

2015 Benefits for Active and Retired Employees

Dental



CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Benefits Division

additional information located at

www.calhr.ca.gov

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A. Introduction and General Information

This dental benefits handbook was prepared by the California Department of Human Resources to provide general information regarding state-sponsored dental coverage for State of California employees, retirees, and their eligible dependents.

Information in this handbook is supplied solely to provide general information regarding eligibility and enrollment and to assist you in comparing dental plan options. This handbook has no legal force or effect. While it is our intention to be as accurate as possible, any discrepancy between the information contained herein and actual dental plan benefits is controlled by the contracts between the state and the dental plan carriers.

For active employees, questions regarding eligibility for enrollment in the state's dental program should be directed to the appropriate personnel office. For retirees, eligibility questions should be directed to the California Public Employees' Retirement System (CalPERS) 1-888-225-7377 / TTY 1-877- 249-7442.

CalHR

The CalHR, Benefits Division administers the state's dental program. CalHR secures and administers contracts with dental companies to provide benefits to active state employees, retirees, and their dependents. Additionally, CalHR is responsible for communicating policies and procedures regarding dental eligibility and enrollment, coordinating dental open enrollment periods, and providing information, guidance, and training to personnel office staff on issues relating to the state's dental program.

State-Sponsored Dental Plans

CalHR currently contracts with Delta Dental (Delta) for an indemnity type plan and a preferred provider option plan. CalHR also contracts with four prepaid dental plans. These prepaid plans are: DeltaCare USA, Premier Access, SafeGuard, and Western Dental.

Here are brief descriptions of the three kinds of dental plans: **prepaid, indemnity type** and **preferred provider option** plans.

A **prepaid** plan requires you and your eligible dependents to select a dental provider when you enroll, choosing from a list of dentists who contract with the plan. These dentists, located only in California, are paid a monthly contracted fee by the dental plan for every state employee, retiree, and dependent who chooses to receive services from their office. No monthly premium is deducted from your pay warrant or retirement warrant; the premium is paid in full by the state. (See page 13 for more details about the prepaid plans.)

An **indemnity type** plan allows you to receive services from any licensed dentist worldwide. However, benefits are maximized when you receive services from a contracting Delta dentist. The plan pays a percentage of the costs for each specific type of dental treatment. You are responsible for paying any remaining balance based on the type of dental treatment you receive. A monthly premium cost share will be deducted from your pay warrant or retirement warrant. (See page 17 for more information about the state-sponsored indemnity type plan.)

A **preferred provider option** plan allows you to select any licensed dentist you wish. However, you receive the maximum benefits available under the program when you choose one of the dentists in the plans network, similar to the indemnity plan. Individuals who enroll in the plan are required to pay a monthly premium cost share. Currently, employees and retirees enrolled at the one-party code (i.e., self only) do not pay a monthly premium cost share. (See page 19 for more information about the state-sponsored preferred provider option plan.)

California Association of Highway Patrolmen (CAHP) Dental Plan

The California Association of Highway Patrolmen (CAHP) administers the indemnity dental plan (Blue Cross) for Bargaining Unit 5 (Unit 5) employees. The exclusive representative of Unit 5 contracts directly with Blue Cross to provide dental insurance to the unit's members and has administrative responsibility for such coverage. All newly hired represented employees in Unit 5 must elect their dental coverage from one of the state-sponsored prepaid dental plans. After completing the 24-month restriction period, Unit 5 employees who are CAHP members may enroll or change to Blue Cross.

For more information on the 24-month restriction period, employees should contact their personnel office. For information regarding the CAHP dental plan, Unit 5 employees should contact the CAHP Benefits Trust at (916) 452-6751 or 1-800-734-2247.

California Correctional Peace Officers Association (CCPOA) Dental Plans

The California Correctional Peace Officers Association (CCPOA) administers the Primary Plan (indemnity) and Western Dental Plan (prepaid) for Bargaining Unit 6 (Unit 6) employees. The exclusive representative of Unit 6 contracts directly with its dental carriers for dental benefits for its members and has administrative responsibility for such coverage. Unit 6 employees have 60 days from the date of hire, or when they become eligible, to enroll in the union-sponsored dental plan. All newly hired or newly eligible Unit 6 employees are required to enroll in Western Dental for 12 consecutive months from the effective date of their enrollment before they can change to the Primary Dental Plan.

Unit 6 employees should contact Western Dental at 1- 800-992-3366 or contact CCPOA directly at (916) 372-6060 or 1-800-468-6486 if they have questions or issues concerning their dental coverage.

Dental Benefits Assistance – Who To Call

If you need assistance with your dental coverage, the lists below show who you need to call for assistance – your personnel office, CalPERS, or CalHR.

Personnel Office (if you are an active employee)

CalPERS (if you are retired): 1-888-225-7377 / TTY 1-877-249-7442

- To find out who your current dental carrier is.

(Note: This information also appears on your pay warrant or retirement warrant/statement.)

- To determine whether a particular enrollment change is permitted outside the dental open enrollment period.

- For questions regarding the dental open enrollment process.
- To verify dental enrollment effective dates.
- For information regarding adding/dropping dependents from your dental coverage.
- To report the death of a spouse or dependent.
- To continue dental coverage of enrolled dependents following the death of an active or retired state employee.
- To report an incorrect premium deduction or dental plan coverage on your pay warrant or retirement warrant/statement.

CalHR Benefits Division

- For assistance resolving problems with your dental plan or dentist that you are unable to resolve through your dental plan's customer service department or through the complaint procedure outlined in your dental plan's Evidence of Coverage (EOC) booklet.
- For questions or concerns regarding your monthly dental plan cost share premium.
- For questions about your dental coverage.

Mailing addresses and telephone numbers for CalHR and the individual dental plans are listed on page 24.

Frequently Asked Questions Regarding Dental Coverage In General

(Questions regarding eligibility, open enrollment, and the plans themselves are covered in separate sections of this handbook)

1. When will my dental enrollment/plan change become effective?

Any allowable changes made during the year become effective the first day of the month following the date your personnel office receives your completed Dental Plan Enrollment Authorization Form (STD. 692), if you are an active employee, or the first day of the month following the date CalPERS receives your written request, if you are retired. Enrollment changes made during the annual open enrollment period become effective January 1 of the following year.

2. Once I've selected a dental plan, may I change dental plans if my dentist cancels his/her contract with the dental carrier?

No. You may change dental plans outside the annual open enrollment period **only** if your dental plan is no longer available to you. For example, if you move to an area where your dental plan is more than 50 miles from your residence, you may enroll in another plan. If you have any questions, contact your personnel office (if you are an active employee), or call CalPERS at 1-888-225-7377 (if you are retired).

3. What should I do if I have a problem or complaint regarding my dental plan or dentist?

Many problems can be resolved by contacting your dental plan's customer service department. You also should refer to the complaint procedure outlined in your dental plan EOC booklet, available from your personnel office, CalPERS, or your dental carrier. If you are unable to resolve your complaint through your carrier, you may contact CalHR for assistance (see page 24 for contact information).

4. What should I do if the payroll deduction for my dental plan is incorrect, or is not shown on my warrant stub or retirement warrant?

When you enroll in a state-sponsored dental plan or change the coverage, it is important to carefully check your pay warrant or retirement warrant/statement to verify that the premium is being paid to the correct dental plan. For prepaid plans, the state pays 100 percent of the cost of the premium, which should be reflected on your pay warrant or retirement warrant/statement.

If the deduction is incorrect, or has not started by the effective date, report the discrepancy to your personnel office (if you are an active employee) or CalPERS Health Account Services (if you are retired).

5. As a retiree, what happens if I have insufficient funds in my retirement warrant to pay my share of the premium?

You may request, in writing, to pay the balance directly to CalPERS. For more information, contact CalPERS at 1-888-225-7377 / TTY 1-877-249-7442.

6. As a retiree, how does CalPERS get information regarding my dental benefits?

When an employee retires, the personnel office will complete and submit an administrative STD. 692 to CalPERS, Health Account Services in order to establish the dental deduction in the retirement payroll system.

B. Eligibility Information

Active State Employees

Who is eligible to enroll or continue enrollment in the state's dental program?

- All permanent state employees who are appointed half-time or more, and limited term or TAU employees whose time base is half-time or more and who have been appointed six months or more.
- Permanent Intermittent (PI) employees who have been credited with a minimum of 480 hours during a six-month qualifying period starting January 1 and ending June 30, or starting July 1 and ending December 31.

Eligible new employees have **60 days** from the date of hire or the date they become eligible to enroll in a dental plan. Employees may enroll in a state/union-sponsored dental plan through their personnel office using the standard STD. 692. Eligible employees who do not enroll at the time of hire or eligibility may enroll during the annual dental open enrollment period.

Contact your personnel office if you have enrollment or eligibility questions.

State Dental Plan Restrictions For Newly Hired State Employees

All eligible newly hired represented employees in Bargaining Units (BU) 1 through 21 (with the exception of BU 2, BU 7, BU 8, BU 16, BU 17, BU 18, and BU 19) are required to enroll in a prepaid plan until they have completed 24 consecutive months of state service. At the end of the 24-month period, employees will have **60 days** to change their enrollment to an indemnity type or preferred provider option plan. (See page 5 for information on the 24-month restriction for Unit 5, and the 12-month restriction for Unit 6.)

All eligible represented employees who reinstate after a permanent separation and who previously had 24 consecutive months of state service may enroll in either an indemnity type, preferred provider option plan, or prepaid plan at the time of hire.

All eligible newly hired excluded employees may select the indemnity type, preferred provider option plan, or prepaid plan at the time of hire.

Retired State Employees

If you are a retired state employee, you are eligible to continue enrollment in the state's dental program if you retired within 120 days after your date of separation **and** you receive a retirement allowance from CalPERS. If you are enrolled in a state-sponsored dental plan, your personnel office is to submit the STD. 692 to CalPERS to continue your dental enrollment into retirement. Retired employees who did not continue dental coverage into retirement may enroll during the annual dental open enrollment period.

Unit 5 employees (CAHP) who retired on or after September 30, 1992, may elect to continue enrollment in their union-sponsored indemnity plan or change to a state-sponsored dental plan. Under the terms of the Memorandum of Understanding (MOU) between the CAHP and CalHR, this is an irrevocable one-time election.

Unit 6 employees (CCPOA) who are enrolled in a union-sponsored dental plan must change to a state-sponsored dental plan and retire within 120 days after their date of separation to continue their dental coverage.

California Public Employees' Retirement System (CalPERS)

CalPERS maintains the dental benefit enrollment records for all state retirees, processes retirees' dental enrollments, and submits eligibility information to the appropriate dental plan. It is important that you keep your home address current at all times, even if your retirement warrant is deposited directly into your bank account. This helps ensure you receive timely information about your state-sponsored dental benefits that may be mailed to your home address by CalHR or CalPERS. Report address changes to CalPERS at the address below (be sure to include your Social Security number and telephone number):

If you are a retired state employee and have any questions regarding your eligibility, contact CalPERS, Health Account Services Division at:

Toll Free 1-888-225-7377
TTY 1-877-249-7442

Dependent Eligibility

Employees and retirees eligible for benefits may also enroll eligible family members.

1. Family Member

Eligible family members include an employee's or retiree's spouse or domestic partner (as recognized by the State of California) and eligible children (see sections 2 and 3 below for discussion of eligible children).

The following documents must be provided at the time of initial enrollment of a spouse or domestic partner: A copy of the marriage certificate or the Declaration of Domestic Partnership and signed Statement of Financial Liability, as filed with the Secretary of State's Office. (Statement of Financial Liability forms are available from CalPERS.) For audit purposes, these documents are maintained along with the dental enrollment materials in active employees' confidential personnel files.

2. Eligible Children

Children under the age of 26 are eligible for enrollment. Children may include the eligible employee's or retiree's birth children, adopted children, or those children placed for adoption, stepchildren, children of a domestic partner, and children living in the household in a parent/child relationship who are **economically dependent** on the employee or retiree.

To enroll an economically dependent child, an eligible employee or retiree needs to complete a State Dental Program Affidavit of Eligibility (CalHR 025).

3. Medically Disabled Children

A child may continue to be enrolled after age 26 if he or she **was enrolled** at the time of the employee's or retiree's initial enrollment and is:

- incapable of self-support because of physical disability or mental incapacity; and
- dependent on the eligible employee or retiree for support and care.

For more details regarding the enrollment criteria for disabled children, contact your personnel office or CalPERS.

Frequently Asked Questions Regarding Eligibility

1. What would cause a family member to lose eligibility for coverage?

Any of the following events would cause a family member or dependent to lose eligibility; his or her coverage would end on the last day of the month in which this event occurred:

- The child turns 26;
- The child moves out of the household and the dental plan subscriber is no longer financially responsible for that child;
- A final divorce decree is granted or a domestic partnership is terminated;
- Coverage of the dependent is voluntarily dropped; or
- Spouse or domestic partner moves out of household due to obtaining employment and dental benefits in another state. Not applicable in the event of a pending divorce, separation, or annulment.

NOTE: Dependents who are voluntarily deleted from coverage may not be reenrolled until open enrollment.

When a family member or other dependent ceases to be eligible, he or she must be dropped from your coverage. Notify your personnel office (if you are an active employee) or CalPERS (if you are retired) as soon as possible, as you do not need to wait until open enrollment. You will be liable for any expenses incurred after this person loses eligibility. Refer to pages 21 - 23 for information about continuation coverage under COBRA.

You also may voluntarily drop dependents from coverage by submitting a request to your personnel office (if you are an active employee) or CalPERS (if you are retired). Such requests may be submitted at any time.

2. As an active employee, I was enrolled in the Delta PPO plus Premier Enhanced plan. Does the enhanced plan continue, if I retire?

Answer: No. When the dental enrollment is processed by CalPERS, the plan is changed to the Delta PPO plus Premier plan.

As an active employee, I was enrolled in the SafeGuard Enhanced plan. Does the enhanced plan continue, if I retire?

Answer: Yes. When the dental enrollment is processed by CalPERS, the SafeGuard Enhanced plan continues. Additionally, all retirees have the SafeGuard enhanced plan. Which means, if you had the SafeGuard basic plan as an active employee, the coverage

will be changed to the SafeGuard enhanced plan when the dental enrollment is processed by CalPERS.

3. Can a person be covered under more than one state-sponsored dental plan?

Answer: No. This would be considered dual coverage, which is not allowed. If a situation involving dual coverage is discovered, it must be corrected retroactively to the date dual coverage began. In addition, a dental plan may request reimbursement for any claims paid.

NOTE: Married employees, domestic partners, and retirees may not split coverage for their dependent children. In other words, all eligible children in a household enrolled in a state-sponsored dental plan must be covered through the same subscriber.

4. In the event of my death, what happens to dental coverage for my family members?

Departments are required to continue paying for a covered employee's spouse, domestic partner, and other eligible family members for up to 120 days following an employee's death. During this time, CalPERS will determine if the spouse or other family members are eligible for survivor benefits. (The law creating this grace period -AB 1639, Chapter 926, Statutes of 1999-is based on collective bargaining agreements with all 21 bargaining units.)

After 120 days, your surviving family member(s) will be eligible to continue your current coverage if they meet all the following criteria:

- they were enrolled as your dependents at the time of your death.
- they qualify for a monthly survivor allowance from CalPERS.
- they continue to qualify as family members.

Questions regarding continuation of dental plan coverage should be directed to your personnel office (if you are an active employee) or CalPERS (if you are retired) at 1-888-225-7377 / TTY 1-877-249-7442

To report the death of a dental plan enrollee, contact CalPERS at 1-888-225-7377 / TTY 1-877-249-7442, or write to CalPERS: Health Account Services, P.O. Box 942715, Sacramento, CA 94229-2715.

NOTE: Surviving enrolled family members who do not qualify to continue their current coverage are eligible for continuation coverage under COBRA (refer to pages 21 - 23 for details).

C. Open Enrollment Information

Each year, a dental open enrollment period is held to allow eligible active and retired state employees to enroll in a dental plan, change plans, and add or drop eligible family members. Open enrollment typically is held from September through mid-October. It is coordinated by CalHR in cooperation with the State Controller's Office (SCO) and CalPERS.

Changes made during the annual dental plan open enrollment period are effective January 1 of the following year.

State employees may obtain enrollment information from their personnel office. Retired employees should contact CalPERS for this information.

Frequently Asked Questions Regarding Open Enrollment

1. May I change dental plans and add/delete family members during the open enrollment period?

Answer: Yes. The open enrollment period is the time when you may change your dental plan coverage. However, if during the year you experience a change in family status (e.g., marriage, domestic partner relationship, newborn child), you may add these family members to your coverage if you make the request within **60 days** of the date the change in family status occurs. You will be required to provide the date of the family status change to your personnel office (if you are an active employee) or CalPERS (if you are retired).

If you need to drop a family member from coverage because he or she becomes ineligible, you should take this action as soon as possible; do not wait for open enrollment, as you will be liable for any costs incurred by this person after he or she ceases to be eligible.

How do I enroll or make allowable changes to my dental coverage during the open enrollment period?

If you are an active employee, contact your personnel office to enroll or make changes to your dental coverage. If you wish to make any changes, complete a STD. 692 form.

If you are a retired employee, check with CalPERS regarding your enrollment information. If you wish to make any allowable changes, send a letter to CalPERS requesting the change. (Refer to page 9 for CalPERS' address.) When adding dependents, be sure to include the allowable event (e.g., marriage, new domestic partnership, divorce, childbirth, etc.) and full name, Social Security number, and date of birth of the eligible dependent and sign and submit any required affidavits.

2. Can a surviving spouse add new family members during open enrollment?

Answer: Yes, but only if the new family member had a family relationship to the deceased employee or retiree prior to the employee's or retiree's death (e.g., the active employee's or retiree's unborn child).

D. Prepaid Dental Plans

DeltaCare USA, Premier Access, SafeGuard, and Western Dental

DeltaCare USA, Premier Access, SafeGuard, and Western Dental are the four state-sponsored **prepaid** dental plan providers. SafeGuard now offers two plans: a standard plan for represented employees, and an enhanced plan for excluded employees and retirees.

The state pays 100 percent of the monthly premium for the prepaid plans, so there is no monthly premium cost share deducted from your pay warrant or retirement warrant. There are no claim forms, deductibles, or maximum allowable benefits.

Prepaid plans provide dental services through pre-selected participating dentists throughout California. When you enroll in one of these plans, you select a dentist from the list of dentists who participate in the plan you have chosen. You may change dentists, either upon your request or if your dentist leaves the plan, to another dentist who participates in your plan. You may change dental plans if you move and your plan has no participating dentists within 50 miles of your new residence.

A prepaid dental plan pays its participating dentists a contracted monthly fee for each person enrolled in the plan served by that dentist. In return, the dentist provides all basic, preventive, and diagnostic services (e.g., cleanings, checkups, x-rays, fillings, oral surgery, and treatment of tooth pulp and gums). The level of coverage for the enrollee and dependents is the same.

While most dental services are performed at little or no charge to the enrollee, there may be a specific fixed charge for certain types of complex procedures such as root canals. There is a limit on the amount a prepaid provider can charge you for orthodontic services.

To obtain brochures describing each **prepaid** plan and a list of the dentists participating in those plans, contact the dental carriers directly. Their toll-free numbers are:

DeltaCare USA	1 (800) 422-4234
Premier Access	1 (888) 534-3466
SafeGuard	1 (800) 880-1800
Western Dental	1 (866) 859-7525

Frequently Asked Questions Regarding Prepaid Dental Plans

Note: The information provided below offers only brief descriptions of the currently available prepaid dental plans. Please consult each plan's EOC booklet or call the plan directly for more detailed explanations.

1. If I enroll in a prepaid dental plan, will I receive an identification card?

Answer: Yes. Shortly after your eligibility is established by your dental plan and you have selected a dentist, you will receive an identification card. The card is a reminder of which dental office you selected. Please confirm the address and telephone number of your selected dental provider with your dental plan carrier.

2. What if there are no participating dentists in my service area for any of the prepaid plans?

If you are unable to locate a participating provider within 50 miles of your residence, contact the customer service department of the prepaid plans for assistance. If it is determined that there are no prepaid providers in your service area, contact your personnel office (if you are an active employee) or CalPERS (if you are retired) for further assistance. (**Note:** The state-sponsored prepaid plans are only available in California.)

3. May I choose any dentist I want if I enroll in a prepaid plan?

Answer: No. The dentists available through each prepaid plan have contracted with that plan to provide services to its enrollees. Your choice is restricted to dentists who have contracted with your plan (called "participating dentists"). Contact the dental plan directly to obtain a list of its participating dentists or to verify whether a particular dental provider is on the plan's list.

4. Once I have selected a prepaid dentist and/or dental office, do I have to remain there?

Answer: No. If for any reason you feel you need to change dental providers, simply contact your dental plan; the customer service representative will assist you in locating another dentist from the plan's list of participating dental providers.

5. What happens if my dentist decides to no longer participate in my prepaid plan?

Your dental plan will notify you if your dentist stops participating in the plan. You will be provided with the name of a new dentist or given the opportunity to select another participating dentist within 50 miles of your residence. If you are unable to locate another participating dentist in your service area, contact your personnel office (if you are an active employee) or CalPERS (if you are retired).

6. What happens if I am enrolled in a prepaid plan and move out of California?

The state-sponsored prepaid plans are only offered in California. **Before** you move out of the state, contact your personnel office (if you are an active employee) or CalPERS (if you are retired) to change your dental plan; be sure to inform them of your moving date.

7. Do I have to pay monthly premiums for my dependents or myself if I enroll in a prepaid plan?

Answer: No. The State of California pays 100 percent of the monthly premium for you and your dependents enrolled in a prepaid plan.

8. Do I have to pay an annual deductible if I am enrolled in a prepaid plan?

Answer: No. There are no annual deductibles under a prepaid plan.

9. What cost share can I expect to pay if I enroll in a prepaid plan?

While there is no monthly premium cost share deducted from your pay warrant or retirement warrant, depending on the type of dental service performed, you could be charged a co-payment. This co-payment is payable at the time the service is rendered. For a listing of covered dental services and applicable co-payments, you may view the information on pages 26 and 27.

10. What actions should I take in an emergency if I am enrolled in a prepaid plan?

First, you should contact your dentist or dental office. If the emergency occurs after normal business hours, or you are advised that there is no plan provider available, or you are more than 50 miles from your selected plan provider, you may receive treatment for the **relief of pain** from any non-plan provider. You **must** call your dental plan before obtaining out-of-area emergency care. Your plan will reimburse up to \$400 per enrolled member, per calendar year for emergency services.

11. How do I access specialist services?

The prepaid plans offer services in most dental specialties, including periodontics (treatment of diseased gums and bones), endodontics (root canal-therapy), and oral surgery procedures. If your dental provider refers you to a specialist, the referral must be approved by the prepaid dental plan.

12. Do my dependents have the same level of benefits that I do in my prepaid plan?

Answer: Yes. The benefits for employees, retirees, and their dependents are identical under a prepaid dental plan.

13. If I am not currently enrolled in a prepaid plan, what things should I consider before I decide to change dental plans?

- **Is it important to you to maintain your current dentist?**

If your answer is NO, enrolling in a prepaid plan and selecting one of its participating dental providers may be a good choice for you.

- **Is the location of your dentist an issue for transportation purposes?**

If your answer is YES, you may want to review the list of participating dental providers for each prepaid plan. You may find a provider within easy access by car or public transportation.

- **Are your out-of-pocket dental costs a significant financial consideration?**

If your answer is YES, you should be aware that the prepaid plans have *no* monthly premium cost share or annual deductibles, and most services are provided at little or no cost to you.

- **Do you live outside of California?**

If your answer is YES, you need to be aware that the prepaid plans are only available in California.

14. How can I find out more about the state-sponsored prepaid dental plans?

Refer to the Directory on page 24. It contains the addresses and toll-free telephone numbers of all four state-sponsored prepaid dental plans. Before changing plans, it is recommended that you request a copy of the plan brochure and list of participating dental providers for any plans you are considering. Review this information and select a dentist from the provider list *prior* to changing plans.

If you decide to change dental plans, be aware that the prepaid plans provide less flexibility in that you are required to choose your dentist from a list of dental providers. However, the prepaid plans provide benefits at less cost to you. (There is a comparison of dental plans beginning on page 25.)

E. Indemnity Type and Preferred Provider Option Dental Plans

Delta Dental PPO plus Premier Plan

Delta Dental Plan of California (Delta) is the carrier for the state-sponsored indemnity type dental plan (Delta Dental PPO plus Premier) available to all retirees, excluded employees, and represented employees in Units 1 through 21 with the exception of Units 5 and 6, which have their own union indemnity plans (see page 5). Delta Dental PPO plus Premier provides two levels of benefit coverage:

- Basic Plan for rank-and-file employees, retirees, and their dependents; and
- Enhanced Plan for excluded employees for managerial, supervisory, confidential, exempt, excluded, Constitutional Officers, employees of the Judicial Council, and all State Superior, Appellate, Supreme Court Judges, and their dependents.

Delta Dental PPO plus Premier allows you to choose to receive services from any licensed dentist, although you may have higher out-of-pocket costs if you receive services from a “non-Delta” dentist. Through Delta’s participating dentists, you have full access to specialty care and guaranteed benefits through Delta’s large network of dentists throughout the United States and abroad.

When you receive services from a participating Delta dentist, Delta pays the dentist directly, based on the fee agreement between Delta and the dentist. If the dentist’s charges exceed the fee paid by Delta, you are responsible for paying the remainder of the bill and any applicable annual deductible.

If you receive treatment from a non-Delta dentist, either in California or out-of-state, you are responsible for paying the dentist’s entire bill. To claim reimbursement, you need to submit an itemized receipt with a standard dental claim form to Delta. Your reimbursement will be based on Delta’s set fee schedule, called Usual, Customary, and Reasonable (UCR) fees for California.

Frequently Asked Questions Regarding the Indemnity Type Dental Plan

1. What is my Delta Dental PPO plus Premier Group Number?

Your Delta Dental PPO plus Premier dental group number is 9949.

2. Will I receive an ID Card?

Delta will send you an identification card indicating your enrollment in the Delta Dental PPO plus Premier plan and your dental group number. When you or a covered dependent/family member goes to the dentist, you will need to provide this group number (9949) and the Social Security number of the primary enrollee (i.e., the state employee or retiree). The dental office will verify your eligibility and covered benefits directly with Delta.

3. Do I have to complete a claim form when I go to a Delta dentist?

Although claim forms are required, the forms will be completed for you at no charge if you receive services from a participating Delta dentist. If you receive services from a non-Delta dentist, you may be required to complete the forms yourself or pay a fee to have the dentist's office do it for you.

4. How do I obtain an EOC booklet for the Delta Dental PPO plus Premier plan?

When you enroll in the Delta Dental PPO plus Premier plan, Delta mails you an EOC booklet with your ID card. Your personnel office also may have a small supply of these

booklets. If you do not receive your booklet, contact Delta at **1-800-225-3368** to request an EOC booklet for Group #9949.

5. If I enroll in Delta Dental PPO plus Premier, do I have to pay a monthly premium cost share?

Answer: Yes. This premium cost share is deducted each month from your pay warrant or CalPERS retirement warrant. The current Delta Dental plus Premier plan monthly premium cost share for retirees and active employees in BUs 1, 3, 4, 9, 10, 11, 12, 13, 14, 15, 20, and 21, plan are listed below.

	<u>2014</u>	<u>2015</u>
• Party Code 1 (self only)	\$12.12	\$12.21
• Party Code 2 (self plus one dependent)	\$21.28	\$21.32
• Party Code 3 (self plus two or more dependents)	\$30.83	\$30.82

NOTE: For active state employees enrolled in the Consolidated Benefits program (CoBen), the monthly premium cost share may vary depending on the employee's other CoBen benefit choices.

6. What is the level of benefits under the Delta Dental Premier Enhanced Plan?

For excluded employees in the Delta Dental PPO plus Premier Enhanced plan, there is an annual maximum benefit of \$2,000 for both the employee and each eligible dependent. The level of benefits for each participating family member is the same as the level of benefits for the employee. There is a \$25 deductible for each family member (maximum of \$100 per family per year). The required \$25 deductible for each participant is waived for preventive and diagnostic care.

The annual deductibles do not apply to diagnostic and preventive benefits such as x-rays, examinations, and cleanings. If the dental costs exceed the annual maximum, the employee or retiree is responsible for paying the difference.

7. What is the level of benefits under the Delta Dental PPO plus Premier Basic plan?

For represented employees and retirees in the Delta Dental Premier Basic plan, there is an annual maximum benefit of \$2,000 for employees and retirees and \$1,000 for each dependent. For some services, the level of benefits for the enrolled dependent is less than the level of benefits for the employee or retiree. There is a \$50 deductible for each family member (maximum of \$150 per family per year). The required \$50 deductible for each participant is waived for preventive and diagnostic care.

The annual deductibles do not apply to diagnostic and preventive benefits such as x-rays, examinations, and cleanings. If the dental costs exceed the annual maximum, the employee or retiree is responsible for paying the difference.

The charts on pages 26 through 27 provide additional coverage information. For a detailed explanation of the limitations and exclusions of the Delta Dental PPO plus Premier plans, consult the EOC booklet, available by Delta at 1-800-225-3368.

Delta Dental Preferred Provider Option Plan

Delta also is the carrier for the state-sponsored “preferred provider option” dental plan, called Delta Dental Preferred Provider Option (PPO).

The Delta Dental PPO offers higher benefit levels when its enrollees receive services from a participating PPO dentist. However, enrollees may choose a non-PPO dentist and still be covered. When you receive services from a participating PPO dentist, your costs are based on a discounted fee agreement between Delta and the dentist.

If you receive services from a Delta dentist who is a non-PPO dentist, your benefits will be reduced. You will be responsible for your share of the costs up to Delta’s allowed amounts under the provider’s filed fee agreement with Delta for the service or services you received. Fees are based on the UCR fee for California.

If you receive services from a non-PPO, non-Delta dentist, you are responsible for paying the full bill directly to the dentist at the time of service and up to the billed amount. Your reimbursement from Delta may be substantially lower. To claim reimbursement, submit your itemized receipt with a standard claim to Delta for review and reimbursement. The reimbursement will be sent directly to you. You may obtain a claim from Delta.

To see if you’re current dentist is a participating PPO dentist, or for more information on the PPO dental plan, contact Delta at 1-800-225-3368.

Frequently Asked Questions Regarding the PPO Dental Plan

1. What is my PPO Group Number?

Your PPO Group Number is 9946.

2. Will I receive an ID Card?

Delta will send you an identification card indicating your enrollment in the PPO plan and your dental group number. When you or a covered dependent/family member goes to the dentist, you will need to provide this group number (9946) and the Social Security number of the primary enrollee (i.e., the state employee or retiree). The dental office will verify your eligibility and covered benefits directly with Delta.

3. Do I have to complete a claim form when I go to a PPO dentist?

Although claim forms are required, the forms will be completed for you at no charge if you receive services from a participating PPO dentist.

If you receive services from a non-PPO dentist, you may be required to complete the forms yourself or pay a fee to have the dentist's office do it for you. The dental office should be able to provide you with the claim form, or you may contact Delta to have a claim form sent to you.

4. How do I obtain an EOC booklet for the PPO Plan?

When you enroll in the PPO plan, Delta will mail you an EOC booklet with your ID card. Your personnel office also may have a small supply of these booklets. If you do not receive your booklet, contact Delta at 1-800-225-3368 to request an EOC booklet for Group #9946.

5. If I enroll in the PPO Plan, do I have to pay a monthly premium cost share?

Answer: Yes. This premium cost share is deducted each month from your pay warrant or CalPERS retirement warrant. The current monthly PPO premium cost share for retirees and active employees in Bargaining Units 1, 3, 4, 9, 10, 11, 12, 13, 14, 15, 20, and 21 plan are listed below.

	<u>2014</u>	<u>2015</u>
• Party Code 1 (self only)	\$11.06	\$11.16
• Party Code 2 (self plus one dependent)	\$21.66	\$21.69
• Party Code 3 (self plus two or more dependents)	\$32.67	\$32.64

NOTE: For active state employees enrolled in the Consolidated Benefits program (CoBen), the monthly premium cost share may vary depending on the employee’s other CoBen benefit choices.

6. What is the level of benefits under the PPO Plan?

The PPO plan provides an annual maximum benefit of \$2,000 for all enrollees who use a participating PPO dentist. There also is a \$25 annual deductible for each enrollee (maximum of \$100 per family) using a participating PPO dentist. Enrollees who receive services from non-PPO dentists must pay a \$75 annual deductible (maximum of \$200 per family). These deductibles do not apply to diagnostic and preventive benefits such as x-rays, examinations, and cleanings.

The charts on pages 26 through 27 provide additional information. For a detailed explanation of the limitations and exclusions of the Delta Dental Preferred Provider Option plan, consult the EOC booklet, available by calling Delta at 1-800-225-3368.

F. COBRA Group Continuation Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, requires employers to offer continuation of dental, medical, and vision benefits to covered employees, spouses, *domestic partner and eligible children who lose coverage due to certain “qualifying events.” Benefits may be continued for 18 or 36 months, depending on the qualifying event. The coverage period is measured from the time of the qualifying event, and applies to each qualified beneficiary, including the covered employee or retiree, spouse, domestic partner, and eligible children.

The chart on this page lists the qualifying events for continuation coverage and the time period of the extended coverage.

COBRA Qualifying Events

<u>Benefits Continued for 18 Months</u>	<u>Benefits Continued for 36 Months</u>
<ul style="list-style-type: none">• Voluntary Termination—Covered employee voluntarily terminates or separates from employment (e.g., retires or quits), and the termination/separation will cause a loss of coverage.• Involuntary Termination—Covered employee is involuntarily terminated from employment (other than for gross misconduct), and the termination will cause a loss of coverage. If the termination is due to “gross misconduct,” the state is not obligated to offer COBRA continuation coverage.• Reduction of hours—Covered employee's work hours are reduced voluntarily or involuntarily, and the reduction of hours will cause a loss of coverage. Reduction of hours may include:<ul style="list-style-type: none">▪ Full-time to part-time▪ Strikes▪ Layoffs▪ Leave of Absence▪ Military call-up	<ul style="list-style-type: none">• Death—Covered employee or retiree dies, and the surviving family member is not eligible for a monthly survivor allowance from CalPERS.• Medicare coverage begins—Covered employee or retiree becomes entitled to Medicare benefits• Divorce or legal separation—Covered employee or retiree is divorced or legally separated• Domestic partnership termination—Covered employee or retiree terminates a domestic partnership (registered in the State of California).• Change in dependent status— An eligible child of a covered employee or retiree marries or turns age 26.

*State of California Legislation

Under COBRA, the administrator is permitted to charge a two percent administrative fee in addition to the premium. Therefore, the cost of COBRA continuation coverage to a state employee, retiree, and/or eligible dependent of an employee/retiree is 102 percent of the premium previously charged to the active employee or retiree.

Monthly Premium

Once enrolled, the enrollee's monthly premiums are due by the first of each following month. While due on the first, the enrollee will have a maximum thirty (30) day grace period following the due date in which to make these premium payments. The plan or its designee is not required to send a monthly bill. All claims occurring during the month will be held pending premium payment being made. If the applicable payment is not made within the grace period, then coverage will be cancelled back to the end of the prior month in which a premium payment had been made. If COBRA coverage is cancelled due to non-payment of premiums, the enrollee will not be reinstated.

Partial Premium Payment

If the dental plan receives a partial monthly premium, the plan will notify the enrollee of the amount of the deficiency and allow 30 days for the deficiency to be paid. All claims incurred during the month when the deficiency exists will be held pending receipt of the deficient amount.

Secondary COBRA Event Occurs During the 18-Month Period

If during the 18 months of continuation coverage, a second event takes place (divorce, termination of domestic partnership, legal separation, death, or a dependent child ceases to be a dependent), then the original 18 months of continuation coverage can be extended to 36 months from the original date of loss of coverage for eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify the plan in writing within 60 days of the second event and within the original 18-month COBRA timeline. In no event will continuation coverage last beyond three years (36 months) from the original date of loss of coverage.

29-Month Qualifying Event (Social Security Disability)

COBRA contains a provision that provides additional protection for qualified beneficiaries who are deemed disabled according to the Social Security Administration. If a state employee who experiences one of the "18-month" qualifying events meets the Social Security definition of disability, the employee and his or her eligible beneficiaries are entitled to continuation coverage of **29 months** (from the date of the qualifying event).

Open Enrollment Period

COBRA enrollees have the same rights as active employees to make allowable changes to their coverage during the annual open enrollment period. Specific instructions will be sent to all COBRA enrollees by CalHR prior to the beginning of the open enrollment period.

COBRA in Retirement

If a former spouse, domestic partner, or dependent child of a retired state employee has a COBRA qualifying event, he/she will be offered continuation coverage through CalPERS.

Loss of COBRA Eligibility

COBRA eligibility ceases for an employee/retiree, spouse, domestic partner, or eligible child if any of the events listed below occurs prior to the expiration of the 18 or 36-month COBRA continuation period. The state does not offer any type of conversion plan after the 18 or 36-month period has expired. The enrollee should contact the dental plan directly for information about a potential individual conversion plan if any of the following occur:

- State employer ceases to offer dental insurance plans.
- Covered employee/retiree fails to pay required premiums on time.
- A covered state employee/retiree becomes covered under another employer's plan that does not contain any exclusion or limitation with respect to preexisting health conditions.
- A determination is reached that a state employee who received extended COBRA coverage of 29 months due to a Social Security-approved disability is no longer disabled.
- A covered state employee's/retiree's former spouse remarries or domestic partner establishes a new domestic partnership and obtains coverage under another group dental plan.
- A covered employee/retiree becomes entitled to Medicare benefits while enrolled in COBRA.
- For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Note: All termination of COBRA coverage notices will be provided by the plan.

For more information about COBRA group continuation coverage, including eligibility, monthly premiums, enrollment procedures, or qualifying events that cause termination of COBRA eligibility, contact your personnel office (if you are an active employee) or CalPERS (if you are retired or a dependent of a retiree).

G. Directory of State-Sponsored Dental Plans

Dental Plan Administrator

California Department of Human Resources
Benefits Division
1515 S Street, North Bldg., Suite 400
Sacramento, CA 95811-7258
(916) 322-0300
(916) 322-3769 FAX

Prepaid Dental Plans

DeltaCare USA
12898 Towne Center Drive
Cerritos, CA 90703
1-800-422-4234
www.deltadentalca.org/state

Premier Access
8890 Cal Center Drive
Sacramento, CA 95826
1-888-534-3466
www.socdhmo.com

SafeGuard
5 Park Plaza, Suite 1850
Irvine, CA 92614
1-800-880-1800
www.safeguard.net

Western Dental
530 South Main Street, 6th Floor
Orange, CA 92868
1-866-859-7525
www.westerndentalbenefits.com/stateofca

Delta Dental Plans

Delta Dental PPO plus Premier and
Delta Dental Preferred Provider Option
Delta Dental
P.O. Box 429086
San Francisco, CA 94142
1-800-225-3368
www.deltadentalca.org/state

H. Comparison Charts

I. Benefit Overview: Indemnity Type, PPO and Prepaid Plans

The following chart provides a general overview of the benefits available under the state-sponsored dental plans. Consult each plan's brochure and evidence of coverage booklet for detailed information and plan limitations.

BENEFITS	INDEMNITY TYPE PPO PLUS PREMIER	PREFERRED PROVIDER OPTION	PREPAID
Type of Plan	Fee-for-Service Plan, this plan provides reimbursement for services rendered	Preferred Provider Plan provides maximum benefit when enrollee visits in PPO network dentist.	Plan pays enrollee's chosen dentist a monthly fixed rate to provide services as needed.
Dental Providers	Any licensed dentist. However, out-of-pocket expenses may be lower when visiting a Delta Dental PPO dentist.	Any licensed dentist, but maximum benefits when visiting a PPO network dentist. If an out-o-PPO network dentist is used, benefits are lower.	Must select a dental provider affiliated with the enrollee's prepaid plan.
Orthodontic Providers	May visit any orthodontist. However, out-of-pocket expenses may be lower when visiting a Delta Dental PPO dentist.	Must visit an in-PPO network orthodontist to receive maximum benefit.	Must use orthodontist affiliated with the enrollee's prepaid plan.
Changing Providers	May change dentist at any time.	May change at any time without pre-approval.	You may change to another dentist affiliated with the plan, with prior approval.
Deductibles	<u>Basic</u> : \$50 per person, up to \$150 annual maximum per family <u>Enhanced</u> : \$25 per person, up to \$100 annual maximum per family	\$25 each, up to \$100 annual maximum per family, for in-PPO network dentists \$75 per person up to \$200 annual maximum per family for out-of-PPO network dentists. Member pays the difference between billed charges and plan payments. When visiting a non-PPO dentist, you pay the difference between the dentist's fee and the Delta approved fee plus the copayment.	No deductible
Co-payments	Member only pays co-payment and any deductibles and charges above the annual maximum for covered services when visiting a Delta Dental dentist. When visiting a non-Delta Dental dentist, enrollee additionally pays the difference between the dentist's submitted charges and Delta Dental's approved fees.	Member only pays co-insurance and any deductibles and charges above the annual maximum for covered services when visiting a Delta Dental dentist. When visiting a non-Delta Dental dentist, enrollees also pay the difference between the dentist's submitted charges and Delta Dental's approved fees.	Generally no charge, with minimal co-payments for certain covered procedures.
Plan Payments	Payments based on Delta Dentist contracted fees or the maximum plan allowance when non-Delta Dental dentists are used.	Payments based on Delta Dentist contracted fees or the maximum plan allowance when non-Delta Dental dentist are used.	For procedures with a co-payment, may require payment at time of treatment.
Maximum Benefits per Calendar Year	Basic: \$2,000 for employee/ retiree, \$1,000 per dependent; Enhanced: \$2,000 for employee and each eligible dependent.	\$2,000 per employee, \$2,000 per eligible dependent	No maximum.
Maximum Lifetime Implant Benefit	Not a covered benefit.	\$2,500 for each employee/ retiree and dependent, if using a Plan provider.	Not a covered benefit.

II. Coverage for Certain Procedures: Indemnity Type and PPO Plans

The following chart compares employee/retiree costs for certain types of procedures under the **Indemnity type and PPO plans**. Consult each plan's EOC booklet for detailed information and plan limitations.

Type of Plan	Delta Dental				
	Basic Delta Dental PPO plus Premier		Enhanced Delta Dental PPO plus Premier	PPO/using Plan provider	PPO/using non-Plan provider
Who is Covered?	Represented Employees and Retirees	Dependents of Represented Employees and Retirees	Excluded Employees and Dependents	All Employees, Retirees and Dependents	All Employees, Retirees and Dependents
Diagnostic and Preventive (two cleanings annually)	0*	0*	0*	0**	20%
Basic Benefits (UCR)	10 %	20%	10%	10%	20%
Crowns	20%	50%	20%	20%	50%
Bridges, Partials and Dentures	50%	50%	50%	40%	50%
Implant Benefit	N/A	N/A	N/A	Will pay 50% up to a lifetime maximum of \$2,500	
Annual Deductibles	\$50*	\$50*	\$25*	\$25*	\$75
Maximum Deductible	\$150 per family	\$150 per family	\$100 per family	\$100 per family	\$200 per family
Annual Maximum	\$2,000	\$1,000	\$2,000	\$2,000	\$1,000

* Diagnostic and Preventive Benefits are exempt from the deductible.

** The level of benefits and covered services reflected in the chart are based on services provided by a PPO Plan dentist; for services provided by a non-PPO Plan dentist, the level of benefits is lower. Additionally, the PPO includes a 3rd cleaning for **high-risk** patients and a benefit for dental implants (up to \$2,500 lifetime maximum).

III. Coverage and Costs: Prepaid Plans

The following chart compares employee/retiree costs and benefits available through each **prepaid dental plan**. Consult each plan's brochure and Evidence of Coverage booklet for detailed information and plan limitations.

	DeltaCare USA, SafeGuard Premier Access, Western	SafeGuard*
Type of Plan	Standard	Enhanced
Who is Covered?	Represented Employees, Retirees, and Dependents	Excluded Employees, Retirees, and Dependents
Diagnostic and Preventive (two cleanings annually)	0	0*
Basic Benefits (UCR)	0	0
Crowns	\$50	0
Implants	Premier Access and Western Dental only -not available through DeltaCare or SafeGuard	N/A
Bridges, Partials and Dentures	\$65 and up	0
Annual Deductibles	No Deductible	No Deductible
Maximum Deductible	N/A	N/A
Annual Maximum	No Maximum	No Maximum

*SafeGuard Enhanced plan provides the availability for a third cleaning to all enrollees.

IV. Orthodontic Benefits and Costs

The following chart compares employee/retiree costs for [orthodontic benefits](#) available through each dental plan. Consult each plan's brochure and EOC booklet for detailed information and plan limitations.

	Delta Dental	DeltaCare USA Premier- Access SafeGuard Western	SafeGuard Enhanced
Orthodontia	Delta Dental PPO plus Premier Plan will pay up to 50 percent of approved fee for orthodontia, with a lifetime maximum for this benefit of \$1,000 for employee and dependent. PPO Plan will pay up to 50 percent of the approved fee, with a lifetime maximum of \$1,000 for each eligible adult and \$1,500 for covered employee's/retiree's eligible children.	\$1,000, plus up to \$250 for start-up costs	\$1,000, plus up to \$250 for start-up costs
Implant Benefit		Premier Access, and Western Dental only This benefit is not available through DeltaCare USA or SafeGuard	N/A

**State of California
California Department of Human Resources
State-sponsored Dental Program
AFFIDAVIT OF ELIGIBILITY**

**For Dependent Children, As Defined Under California Code of Regulations Section
599.500 (o)**

I, _____ understand that the California Department of Human Resources (CalHR) allows for the enrollment of a child(ren) other than a natural, adopted or step child(ren), who is considered a family member(s) and where the employee or annuitant has established a parent-child relationship, on or before the time of enrollment, through the assuming of parental duties in the same or similar manor as the child's(') biological parents. I also recognize this affidavit is a legally binding document and I accept full and unconditional responsibility for notifying my departmental personnel office immediately and in writing, if there are any changes in the child's status as my dependent under the conditions setforth herein. I further agree to provide supporting documentation, such as tax, court, or custody records, if available, when at any time requested by my employing department, CalPERS or CalHR, as long as the child is enrolled on my state-sponsored dental coverage as my eligible dependent.

By signing this affidavit, I also attest to and certify under penalty of perjury that I am exercising parental authority, and responsibility, as defined under federal and California State law. If I have legal custody (sole or joint) of the child(ren), I agree to provide proof of legal custody of the child(ren) at the time of enrollment or when those documents are first available to me.

I acknowledge I have read and understand declarations on this page:

Employee/Retiree Signature _____ Date: _____

Child's Name						
Child's SSN						
Child's DOB						
Parent's Names (if available)						
Child's Relationship to Employee						
Is Child Your Tax Dependent?	Yes	No	Yes	No	Yes	No

For other dependent children, please attach list or use another affidavit. **Please note that this affidavit is subject to yearly renewal.**

By signing this affidavit I understand that making, or causing to be made, any knowingly false material statement or material representation; knowingly failing to disclose a material fact, or to otherwise provided false information with the intent to use it, or allow it to be used, to obtain, receive, continue, and/or increase, benefits administered by CalHR, may constitute fraud and may result in financial liability to me, and possible employment action up to and including termination of employment.

AFFIDAVIT OF ELIGIBILITY

(continued)

By signing this document, I therefore swear (or affirm), under penalty of perjury, that I understand the eligibility requirements described in this document and that all information provided is true and correct to the best of my knowledge. The child(ren) listed on this affidavit is/are for benefit enrollment purposes my dependent(s); is/are in a parent-child relationship with me, and that I act as a primary care parent in the relationship. I also swear (or affirm) that I understand that spouses of your recognized natural, adopted, step, or child(ren) enrolled under this affidavit, are not eligible for enrollment; that the dependent child(ren) is/are not a foster child; and, is/are not enrolled in dental benefit coverage from any other California State-sponsored civil service employment or California State University employment source.

Employee/Retiree Signature: _____ Date Signed _____

Social Security Number: _____ - _____ - _____

Employing Agency: _____

City: _____ Daytime Phone Number: (_____) _____

EMPLOYING DEPARTMENT USE ONLY

The personnel office must maintain this document in the employee's official personnel file, attached to the agency copy of the Dental Enrollment Authorization (STD. 692). Do not send a copy of affidavit to SCO or CalHR.

Date received in authorized departmental personnel office: _____,

I have verified that all portions of this affidavit are complete to the best of my knowledge and any requested documentation has been submitted to the human resources office at the time this document was submitted.

Employing Department Personnel - Authorized Signatory

PRIVACY NOTICE

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the California Department of Human Resources and the dental insurance company for the purpose of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The California Department of Human Resources requires a social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151, 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the dental carrier providing coverage. Copies of the Affidavit of Eligibility for Dependent Children are maintained in confidential files of your personnel office for five years. For retirees, these forms are maintained with the California Public Employees' Retirement System (CalPERS) for five years. Individuals have the right of access to copies of their Affidavit of Eligibility for Dependent Children upon request. For active employees, please send requests to your personnel office. For retirees, please send your request to the California Public Employees' Retirement System (CalPERS), P.O. Box 942715, Sacramento, CA. 94229-2715, Attn: Health Account Services.