

Frequently Asked Questions During Open Enrollment 2017

MEDICAL

Will medical plan premiums be changing in 2017?

There will be modest premium increases to the Gold and EPO medical plans and a decrease to the HMO plan.

Can I change medical plans?

Yes, you may change your medical plan to Gold, EPO or HMO. You and your covered dependent(s) are required to be on the same plan. Please note, Medicare-Eligible participants may only select the Gold Plan. The HMO plan is also not available to Medicare-Eligible or out-of-state participants; however, the HMO Plan does have a BlueCross BlueShield Association's Away from Home Care Program that is for students, long-term travelers, and families living apart. The Away from Home Care is available in most, but not all states. Participants are encouraged to call (800) 622-9402 to find out which states are part of the Away from Home Care program before selecting the HMO Plan. (Benefits from the Away from Home Care Plan may differ from the Access+ HMO 15 Plan.)

How can I verify that my existing providers are in the Blue Shield network?

All three SDRMA medical plans (Gold PPO, EPO, and HMO) have access to the Blue Shield network. To determine if your physicians are still in the network go to www.blueshieldca.com/csac and follow the prompts on how to "Find a Provider Now" or call (800) 642-6155.

Will I be receiving a new Blue Shield Medical ID Card?

You will be receiving a new Blue Shield ID Card ONLY if you are changing to a new plan. The new medical ID Cards will arrive to your home prior to January 1st.

If I join the Access + HMO 15 Plan, when do I select a new Primary Care Physician?

If you join the HMO Plan, you will need to select a Primary Care Physician when you turn in your enrollment form by going on the www.blueshieldca.com/csac website or by calling (800) 642-6155. Once you have confirmed that the doctor is in the Access + HMO 15 network, you will need to get your Primary Care Physician's "Provider Number" (either through the 800 # or from the website) and indicate that number on the Enrollment Form. On the Enrollment Form, you will also need to indicate whether or not you are a prior patient of that Provider. If you are unsure which provider to select or you do not provide a Provider Number, Blue Shield will automatically assign a physician to you and it could take up to 30 days to change your provider.

Can I waive medical coverage for myself and my dependents?

Yes, subject to Plan provisions and District approval, you can request to waive coverage for yourself and/or your dependents, if you or your dependents have other coverage. If you elect to waive coverage for yourself, the District will reimburse you \$46.15 per-pay-period (\$1,200 annually), which will be treated as taxable income. Additionally, you must not use the waiver compensation to purchase an individual plan in the market place or a state exchange plan. There is no reimbursement for waiving coverage for your dependents. You must provide proof of other coverage.

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DENTAL

Will dental premiums be changing in 2017?

No, there will not be any adjustments to the dental premiums.

How can I find a dentist that is in the network?

Log on to www.deltadentalins.com and click on "Find a Dentist" or call (800) 765-6003. With Delta Dental, you may choose to go to an in-network or out-of-network dentist. If you are online, select either the Delta Dental PPO plan or Delta Dental Premier plan for the most cost-savings. They both cover the same benefits allowances however, you will save more by going to a Delta PPO dentist. The next best option if you cannot find a PPO dentist is to select a dentist from their Premier Network. If you visit a Premier Dentist, you still will see a cost-savings because the dentist in that network will not bill you above their contracted fees, unlike the out-of-network dentists. As a third option, you can always choose to visit an out-of-network dentist. More detailed information on how to find a dentist are located in SharePoint.

How will I be billed for using an out-of-network dentist?

The plan gives you the choice of using a PPO or Non-PPO provider. Employees are encouraged to use PPO providers to take advantage of the additional benefits and discounts. The PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. If you don't choose to visit a PPO dentist, you also have access to the Delta Dental Premier network. You'll usually pay more than if you visit a PPO dentist, but you'll still have cost protections that you don't get when you visit a non-Delta Dental dentist. Most non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement from Delta Dental. However, Delta Dental will only reimburse you for the usual and customary cost of the treatment/procedure which may sometimes be less than what the non-Delta Dental dentist charged you, since they are not contracted with Delta Dental and are not required to accept reduced fees for services.

Can I waive Dental coverage?

No. Employees cannot waive dental coverage for themselves. Employees are required to enroll on the dental plan however, you may waive dental coverage for your dependents. You will **NOT** need to submit proof of other dental coverage for dependents.