FRMS | Fire Risk Management Services

2024 ACTIVE OPEN ENROLLMENT GUIDE

North Central Fire Protection District

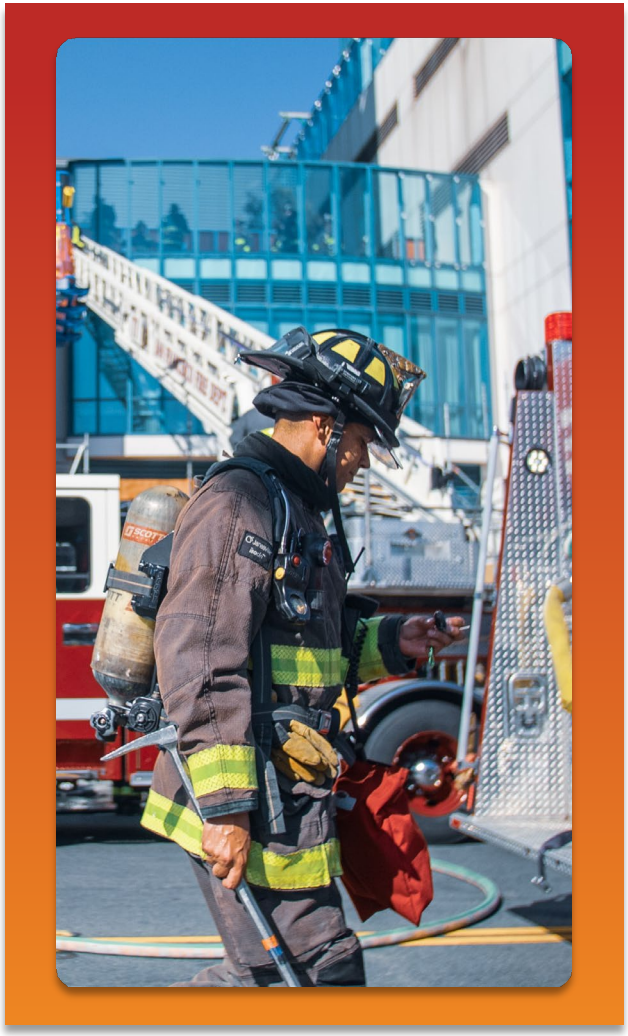
TABLE OF CONTENTS

FRMS

FRMS Benefit Program

Open Enrollment is the one time of the year you can change your employee benefit elections without a "qualifying event". If you would like to change from one plan to another or change your enrollment for yourself or your dependents, you must do so during Open Enrollment. The Open Enrollment period is from **October 1, 2023, to November 15, 2023. Any changes will go into effect on January 1, 2024.**

Please complete the "Benefit Election/Change Request Form" included in this packet; if you are enrolling yourself or your eligible dependents for the first time, please confirm with your Benefits Administrator if any additional forms or information may be needed. If you are not making any changes or are declining coverage, please check the appropriate boxes on the Benefit Election/Change Request Form and return the form to your Finance Department by **November 13, 2023**.



FRMS Benefit Program *(Cont…)*

WHEN MAKING YOUR ELECTIONS YOU SHOULD BE AWARE OF THE FOLLOWING INFORMATION:

- There are no changes to the benefit designs for the 2024 Medical, Life, or Employee Assistance Program (EAP) coverages. However, please submit an updated Life Insurance beneficiary form if necessary.
- If you request to elect supplemental life insurance for the first time or request to increase your existing coverage amount, you will be required to complete & submit the Evidence of Insurability application.
- ***If you're not making any changes to your benefits, select the "No Change" box for each line of coverage on your Benefit Election/Change Request Form.***

FRMS Medical Program

Blue Shield & Kaiser Permanente

North Central FPD							
Medical Plans	**Blue Shield Premium EPO**	**Blue Shield Premium PPO**		**Blue Shield Basic PPO**		**Kaiser Premium HMO**	**Kaiser Basic HMO**
Network	**In-Network Only**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network Only**	**In-Network Only**
Deductible	None	$500 / $1,500		$1,000 / $3,000		None	$500 / $1,000
Out-of-Pocket Max Ind/Fam	$1,500 / $4,500	$2,000 / $6,000	$4,000 / $12,000	$3,000 / $9,000	$6,000 / $18,000	$1,500 / $3,000	$3,000 / $6,000
Office Primary / Specialist Visit	$15 Copay	$15 Copay	30%	$30 Copay	40%	$15 Copay	$20/$40 Copay
Urgent Care	$15 Copay	$15 Copay	30%	$60 Copay	40%	$15 Copay	$20 Copay
Laboratory Outpatient	No Charge	10%	30%	20%	40%	No Charge	$10 per encounter
X-ray & Diagnostic Imaging	No Charge	10%	30%	20%	40%	No Charge	$10 per encounter
Imaging (CT/PET Scans, MRIs)	$100 Copay	10%	30%	20%	40%	No Charge	$50/procedure
Emergency Room	$100 Copay	$100 Copay + 10%	$100 Copay + 10%	$150 Copay + 20%	$150 Copay + 20%	$100 Copay	10% of visit
Hospital Services	$250/admit	10%	30%	20%	40%	No Charge	10%/admit
Inpatient Physician	100%	10%	30%	20%	40%	100%	100%
Outpatient Facility Charge	$250 / surgery	10%	30%	20%	40%	$15 / occurrence	10% / occurrence
Rehabilitative Speech Therapy	$15 Copay	10%	30%	20%	40%	$15 Copay	$20 Copay
Occupational/Physical Therapy	$15 Copay	10%	30%	20%	40%	$15 Copay	$20 Copay
Skilled Nursing Facility	$0 First 10 days then $25/day	10%	30%	20%	40%	No Charge	10%
Mental Health Outpatient	$15 Copay	$15 Copay	30%	$30 Copay	40%	$15 Copay	$20 Copay
Rx - Deductible	$100	None		None		None	None
Generic	$10 Copay	$10 Copay	$10 Copay + 50% AWP	$20 Copay	$20 Copay + 50% AWP	$10 Copay	$10 Copay
Formulary Brand (Non-Formulary Brand)	$20 ($35) Copay	$20 ($35) Copay	$20 ($35) Copay + 50% AWP	$30 ($50) Copay	$30 ($50) Copay + 50% AWP	$30 Copay	$30 Copay
Specialty Drugs	20% to $100 per script	20% to $100 per script	20% to $100 per script	20% to $100 per script	20% to $100 per script	20% up to $100 per script	20% up to $150 per script

FRMS Critical Illness Program

The Hartford

- This coverage is included for each employee and their dependent children that are **enrolled in an FDAC EBA medical plan**
- $5,000 lump sum benefit for the employee and 25% for children
- No additional cost
- Spouses are not eligible
- Employees that waive the medical are not eligible
- Completed beneficiary form needed
- Retirees are not eligible

Critical Illness	Benefit
Invasive Cancer	100%
Heart Attack	100%
Permanent Damage due to Stroke	100%
End Stage Renal Failure	100%
Major Organ Failure	100%
Permanent Paralysis due to a Covered Accident	100%

CORDICO First Responders Mobile App

- This benefit is included for each fire district that offers an FRMS **medical plan**
- No additional cost
- Confidential
- On-Demand 24/7
- Peer Support Program
- In-Hand Wellness Tools
- Self-Assessments, Cancer Awareness, Employee Assistance Program, and more

CORE FEATURES AND BENEFITS

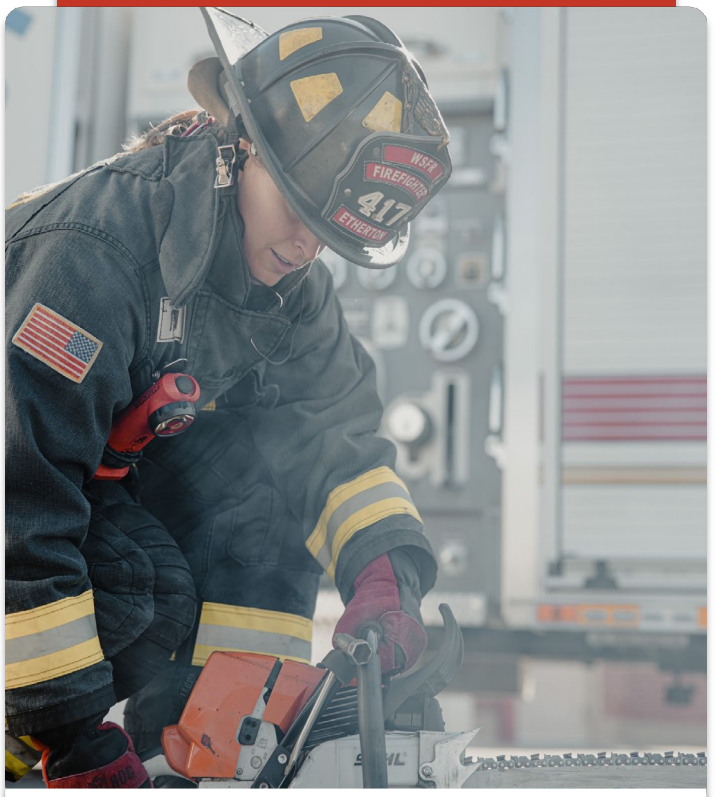
- Alcohol Abuse
- Anger Management
- Anxiety, Panic Attacks & Worry
- Behavioral Health Tools
- Brain Health & Cognitive Strength
- Chaplain Support
- Compassion Fatigue
- Critical Incidents
- Depression
- Emotional Health
- Family Support
- Financial Fitness
- Firefighter Wellness
- Grief & Loss
- Healthy Habits
- Injury Prevention for Firefighters
- Major Life Events
- Marriage Guidance
- Mental Toughness
- Mindfulness
- Moral Injury
- New Hire: Keys to Wellness
- Nutrition for Firefighters
- Parenting Tips for Firefighters
- Peak Performance
- Peer Support
- Physical Fitness for Firefighters
- Posttraumatic Stress
- Psychological First Aid
- Relationship Success
- Resilience Development
- Retirement: Getting Prepared
- Self-Care Checklists
- Sleep Optimization
- Stress Management
- Stress Response
- Substance Abuse
- Suicide Prevention
- Supporting Children Who Fear for Your Safety
- Therapist Finder
- Trauma
- Wellness Self-Assessment Tools
- Wellness Videos
- Work-Life Balance

FRMS

Employee Assistance Program

Halcyon EAP offers expert guidance & resources, including:

- Access to licensed clinicians & immediate assistance 24/7/365
- Up to 6 in-person or virtual, CONFIDENTIAL counseling sessions
- Access to financial consultations
- Access to legal consultations
- Access to family resources & referrals for child & elder care, home repair, pet care, & more



Halcyon EAP

FRMS Life/AD&D Program

The Hartford

NORTH CENTRAL FPD		
The Hartford		
Basic Life Insurance - Employer Paid	***Benefit***	
Basic Employee Life Insurance	$15,000	
Basic Employee AD&D Insurance	$15,000	
Basic Family Life Insurance	$10,000 Spouse/$5,000 Child	
Supplemental Life Insurance - Voluntary Employee Paid	**Benefit Range**	
	Minimum	**Maximum**
Supplemental Employee Life Insurance		
Guaranteed Issue Amount When First Eligible - $200,000	$20,000	$500,000
Purchased in increments of $10,000		
Supplemental Spouse Life Insurance		
Guaranteed Issue Amount When First Eligible - $50,000		
A spouse can enroll for up to 100% of the Employee's current Supplemental Life coverage amount	$5,000	$150,000
Purchased in increments of $5,000		
Supplemental Dependent Child Life Insurance		
Guaranteed Issue Amount When First Eligible- $10,000		
Single purchase covers all eligible child(ren) to age 26	$2,000	$10,000
Requires current Supplemental Employee Life enrollment		
Purchased in increments of $2,000		

Members not currently enrolled will be required to complete the Evidence of Insurability process for <u>all</u> amounts.
Any requested increase will require the Evidence of Insurability process to be completed for enrolled members.
Employees that were previously declined for coverage are <u>not</u> eligible.

FRMS Rates

2024 Monthly Premiums

North Central FPD						
Medical Coverage:	**Blue Shield Premium EPO**	**Blue Shield Premium PPO**	**Blue Shield Basic PPO**	**Blue Shield HSA PPO**	**Kaiser Premium HMO**	**Kaiser Basic HMO**
Employee Only:	$1,024.03	$1,069.27	$998.72	$929.11	$909.44	$820.29
Employee + 1 Dependent:	$2,048.07	$2,138.60	$1,997.41	$1,858.21	$1,809.49	$1,631.17
Employee + 2 or more Dependents:	$2,662.48	$2,780.16	$2,596.62	$2,415.67	$2,349.53	$2,117.69

Supplemental Life Insurance:	**The Hartford**
Voluntary Employee/Spouse Life	**Age Banded***
<29	$0.07
30 - 34	$0.09
35 - 39	$0.11
40 - 44	$0.13
45 - 49	$0.14
50 - 54	$0.21
55 - 59	$0.33
60 - 64	$0.61
65 - 69	$0.94
70 - 74	$1.80
75+	$2.92
Voluntary Dependent Child Life	$0.06

* Rates per $1,000 of coverage

FRMS Benefit Program

2024 Benefit/Change Request Form

	Step 1 - Check Coverage Boxes			Step 2 - Check Tier/Amount Coverage			Step 3 - Sign & Return
MEDICAL	**No Change**	**Enroll / Change**	**Decline Coverage**	**Employee Only**	**Employee + 1 Dependent**	**Employee + Family**	**Benefit Election Form**
							I affirm that the benefit selections made confirm my intent for the 2024 plan year.
Blue Shield	Check one box						
Premium EPO							
Premium PPO							
Basic PPO							
Kaiser							**Print Name**
Premium HMO							
Basic HMO							
				Check one box (only if "Enroll/Change" box is checked)			
SUPPLEMENTAL LIFE*	**No Change**			**Enroll / Change**			**Employee Signature**
Employee Life				SEE BENEFITS CONTACT PERSON			
Spouse Life							
Dependent Child Life							**Date**
							Upon completion return to Finance

* May require approval through the Evidence of Insurability (EOI) process.

North Central Fire Protection District
Monthly Employee 20% Deduction

Carrier	Coverage		2024 Employee 20% Rates		
			EE Only	EE + 1 Dep	EE + Family
Blue Shield	Premium EPO		204.806	448.07	1062.48
Blue Shield	Premium PPO		213.854	538.6	1180.16
Blue Shield	Basic PPO		199.744	399.482	996.62
Blue Shield	HAS PPO		185.822	371.642	815.67
Kaiser	Premium HMO		181.888	361.898	749.53
Kaiser	Basic HMO		164.058	326.234	517.69

Please Divide by 2 to get your deduction per Paycheck for the 125 flex form. If you want it to be taken out pre-taxed.

Health Benefits Waiver Form

Employer: North Central Fire Protection District 15850 W. Kearney Blvd., Kerman, CA 93630			
Employee Name:	*Last*	*First*	*Middle Initial*
Employee Social Security Number:			
Date of Employment:			
Date of Birth:			

For the plan year effective _____/_____/_____ I am declining coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependent(s) – Please list names: _____

I am declining to enroll for the reason shown below:

☐ Covered under my spouse's/domestic partner/parent plan

Carrier Name and Member ID_____

☐ Enrolled in another Insurance Carrier Plan

Carrier Name and Member ID_____

☐ Covered by Medicare, Medi-Cal, COBRA, Medicaid, TRICARE or CHAMP VA (please circle)

☐ Other *(Please explain)* _____

By signing below, I acknowledge that I have been given the opportunity to enroll in a group insurance health plan for myself and my eligible dependents, if any. I understand that I am declining enrollment for myself or my eligible dependents (including spouse) because of other health insurance or group health plan coverage. I may be able to enroll myself and my eligible dependents in this plan if I or my eligible dependents lose eligibility for that other coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until the plan's next open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

_____ _____

Employee Signature Date

ASi ADMINISTRATIVE SOLUTIONS | a division of navia

Employee Enrollment / Change Form

Please write legibly, complete all applicable sections, and sign where indicated.

EMPLOYER INFORMATION

Group Name

Check appropriate box(es) and provide effective date

☐ Medical ☐ Dental ☐ Vision ☐ HRA ☐ MEC **Effective Date:** _____

☐ New Group ☐ Family Addition ☐ New Hire ☐ Other-Specify: _____

☐ Termination/Date _____ ☐ COBRA Enrollment/Qualifying Date _____

EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial
Home Address	City/State	Zip Code
Email Address (required)	Phone Number	Hire Date
Social Security Number	Date of Birth	Sex

Marital Status ☐ Single ☐ Married ☐ Divorced/Separated

Are you or your dependents covered by another plan ☐Yes ☐No **Medical** ☐ **Dental** ☐ **Vision** ☐

Carrier's Name:

SPOUSE

Last Name	First Name	Sex	Social Security	Date of Birth

CHILDREN

Last Name	First Name	Sex	Social Security	Date of Birth
1.				
2.				
3.				
4.				
5.				

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I provide this information as part of my employer's application for coverage for myself and my eligible dependents listed above. To the extent that I am responsible for the payment of plan costs, I authorize appropriate deductions from my earnings. I authorize any "provider of care", insurer, third party administrator, or health plan to release information regarding me, my spouse and/or my children as necessary and for the purpose of determining claims for benefits, quality assurance, and peer review. This authorization will remain in effect for the term of coverage under my employer's plan. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to a copy of this authorization.

Employee Signature: _____ **Date:** _____

Mail completed form to Administrative Solutions
PO Box 5809 Fresno CA 93755-5809 or Fax to 559-475-5786 or Email to spseligibility@naviabenefits.com

DENTAL SCHEDULE OF BENEFITS

North Central Fire Protection District

January 1, 2024

The Schedule of Benefits is a summary of the benefits, exclusions and limitations that you receive as covered services from a provider. All covered services are subject to the conditions, exclusions, limitations, terms and provisions of the plan including any attachments or riders.

Coverage Year: Calendar Year

Dependent Age Limit: To the end of the month in which the child attains age 26.

Benefit Waiting Period: There are no benefit waiting periods.

DENTAL COVERED SERVICES

After you have satisfied the deductible, we will pay benefits for covered services at the percentage or applicable amount up to the maximum allowed amount for each completed dental service. The maximum allowed amount payable for each dental procedure is determined by Navia, and there may be different levels of reimbursement for the maximum allowed amount depending upon whether you elect to receive services from a contracted provider or a non-contracted provider.

	Navia Contracted Provider	Non-Contracted Provider
Diagnostic and Preventive Services*	80%	80%
Basic Restorative Services	80%	80%
Endodontic Services	80%	80%
Periodontal Services	80%	80%
Oral Surgery Services	80%	80%
Major Restorative Services	80%	80%
Prosthetic Services	80%	80%
Orthodontic Services	80%	80%

*Not subject to the Deductible

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

DEDUCTIBLES (combined for Navia Contracted and Non-Contracted Providers)

You are responsible for satisfying the deductible before Navia pays for benefits. If 3 family members satisfy their individual deductible, the family deductible will be met. Only charges that are considered a maximum allowed amount will apply toward satisfaction of the deductibles.

Per Member	$0
Per Family	$0

DENTAL BENEFIT MAXIMUMS (combined for Navia Contracted Providers and Non-Contracted Providers)

Coverage Year Maximum: Your combined benefits, excluding orthodontics, are subject to the coverage year maximum. Navia will not pay any benefits in excess of that amount during a coverage year.

Orthodontic Services Lifetime Maximum: Your orthodontic benefits are subject to the coverage year maximum. Navia will not pay any orthodontic benefits in excess of that amount during a member's lifetime.

Dental Coverage Year Maximum:	$1,000 per Member
Orthodontic Services Lifetime Maximum:	Included in dental max – no lifetime limit

**Non-Participating Providers: 90th percentile of National Dental Advisory Survey (NDAS)*

PROVIDER NETWORK

Central Valley Dental Partners
(559) 256-1320
Provider Directory: https://docs.naviabenefits.com/files/CVDP-Provider-directory.pdf

First Dental Health
(559) 256-1320
Provider Directory: http://fdh.go2dental.com/

*****Pre-Determination of Benefits: Recommended when a course of treatment is expected to exceed $300***

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

DENTAL COVERED SERVICES

Diagnostic and Preventive Services

Diagnostic and Preventive Treatment

- Oral Evaluations
- Radiographic imaging (x-rays)
- Prophylaxis (tooth cleaning)
- Fluoride Treatment
- Space Maintainers
- Sealants
- Biopsy/Tissue Examination
- Consultations

LIMITATIONS:

1. Oral Evaluations: Any type of oral evaluation, screening, case management and/or consultation is an aggregate benefit twice per calendar year.
2. Bitewing image series: Covered once per calendar year through the age of 18; over age 18 are covered once per two calendar years.
3. Full mouth (complete series) or panoramic images are covered once every five calendar years.
4. Prophylaxis: Any combinations of this procedure, and/or periodontal maintenance procedures are covered twice per calendar year.
5. A prophylaxis performed on a patient through the age of 12 will be benefitted as a child prophylaxis.
6. A prophylaxis performed on a patient age 13 or older will be benefitted as an adult prophylaxis.
7. Fluoride Topical Treatment: A benefit twice per calendar year through age 18.
8. Fluoride Varnish Treatment: A benefit once per calendar year period through age 18.
9. Space Maintainers: For a prematurely lost primary tooth, through age 14.
10. Repair or replacement of a lost/broken appliance is not a covered benefit.
11. Sealants: A benefit one time per three calendar years on unrestored permanent molars through age 18.

Basic Services

Restorative Treatment

- Emergency Treatment (palliative) treatment for relief of pain or infection
- Amalgam, composite resin restorations (fillings) for the treatment of cavities (decay)
- Prefabricated Stainless steel crowns
- Recement or rebond crowns, veneers, fixed bridges, inlays, and onlays
- Core buildups with or without post retention

LIMITATIONS:

1. Amalgam and composite resin restorations are to restore decayed or fractured permanent or primary teeth.
2. Composite resin restorations on posterior teeth are covered for all teeth.
3. A core buildup is a benefit only when insufficient tooth structure remains to retain an indirect restoration, or is placed in a non-vital tooth.
4. Stainless steel crowns are a benefit per tooth once in a five calendar year period.
5. A posts, in conjunction with a core buildup on a non-vital tooth, is a benefit only when necessary to retain the core.
6. Recement/rebond a restoration, or fixed bridge, is covered once per calendar year, beginning six months after initial placement.

Endodontic Treatment (Nerve or Pulpal Treatment)

- Pulpal therapy on primary and adult teeth
- Therapeutic pulpotomy on primary teeth
- Initial root canal treatment
- Retreatment of root canals

LIMITATIONS:

1. Primary tooth pulpal therapy and therapeutic pulpotomy is a benefit one time per tooth.
2. Retreatment of a previous root canal therapy is a benefit after at least 12 months has elapsed since original treatment. Any subsequent endodontic treatment, following retreatment, on the same tooth is not benefitted.
3. Pulpal debridement and other procedures and materials used to prepare and place materials in the canals are considered integral to the endodontic procedure.
4. Incomplete therapy is without benefit.

Periodontal Treatment (Gum and Bone Treatment)

- Non-surgical periodontal care (scaling and/or root planning)
- Periodontal maintenance procedure
- Full mouth debridement procedure
- Complex surgical periodontal treatment: soft tissue and hard tissue procedures, intra-oral grafts, crown lengthening procedures.

LIMITATIONS:

1. Scaling and root planning procedure is a benefit one time in two calendar years in each full or partial mouth quadrant.
2. Periodontal maintenance procedure and any combination of this procedure with prophylaxis, and/or non-surgical scaling procedures are covered an aggregate of twice per calendar year.
3. Periodontal maintenance procedure is a benefit after at least 6 months has elapsed following active periodontal treatment.
4. Full mouth debridement procedure is a benefit once per lifetime.
5. Complex periodontal procedures are a benefit once in a three calendar year period per single or multiple teeth in the same quadrant.
6. Scaling and root planning requires documentation by periodontal a sulcus probing record and intraoral radiographic images.

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

Oral Surgery Treatment

- Removal of erupted teeth
- Surgical removal of impacted teeth
- Surgical removal of residual tooth roots
- Coronectomy
- Alveoloplasty, vestiuloplasty, exostosis removal, reduction of osseous tuberosity
- Deep sedation/general anesthesia, or IV conscious sedation

LIMITATIONS:

1. Removal of teeth for orthodontic reasons is a benefit only if there is orthodontic benefit coverage. Fees associated with oral surgery, for orthodontic reasons, become part of the global orthodontic benefit.
2. Surgical removal of 3rd molars is covered if the removal is associated with symptoms or oral pathology.
3. Deep sedation/general anesthesia, or IV conscious sedation is a benefit when provided with oral surgery services upon determination of medical necessary.

Major Services

Restorative Treatment

- Inlays
- Onlays
- Veneers
- Repair of a major restoration
- Crowns

LIMITATIONS:

1. An indirect restoration is payable when justified by caries and/or tooth fracture which results in significant loss of tooth structure and the tooth cannot be adequately restored with amalgam or composite resin.
2. Porcelain facings, veneers, crowns, inlays, or onlays on teeth behind second bicuspids are considered cosmetic; therefore the benefit is limited to the corresponding all metal restoration.
3. Replacement benefit of a major restorative service is excluded from benefit for seven years following initial placement. If a replacement is required because of an accidental bodily injury sustained while the insured is covered, it will be a covered expense.
4. Repair of a restoration is a benefit once per calendar year, beginning 24-months following initial placement.

Prosthodontic Treatment

- Full Dentures
- Removable Partial Dentures
- Fixed Bridges

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

LIMITATIONS:

1. Initial placement of any prosthetic appliance is a benefit only to replace tooth/teeth lost while covered under this plan. The extraction of a third molar is not a qualifying extraction.
2. Tissue conditioning is a benefit twice per two calendar years per denture and only after 6 months following initial placement.
3. Relining or rebasing a removable denture is a benefit once per two calendar years per denture.
4. A repair, replacement of broken teeth or clasps is a benefit once per calendar year and only after 6 months following initial placement. Benefit reimbursement is limited to 20% of a replacement denture.
5. Full and/or partial denture adjustments are a benefit twice in a calendar year, and only after 6 months following initial placement.
6. Replacement benefit of a full or partial denture and a fixed bridge is excluded from benefit for seven years following initial placement and only if the existing prosthesis cannot be repaired or adjusted satisfactorily. If a replacement is required because of an accidental bodily injury sustained while the insured is covered, it will be a covered expense.

ORTHODONTIC Treatment (only if Orthodontic addendum is added to the base policy)

- Limited Treatment
- Interceptive Treatment
- Comprehensive Treatment
- Removable Appliance Therapy
- Fixed Appliance Therapy

LIMITATIONS:

1. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment, and must have continuous eligibility to receive ongoing orthodontic benefits.
2. Benefits include radiographic images, diagnostic models, evaluations and necessary extractions.

EXCLUSIONS: BENEFITS ARE NOT PROVIDED FOR --

1. For any procedure before the insured was covered by this policy.
2. For any treatment services not included as covered treatment.
3. For completion of claim forms.
4. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
5. For counseling, instruction, or supplies relating to oral hygiene, plaque control, nutrition or tobacco cessation.
6. For pulpal vitality tests, secondary diagnostic tests, diagnostic models, cone beam images, anatomical crown exposure, temporary anchorage devices, sinus augmentation, or cytology sample collection.
7. For restorations placed for preventive purposes.
8. For services which the submitted documentation indicates a poor prognosis.
9. For root canal obstructions, internal root repair of perforation defects, or incomplete endodontic treatment.
10. For intentional reimplantation, apexification/recalcification, pulpal regeneration, apicoectomy, periradicular services, root amputation, hemisection, or similar procedures.
11. For bleaching of discolored teeth or any treatment primarily for cosmetic purposes, including porcelain on crowns and pontics beyond the second bicuspid.
12. For bacteriologic or genetic tests used for the determination of periodontal disease susceptibility, or pathologic agents.
13. For the controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

13. For provisional splinting or other temporary procedures used for the interim stabilization of teeth.
14. For any material grafted on to bone or soft tissues from outside the mouth to tissue inside the mouth.
15. For analgesia, analgesic agents, anxiolysis, inhalation of nitrous oxide or therapeutic drug injections, and prescribed drugs or medications.
16. For deep sedation/general anesthesia, or IV conscious sedation when provided with non-oral surgery dental treatment.
17. For any treatment related to Temporomandibular Joint Dysfunction (TMJ), including but not limited to splints, occlusal guards, including nightguards and athletic mouth guards.
18. For cast post and cores.
19. For procedures designed to alter, restore, or maintain occlusion, including but not limited to increasing vertical dimension, replacing, or stabilizing tooth structure lost by attrition, abrasion, abfraction, realignment of teeth, periodontal splinting, equilibration and gnathological recordings.
20. For initial installation of full or partial dentures, or fixed bridgework to replace a tooth or teeth lost prior to coverage under this plan.
21. For implants and all services related to the placement, restoration, repair, or removal.
22. For replacement of an existing removable partial denture with a fixed bridge.
23. For services related to conditions that are the result of hereditary or developmental defects, including but not limited to, cleft palate, upper and/or lower jaw malformations, congenitally missing or deformed teeth, and teeth discolored or lacking enamel.
24. For orthognathic surgery
25. For incomplete, interim, or temporary removable or fixed prosthetic appliances.
26. For additional elective or enhanced prosthetic services including but not limited to connector bars, stress breakers and precision attachments.
27. For dental services caused by an event for which there is eligibility for benefits under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, benefit payment will not be excluded for such services if the governmental plan requires the dental insurance under this group policy be paid first. However, if a bill or direct charges for dental services under any governmental program is received, then this exclusion shall not apply.
28. For dental services or health care services not specifically covered under the Group Contract which are considered medical in nature.
29. For anesthesia services, except by a Dentist or an employee of the Dentist, when the service is performed in their office, who is licensed in their profession to provide anesthesia services.
30. For the replacement of lost or stolen appliances.
31. For any procedure begun after the Covered Person's benefits under this plan terminates, or for any prosthetic dental appliances, installed or delivered more than 90 days after the Covered Person's benefits under this section terminates.
32. For professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.
33. For hospital and/or surgical or treatment facility charges of any kind, including the dentist for facility charge.
34. For services which are not dentally necessary or those that do not meet generally accepted standards of care for treating the particular dental condition, or which is deemed experimental in nature.
35. For charges of treatment by other than a licensed dentist or physician, except treatment provided by a licensed dental hygienist, consistent with California statutes.
36. Missed appointments.
37. Caries susceptibility tests.

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

BENEFIT DETERMINATION

Alternate Treatment Benefit:

- Many dental conditions can be treated in more than one way. This plan has an "alternate treatment" clause, which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to satisfactorily correct a dental problem, according to generally accepted standards of dental care, the benefit payment will be based on the cost of the treatment, which provides professionally satisfactory results at the most cost-effective level.

Note: Benefits are subject to change and are based on member eligibility at the time services are rendered.

VISION SCHEDULE OF BENEFITS

North Central Fire Protection District

January 1, 2024

The Schedule of Benefits provides you a brief of the key benefits of the vision plan available from Navia. Following the chart, you will find additional information to answer questions you may have. Services are subject to the conditions, exclusions, limitations, terms and provisions of the plan including any attachments or riders.

Coverage Year: Calendar Year

Dependent Age Limit: To the end of the month in which the child attains age 26.

Benefit Waiting Period: There are no benefit waiting periods.

VISION COVERED SERVICES

Benefits for covered services at the percentage or applicable amount up to the maximum allowed amount for each completed vision service. The maximum allowed amount payable for each vision procedure is determined by Navia, and there may be different levels of reimbursement for the maximum allowed amount depending upon services from a provider.

	Benefit	Frequency
Exams	100%	One exam every 12 months
Prescription Lenses	100%	One pair every 12 months
Prescription Frames	100%	One set every 24 months
Contact Lenses	100%	One pair every 12 months

Note: Benefits are subject to change and are based on the members eligibility at the time services are rendered.

COPAYMENTS

You are responsible for copayments applied to vision services at the time the treatment is rendered.

Exam	$0
Materials	$0

VISION BENEFIT MAXIMUMS

Coverage Year Maximum: Your combined benefits are subject to the coverage year maximum. Navia will not pay any benefits in excess of that amount during a coverage year.

Vision Coverage Year Maximum:	$250 per Member plus Exam

RESTRICTIONS OF COVERAGE

Non-Medically Necessary Services	**The coverage does not pay for visual analysis or vision aids that are not medically necessary.**
Benefit Limitations	▪ Two pairs of glasses instead of bifocals ▪ Replacement of lenses, frames or contacts ▪ Orthoptics, vision training or supplemental testing ▪ Plano lenses (lenses with refractive correction of less than ± .50 diopter)
Contact Lens Limitations	▪ Insurance policies or service agreements ▪ Artistically painted or non-prescription lenses ▪ Additional office visits for contact lens pathology ▪ Contact lens modification, polishing or cleaning ▪ Refitting of contact lenses after the initial (90 day) fitted period

Note: Benefits are subject to change and are based on the members eligibility at the time services are rendered.

SECTION 125 CAFETERIA BENEFIT PLAN

2024 EMPLOYEE ENROLLMENT AUTHORIZATION FORM

Employer North Central Fire Protection District		Job Title	Present Salary $	
Employee's Last Name		First Name	Mid.	Phone#
Employee's Address: (Reimbursement Checks will be sent to this address) Street		City	State	Zip
Social Security Number	Date of Birth	___ Male ___ Single ___ Divorced ___ Female ___ Married ___ Widowed	Hire Date	Hrs. Worked Weekly?

Are you paid: [ ] Weekly (52/yr) [X] Semi Monthly (24/yr) [ ] Other _____

[ ] Bi-weekly (26/yr) [ ] Monthly (12/yr)

AUTHORIZATION FOR COVERAGE AND PARTICIPATION

I request the following amounts to be deducted from my salary **per pay period,** as follows:

Health Insurance Premiums $_____ Day Care Expenses $_____

Administration Fees $_____ Medical Expenses $_____

I certify the information above to be correct and true to the best of my knowledge. I authorize payroll deductions from my earnings for any contribution I am making toward the cost of any of the above. Applicable account(s) at the end of the plan year not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Section 125 Flexible Benefit Plan deductions(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status as defined in the Plan Document.

_____ _____

Signature Date

DECLINATION OF COVERAGE AND PARTICIPATION

I have been given the opportunity to participate in the above Section 125 Flexible Benefit Plan and have elected not to do so. If I later wish to enroll in this Plan, I understand that my eligibility and effective date will be determined according to Plan Document provisions elected by my Employer.

_____ _____

Signature Date

North Central Fire Protection District
Monthly Employee 20% Deduction

Carrier	Coverage		Per paycheck deductions for the 2024 Employee 20% Portion							
			EE Only	EE Only / With (Single) D&V	EE Only / With (Fam) D&V	EE + 1 Dep	EE + 1 Dep / With (Single)D&V	EE + 1 Dep / With (fam)D&V	EE + Family	EE + Family /(fam) With D&V
Blue Shield	Premium EPO		102.40	106.70	112.70	224.04	245.54	275.54	531.24	528.74
Blue Shield	Premium PPO		106.93	111.23	117.23	269.30	218.16	320.80	590.08	641.58
Blue Shield	Basic PPO		99.87	104.17	110.17	199.74	204.04	250.21	498.31	549.81
Blue Shield	HSA PPO		92.91	97.21	103.21	185.82	190.12	196.12	407.84	407.84
Kaiser	Premium HMO		90.94	95.24	101.24	180.95	185.25	191.25	374.77	426.27
Kaiser	Basic HMO		82.03	86.33	92.33	163.12	167.42	173.42	258.85	310.35

If you want to have your Health Premiums deducted before taxes, please complete the Flex 125 and use these amounts on the Health Insurance Premium line and sign the form. If you have any questions, please contact Finance. Thank you.

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

THE HARTFORD

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer: Fire Risk Management Services - North Central Fire Protection District		Policy Number: 715022

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)