2027 MMC Global Plan Rates

Carrier & Plan Name	Description	Enrollment Tiers & Rates			
		Employee	Employee + Spouse	Employee +Child(ren)	Family
Kaiser Permanente HMO40	*$40 Office Co-Pay – Annual Ded $3,000/$6,000* *Calendar out-of-pocket Max - $6,000/$12,000* *Inpatient & Outpatient Hospital - 30% after Ded* *Emergency 30% after Ded ~ Ambulance $150* *Rx $10 Generic/$30 Brand*	**$645.00**	**$1,380.30**	**$1,219.05**	**$2,064.00**
Kaiser Permanente HMO25	*$25 Office Co-Pay* *Calendar out-of-pocket Max - $1,500* *Inpatient Hosp $500/admit ~Outpatient $25* *Emergency $125 ~ Ambulance $150* *Rx $15 Generic/$30 Brand*	**$881.06**	**$1,885.47**	**$1,665.20**	**$2,819.39**
Kaiser Permanente PPO	*Annual Deductible $4,500/$6,500* *Calendar Out of Pocket Max $6,500* *$40 Office Co-Pay, Hospital $1,000 Ded/30%* *ER $100, Rx $40/$15*	**$1,196.90**	**$2,561.37**	**$2,262.14**	**$3,830.08**
Minimum Employer contribution for Medical Enrollees = $325/per month per EE					
Aetna Freedom of Choice	*DMO: Preventative 100%, Basic 100%, Major 60%,* *$5 office Co-Pay, Ortho Adult & Child 50%* *PPO In-network Option: $50 Deductible* *Preventative 100%, Basic 80%, Major 50%,* *PPO Out-of-Network: $50 Deductible* *Preventative 80%/Basic 60%/Major 50%*	**$54.50**	**$99.20**	**$97.40**	**$138.70**
VSP NEW Enhanced benefits ➔	*In Network: $25 Deductible* ***Exam/ Lenses/Frames** – Covered every **12 months*** *Frames $200/ 24 mos.+ $50 Enhanced Feature Frame* *Contact Lenses - **$180** allowance*	**$19.80**	**$32.20**	**$31.80**	**$47.10**

Reminder: Annual preventative health services provided at $0 Copay
Schedule your check up and refer to your summary of benefits for details & information

California Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only.

A. Company information (to be completed by administrator)

Number of pages including this page

Company name

Customer ID*

Enrollment unit ID*

Enrollment unit name/classification

Eligibility contact phone

Plan (example: HMO 20, DHMO 500/30)

Employee Number/ID

Effective date of enrollment/change* (mm/dd/yyyy)

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

- ☐ Enroll subscriber (and dependents)
- ☐ Add dependent(s) to existing subscriber account
- ☐ Remove dependent(s) from subscriber account
- ☐ Change name of subscriber and/or dependent(s)
- ☐ Update address
- ☐ Other

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition for obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth* (mm/dd/yyyy)

Home address* (physical location, no P.O. Box)

City*

State*

ZIP code*

Phone

Mailing address (if different than home)

City

State

ZIP code

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan Arbitration Agreement.† I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

X

Subscriber signature*

Date (mm/dd/yyyy)

*Field required for all enrollments and changes. †Disputes arising from the following fully-insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A–D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

2 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

3 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female ☐ Undeclared

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth* (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber

Home address* (physical location, no P.O. Box)

City State ZIP code

*Field required for all enrollments and changes.

Disclosure Form Part One

107720 MEDICAL MANAGEMENT CONSULTANTS, INC.
Home Region: Southern California

1/1/27 through 12/31/27

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for Covered Benefits you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$6,000	$6,000	$12,000
Plan Deductible	$3,000	$3,000	$6,000
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$40 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$40 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (up to and including 23 months)	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Most urgent care consultations, evaluations, and treatment	$40 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$40 per visit after Plan Deductible

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video or telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	30% Coinsurance up to a maximum of $50 per procedure after Plan Deductible

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Plan Deductible

Emergency Services and Care	**You Pay**
Emergency department visits	30% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for Covered Benefits, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services	**You Pay**
Ambulance services	30% Coinsurance up to a maximum of $150 per trip after Plan Deductible

Disclosure Form Part One

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$40 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$20 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$40 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Fertility Services, such as outpatient procedures or laboratory tests, as described in the *EOC* (see *EOC* for benefit limits)	The Cost Share you would pay if the services were to treat any other condition

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Covered Benefits, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

Disclosure Form Part One

107720 MEDICAL MANAGEMENT CONSULTANTS, INC.
Home Region: Southern California

1/1/27 through 12/31/27

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (up to and including 23 months)	No charge
Routine eye exams with a Plan Optometrist	No charge
Most urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video or telephone	No charge
Physician Specialist Visits by interactive video or telephone	No charge

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per admission

Emergency Services and Care	**You Pay**
Emergency department visits	$125 per visit

Note: If you are admitted directly to the hospital as an inpatient for Covered Benefits, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services	**You Pay**
Ambulance services	$125 per trip

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$15 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$30 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	No charge

Disclosure Form Part One

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$500 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$500 per admission
Individual outpatient substance use disorder evaluation and treatment	$25 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Fertility Services, such as outpatient procedures or laboratory tests, as described in the *EOC* (see *EOC* for benefit limits)	The Cost Share you would pay if the services were to treat any other condition

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*.

Disclosure Form Part Two

The *Disclosure Form Part Two* provides an overview of important features of your Health Plan membership, including how to obtain Covered Benefits, principal exclusions, and important notices. To view or download a copy, go to **kp.org/choosekp** or call Member Services at 1-800-464-4000 (TTY users call 711).

Benefit Summary

2027 Benefit Plan 10234

Principal Benefits for Kaiser Permanente PPO Plan

The **Accumulation Period** for this plan is Calendar **Year**.

	Member Pays	
	Participating Provider Tier	**Non-Participating Provider Tier**
Deductible	$4,500 Individual $9,000 Family	$9,000 Individual $18,000 Family
Out-of-Pocket Maximum	$6,500 Individual $13,000 Family	$13,000 Individual $26,000 Family
Provider Office Visits		
Physician Office Visits	$40	50%
Specialty Care	$40	50%
Telehealth Visits	$40	50%
Preventive Screenings	No Charge	50%
Adult Routine Physical Exam (limit 1 every 12 months)	No Charge	50%
Well-child Preventive Care Visits	No Charge	50%
Physical, Occupational, and Speech Therapy	30% after deductible	50% after deductible
Outpatient Services		
Outpatient Surgery (per procedure)	$100, then 30% after deductible	$150, then 50% after deductible
X-rays and Lab Tests	30% after deductible	50% after deductible
CT/PET scans and MRIs	30% after deductible	50% after deductible
Urgent Care	30% after deductible	50% after deductible
Emergency Services (Copayment waived if admitted directly to hospital)	$100, then 30% after deductible	
Emergency Ambulance Service	30% after deductible	30% after deductible
Hospital Inpatient Care (per admission) (Room and board, surgery, birth services, anesthesia, X-rays, laboratory tests, and drugs)	$1,000, then 30% after deductible	$1,500, then 50% after deductible
Mental Health Services		
Inpatient Hospitalization (per admission)	$1,000, then 30% after deductible	$1,500, then 50% after deductible
Individual Outpatient Visits	$40	50%
Group Outpatient Visits	$20	50%
Substance Use Disorder Treatment		
Inpatient Hospitalization (per admission)	$1,000, then 30% after deductible	$1,500, then 50% after deductible
Individual Outpatient Visits	$40	50%
Group Outpatient Visits	$20	50%
Additional Benefits		
Durable Medical Equipment (limits apply, see COI)	30% after deductible	50% after deductible
Prosthetic and Orthotics (limits apply, see COI)	30% after deductible	50% after deductible
Skilled Nursing Facility Care (per admission) (60-day limit per benefit period)	$1,000, then 30% after deductible	$1,500, then 50% after deductible
Home Health Care (100-visit limit per accumulation period)	20%	20%
Hospice Care	30% after deductible	50% after deductible
Fertility Services (limits apply, see COI) (Cost shares equal to services to treat any other condition)	Same as medical benefit	Same as medical benefit

Prescription Drug Coverage (30-day supply)	**MedImpact Pharmacies**	**Non-Participating Pharmacies**
Generic drugs	$15	Not covered
Brand drugs	$40	Not covered
Contraceptive drugs	No charge	Not covered
Specialty tier	30% up to $250	Not covered
Mail-order Prescriptions (Maximum 100-day supply)	**MedImpact Pharmacies**	**Non-Participating Pharmacies**
Generic Drugs	$30	Not covered
Brand Preferred Drugs	$80	

Notes:

These benefits are subject to regulatory approval. The table above describes a summary of the benefits of the plan. For a complete understanding of benefits, cost shares, exclusions, and limitations, please read the Kaiser Permanente Insurance Company Certificate of Insurance (COI).

Deductibles contribute towards satisfying the Out-of-Pocket Maximum. This plan carries an embedded Deductible and Out-of-Pocket Maximum. Benefits become payable for each family member after their individual annual Deductible is met, or when the family Deductible is satisfied. A family member can meet the individual annual Out-of-Pocket Maximum before the family Out-of-Pocket Maximum is satisfied.

Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Participating Provider Tier. Likewise, Covered Charges incurred toward satisfaction of the Deductible or Out-of-Pocket Maximum at the Non-Participating Provider Tier will accumulate toward satisfaction of the Deductible or Out-of-Pocket Maximum on the Non-Participating Provider Tier. The Deductible, Copayments, and Coinsurance paid for most covered services contribute towards the satisfaction of the Out-of-Pocket Maximum.

MedImpact Pharmacy Copayments and Coinsurance are not subject to, nor do they contribute toward satisfaction of the Deductible. However, they do contribute toward the satisfaction of the Out-of-Pocket Maximum.

Precertification is required before having certain services. For a complete understanding of precertification requirements, please refer to your Schedule of Coverage and Certificate of Insurance.

PPO Benefits are underwritten by Kaiser Permanente Insurance Company (KPIC), a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP)

California Employee Enrollment/Change Form

The following entities provide coverage: Aetna Health of California Inc. for HMO, Aetna Dental of California Inc. for Dental (DMO® only) and Aetna Life Insurance Company for all other coverages. For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care LLC ("EyeMed") provides certain network administration services.

INSTRUCTIONS: You, the employee, must complete this enrollment form in full. If you do not, we will return it to you or your employer, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you are enrolling, please be sure to sign and date Employee Signature on page 4. If you are declining coverage, you must complete Section F on page 4.** Please use only black ink to complete this form.

Control number (if available)
Aetna member ID number (if available)

Company name – Full legal name of business

Effective date / / **Date of hire** / /	☐ New hire ☐ Rehire / reinstatement ☐ New group enrollment ☐ Late enrollment ☐ Open enrollment ☐ Waiver	☐ Add spouse / dependent child ☐ Change of coverage ☐ Name change ☐ Other _____	☐ Employee termination ☐ Remove spouse / dependent child ☐ Cancel coverage

☐ **COBRA** ☐ **Cal-COBRA** for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 months ☐ 36 months ☐ Other _____

Qualifying event _____ Original qualifying event date _____ Loss of coverage date _____

A. Employee information – *You must complete this section.*

Member Social Security number*	Last name, first name, middle initial		
Home address (PO box not acceptable)	Apt. number	City, state	ZIP code
Work address (PO box not acceptable)		City, state	ZIP code

Home/cell telephone ( ) -	Work telephone ( ) -	Primary language spoken (optional)	Number of dependents enrolling for medical coverage including spouse
Number of hours worked a week	Check one: ☐ Full time ☐ Part time ☐ 1099 ☐ Retiree ☐ Seasonal ☐ Temporary ☐ Union		Job title

*Social Security number is optional; tax identification number is acceptable. Please provide either Social Security number or tax ID number.

B. Coverage selection

Control/Group number	Suffix	Account	Plan number

Dental ☐ Yes ☐ No *To enroll, check "yes" and enter the plan option elected below. Please print clearly.*

Plan option / name _____

If Freedom-of-Choice (FOC), choose: ☐ DMO® *or* ☐ PPO / Indemnity

DMO® and FOC are not an available option if you reside in any of the following states or U.S. territories: AK, AL, AR, GU, LA, ME, MS, MT, ND, NH, PR, SC, SD, VI, VT, WV and WY.

Employees in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.

Individuals covered – ***List individuals for whom you are enrolling or adding / changing / removing coverage. Add more sheets if needed. For dependents with different last names or living at another address, complete Section D below.*** **NOTE FOR MEDICAL COVERAGE:** While the Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Disabled children may be covered if they are over age 26. Please refer to your plan documents or contact your benefits administrator.

1	**Employee name** (Last, first, middle initial)			Sex (M/F)	Birthdate (MM/DD/YYYY) / /	
Status ☐ Single ☐ Married ☐ Divorced ☐ Legally separated ☐ Domestic partnership	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
2	**Spouse name** (Last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Spouse ☐ Domestic partner ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
3	**Child name** (Last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
4	**Child name** (Last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	
5	**Child name** (Last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision	Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes	

Continued on next page

C. Individuals covered *(Continued)*

6	**Child name** (Last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes

7	**Child name** (Last, first, middle initial)	Sex (M/F)	Social Security number		Birthdate (MM/DD/YYYY) / /	
Relationship ☐ Child ☐ Stepchild ☐ Other _____	Choosing coverage for: ☐ Medical ☐ Dental ☐ Vision		Primary care ID number	Current patient ☐ Yes	Dental office ID number (if applicable)	Current patient ☐ Yes

D. Dependent information

List any dependent in Section **C** living at another address.

Name	Address

E. Coordination of benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

If **yes**, will the Aetna coverage you're applying for replace the coverage you have now? ☐ Yes ☐ No

Name of person	Carrier name	Name of person	Carrier name

Conditions of enrollment

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I understand that the following legal entities (collectively referred to as "Aetna") underwrite the plans I apply for:

- Aetna Health of California Inc. underwrites Aetna HMO plans.
- Aetna Life Insurance Company underwrites Aetna Vision plans, Aetna Traditional Choice plans, Aetna EPO plans, Aetna PPO plans and Aetna MC plans.
- Aetna Dental of California Inc. and Aetna Life Insurance Company underwrite Aetna Dental plans.

1. The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
   - Benefits comparison
   - Summary
   - Other description of the plan
2. Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
3. You may keep your medical information private by requesting a confidential communication.
4. I understand that, with certain exceptions described in the plan documents, HMO and DMO© plans only provide coverage for network covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician

Continued on next page

Conditions of enrollment *(Continued)*

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment on this enrollment / change form. I understand in the event I fail to sign and return this form within 31 days of my eligibility date or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am employed by the employer shown on page 1. I authorize deductions from my earnings for any contributions required for coverage. I agree to make any necessary payments as required for coverage.

To receive documents online, please visit your secure member account at www.aetna.com.

For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Please sign here ONLY if you are enrolling in coverage for yourself and / or dependents.	***Employee email***	***Date (Month/Day/Year)***
☐ **I AM ENROLLING FOR COVERAGE:** ***Employee signature*** **X**		

F. Declining coverage – ***Check all that apply.***

I understand I am eligible to apply for this coverage through my employer. However, I am declining the coverage I checked below.

☐ **Employee:**
- ☐ Medical ☐ Dental ☐ Vision

☐ **Spouse:**
- ☐ Medical ☐ Dental ☐ Vision

☐ **Children:**
- ☐ Medical ☐ Dental ☐ Vision

Reason for declining coverage

- ☐ Spouse group coverage
- ☐ Parental group coverage
- ☐ Medicare
- ☐ Medi-Cal
- ☐ Retiree coverage
- ☐ Another group plan provided by my employer
- ☐ COBRA coverage
- ☐ Insurance through another job
- ☐ TRICARE Military coverage
- ☐ Individual coverage – On Exchange
- ☐ Individual coverage – Off Exchange
- ☐ I have no other coverage
- ☐ Do not want
- ☐ Other _____

I certify I have been given the right to apply for this coverage. However, I am declining coverage as noted above. By declining this group coverage I acknowledge that I and / or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage.

Please sign here ONLY if you are declining coverage for yourself and / or dependents.	***Date (Month/Day/Year)***
☐ **I AM DECLINING COVERAGE:** ***Employee signature*** **X**	

aetna®

MEDICAL MANAGEMENT
CONSULTANTS
812347
Effective Date: 01-01-2027

Dental Benefits Summary

	DMO® Member Responsibility
Annual Deductible	
Individual	**None**
Family	**None**
Preventive Services	**0%**
Basic Services	**0%**
Major Services	**40%**
Annual Benefit Maximum	**None**
Office Visit Copay	**$5**
Orthodontic Services (Adult and Child)	**50%**
Orthodontic Deductible	**None**
Orthodontic Lifetime Maximum	*******

***** 24 months of comprehensive orthodontic treatment plus 24 months of retention.**

Partial List of Services	DMO® Member Responsibility
Preventive	
Oral examinations (a)	**0%**
Cleanings (a) Adult/Child	**0%**
Fluoride (a)	**0%**
Sealants (permanent molars only) (a)	**0%**
Bitewing Images (a)	**0%**
Full mouth series Images (a)	**0%**
Basic	
Root canal therapy, anterior teeth and bicuspid teeth	**0%**
Scaling and root planing (a)	**0%**
Gingivectomy (a)*	**0%**
Amalgam (silver) fillings	**0%**

Dental Benefits Summary

Composite fillings	**0%**
Stainless steel crowns	**0%**
Incision and drainage of abscess*	**0%**
Uncomplicated extractions	**0%**
Surgical removal of erupted tooth*	**0%**
Surgical removal of impacted tooth (soft tissue)*	**0%**
Major	
Inlays	**40%**
Onlays	**40%**
Crowns	**40%**
Full & partial dentures	**40%**
Pontics	**40%**
Root canal therapy, molar teeth	**40%**
Osseous surgery (a)*	**40%**
Surgical removal of impacted tooth (partial bony/ full bony)*	**40%**
General anesthesia/intravenous sedation*	**40%**
Denture repairs	**40%**
Space Maintainers	**40%**
***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**	
(a) Frequency and/or age limitations may apply. Limits are described in the booklet/certificate.	

Other Important Information

This benefits summary of the Aetna Dental DMO (Dental Maintenance Organization) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists.

Employees residing in AZ, CA, GA, MA, MD, MO, NC, NJ and TX must either live or work within the approved DMO® service area to be eligible to enroll in the DMO®.
The DMO® plan is not available for employees that reside in the following states: AK, AL, AR, LA, ME, MS, MT, ND, NH, PR, SC, SD, WY and VT.

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MEDICAL MANAGEMENT
CONSULTANTS
812347
Effective Date: 01-01-2027

Dental Benefits Summary

	Active PPO MAX With PPOII and Extend℠ Networks	
	Participating	Non-participating
Annual Deductible*		
Individual	**$50**	**$150**
Family	**$150**	**$450**
Preventive Services	**100%**	**80%**
Basic Services	**80%**	**60%**
Major Services	**50%**	**50%**
Annual Benefit Maximum	**$1500**	**$1500**
Office Visit Copay	**N/A**	**N/A**
Orthodontic Services	**Not Covered**	**Not Covered**
Orthodontic Deductible	**Not Covered**	**Not Covered**
Orthodontic Lifetime Maximum	**Not Covered**	**Not Covered**
***The deductible applies to: Basic & Major services only**		

Partial List of Services	Active PPO MAX With PPOII and Extend℠ Networks	
Preventive	Participating	Non-participating
Oral examinations (a)	**100%**	**80%**
Cleanings (a) Adult/Child	**100%**	**80%**
Fluoride (a)	**100%**	**80%**
Bitewing Images (a)	**100%**	**80%**
Full mouth series Images (a)	**100%**	**80%**
Basic		
Denture repairs	**80%**	**60%**
Space Maintainers	**80%**	**60%**
Root canal therapy, anterior teeth and bicuspid teeth	**80%**	**60%**
Root canal therapy, molar teeth	**80%**	**60%**
Scaling and root planing (a)	**80%**	**60%**
Gingivectomy (a)*	**80%**	**60%**

Dental Benefits Summary

Amalgam (silver) fillings	**80%**	**60%**
Composite fillings (anterior teeth only)	**80%**	**60%**
Stainless steel crowns	**80%**	**60%**
Incision and drainage of abscess*	**80%**	**60%**
Uncomplicated extractions	**80%**	**60%**
Surgical removal of erupted tooth*	**80%**	**60%**
Surgical removal of impacted tooth (soft tissue)*	**80%**	**60%**
Osseous surgery (a)*	**80%**	**60%**
Surgical removal of impacted tooth (partial bony/ full bony)*	**80%**	**60%**
General anesthesia/intravenous sedation*	**80%**	**60%**
Major		
Inlays	**50%**	**50%**
Onlays	**50%**	**50%**
Crowns	**50%**	**50%**
Full & partial dentures	**50%**	**50%**
Pontics	**50%**	**50%**

***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**

(a) Frequency and/or age limitations may apply. Limits are described in the booklet/certificate.

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) MAX benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) MAX plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO MAX plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-Participating coverage is limited to a maximum allowable charge (MAX) of the plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

2027 - ENROLLMENT/CHANGE/TERMINATION FORM

GROUP NUMBER: 12103137/DIVISION NUMBER: 0001

VSP Vision care for life

Please Print

EMPLOYEE NAME: _____

EMPLOYER: _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

HOME ADDRESS: _____

_____

Effective Date: _____

Please Select One:

- ○ Enrollment (initial eligibility, qualifying event, or Open Enrollment)
- ○ Change (addition or deletion of dependents)
- ○ Termination (cancellation of coverage)

Coverage Level/Please Select Tier:

○	EMPLOYEE ONLY	$ 19.80 / MONTH
○	EMPLOYEE + SPOUSE	$ 32.20 / MONTH
○	EMPLOYEE + CHILD (REN)	$ 31.80 / MONTH
○	EMPLOYEE + FAMILY	$ 47.10 / MONTH

Employee Signature: _____

Date: _____

vsp vision care

Make Eye Health a Priority with VSP!

With VSP® Vision Care and MEDICAL MANAGEMENT CONSULTANTS, INC., your eye health matters. Take a look at your vision care coverage.



VSP members save an annual average of

$501*

Get an Additional $50 to spend on Featured Frame Brands.

Just look for the **VSP heart logo** on the lens to maximize your benefits.†

bebe Calvin Klein COLE HAAN

DRAGON FLEXON LONGCHAMP PARIS

and more at **vsp.com/framebrands**

Up to 40% savings on lens enhancements‡

Learn more at **vsp.com/offers**.

Enroll through your employer today.
Questions?
vsp.com
800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your eye doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members can get special savings on popular frame brands and contact lenses, and additional discounts on things like LASIK, and more.

The choice is yours!

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Simply connect your benefits when you log in to **eyeconic.com** and have a valid prescription ready when you check out.

Getting started is easy!

Make the most of your plan by creating an account on **vsp.com**. Log in to view your in-network coverage, find a VSP network doctor, download your Member ID card (and save it to your digital wallet), and discover extra savings.

*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **Full Picture of Eye Health, American Optometric Association. †Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Availability of VSP Premier Edge™ may vary.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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VSP, VSP (Heart) Logo, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 142819 VCCM

Classification: Restricted

Your VSP Benefits Summary

With a VSP plan through MEDICAL MANAGEMENT CONSULTANTS, INC., you get affordable vision coverage for glasses, contacts, and more.

Provider Network:
VSP Signature
Effective Date:
01/01/2027

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$25 for exam and glasses Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME[+]	• $250 Featured Frame Brands allowance • $250 Visionworks or Eyemart Express frame allowance on any frame • $200 frame allowance • 20% savings on the amount over your allowance	Combined with exam	Every 12 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $180 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam. • Get 20% off eyewear on **eyeconic.com** just for being a VSP member.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

GET MORE AT PREFERRED IN-NETWORK LOCATIONS

With so many in-network choices, including private practice and retail locations, VSP makes it easy to maximize your benefits. Log in to **vsp.com** to find an in-network doctor near you!