above and agree to authorize deductions from (1) my salary to cover my share of the cost of enrollment as it is now or as it may be in the future (2) my retirement allowance to continue health benefits coverage into retirement. **I CERTIFY** that the information provided herein is accurate and listed dependents are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I VOLUNTARILY enroll into the selected Health Plan. **I AGREE** to read the associated Evidence of Coverage (EOC) and any subsequent EOCs in the following years to understand the benefits of the plan. The Subscriber and all eligible dependents agree to all the terms and conditions of the EOC and the Health Plan.

I UNDERSTAND that enrolling in certain health plans requires binding arbitration and 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 provided by California Law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The parties to this agreement, 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.

17. **To decline, carefully review the information in this section and check the box:**

☐ **I DECLINE ENROLLMENT** into the CalPERS Health Program for myself and my dependents.

I UNDERSTAND that if I choose to enroll at a later date, I must wait at least 90 days after I request enrollment or until the next Open Enrollment (OE) period before enrolling in the CalPERS Health Program. Furthermore, if I or my dependents involuntarily lose other health insurance coverage, I may request enrollment into the Program within 60 days from the date of lost coverage. If I do not request enrollment within 60 days, I must wait at least 90 days or until the next OE period before I can enroll. The effective date of coverage will be the first of the month following the 90 day waiting period or the OE effective date.

18. **Employee Signature:**
19. **Date:** *(mm/dd/yyyy)*

SECTION F: CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code Sections (20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in the system being unable to perform its functions regarding your status.

Please do not include information that is not requested.

SSN
Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS first request for disclosure of your SSN, then disclosure is mandatory. If your SSN has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction / state contributions
3. Billing of contracting agencies for employee / employer contributions
4. Reports to the CalPERS system and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by the system. For questions about this notice, our Privacy Policy, or your rights, please write the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call our Customer Contact Center at 888-CalPERS (888-225-7377).

SECTION G: Privacy Information

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership files. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security account number to inform the individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and State contribution for State employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include domestic partnership termination, establishment of a parent-child relationship, acquisition of a dependent child, change of address, marriage, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

SECTION H: For Employer Use

Please retain original signed form and all supporting documentation or affidavits in employee file. DO NOT send to CalPERS.

20. Agency Name:	**21. Date of Hire:** *(mm/dd/yyyy)*	**22. Retirement System:** ☐ CalPERS ☐ CalSTRS ☐ Other
23. CalPERS Employer ID:	**24. Division ID:**	**25. Employee Bargaining Unit/Employee Group:**
26. Payroll Office: ☐ State Controller's Office ☐ Non Central ☐ Public Agency Billing	**27. Date Received by Employer:**	**28 Effective Date:** *(mm/dd/yyyy)*

I hereby certify under the penalty of perjury that I am a duly appointed, qualified and acting Health Benefits Officer (HBO) of the above named agency, and the payment by the agency as provided by Section 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

29. Health Benefits Officer: (Print name)	**30. Signature:**	**31. Date:** *(mm/dd/yyyy)*	**32. Phone Number:**

33. Remarks:

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

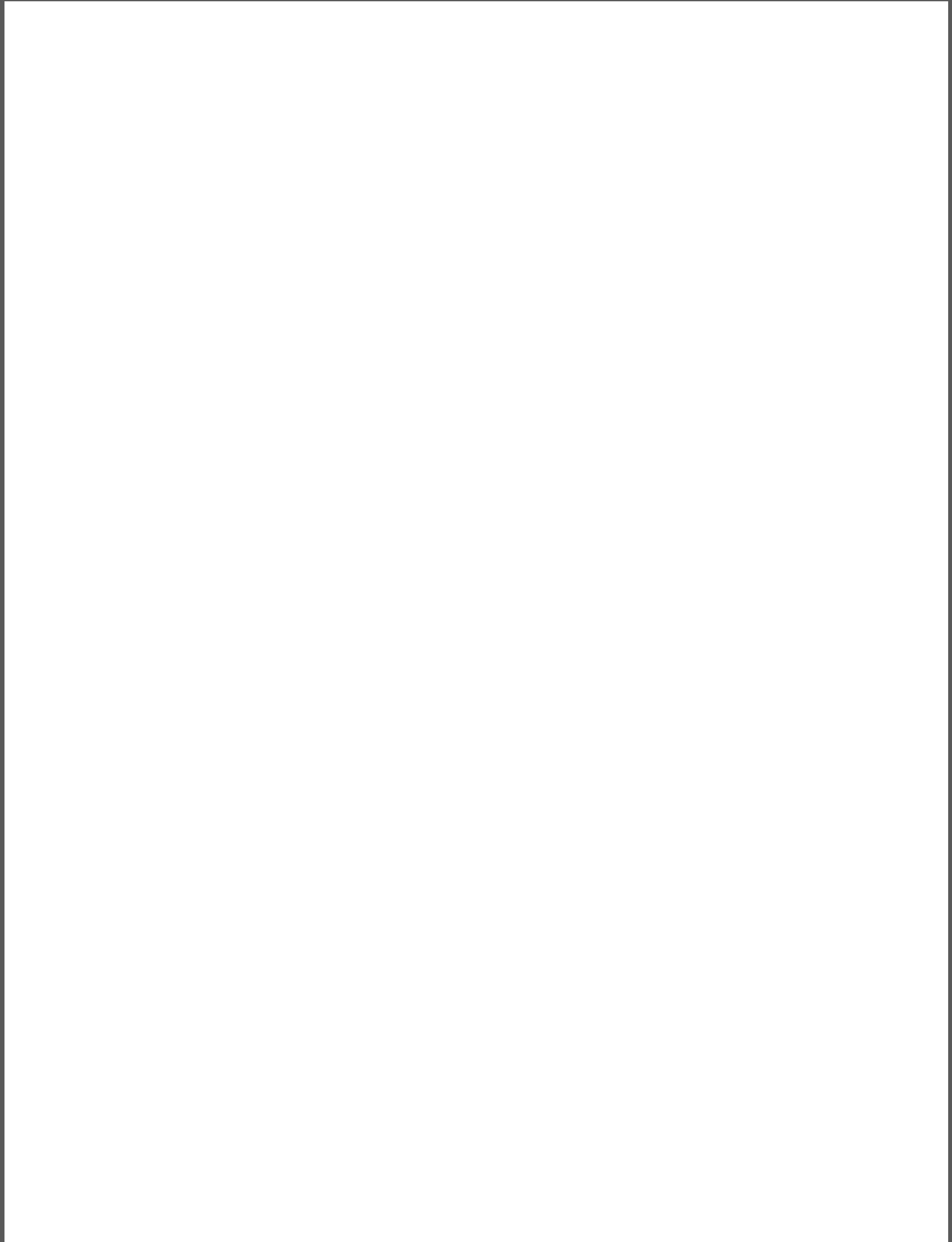
1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at **888 CalPERS** (or 888-225-7377).



WORKSHEET INSTRUCTIONS PAGE

Classified Employee Instructions

#1) A PART TIME EMPLOYEE (50% FTE TO 99% FTE) WILL RECEIVE A PRORATED AMOUNT OF THE BENEFIT CAP.***

TO FIGURE OUT YOUR PROTATED AMOUNT, ENTER THE AMOUNTS IN THE HIGHLIGHTED FIELDS

EXAMPLE: IF YOU ARE A 60% EMPLOYEE:

****	$9,472.65	Benefit Cap/Full Time Employee ****
×	60.00%	FTE
=	$5,683.59	Amount of cap you will receive for the plan year.

#2) NEXT, GET THE COST OF YOUR PLAN CHOICES FOR THIS PLAN YEAR: EXAMPLE: USING PERS CHOICE (80/20) SINGLE COVERAGE WITH PPO INCENTIVE DENTAL AND VISION USING <u>10 MONTH PREMIUM RATES</u>:

EXAMPLE:

	$1,125.70	PERS Choice
+	$135.12	Dental
+	$26.50	Vision
=	$1,287.32	Per Month
×	10	Checks
=	$12,873.20	Total Plan Year Cost

#3) NOW, SUBTRACT YOUR CAP AMOUNT FROM THE PLAN YEAR COST:

EXAMPLE:

	$12,873.20	Total Plan Year Cost
-	$5,683.59	Using cap for 60% FTE employee (#1 above) use annual cap of $9,081.80 if you are full time
=	$ 7,189.61	Plan year cost for .60 % FTE employee

#4) FINALLY, TO GET THE MONTHLY COST TO YOU:

EXAMPLE:

	$ 7,189.61	Plan Year Cost
÷	10	Checks
=	$ 718.96	Your cost per month

***** EMPLOYEES WORKING LESS THAN 4 HOURS/DAY ARE NOT ENTITLED TO PAID INSURANCE BENEFITS, BUT MAY PURCHASE BENEFITS AT FULL COST OF PLANS.**

****** The adjusted Classified cap is $9472.65 based upon the MOU between CSEA and the district.**

Estimated Monthly Cost of based on Selected Plans and Percentage of FTE

WORKSHEET INSTRUCTIONS PAGE

Worksheet - Plug in your numbers

#1) FIGURE OUT YOUR CAP AMOUNT:

	$9,472.65	Benefit Cap/Full Time Employee
×	0.00%	FTE
=	$0.00	Amount of cap you will receive for the plan year.

#2) GET THE COST OF YOUR PLAN CHOICES FOR THIS PLAN YEAR:

EXAMPLE:

	$0.00	Medical
+	$0.00	Dental
+	$0.00	Vision
=	$0.00	Month
×	0	Checks
=	$0.00	Total Plan Year Cost

#3) SUBTRACT YOUR CAP AMOUNT FROM THE PLAN YEAR COST:

EXAMPLE:

	$0.00	Total Plan Year Cost
-	$0.00	Your Cap Amount
=	$ -	Your cost for plan year

#4) THE MONTHLY COST TO YOU:

EXAMPLE:

	$ -	Plan Year Cost
÷	0	Checks
=	#DIV/0!	Your cost per month

El Dorado Union High SD

Delta Dental PPO Incentive Plan Summary of Benefits

Effective October 1, 2020 to September 30, 2021

Benefits and Covered Services*	PPO Network **	Premier Network and Out of Network **
Calendar Year Deductible	None	None
Calendar Year Maximum Benefit	$2,200	$2,000
Diagnostic & Preventive Services Oral Examinations: 2 Annual Cleanings: 2 X-rays	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Basic Services Fillings Posterior Composite Restorations Sealants	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Periodontics (gum treatment) Covered Under Basic Services	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Endodontics (root canals)	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Oral Surgery (extraction) Covered Under Basic Services	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Major Services Crowns, Inlays, Onlays & Cast Restorations	Paid at: 70% - 100% *	Paid at: 70% - 100% *
Prosthodontics Bridges Dentures Implants	Paid at: 50% *	Paid at: 50% *
Dental Accident Benefits	Paid at: 100% * ($1,000 maximum per enrollee each calendar year)	Paid at: 100% * ($1,000 maximum per enrollee each calendar year)

*** This summary is for comparison purposes only. The Evidence of Coverage should be consulted for a detailed description of the covered benefits and is available at www.cvtrust.org/plandocuments.**

** See back for additional details

What are my Delta Dental Network options?

The Delta Dental PPO plan allows you the option to visit any licensed dentist. You will usually save more on your out-of-pocket costs when you visit a **Delta Dental PPO** dentist. The **Delta Dental Premier** network also provides cost-saving features and is the next best option when you can't find a PPO dentist. Non-Delta Dental (Out of Network) dentists have no fee agreements with Delta Dental, so you will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist. You are responsible for the difference between what Delta Dental pays and the dentist's fee.

How do I find a Delta Dental dentist?

To locate a Delta Dental dentist near you, check the dentist directory on the Delta Dental website **(deltadentalins.com)**, which also provides a map to the dental office. Or, to hear or receive a faxed listing of dentists in your area, call **866-499-3001**. Follow the automated instructions to search for a dentist.

How does my Delta Dental incentive plan work?

Your dental benefit incentive plan is designed to encourage regular visits to the dentist to keep your teeth and gums healthy. Here is an example of how an incentive plan works. (This is the most common incentive plan. Check your benefits information for details of your particular incentive plan.)

First Year	Second Year	Third Year	Fourth Year
70%	**80%**	**90%**	**100%**
Percentage paid for certain benefits as long as you visit the dentist each year.			

What are my online resources?

The full Delta Dental website is a one-stop-shop for plan and oral health information.
Also available in Spanish: **es.deltadentalins.com**.

Create a free Online Services account at **deltadentalins.com** to:

- Locate a Delta Dental dentist
- Check benefits, eligibility, and claim status
- Opt for paperless statements
- View or print your ID card
- Check average dental costs in your area

Check out **Your Dental Plan Support Guide** for money-saving tips and treatment information. And, don't miss **mysmileway.com** – a great resource for oral health-related tools and tips.

Mobile? Get the information you need on the go. Bookmark or add a shortcut to the mobile site to return in just one tap from your phone. Download the free, convenient smartphone Delta Dental app from the App Store or Google Play.

El Dorado Union High SD
Classified

Delta Dental PPO 70/30 Plan Summary of Benefits
Effective October 1, 2020 to September 30, 2021

Benefits and Covered Services*	PPO Network **	Premier Network and Out of Network **
Calendar Year Deductible	None	$25 per person / $75 per family per calendar year
Calendar Year Maximum Benefit	$1,000	$1,000
Diagnostic & Preventive Services Oral Examinations: 2 Annual Cleanings: 2 X-rays	Paid at: 100% *	Paid at: 70% *
Basic Services Fillings Posterior Composite Restorations Sealants	Paid at: 80% *	Paid at: 60% *
Periodontics (gum treatment) Covered Under Basic Services	Paid at: 80% *	Paid at: 60% *
Endodontics (root canals)	Paid at: 80% *	Paid at: 60% *
Oral Surgery (extraction) Covered Under Basic Services	Paid at: 80% *	Paid at: 60% *
Major Services Crowns, Inlays, Onlays & Cast Restorations	Paid at: 60% *	Paid at: 50% *
Prosthodontics Bridges Dentures Implants	Paid at: 60% *	Paid at: 50% *
Dental Accident Benefits	Paid at: 100% * ($1,000 maximum per enrollee each calendar year)	Paid at: 100% * ($1,000 maximum per enrollee each calendar year)

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Most potential savings with Delta Dental PPO dentists	***Some savings with Delta Dental Premier dentists***	***No savings with non-Delta Dental dentists***
➢ Delta Dental PPO dentists agree to accept Delta Dental PPO contracted fees as full payment. ➢ You'll usually pay less when you visit a Delta Dental PPO dentist. ➢ When you visit your dentist, you should ask specifically if he or she is a contracted Delta Dental PPO dentist.	➢ Premier dentists' contracted fees are usually slightly higher than PPO dentists' contracted fees. ➢ Premier dentists will not bill you above their contracted fees, so you still receive some cost protections not available with a non-Delta Dental dentist.	➢ Non-Delta Dental dentists have no fee agreements with Delta Dental, so you will usually have the highest out-of-pocket costs when you visit a non-Delta Dental dentist. ➢ You are responsible for the difference between what Delta Dental pays and the dentist's fee.

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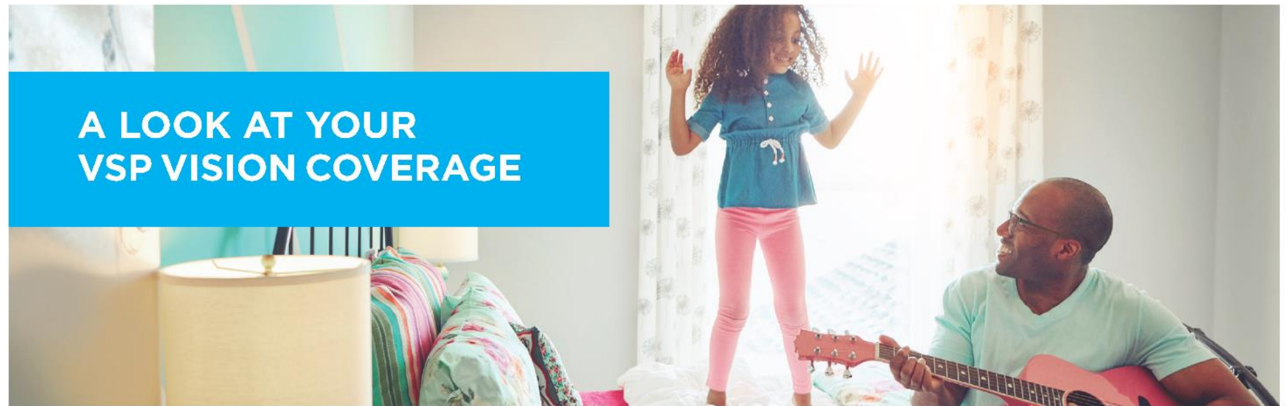

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Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

$ Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

PREMIER PROGRAM With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor or retail chain. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

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SEE MORE BRANDS AT **VSP.COM/OFFERS.**

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USING YOUR BENEFIT IS EASY!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

Enroll today.

Contact us: **800.877.7195** or **vsp.com**

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