Enrollment Information

Who May Enroll

If you are a full time employee working 30+ hours per week, you and your eligible dependents may participate in CAPK's benefits program. Your eligible dependents include:

- Legally married spouse
- Children under the age of 26, regardless of student or marital status and unmarried dependent child(ren) over the carrier age limits who are physically or mentally incapable of self-support
- Registered domestic partner

When You Can Enroll

As an eligible employee, you may enroll at the following times:

- As a new hire, you may participate in CAPK's benefits program on the first day of the month following your date of hire; you must enroll within 30 days from your date of hire
- Each year, during open enrollment
- Within 30 days of a qualifying event as defined by the IRS (see Making Changes To Enrollment below)

Making Changes to Enrollment

Our benefit plans are effective January 1st through December 31st of each year. There is an annual open enrollment period during which you can make new benefit elections for the following January 1st effective date. Once you make your benefit elections, you cannot change them during the year unless you experience a qualifying event as defined by the IRS. Examples include, but are not limited to the following:

- Marriage, divorce, legal separation or annulment
- Birth or adoption of a child
- A qualified medical child support order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)
- Becoming eligible for a state's premium assistance program under Medicaid or CHIP

Coverage for a new dependent is not automatic. If you experience a qualifying event, you have 30 days to update your coverage. Please contact the HR Office immediately following a qualifying event to complete the appropriate election forms. If you do not update your coverage within 30 days from the qualifying event, you must wait until the next annual open enrollment period to update your coverage.

Insurance Basics

Medical HMO

An HMO is a plan that offers coverage within a specific network of doctors and hospitals. Coverage under an HMO is only available through providers and facilities that are in-network. If you visit a doctor that is not in the HMO network, you are responsible for 100% of the cost of services unless you're seeking emergency medical treatment.

Who should consider opting for a HMO?

Someone who is looking to pay reduced premiums, lower copays, and no coinsurance for in-network and covered services. HMOs are also great for patients who want a doctor dedicated to coordinating their care. Under an HMO plan, your primary care doctor (also called a primary care provider) will provide referrals when a specialist visit is necessary. An HMO could be a good option if your providers are contracted in the HMO network. An HMO plan may limit your ability to see doctors that you've seen in the past if they're not in-network.

Medical PPO

PPO plans typically have premiums and deductibles that are higher compared to HMO plans. They also offer greater flexibility, such as expanded networks and no referral requirements.

Who should consider opting for a PPO?

If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, or have covered dependents who live out of state a PPO plan might be a better fit.

Dental PPO (DPPO)

Similar to a medical PPO plan, a dental PPO allows you to choose an in-network or out-of-network provider. Remember, going out-of-network will be more costly than visiting an in-network dentist. If you need services or treatments that will cost $300 or more, it is strongly recommended to ask for a predetermination of benefits from your dentist to understand the cost of services. Please be advised that ID cards are not necessary, and DPPO members may not receive ID cards.

Insurance Basics (continued)

How to Find a Provider

How To Find an Anthem Medical Provider

1. Visit www.anthem.com/ca and click "Find Care"
2. You can log in to your Anthem portal or click on 'Select a plan for basic search' to search as a guest.
3. **Once prompted, complete the series of questions:**
4. **Select the type of plan or network:** Medical plan or Network (may also include dental, vision, or pharmacy benefits)
5. **Select the state where the plan or network is offered (For employee-sponsored plans, select the state where your employer's plan is contracted in. Most of the time, it's where the headquarters is located.):** California
6. **Select how you get health insurance:** Medical (Employer-Sponsored)
7. **Select a plan or network:** Blue Cross HMO (CACare) - Large Group
8. Click "Continue"
9. Enter your specific search criteria (provider name, address, zip code etc) and click "Search"
10. View your search results. From this page you can email or print your results or return to search to edit your criteria

How to Find a Kaiser Medical Provider:

1. **Based on where you reside please visit:**

   Northern California:

   https://healthy.kaiserpermanente.org/northern-california/doctors-locations#/simple-form

   Southern California:

   https://healthy.kaiserpermanente.org/southern-california/doctors-locations#/simple-form

2. **Call Kaiser Permanente Member Services phone number:** 800-464-4000.

Important Information about electing a PCP in Network (HMO) plans

- All HMO enrollees must select a PCP and designate their PCP#. If you enter an invalid PCP# or leave this blank, you will be auto assigned to a provider based on your home zip code. If you receive an ID with an incorrect PCP listed, please contact your carrier member services to correct.
- If you decide to change your PCP at any time, you can do this by phone or online.

Information about the PPO plan

- You have the option of choosing a primary care provider (PCP) to guide your care (it is recommended but not required). You can see a specialist without a referral.
- Using in-network doctors and health care facilities may keep your costs lower.
- You can choose out-of-network doctors or facilities, but your costs may be higher.
- You'll pay an annual amount called a deductible before the plan begins to pay for covered costs. Once you meet your deductible, you pay a copay or coinsurance amount and the plan pays the rest of covered costs.
- Once you meet an annual limit on your payments called an out-of-pocket maximum, your plan pays 100% of covered costs.

Insurance Basics (continued)

Finding a Dentist:

Step 1 - Know your Network - Classic PPO and Plus

Find the network name by looking at your ID card, plan materials, or calling customer connections at 800-487-5553.

Step 2: Go online

- Go to dentalnetwork.ameritas.com or ameritas.com – Find a Health Provider
- Enter your location and then choose the network name to search for a dental provider.

Step 3: Search providers

- Network providers charge 25-50% less than their regular rates. Dentists in green offer the most savings, closer to 50%.
- Use Additional Filters to search by provider name, practice/business name, or specialty.
- **Tip:** If you can't find a specific provider or location by name, search by ZIP Code or city.

Finding an Eye doctor:

1. Visit https://eyedoclocator.eyemedvisioncare.com/
2. You can choose to search by location or doctor
3. Under Network select "Insight Network"
4. Enter you Zip Code
5. Then click search, a list of relevant providers will populate.

Paying For Your Coverage

- You and CAPK share in the cost of your Medical, Dental, and Vision benefits. Your contributions are deducted before taxes are withheld, which saves you tax dollars. Paying for benefits before-tax means your share of the costs are deducted before taxes are determined, resulting in more take-home pay for you.
- Basic Life and AD&D benefits are provided at no cost to you and are paid entirely by CAPK for employees who qualify.
- Any Voluntary Life Insurance benefits you elect will be paid by you at discounted group rates.
- Any additional Voluntary Benefit options you elect will be paid by you at discounted group rates.

Value Added Services

The following value added services are available to all employees enrolled in the corresponding carrier's coverage.

Anthem

Nurseline Benefits

Phone and/or video visits are an excellent option for convenient, accessible care when you don't need a doctor to see you in person. They are also a good choice when away from home or if you need short term prescription drug refills. CAPK provides telemedicine coverage with all medical plans.

Telemedicine - LiveHealth Online

When you're not feeling well you want to feel better fast. With LiveHealth Online, you don't need to make an appointment and there is no out of pocket costs to you. Just sign up at www.livehealthonline.com or use the app and see a board-certified doctor in a few minutes. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if needed.

LiveHealth Online also provides services when you are feeling stressed, anxious or having a tough time coping. Schedule a virtual visit with a licensed therapist or board-certified psychiatrist. Appointments with a licensed therapist are typically available in 4 days or less and two weeks with a psychiatrist. These services are also provided to you at no cost to you.

The LiveHealth Online program is available to employees and their dependents that are enrolled.

Telemedicine visit cost are as follows:

Primary Care Visits & Non-Physician Specialist Visits: $0

Specialist Visits: $0

- **Anthem HMO 35 Plan**
  - $0 for Medical, Mental Health & Substance Use Disorder Service ;$45 copay for Specialist Care
- **Anthem 1600 PPO Plan**
  - **Medical services/Allergy visits** $55 until deductible met and then $0
  - **Mental Health & Substance Use Disorder Service** $0 once deductible is met, prior to deductible variable pricing based upon service. Therapy appointments (LMFT, psychologist) are $85-100. Psychiatry appts (only with a psychiatrist) are the $80-$185
  - **Specialist Care** $55 to $270 after deductible

Anthem Sydney app

https://www.sydneyhealth.com/

Kaiser Permanente

Virtual Visits

The next time you schedule an appointment at Kaiser Permanente, you may be offered a virtual visit with your doctor. All you need is a computer with a high-speed internet connection and a webcam or smartphone mobile device using the latest version of the KP Preventive Care App.

Advice Nurse

Get the care you need the way you want it. No matter which option you choose, your Kaiser providers can see your health history, update your medical record, and give you personalized care that fits your life. Call Kaiser at 866-454-8855 to make an appointment or speak to an advise nurse.

ChooseHealthy

The road to good health can take you well beyond your doctor's office. With Kaiser Permanente, you get a wide range of wellness resources. You may pay lower fees on many non-Kaiser Permanente services designed to help you get active and stay healthy. For more information about services available through ChooseHealthy call 877-335-2746 or visit kp.org/choosehealthy.

Kaiser mobile app

https://healthy.kaiserpermanente.org/pages/mobile-app

Medical Benefits

	Anthem Classic HMO
Calendar Year Deductible	
• Individual	$0
• Family	$0
Calendar Year Out-of-Pocket Maximum	
• Individual	$2,500
• Family	$5,000
Lifetime Maximum Benefit	Unlimited
Health Benefits	**You Pay**
Office Visit *(Includes Specialists)*	$35 copay (Specialist copay is $45)
Lab and X-Ray	No charge
Imaging *(CT/PET scans, MRIs)*	$100 copay
Urgent Care Copay	$35 copay
Emergency Room	$100 copay
Emergency Medical Ambulance	$100 copay
Inpatient Hospital & Surgery	$750 copay
Outpatient Surgery	$375 copay
Chiropractic	$35 copay up to 60 days combined with physical therapy, occupational therapy and manipulative treatment
Acupuncture	$35 copay
Mental Health/Substance Abuse	
• Outpatient Visit	$35 Copay
• Inpatient Care	No charge
Pharmacy Benefits	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*	
• Generic	$5 copay Tier 1a/$15 copay Tier 1b
• Brand *(Formulary/Preferred)*	$30 copay
• Brand *(Non-Formulary/Non-Preferred)*	$50 copay
• Speciality	30% up to $250/prescription
Mail Order Pharmacy *(Up to 90 Day Supply)*	
• Generic	$12.50 copay Tier 1a/$37.50 copay Tier 1b
• Brand *(Formulary/Preferred)*	$90 copay
• Brand *(Non-Formulary/Non Preferred)*	$150 copay

CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical Benefits (continued)

	Kaiser Traditional HMO
Calendar Year Deductible	
• Individual	$0
• Family	$0
Calendar Year Out-of-Pocket Maximum	
• Individual	$1,500
• Family	$3,000
Lifetime Maximum Benefit	Unlimited
Health Benefits	**You Pay**
Office Visit *(Includes Specialists)*	$25 copay
Hospital Coinsurance / Copay	$250 copay
Lab and X-Ray	No charge
Urgent Care Copay	$25 copay
Emergency Room	$100 copay if you are admitted directly to the hospital as an inpatient, you will pay the inpatient Cost Share
Emergency Medical Ambulance	No charge
Inpatient Hospital & Surgery	$250 copay
Outpatient Surgery	$25 copay
Mental Health/Substance Abuse	
• Outpatient Visit	$12 copay group/$25 copay individual
• Inpatient Care	$250 copay (per admission)
Prescription Drug Coverage	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*	
• Generic	$15 copay
• Brand *(Formulary/Preferred)*	$30 copay
• Speciality	30% up to $150/prescription
Mail Order Pharmacy *(Up to 100 Day Supply)*	
• Generic	$30 copay
• Brand *(Formulary/Preferred)*	$60 copay

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical Benefits (continued)

High Deductible Health Plan with Health Savings Account Option

	Anthem HSA PPO	
	In-Network	Out-of-Network
Calendar Year Deductible		
• Individual	$1,600	
• Family	$3,200	
Calendar Year Out-of-Pocket Maximum		
• Individual	$2,500	$5,000
• Family	$5,000	$10,000
Lifetime Maximum Benefit	Unlimited	Unlimited
Health Benefits	**You Pay**	**You Pay**
Office Visit *(Includes Specialists)*	10%[1]	30%[1]
Coinsurance	10%[1]	30%[1]
Hospital Coinsurance / Copay	10%[1]	30% Up to $1,000 per day for non-emergency[1]
Lab and X-Ray	10%[1]	30%[1]
Urgent Care Copay	10%[1]	30%[1]
Emergency Room	10%[1]	paid as In-Network
Emergency Medical Ambulance	10%[1]	paid as In-Network
Inpatient Hospital & Surgery	10%[1]	30% Up to $1,000 per day for non-emergency[1]
Outpatient Surgery	10%[1]	30% $350 benefit max per admit[1]
Chiropractic	10%[1] up to 30 visits per calendar year	30%[1] up to 30 visits per calendar year
Acupuncture	10%[1] up to 20 visits per calendar year	30%[1] up to 20 visits per calendar year
Mental Health/Substance Abuse		
• Outpatient Visit	10%[1]	30%[1]
• Inpatient Care	10%[1]	30% Up to $1,000 per day for non-emergency[1]
Pharmacy Benefits	**You Pay**	**You Pay**
Retail Pharmacy *(Up to 30 Day Supply)*		
• Tier 1 - Generic	$10 copay[1]	30% up to $250[1]
• Tier 2 - Non-preferred Generic/Preferred Brand	$30 copay[1]	30% up to $250[1]
• Tier 3 - Non-preferred Brand and Generic	$50 copay[1]	30% up to $250[1]
• Tier 4 - Preferred Speciality	30% up to $150[1]	30% up to $250[1]
Mail Order Pharmacy *(Up to 90 Day Supply)*		
• Tier 1 - Preferred Generic	$10 copay[1]	Not covered
• Tier 2 - Non-preferred Generic/Preferred Brand	$60 copay[1]	Not covered
• Tier 3 - Non-preferred Brand and Generic	$100 copay[1]	Not covered
• Tier 4 - Preferred Speciality	30% up to $300[1]	Not covered

1 After the deductible

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.