



Benefit Guide

August 01, 2011 - July 31, 2012

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Welcome

Welcome!

At CAPOC we're proud of our accomplishments and especially proud of our people. We recognize the importance of delivering a comprehensive benefits program that is responsive to everyone. Our benefits program was developed in order to provide multiple benefit choices to support the needs of you and your dependents.

Some of our overriding objectives in developing the benefits program include:

- Meeting the diverse needs of our employees by offering flexible benefit choices
- Providing financial protection for employees against illness, injury and death
- Positioning our benefits program as a competitive tool to attract and retain a quality workforce
- Promoting and enhancing employees' understanding of all benefits offered and costs associated with the plan

Design Your Benefits

We hope this guide provides valuable information to help you make wise decisions and to tailor your benefit plans to your specific needs. Its intent is to answer most questions; however, if additional information is needed, please contact CAPOC's Human Resources Department.

Considerations When Making Your Benefit Decisions

- Understand the benefit offerings provided in the plan
- Review the benefit costs associated with each benefit
- Think through your personal benefits needs

You may also want to:

- Evaluate your access to key medical and dental providers

This guide does not include all the plan details, but provides a summary of the information and issues you need to consider when making your choices.

For more complete benefit plan information, please refer to the Summary Plan Descriptions.

Health Management and Wellness Programs

The best time to use your medical plan is before you get sick. Take advantage of the programs and resources that promote your health and wellness. Whether your goal is to lose weight, lower your blood pressure or cholesterol, or just to make healthier choices, CAPOC offers plans that can help you:

Anthem Plans

The Anthem plans provide 360 Health, a comprehensive suite of resources and services. 360 Health can help you become more engaged in your health and empower you to make health care decisions that are right for you and your family.

Tools & Resources

Good information is vital to good health. The Health & Wellness tab on www.anthem.com/ca is an online resource for health and wellness information that enables you to learn more about what you want, when you want – and all at your fingertips. You'll find the most up-to-date and relevant information of a myriad of health topics and conditions, even treatment options. Calculate your body mass index, track your diet and exercise, even take a Health Risk Assessment (HRA) that will give you personalized information about your health. Not into the Net? Receive a free newsletter at home through the mail. Or call Anthem's Audio Health Library to hear confidential recorded messages about hundreds of health topics in English and Spanish. Tools & Resources can help you save money too. Take advantage of discounts and special offers on smoking cessation, fitness club memberships and weight management. Anthem's Tools & Resources are so easy to access and use, you'll want them handy every day.

All Anthem Blue Cross members have access to 24/7 NurseLine®, a 24-hour telephone service that connects you to a registered nurse to help you make informed health decisions. The 24/7 NurseLine® toll free number is printed on your member ID card.

Ways to Save All Year Long

Stay healthy to save on medical care and prescription drugs. Use your plans preventive care services, such as annual physicals, early detection screenings and blood tests to maintain good health. Preventive care services are covered at 100%.

Take advantage of wellness programs

Combine prevention screening with resources from your medical plan, such as weight loss and stress management coaching to maximize your wellness.

MyHealth Advantage

Targets and reaches out to Anthem members when gaps in care, safety issues and opportunities for saving money are identified.

If you have diabetes, heart disease or another chronic condition

You may have access to free condition management programs through your health plans. Contact your plan for more information. Contact numbers and websites can be found on page 14.

Be a good consumer of health care

By minimizing avoidable expenses, you can reduce your out-of-pocket expenses. If you need immediate, but non-emergency medical care, think about going to an urgent care center instead of the emergency room.

Use generic drugs and order through your plans mail order program

Generic prescription drugs cost 30-80% less than brand-name drugs.

Take your medication as prescribed

Many prescriptions, when taken as directed, can keep you from needing expensive medical care or hospitalization.

Future Moms—Preconception Program

Provides a dedicated maternity nurse who is supported by an onsite team of clinical specialists for women who are trying to conceive, or are thinking about it. The program is intended to provide additional resources to become well informed in making better decisions that may result in healthier pregnancies.

Future Moms—Parenting Program

Provides new parents with the resources and help they need to make better decisions about caring for their baby. New parents will have access to an assigned nurse health coach who is supported by an onsite team of clinical specialists.

Kaiser Permanente HMO

Kaiser Permanente HMO offers many wellness resources and condition management programs through its Healthy Lifestyles program. This includes a total health assessment and programs to help with weight loss, stress management and tobacco cessation. Go to <https://members.kaiserpermanente.org> and click on the link for the Healthy Lifestyles Program or call Member Services in your area for more information.

Eligibility and Enrollment

Eligible Employees

You may enroll in our benefits program if you are an active, regular employee working a minimum of 30 hours per week. Your benefit eligibility begins on the first day of the month following 30 days of employment with CAPOC.

Eligible Dependents

As you become eligible for these benefits, so do your eligible dependents. In general, eligible dependents include your spouse or domestic partner (as required by Assembly Bill 2208 which states that employers must offer coverage to same-sex domestic partners, and opposite-sex domestic partners when at least one of them is eligible for Social Security benefits and is 62 years of age, or older), and children up to the age of 26. If your child is mentally or physically disabled, coverage may continue beyond the age of 26 once proof of the ongoing disability is provided. Children may include natural, adopted, foster, stepchildren, or domestic partner's children.

When Coverage Begins

Employees will be eligible for medical, dental and life benefits on the first of the month following 30 days as an active, regular employee.

NOTE: If you do not make health benefit elections within 30 days of your eligibility date, you will be deemed to have waived coverage until the next open enrollment period.

Open Enrollment

Our plan year runs from August 1st through July 31st. Elections you make during this open enrollment period will remain in effect from August 1, 2011 through July 31, 2012.

Changes in Benefit Elections

Each year, during Open Enrollment, you will have the opportunity to change your elections for the following plan year. Only during Open Enrollment will you have the opportunity to:

- Add or delete lines of coverage
- Add or delete dependents from coverage
- Enroll or increase Optional Life Insurance amounts for yourself or your dependents

You can make some limited changes during the year due to a Qualified Status Change. You must notify Human Resources within 31 days of a Qualified Status Change.

Qualified Status Changes Include:

- Change of domestic partnership status, participant's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment
- Termination or commencement of employment by the participant, spouse/domestic partner, or dependent
- A reduction or increase in hours of employment by the participant, spouse/domestic partner, or dependent, including a switch between part-time and full-time status, strike or lockout, or commencement of or return from an unpaid leave of absence
- An event that causes the participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance as provided in the health plan in which the participant participates
- A change in the place of residence or work of the participant, spouse/domestic partner, or dependent

When Coverage Ends

Coverage in CAPOC's medical and dental program for you and your eligible dependents ends on the last day of the month in which you leave employment. Life coverage ends on your last day of employment.

Dependent children are covered until the end of the month in which they reach their maximum age of 26.

Covered employees and qualified dependents are permitted to continue coverage at their own expense after leaving the company as provided by federal law (COBRA). Refer to page 13 for additional details.

Health Care Reform's Impact on You

Health Care Reform Overview

In March 2010, President Obama signed the Affordable Care Act. There are many changes in the new law that will impact you in the coming year. Below are the changes that will take effect with our new plan year (August 1, 2011):

- **Extension of Dependent Coverage.** Dependent children will be allowed to stay on their parent's medical and dental plans up to the age of 26, regardless of full-time student status. Dependent children may be married or live outside their parent's home. Any dependent under the age of 26 that was removed from coverage in the past may re-enroll during Open Enrollment. Coverage will be reinstated August 1, 2011.
- **Preventive Services Coverage.** All new plans must cover certain in-network preventive services, such as mammograms and colonoscopies, without charging a deductible, co-pay, or coinsurance
- **Lifetime Coverage Limit.** Insurance companies can no longer impose lifetime dollar limits on essential benefits, like hospital stays
- **Pre-existing Condition Exclusion.** Children under age 19 may no longer be denied coverage based on pre-existing conditions

For more information on health care reform, please visit www.healthcare.gov.



Over the next several years, additional Health Care Reform provisions will be adopted by CAPOC as they become effective.

There are outstanding questions regarding some provisions of the Health Care Reform law. Guidance and clarifications are being published by various government entities to answer these questions.

CAPOC will continue to keep employees updated as these new Health Care Reform provisions are finalized.

Medical

We have four medical plans to choose from. Please refer to our Medical Plan Comparison Charts on pages 7-8 for more details about these plans, or access the Summary Plan Descriptions.

Anthem Blue Cross Health Maintenance Organization (HMO)

The Anthem Blue Cross Health Maintenance Organization (HMO) is designed to have you pay a co-pay for most services you receive. After that, most services are covered at 100%. You generally don't have to worry about paying deductibles or coinsurance when you receive care from your Primary Care Physician (PCP). And there are no claim forms to submit for services received.

Under the HMO plan, you and your family members must select a medical group or Independent Practice Association (IPA) and PCP. Your PCP will provide preventive care, arrange admissions to hospitals, refer you to specialists (and coordinate the care you receive from them) and help you make decisions about your health. When selecting your Primary Care Physician, please keep the following in mind:

- You must live or work within 15 miles or 30 minutes of your PCP
- You and your family members do not have to select the same PCP
- You can change your PCP at any time by contacting member services
- Your PCP will admit you only to hospitals where he/she has admitting privileges. If your Primary Care Physician withdraws from the network of participating physicians, you must choose a new PCP. If you do not select a PCP, one will be assigned to you based on your home address.

Anthem Blue Cross Select HMO

The Select HMO functions very similarly to the Classic HMO. Health care is coordinated through a Primary Care Physician of your choice, but from a smaller network of participating physicians than the Classic HMO. There are also some plan differences, such as different co-pays and a deductible for brand name prescriptions.

Anthem Blue Cross HMO Guest Membership

If you have dependents residing outside of California, and want to enroll them on either of the HMO plans, you may be able to do so by calling guest membership at 800-827-6422. You'll need to verify that the state your dependent resides in participates in this program, and if so, you will need to request an application. Once approved for guest membership, your dependent(s) would be able to see a doctor on a regular basis, as if they were in California. You must re-apply every year to continue on the guest membership program.

Kaiser Permanente HMO (California Employees)

Kaiser Permanente is a Health Maintenance Organization (HMO) providing medical and hospital services ranging from preventive medicine to major care and surgery. Kaiser also offers many health education classes to its members. Most services are covered in full or require a co-pay. You may select a primary care physician (PCP) from any of the 160 Kaiser Permanente locations, but it is not required.

You can enroll in the Kaiser Permanente HMO if you live or work within the Kaiser service area. Under the plan, you must receive non-emergency, routine, and scheduled services (e.g., preventive care appointments, school physicals) from Kaiser physicians and facilities. You are covered world-wide. Emergency care is covered at any hospital facility, including non-Kaiser facilities. Emergency care is covered outside the Kaiser service area for any unforeseen illness, injury, accident, or health complication. Kaiser Permanente members may need to submit itemized bills and a claim form to Kaiser for services received from non-Kaiser providers.

For urgent care, advice nurses can often answer questions about a minor concern, tell you what to do if a plan medical office is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to your Service Area Guidebook (provided by Kaiser when you initially elected coverage, and available online) for the telephone numbers. Kaiser advice nurses and physicians are available 24-hours a day 7 days per week. The nurses and physicians are specially trained to help assess medical symptoms and provide advice over the phone. If necessary, appointments can be scheduled and direction for care is determined through the advice center.

Anthem Blue Cross/BC Lumenos Health Incentive Account (HIA) Plus

The Lumenos Health Incentive Account (HIA) Plus plan offered by Anthem Blue Cross is a high deductible plan with an employer-funded spending account available to help you meet the deductible. After meeting the deductible, most benefits are paid on a percentage basis rather than flat dollar co-pays.

Important Components of the HIA Plus

Health Incentive Account

Your Health Incentive Account (HIA), funded by CAPOC, is \$1,500 if you enroll yourself only or \$3,000 if you enroll one or more dependents, for a plan year (August 1—July 31). HIA allocations are pro-rated for new hires. You will receive 1/12 of the annual allocation for each month. If you enroll yourself in the plan December 1, the pro-rated allocation would be \$1,000 (1/12th of the annual allocation for eight months). The following August 1, you would receive the full \$1,500 allocation.

HIA allocations from CAPOC are used to help you satisfy your deductible. They are used to pay for covered health care expenses, such as office visits, hospital stays, prescription drugs, etc.

Deductible

Your traditional health coverage begins after you meet the deductible (\$3,000 if you enroll yourself only, or \$6,000 if you enroll one or more family members). If you enroll one or more of your dependents, the \$3,000 HIA allocation and \$6,000 deductible are aggregate for all family members. There are no individual deductibles to satisfy within the family deductible.

Preventive Care

Preventive care and wellness visits for adults and children are paid in full when you use PPO network providers. You don't need to meet any deductibles for preventive care/wellness visits and these expenses do not count against your Health Incentive Account balance.

Rollover Feature

Your unused HIA allocation rolls over to the next year. For example, if the \$1,500 for 2011 is not used, it rolls over to 2012 if you continue to be enrolled in the plan.

How the Lumenos HIA Plus Plan Works

First, use your Health Incentive Account (HIA) to pay for medical care and prescriptions. Unused HIA funds roll-over from year to year, and you can earn additional funds for your HIA with rewards for healthy behaviors.

Healthy Reward	Healthy Behavior
\$50	Complete MyHealth Assessment online (one per family, per calendar year)
\$100	Enroll in a Health Coaching Program (one per family member, per calendar year)
\$200	Graduate from a Health Coaching Program (one per family member, per calendar year)
\$50	Complete Healthy Lifestyles: Tobacco-Free Program (one per family member*)
\$50	Complete Healthy Lifestyles: Healthy Weight Program (one per family member*)

* Once for you and once for your spouse or domestic partner per lifetime.

After you have used all of your HIA Plus allocation, you will be responsible for the remainder of your plan year deductible. Once your plan year deductible is satisfied, you will pay a percentage of the cost (your coinsurance) until your annual out-of-pocket maximum is reached. Once your annual out-of-pocket maximum is reached, the plan will pay 100% of the cost of covered services. Please note you will still be responsible for costs in excess of reasonable and customary limits (applies to non-network providers only).

Employee Only Coverage Example

Carol Lewis' Lumenos HIA Plus Plan		
\$1,500 allocation	\$1,500	
Expenses: Ob/Gyn visit & lab tests - \$350 Prescription Drugs - \$150	\$500	
	Plan Pays	Carol Pays
Paid by Preventive Care benefit at 100%	\$350	\$0
Paid from HIA	\$150	\$0
Total Paid	\$500	\$0

Remaining HIA balance at end of year: \$1,500 minus \$150 = \$1,350 (rolls over to the following plan year). Remember, the cost of preventive care is not deducted from your HIA.

Medical Plan Comparison

Different medical plan providers charge different rates for services in addition to the rates you pay to belong to the plan. This chart provides a comparison of basic fees and provisions of the HMO plans CAPOC offers. This chart is only a partial listing of features and services. See each Summary Plan Description for full details.

Medical Plan Options			
Feature or Service	Anthem Blue Cross Classic HMO	Anthem Blue Cross Select HMO	Kaiser HMO
Annual Deductible	None	None	None
Out-of-Pocket Maximum	\$1,500/member \$3,000/family	\$1,500/member \$3,000/family	\$1,500/member \$3,000/family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Preventive (physical exams, well-baby & child care, adult preventive, etc.)	No co-pay	No co-pay	No co-pay
Office Visit	\$20 co-pay primary \$20 co-pay specialist	\$20 co-pay primary \$30 co-pay specialist	\$20 co-pay primary \$20 co-pay specialist
Diagnostic X-Ray & Labs	No co-pay	No co-pay	No co-pay
Complex X-Ray (CT or CAT scan, MRI, PET scan)	\$100 per test	\$100 per test	No co-pay
Chiropractic & Acupuncture Services	\$20 per visit	\$20 per visit	
Emergency Room Co-pay	\$100 per visit (waived if admitted)	\$100 per visit (waived if admitted)	\$100 per visit
Hospital Coverage			
Inpatient	\$250 per day (3-day maximum)	\$100 per day	\$500 per admission
Outpatient	No co-pay	No co-pay	\$20/procedure
Pregnancy & Maternity Prenatal & Postpartum Office Visits Inpatient Hospital & Physician Services	\$20 per visit \$250 per day (3-day max)	\$20 per visit \$100 per day	\$20 per visit \$500 per admission
Mental Health (MH) & Substance Abuse (SA) Inpatient Outpatient	\$250 per day (3-day max) \$20 per visit	\$100 per day \$20 per visit	\$500 per admission \$20 per Individual visit \$10 per Group visit (MH) \$5 per Group visit (SA)
Prescription Drug Co-pay: Retail (30-day supply)	Generic: \$10 Brand formulary: \$25 Brand non-formulary*: \$40	\$100 deductible (brand & non-formulary) Generic: \$10 Brand formulary: \$25 Brand non-formulary*: \$40	<u>Generic</u> \$10 (up to 30 days) \$20 (31-60 days) \$30 (61-100 days) <u>Brand</u> \$20 (up to 30 days) \$40 (31-60 days) \$60 (61-100 days)
Prescription Drug Co-pay: Mail Order (90-day supply)	Generic: \$10 Brand formulary: \$50 Brand non-formulary*: \$80		<u>Generic</u> \$20 (31-100 days) <u>Brand</u> \$40 (31-100 days)

*A non-formulary prescription drug is a drug covered under the plan at a higher cost than a generic or formulary brand name drug. See the Plan Summary for full details.

Vision: Employees enrolled with Anthem or Kaiser HMO medical plans have access to an annual vision exam only when referred to an ophthalmologist or optometrist. Discounts on frames, lenses, contact lenses and LASIK eye correction surgery are available when using a contracted vendor. Lumenos HIA Plus members do not have an annual eye exam included in their plan design, but are eligible to receive discounts on their exam and material by using a contracted vendor.

For more details, please contact Anthem or Kaiser directly for participating vendors and information.

Medical Plan Comparison (*continued*)

Different medical plan providers charge different rates for services in addition to the rates you pay to belong to the plan. This chart provides a summary of basic fees and provisions of the HIA Plus plan CAPOC offers. This chart is only a partial listing of features and services. See the Summary Plan Description for full details.

Medical Plan Options		
Feature or Service	Anthem Blue Cross Lumenos HIA Plus	
	In-Network	Non-Network*
Annual Deductible	\$3,000/individual \$6,000/individual + 1 or more	
HIA Plus Allocation (available for medical and RX expenses)	\$,1500/individual \$3,000/individual + 1 or more	
Bridge Amount	\$1,500/individual \$3,000/individual + 1 or more	
Out-of-Pocket Maximum	\$4,000/individual \$8,000/family	\$6,000/individual \$12,000/family
Lifetime Maximum Benefit	Unlimited	Unlimited
Preventive (physical exams, well-baby & child care, adult preventive, etc.)	No co-pay (deductible waived)	30%
Office Visit	No co-pay	30%
Diagnostic X-Ray & Labs	No co-pay	30%
Complex X-Ray	No co-pay	30%
Chiropractic & Acupuncture Services	No co-pay	30%
Emergency Room Co-pay	No co-pay	
Hospital Coverage		
Inpatient	No co-pay	30%
Outpatient	No co-pay	30%
Pregnancy & Maternity Prenatal & Postpartum Office Visits Inpatient Hospital & Physician Services	No co-pay	30%
Mental Health & Substance Abuse		
Inpatient	No co-pay	30%
Outpatient	No co-pay	30%
Prescription Drug Co-pay: Retail (30-day supply)	Generic: \$10 Brand formulary: \$30 Brand non-formulary**: \$50	In-network co-pay + 30% in excess of max allowed amount
Prescription Drug Co-pay: Mail Order (90-day supply)	Generic: \$10 Brand formulary: \$60 Brand non-formulary**: \$100	In-network co-pay + 30% in excess of max allowed amount

*Services are covered at the negotiated fee. Should your provider charge more than the negotiated fee, you will be responsible for this entire amount.

**A non-formulary prescription drug is a drug covered under the plan at a higher cost than a generic or formulary brand name drug. See the Plan Summary for full details.

Prescription Drug Benefits

Anthem Blue Cross Prescription Drug Benefit Program

Anthem Blue Cross maintains a formulary list of preferred brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. By selecting drugs that are on the formulary, you can ensure that you receive the highest level of reimbursement possible. Copies of the Anthem Blue Cross formulary are furnished to your providers and are available online at www.anthem.com/ca. You or your provider may also contact Anthem Blue Cross' Pharmacy Customer Service at 800-700-2541 for a copy of the list.

Because Anthem Blue Cross' pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by going to Anthem Blue Cross' Web site at www.anthem.com/ca.

Preferred Generic Program

The Preferred Generic Program requires that pharmacies, including mail order, automatically fill prescriptions with generic equivalent drugs, if available. When a formulary or non-formulary brand name drug is requested and a generic version exists, you will be responsible for the generic drug co-pay, plus the difference in cost between the generic and brand name drug (up to 50% of Anthem's cost).

The Preferred Generic Program does not apply when a physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary. In such cases, the applicable co-pay for the dispensed drug will apply.

Specialty Pharmacy

Specialty medications (except insulin) such as self-injectables, infused or inhaled which typically require special administration, monitoring, storage or handling must be filled through CuraScript, the Express Scripts specialty pharmacy. The specialty pharmacy will send your medication to your home or doctor's office. In addition, there is a team of pharmacists, nurses and patient care advocates who will work with you to provide additional services to ensure your safety and optimize care.

Anthem Blue Cross WellPoint Express Scripts Mail Order Program

Anthem Blue Cross' WellPoint Express Scripts mail order program allows you to purchase maintenance medications through the mail. If you regularly take a prescription drug for a permanent condition or will need drug treatment for a long-term illness, you may wish to take advantage of this program. By utilizing the Express Scripts mail order program, you can purchase a 90-day supply of medication. Generics are only one times the applicable co-pay and brand name medications are two times the applicable co-pay. For more information regarding the mail order program or to request a mail order form, go online to www.express-scripts.com.

Prior Authorization

Prior authorization applies to a select pool of medications that are often a second line of therapy. To require prior authorization, a drug must meet specific criteria. This criteria is based on FDA-approved drug indications, targeted populations and the current availability of effective drug therapies. Prior authorization drugs are not covered unless you receive an approval from Anthem Blue Cross.

Anthem Blue Cross distributes instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service (at the toll-free number printed on your member ID card) or visit www.anthem.com/ca for information regarding the Specialty Pharmacy Program, as well as lists of medications requiring pre-authorization and their prior authorization of benefits form.

Kaiser Prescription Drug Program

Kaiser Permanente covers prescription drugs, supplies and supplements when prescribed in accordance with their formulary guidelines. You must obtain covered drugs, supplies and supplements from a plan pharmacy or another Kaiser-designated pharmacy.

You may be able to get up to a 100-day supply for certain refills through the mail order program. The mail order program allows you to purchase maintenance medication through the mail. If you regularly take a prescription drug for a permanent condition or will need drug treatment for a long-term illness, you may wish to take advantage of this program.

Dental



You have the option to enroll in either the Cigna DHMO or PPO option for you and your dependents.

DHMO: A participating network dentist must be selected at time of your enrollment and all services must be coordinated through your selected dentist. There is no coverage available when using a non-network dentist. You may change your dentist selection on a monthly basis by simply contacting Cigna.

PPO: The Dental PPO allows you the flexibility of seeking services from a network or non-network dentist and you are not required to select a dentist. Out of pocket expenses are significantly reduced when using a network dentist due to negotiated rates. Please be sure to use caution when seeking services from a non-network dentist as you will be responsible for the difference between the billed amount and Cigna's usual and customary charges.

Coverage	DHMO	Dental PPO	
		Network	Non-Network
Annual Deductible	None	\$50 individual / \$150 family	
Annual Maximum	Unlimited	\$1,500 individual	
Office Visit	\$5 per visit	None	
Preventive & Diagnostic Services (Cleanings, x-rays)	No charge	No co-pay No deductible	20% after deductible
Basic Services (fillings)	See patient charge schedule	20% after deductible	20% after deductible
Major Services (crowns/bridges)	See patient charge schedule	50% after deductible	50% after deductible
Orthodontia Child Adult	\$1,600 \$1,800	50% to \$1500 Lifetime maximum	

Using Your Dental Benefits Wisely

- To pay the least amount out-of-pocket, always use in-network dentists
- Use your preventive benefits and get cleanings for you and your family twice a year
- If your services are estimated to be \$350 or more by your dentist, be sure to have your dentist get pre-determination of benefits to Cigna to ensure services are covered and to get an estimate of what the plan will pay

Life and Accident Insurance

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance

Because we are concerned about the well-being of you and your family, CAPOC funds 100% of the cost of a Basic Life and AD&D policy for all eligible employees through Anthem Blue Cross. The policy will pay a benefit of \$15,000.

Each covered employee's life policy also includes Accidental Death & Dismemberment (AD&D) coverage. This AD&D provision pays a benefit up to \$15,000 should you experience a loss of limb or life as a result of an accident.

Optional Life

You may purchase additional insurance coverage for yourself, as well as coverage for your spouse/domestic partner and/or child(ren) through Anthem Blue Cross. You must elect this coverage in order to elect spouse and/or dependent child coverage. Because this coverage is paid with after-tax dollars, beneficiaries will receive a non-taxable benefit.

Coverage Type	Coverage Amounts
Employee	<ul style="list-style-type: none"> 1-5 times annual salary to maximum of \$250,000 (not to exceed 5 times salary) Guarantee Issue \$50,000
Spouse/ Domestic Partner	<ul style="list-style-type: none"> 50% of employee amount to maximum of \$50,000 Guarantee Issue \$25,000
Children (to age 26)	<ul style="list-style-type: none"> Children eight days to six months: \$500; Six months or older: 50% of employee amount to a maximum of \$10,000 Guarantee Issue: \$10,000

Limited Medical Underwriting for Optional Life

No medical underwriting is required for newly eligible employees who elect insurance amounts up to \$50,000. Medical questions are asked and a blood test may be required for amounts over \$50,000. The non-medical maximum for spouses/domestic partner is \$25,000. If you (and/or your dependents) do not elect Optional Life insurance coverage when first eligible and elect coverage at the next enrollment period, the entire amount of life insurance elected will require medical underwriting. Generally speaking, disabled dependents are not eligible for this coverage. Refer to the contract to determine eligibility of disabled dependents.

Optional Life Insurance Features

Living (Accelerated) Benefit: Should you be diagnosed as terminally ill with less than 12 months to live, you can request up to 75% of your group life benefit, to a maximum of \$250,000, in a lump sum prior to death. The benefit paid to your beneficiary after your death will then be reduced by the Living Benefit amount requested.

Portability and Conversion Features: If you retire, reduce your hours, or terminate employment, you may be able to take this coverage with you according to the terms outlined in the contract.

Waiver of Premium: Premium payments will not be required if you are under the age of 60 and disabled for six months. Proof of disability must be filed by you and approved by Anthem Blue Cross.

Resource Advisor Program:

This value-added program gives you and your family free and confidential access to work/life resources, including: counseling sessions for qualifying events; legal/financial consultations; toll-free, 24/7 telephone consultations and referrals from anywhere in the United States; and unlimited access to Resources Advisor Web site resources.

Important Note

The combined benefit amount for Basic Life/AD&D Insurance and Optional Life Insurance may not exceed 265,000.

Colonial Voluntary Products

In addition to the benefits detailed on the previous pages, CAPOC also provides an opportunity to purchase additional voluntary products on an individual basis through Colonial Life. The benefits offered are listed below:

Universal Life Insurance: Combines permanent life insurance protection with a cash value at competitive rates. The cash value accumulation is available to you through loan or policy surrender. Individual plans are available for employees and family members.

Cancer Wellness: This coverage helps pay for direct or indirect out of pocket expenses not covered by medical plans. Coverage includes initial diagnosis, screenings, mammograms and pap tests, radiation and chemotherapy, bone marrow transplants, surgery, prosthesis, etc.

Accident Expense: Helps cover out of pocket expenses due to injuries, emergencies, hospitalization, outpatient surgery, and more, as a result of an accident for any member of the family.

Critical Illness: An employee can select a \$5,000 to \$50,000 lump sum payment for assistance if one experiences certain critical illnesses.

Premiums for these plans will be payroll deducted and, with the exception of Universal Life, can be deducted on either a pre-tax or after-tax basis. Benefit payments may be affected by selecting to pay the premiums on a pre or post tax basis; therefore, we recommend that you speak with a Colonial representative.

If interested, a Colonial representative will contact you directly to discuss each plan in complete detail and will assist you in the enrollment process. All communication following enrollment will be handled directly with Colonial on an individual basis.

COBRA (When Benefits End)

COBRA Coverage

In compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), CAPOC offers extended coverage for the medical and dental plans. Extended coverage is offered when coverage under these plans would otherwise end.

You and your eligible dependents may extend coverage in these plans for 18 months if you lose coverage due to one of the following qualifying events:

- Voluntary termination
- Involuntary termination (except for Gross Misconduct)
- Reduction of hours (strike, layoff, leave of absence (not FMLA), and full-time to part-time)

COBRA may be extended from 18 to 29 months for qualified beneficiaries who are deemed by the Social Security Administration to have been disabled before the end of the first 60 days of COBRA continuation coverage.*

Your eligible dependents may extend coverage for 36 months if any of the following qualifying events occur:

- Death of the employee
- Employee's Medicare entitlement
- Divorce or legal separation
- Dependent child ceasing to be a dependent

Even though more than one qualifying event may occur, 36 months of extended coverage is the maximum extension available.

You (or your dependent(s)) pay the full cost of the extended coverages you choose plus an administrative fee.

*The disability premium is 150% of the total monthly cost for an active employee.

Receiving Extended Coverage

If an event takes place that qualifies you or your dependents for extended coverage, Human Resources will contact you within 14 days after receiving notification of the qualifying event from you. If you die while employed, your eligible dependents will be contacted by CAPOC upon receipt of notice of your death.

Eligibility for extended coverage begins the day after the qualifying event occurs. COBRA coverage will terminate due to any one of the following events:

- You reach the end of your initial coverage period (18, 29 or 36 months)
- Failure to pay COBRA premiums in a timely manner (specified timelines would apply)
- You become covered under another health plan without pre-existing condition limitations or exclusions applying to your or your beneficiaries' health plan
- You become entitled to Medicare
- CAPOC's cancellation of all group plans

Once extended coverage ends for any reason, it will not be reinstated.

For additional details about COBRA continuation coverage, please refer to the Summary Plan Description (SPD) and the COBRA General Notice provided to you.

Customer Service

Benefit	Provider	Group ID	Phone #	Website/Email
Medical Classic HMO Select HMO HIA Plus Guest Membership for HMO (for dependents residing outside of CA)	Anthem Blue Cross	154278-H007 154278-H001 154278-M004	800.227.3560 800.227.3560 866.207.9878 800-827-6422	www.anthem.com/ca
Medical	Kaiser	226458	800.464.4000	www.kp.org
Dental DHMO	Cigna	3334955	800.244.6224	mycigna.com
Dental PPO	Cigna	3334955	800.244.6224	mycigna.com
Basic Life and AD&D Optional Life	Anthem Blue Cross	154278-0001 154278-0003	800.231.5032	www.anthem.com/ca
Voluntary Products	Colonial (Dave Rackliffe)	N/A	949.679.4415	drackliffe@cox.net

Questions?

This benefits guide summarizes the benefits that are available to you as an employee of CAPOC. This is a brief summary and is not intended to cover all the details.

Please refer to the Medical and Dental Summary Plan Descriptions (included in your packets) for more detailed information.

For specific questions, please contact the benefits providers at the numbers listed on this page.

Employee Contributions

Carrier	Coverage	Category	Monthly Cost
Anthem Blue Cross	Classic HMO	Employee Only	\$125.42
		Employee + Spouse/Domestic Partner*	\$908.17
		Employee + Child(ren)	\$647.25
		Employee + Family	\$1,495.23
Anthem Blue Cross	Select HMO	Employee Only	\$0.00
		Employee + Spouse/Domestic Partner*	\$632.27
		Employee + Child(ren)	\$421.52
		Employee + Family	\$1,106.46
Anthem Blue Cross	HIA Plus	Employee Only	\$320.36
		Employee + Spouse/Domestic Partner*	\$1,337.03
		Employee + Child(ren)	\$998.15
		Employee + Family	\$2,099.53
Kaiser	HMO	Employee Only	\$0.00
		Employee + Spouse/Domestic Partner*	\$551.94
		Employee + Child(ren)	\$330.33
		Employee + Family	\$773.55
Dental Coverage			
Cigna	DHMO	Employee Only	\$0.00
		Employee + Spouse/Domestic Partner*	\$13.25
		Employee + Child(ren)	\$9.09
		Employee + Family	\$24.03
Cigna	PPO	Employee Only	\$46.51
		Employee + Spouse/Domestic Partner*	\$103.96
		Employee + Child(ren)	\$134.81
		Employee + Family	\$192.24
Life Plans			
Anthem Blue Cross	Basic Life & AD&D	Employee Only	Paid by CAPOC
Anthem Blue Cross	Optional Life	Employee + Family	Employee Paid
Voluntary Products			
Colonial	Voluntary Products	Employee + Family	Employee Paid

*Taxation For A Domestic Partnership—Domestic partners are not currently recognized as IRS dependents. Therefore, the portion of premiums CAPOC pays on behalf of your domestic partner must be taxed. This process is called “imputed income”. Also, any premiums you pay which are attributable toward the domestic partner must be taxed. Therefore, these premiums are deducted on an after-tax basis versus pre-tax. (Assembly Bill 25, ‘AB25’ and other similar legislation, may have an impact on imputed income. Additionally, filing an Affidavit of Domestic Partnership through the “State of California” may have a tax-favored impact. It is the employee’s responsibility to communicate “State” filing to Human Resources. Any impact to your payroll check will occur the first pay period following the date State filing has been communicated. Please contact Human Resources for details.)

Glossary

Coinsurance: The percentage of covered expenses not paid by your medical plan. Coinsurance is the amount you pay toward your medical cost once the deductible has been met. For example, when the plan pays 80% of covered expenses, the remaining 20% of which you pay is called your coinsurance.

Co-pay: A fixed amount that your health plan may require you to pay for health care services each time you use them, independent of the deductible and the cost of the service. For example, you may pay a \$20 copayment for a doctor's office visit to a network doctor HMO plan.

Covered Expense: Expenses that will be paid by your health plan.

Deductible: This is the amount of covered expenses you pay each plan year before the plan begins to pay benefits. The PPO Medical plans and the PPO Dental plan require that you meet a deductible.

Most PPO plans have a per person and family deductible. Here's an example of how they work: Once an individual meets their individual deductible, he or she may begin to receive benefits. If members of an enrolled family pay deductible expenses in a year equal to the family deductible, the individual calendar year deductible for all family members will be considered to have been met.

Domestic Partner: A domestic partner is a legal or personal relationship between two individuals who live together and have shared a common domestic life for a minimum of 12 months, but are neither joined by marriage nor a civil union.

Evidence of Insurability (EOI): This is documentation proving that one is in good health for the purpose of obtaining insurance.

ERISA: Employee Retirement Income Security Act of 1974 (Pub L. 93-406, 88 Stat.829, enacted September 2, 1974) is an American federal statute that establishes minimum standards for pension plans in private industry and provides for extensive rules on the federal income tax effects of transactions associated with employee benefit plans. ERISA was enacted to protect the interests of employee benefit plan participants and their beneficiaries by requiring the disclosure to them of financial and other information concerning the plan; by establishing standards of conduct for plan fiduciaries; and by providing for appropriate remedies and access to the federal courts.

Explanation of Benefits (EOB): An EOB is your record of the types of services you received, the total charges and the amount the administrator paid. Every time the plan administrator processes a claim, an EOB is sent to you.

Health Maintenance Organization (HMO): A health maintenance organization is a managed care health care program where medical services are coordinated by a member's selected primary care physician (PCP), including referrals to specialists and hospital admissions. With certain exceptions, such as emergency care, the member must receive all services through the primary medical group the PCP is associated with.

High Deductible Health Plan (HDHP): A high-deductible health plan is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.

Glossary

Maintenance Medications: Prescription drugs taken on an ongoing basis, such as birth control, high blood pressure or diabetes medications.

Negotiated Fee: This is the amount allowable for a specific service. The insurance company determines eligible expenses for all services offered and does not pay benefits for charges that exceed the eligible expense level.

Network Provider: A health care provider who is affiliated with a particular plan and is listed as a provider in the plan's directory. When using network providers, you won't be subject to amounts in excess of the negotiated fee.

Non-Network Provider: A health care provider who is not affiliated with a particular plan and is not listed as a provider in the plan's directory. Non-network providers can charge you more than the negotiated fee, and you will be responsible for excess amounts. These amounts do not apply to the out-of-pocket maximum.

Out-of-Pocket Maximum: This is the maximum amount of covered expenses you'll pay in a plan year. After you have reached the annual out-of-pocket maximum, the plan usually pays the full cost of covered expenses – up to the usual, customary and reasonable rates – for the rest of the plan year. Often there are expenses that are not counted toward the out-of-pocket maximum. See your Summary Plan Description for a list of these expenses.

PPO: A Preferred Provider Organization (PPO) contracts with doctors and hospitals who agree to charge lower than normal fees to their members. When you are a PPO member and use a PPO provider, you generally pay lower out-of-pocket costs.

Pre-Service Notification: The PPO plans require that you call Member Services to pre-approve a procedure or hospitalization before you are admitted or obtain services. Following this procedure will help ensure that you receive the most appropriate care and avoid any extra cost to you.

Summary Plan Description: A document containing a summary description of ERISA covered health benefit plans, including terms and conditions of participation.

Usual, Customary and Reasonable: This term applies to the out-of-network expenses under the medical and dental plans. This is the rate payable for a specific service and the plan does not pay benefits for charges that exceed this level.

Notes

Notes

**Contributors: CAPOC
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Precept**

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This is not a legal document. Please refer to the Summary Plan Descriptions for detailed information. This document is not intended to cover every option in detail. Complete details are in the legal documents, contracts, and administrative policies that govern benefit operation and administration.

If there should ever be any differences between the summaries in this guide and the legal documents, contracts and policies, the legal documents, contracts and policies will be the final authority.

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