RESOLUTION NO. _____

A RESOLUTION OF THE OF THE (GOVERNING BODY) OF Grizzly Ranch Community Services District APPROVING THE FORM OF AND AUTHORIZING THE EXECUTION OF A MEMORANDUM OF UNDERSTANDING AND AUTHORIZING PARTICIPATION IN THE SPECIAL DISTRICT RISK MANAGEMENT AUTHORITY'S HEALTH BENEFITS PROGRAM

WHEREAS, Grizzly Ranch Community Services District, a public agency duly organized and existing under and by virtue of the laws of the State of California (the "ENTITY"), has determined that it is in the best interest and to the advantage of the ENTITY to participate in the Health Benefits Program offered by Special District Risk Management Authority (the "Authority"); and

WHEREAS, the Authority was formed in 1986 in accordance with the provisions of California Government Code 6500 *et seq.,* for the purpose of providing risk financing, risk management programs and other coverage protection programs; and

WHEREAS, participation in Authority programs requires the ENTITY to execute and enter into a Memorandum of Understanding which states the purpose and participation requirements for the Health Benefits Program; and

WHEREAS, all acts, conditions and things required by the laws of the State of California to exist, to have happened and to have been performed precedent to and in connection with the consummation of the transactions authorized hereby do exist, have happened and have been performed in regular and due time, form and manner as required by law, and the ENTITY is now duly authorized and empowered, pursuant to each and every requirement of law, to consummate such transactions for the purpose, in the manner and upon the terms herein provided.

NOW, THEREFORE, BE IT RESOLVED BY THE GOVERNING BODY OF THE ENTITY AS FOLLOWS:

Section 1. Findings. The ENTITY's Governing Body hereby specifically finds and determines that the actions authorized hereby relate to the public affairs of the ENTITY.

Section 2. Memorandum of Understanding. The Memorandum of Understanding, to be executed and entered into by and between the ENTITY and the Authority, in the form presented at this meeting and on file with the ENTITY's Secretary, is hereby approved. The ENTITY's Governing Body and/or Authorized Officers ("The Authorized Officers") are hereby authorized and directed, for and in the name and on behalf of the ENTITY, to execute and deliver to the Authority the Memorandum of Understanding.

Section 3. Program Participation. The ENTITY's Governing Body approves participating in the Special District Risk Management Authority's Health Benefits Program.

Section 4. Severability. If any provision of this resolution or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the resolution which can be given effect without the invalid provision or application, and to this end the provisions of this resolution are severable.

Section 5. Other Actions. The Authorized Officers of the ENTITY are each hereby authorized and directed to execute and deliver any and all documents which are necessary in order to consummate the transactions authorized hereby and all such actions heretofore taken by such officers are hereby ratified, confirmed and approved.

Section 6. Effective Date. This resolution shall take effect immediately upon its passage.

PASSED AND ADOPTED this _____ day of _____, 20_____ by the following vote:

AYES: _____

NOES: _____

ABSENT: _____

_____
Name

_____
Title

_____
ENTITY Secretary

PLAN SUMMARY – BLUE SHIELD

*See page 3, note 14 for Plan Selections and Combination Guidelines

DEDUCTIBLES/COINSURANCE	EPO	HDHP 10 (HSA)		HDHP 20 (HSA)	
Calendar Year Deductible(s) (Individual/ Family)	$300 / $600	$1,600 / $3,200		$3,000 / $6,000	
Maximum Medical Out of Pocket (Individual/ Family)	$1,300 / $2,600	$5,000 / $10,000		$5,950 / $11,900	
Medicare Medical Maximum Out of Pocket	$1,000 / $2,000	Non-Applicable		Non-Applicable	
Services/Coverages	**Participating Providers (You Pay)**	**Participating Providers (You Pay)**	**Non-Participating Providers (You Pay)**	**Participating Providers (You Pay)**	**Non-Participating Providers (You Pay)**
Inpatient Hospital Room, Board & Support Services (prior authorization required)	No Charge	10%	50% up to $600 per day	20%	50% up to $600 per day
Outpatient Hospital	$30 co-pay	10%	50% up to $350 per day	20%	50% up to $350 per day
Ambulatory Surgery Center	No Charge; Deductible Waived	No Charge	50% up to $350 per day	10%	50% up to $350 per day
Emergency Room	$100 co-pay (co-pay waived if admitted)	$100 co-pay + 10% (co-pay waived if admitted)		$100 co-pay + 20% (co-pay waived if admitted)	
Urgent Care	$30 co-pay	10%	50%	20%	50%
Physician Benefits (office visits)	$30 co-pay	10%	50%	20%	50%
Preventative Care	No Charge	No Charge	Not Covered	No Charge	Not Covered
Lab/X-ray	$0 ($25 co-pay if services provided by Hospital)	$0 ($25 co-pay + 10% if services provided by Hospital)	50% (up to $350/ per day within Hospital)	$0 ($25 co-pay + 20% if services provided by Hospital)	50% (up to $350/ per day within Hospital)
Complex Imaging (CT, PET, MRI, etc.)	$0 ($100 co-pay if services provided by Hospital)	10% ($100 co-pay + 10% if services provided by Hospital)	50% up to $800 per day	20% ($100 co-pay + 20% if services provided by Hospital)	50% up to $800 per day
Acupuncture (26 visits per calendar year/ combined with Chiropractic)	$30 co-pay	10% up to $30 per visit		20% up to $30 per visit	
Chiropractic Services (26 visits per calendar year/combined with Acupuncture)	$30 co-pay	10% up to $25 per visit	50% up to $25 per visit	20% up to $25 per visit	50% up to $25 per visit
Prescription Drugs *Active/Early Retiree Plans Only*	**Express Scripts***	**Blue Shield**		**Blue Shield**	
Prescription Maximum Out of Pocket	$5,300 / $10,600	Combined with Medical		Combined with Medical	
(At Participating Pharmacies only)	Generic / Brand / Non-Formulary / Specialty	Generic / Brand / Specialty	Generic / Brand / Specialty	Generic / Brand / Specialty	Generic / Brand / Specialty
Retail - 30 day supply	$10 / $20 / $45 / 30% (max co-pay $150)	$7 / $25 / 30% up to $150 / prescription	$7 / $25 / 30% up to $150 / prescription	$7 / $25 / 30% up to $150 / prescription	$7 / $25 / 30% up to $150 / prescription
Mail Order - 90 day supply	$15 / $50 / $112.50 / 30% (max co-pay $150)	$14 / $60 / 30% up to $300 / prescription	Not Covered	$14 / $60 / 30% up to $300 / prescription	Not Covered
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	$200	Subject to Deductible		Subject to Deductible	

THIS SUMMARY IS INTENDED TO COMPARE COVERAGE BENEFITS ONLY. THE ACTUAL PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. NON-PARTICIPATING PROVIDER MEMBER COST MAY NOT APPLY TO MAXIMUM OUT OF POCKET COSTS.

*See Rx benefits for Medicare on page 15 under the "EGWP" pharmacy co-pay structure.

MEDICAL BENEFIT RATES FOR 2024 – GUARANTEED UNTIL JANUARY 1, 2025

AREA IV - Southern CA: Other Counties

Fresno,* Imperial, Inyo, Kern, Kings, Madera, Riverside, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare

*Fresno County: For Kaiser Active and Early Retiree rates please refer to Area VI rates per Kaiser Guidelines.

PLAN	Employee	Employee + 1	Employee + 2 or More
Gold PPO	$1,141.24	$2,274.24	$2,950.95
Platinum PPO	$1,255.57	$2,497.75	$3,248.62
Silver PPO	$820.91	$1,638.73	$2,124.89
Bronze PPO	$751.90	$1,501.74	$1,946.70
EPO	$1,271.02	$2,530.71	$3,287.76
HDHP 10	$1,002.19	$1,998.20	$2,594.57
HDHP 20	$824.00	$1,646.97	$2,142.40
Access+ HMO 15	$1,231.88	$2,462.73	$3,194.03
Access+ HMO 20	$1,147.42	$2,285.57	$2,972.58
Kaiser HMO 15	$1,036.18	$2,042.49	$2,648.13
Kaiser HMO 20	$989.83	$1,950.82	$2,529.68

AREA V - Out of State Early Retirees Only

PLAN	Employee	Employee + 1	Employee + 2 or More
Gold PPO	$1,337.97	$2,672.85	$3,476.25
Platinum PPO	$1,463.63	$2,930.35	$3,805.85
Silver PPO	$962.02	$1,921.98	$2,495.69
Bronze PPO	$880.65	$1,761.30	$2,286.60
EPO	$1,563.54	$3,125.02	$4,064.38
HDHP 10	$1,149.48	$2,293.81	$2,984.94
HDHP 20	$941.42	$1,881.81	$2,447.28
Access+ HMO 15	N/A	N/A	N/A
Access+ HMO 20	N/A	N/A	N/A
Kaiser HMO 15	N/A	N/A	N/A
Kaiser HMO 20	N/A	N/A	N/A

AREA VI - Northern CA: Sacramento

El Dorado, Placer, Sacramento

*Fresno County Kaiser Active and Early Retiree Rates

PLAN	Employee	Employee + 1	Employee + 2 or More
Gold PPO	$1,170.08	$2,340.16	$3,042.62
Platinum PPO	$1,280.29	$2,560.58	$3,325.87
Silver PPO	$843.57	$1,689.20	$2,196.99
Bronze PPO	$772.50	$1,548.09	$2,012.62
EPO	$1,367.84	$2,739.80	$3,556.59
HDHP 10	$1,027.94	$2,061.03	$2,676.97
HDHP 20	$848.72	$1,696.41	$2,204.20
Access+ HMO 15	$1,377.11	$2,755.25	$3,583.37
Access+ HMO 20	$1,278.23	$2,561.61	$3,328.96
Kaiser HMO 15	$1,210.25	$2,392.69	$3,100.30
Kaiser HMO 20	$1,166.99	$2,307.20	$2,989.06

Rates shown are for active, early retiree and public officials.

DELTA DENTAL PPO – RATES GUARANTEED UNTIL JANUARY 1, 2025

*See page 3, note 14 for Plan Selections and Combination Guidelines

DENTAL BENEFITS	Low Plan	
	PPO	Non-PPO
Calendar Year Maximum	$1,000 (Per patient per calendar year)	$500
Calendar Year Deductible Individual / Family	$50 / $150 (Waived for Preventive)	
Age Limitations	Dependents to Age 26	
Diagnostic and Preventive	100%	100%
Oral Exam		
Routine Cleaning		
X-Rays		
Fluoride Treatment		
Space Maintainers		
Specialist Consultations		
Basic Services	80%	80%
Fillings		
Endodontics (Root Canal)		
Periodontics (Gum Treatment)		
Tissue Removal (Biopsy)		
Extractions & Other Oral Surgery		
Sealants		
Major Services	50%	50%
Crown Repair		
Inlays, Onlays		
Cast Restorations		
Bridges		
Partial and Full Dentures		
Orthodontics		
Eligible for Benefit	Not Covered	
Lifetime Maximum		
(Employer Contributes 51-100% of dependent cost):		
Rates		
Employee Only	$29.56	
Employee + 1 Dependent	$50.57	
Employee + 2 or More Dependents	$81.58	
(Employer Contributes 0-50% of dependent cost):		
Rates		
Employee Only	$29.56	
Employee + 1 Dependent	$53.87	
Employee + 2 or More Dependents	$89.10	

THIS SUMMARY IS INTENDED TO COMPARE COVERAGE BENEFITS ONLY. THE ACTUAL PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

VSP VISION – RATES GUARANTEED UNTIL JANUARY 1, 2026

*See page 3, note 14 for Plan Selections and Combination Guidelines

VISION BENEFITS	Option 1		Option 2	
	In-Network	Non-Network	In-Network	Non-Network
Co-pay	$25 for Exam and/or Materials		$25 for Exam and/or Materials	
Exam	Covered after Co-pay	Plan pays up to: $50	Covered after Co-pay	Plan pays up to: $50
Lenses				
Single	Covered after Co-pay	$50	Covered after Co-pay	$50
Bifocal	Covered after Co-pay	$75	Covered after Co-pay	$75
Trifocal	Covered after Co-pay	$100	Covered after Co-pay	$100
Frames	$130 Allowance 20% off amount over allowance	$70	$130 Allowance 20% off amount over allowance	$70
Contact Lenses - Elective	$130 Allowance	$105	$130 Allowance	$105
Contact Lenses - Medically Necessary	Covered after Co-pay	$210	Covered after Co-pay	$210
Contact Exam and Fitting	Up to $60	$0	Up to $60	$0
Frequency of Services				
Eye Examination	12 months		12 months	
Lenses	24 months		12 months	
Frames	24 months		24 months	
Contact Lenses[1]	24 months		12 months	
Rates				
Employee Only	$6.59		$7.62	
Employee + 1 Dependent	$12.77		$14.83	
Employee + 2 or More Dependents	$20.19		$23.48	

[1] Contact lenses are in lieu of spectacle lenses and frames

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VOYA FINANCIAL LONG TERM DISABILITY – RATES GUARANTEED UNTIL JULY 1, 2027

For Groups with less than 10 Employee lives		
Long Term Disability Benefits	**Option 1**	**Option 2**
Eligibility:	All Eligible Employees working at least 20 hrs/wk	All Eligible Employees working at least 20 hrs/wk
Elimination Period	90 Days (1)	180 Days (2)
Monthly Benefit Percentage	60%	60%
Maximum Monthly Benefit	$5,000	$5,000
Own Occupation Timeframe or Coverage Period	24 Months	24 Months
Disability Earnings Test	80%	80%
Definition of Disability	Earnings & Occupation	Earnings & Occupation
Recurrent Disabilities	6 Months	6 Months
Mental Health/Substance Abuse Limitations	24 Months	24 Months
Maximum Benefit Duration	To Age 65 or SSNRA	To Age 65 or SSNRA
Pre-Existing Condition	3/12	3/12
Age Banded Rates	**Option 1 – 90 days**	**Option 2 – 180 days**
Rate per $100: Under age 25	$0.131*	$0.103*
Rate per $100: Age 25-29	$0.177*	$0.130*
Rate per $100: Age 30-34	$0.225*	$0.168*
Rate per $100: Age 35-39	$0.289*	$0.214*
Rate per $100: Age 40-44	$0.374*	$0.280*
Rate per $100: Age 45-49	$0.485*	$0.365*
Rate per $100: Age 50-54	$0.634*	$0.476*
Rate per $100: Age 55-59	$0.830*	$0.625*
Rate per $100: Over age 60	$1.083*	$0.812*

Example Calculation
Example based on an individual under age 25
Monthly Covered Salary X Rate/100
Monthly Covered Salary = Annual Salary/12
50,000/12 = $4,166
$4,166 (monthly covered salary) X 0.131 (rate)/100 = 5.46

(1) Benefit begins after 90 days
(2) Benefit begins after 180 days

Definitions:
Elimination Period – Benefits begin the day after the elimination period ends.

Own Occupation Timeframe or Coverage Period – Employee's disability will be evaluated on their ability to perform their own occupations to a certain degree.

Recurrent Disabilities – Refers to the instance where an employee recovers temporarily from a disability and returns to work, but then the disability resurfaces. If the disability resurfaces within a set time frame, the elimination period does not have to be satisfied again.

* Rates provided on Ancillary invoice may vary slightly because of rounding.

NOTE: THIS SUMMARY IS FOR INFORMATIONAL PURPOSE ONLY. IT DOES NOT AMEND, EXTEND, OR ALTER THE CURRENT POLICY IN ANY WAY. IN THE EVENT INFORMATION IN THIS SUMMARY DIFFERS FROM THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL PREVAIL.

THIS SUMMARY IS INTENDED TO COMPARE COVERAGE BENEFITS ONLY. THE ACTUAL PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.