Tracy Public Cemetery District

Special Meeting Minutes
Of
May 30, 2024

Special Meeting was called to order at 6:00 pm by Chairman Derrick Davis.

Roll Call:
Present: Chairman Derrick Davis, Vice-Chair Scott Argenbright, Trustees Kevin Tobeck, Eugene Birk, Bill Kaska, Manager Warner and Office Admin Kim Jager Queirolo.

Manager Warner presented all the board members with a packet comparing the different medical pricing from CalPers, GSRMA and Sousa Insurance, they asked to have this on an excel spreadsheet or to see if David Farnsworth the Districts auditor can help put this medical information on an excel spread sheet to do a price comparison and to approve medical at the next meeting. Update at next meeting.

Being no other business to report, Special Meeting ended at 7:07 pm.

Respectfully,

Maylene Warner
District Manage

Delta Dental Summary – (May Choose 1 Plan)

Coverages	Low Plan	Medium Plan	High Plan
Calendar Year Maximum (Network / Non-Network)	$1,000 / $750	$1,500 / $1,250	$2,000 / $1,500
Calendar Year Deductible (Network / Non-Network) (Waived for Preventative)	$50 / $150	$50 / $150	$50 / $150
Employee Only	$30.14	$40.95	$52.50
Employee + 2 or more dependents	$83.16	$108.78	$134.40

Tracy Public Cemetery District

Employee	Dependent	Anthem Platinum	Anthem Gold	Kaiser Platinum	Kaiser Gold	Delta Dental
Celaya, Alma		$ 1,734.03	$ 1,792.23	$ 1,392.66	$ 1,314.84	$ 84.70
Jager-Queirolo, Kimberly		$ 1,348.50	$ 1,160.46	$ 1,083.03	$ 1,022.50	$ 84.70
	Spouse	$ 1,408.61	$ 1,212.19	$ 1,131.31	$ 1,068.08	$ 65.70
Leon Ramirez, Antonio Daniel		$ 578.01	$ 497.41	$ 464.22	$ 438.28	$ 84.70
Manriquez, Jose		$ 720.20	$ 619.77	$ 578.42	$ 546.09	$ 84.70
	Family	$ 2,929.36	$ 2,520.88	$ 2,381.23	$ 2,249.72	$ 148.90
Manzo, Jesus		$ 867.02	$ 746.12	$ 696.34	$ 657.41	$ 84.70
	Family	$ 2,509.15	$ 2,159.26	$ 2,029.46	$ 1,916.83	$ 148.90
Meza,Jose		$ 710.95	$ 611.81	$ 571.00	$ 539.08	$ 84.70
	Family	$ 2,173.90	$ 1,870.46	$ 1,788.76	$ 1,691.16	$ 148.90
Prater, Loran		$ 867.02	$ 746.12	$ 696.34	$ 657.41	$ 84.70
	Family	$ 2,382.56	$ 2,050.33	$ 1,942.07	$ 1,835.12	$ 148.90
Torres, Axel		$ 578.01	$ 497.41	$ 464.22	$ 438.28	$ 84.70
Warner, Maylene		$ 903.43	$ 777.45	$ 725.58	$ 685.03	$ 84.70
	Spouse	$ 986.09	$ 898.58	$ 791.97	$ 747.70	$ 65.70
Totals		$ ~~20,696.84~~	$ ~~18,160.48~~	$ ~~16,736.61~~	$ 15,807.53	$ 1,489.30
		7577.73	$6871.15	10,636.38	10,047.44	

$18.214.11

Tracy Public Cemetery District

Plan Comparison

Anthem / Blue Shield Summary

Coverages	Gold PPO	Platinum PPO	Silver PPO
Calendar Year Deductible (EE / Family)	$500 / $1,000	$300 / $600	$2,000 / $4,000
Maximum Medical Out of Pocket (EE / Family)	$2,000 / $4,000	$1,300 / $3,600	$5,000 / $10,000
Copay / Co-Insurance	$20 / 20%	$10 / 20%	$30 / 20%
Prescription Drugs (Express Scripts)			
Maximum Out of Pocket / Yr	$4,600 / $9,200	$5,300 / $9,600	$1,600 / $3,200
Retail – 30 day supply Generic / Brand / Non-formulary / Specialty	$5 / $30 / 45 / 30% (max co-pay $150)	$5 / $30 / 45 / 30% (max co-pay $150)	$10 / $20 / $45 / 30% (max co-pay $150)
Mail Order – 90 day supply	$10 / $75 / $112.50 / 30% (max co-pay $300)	$10 / $75 / $112.50 / 30% (max co-pay $300)	$20 / $40 / $90 / 30% (max co-pay $300)
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	None	None	$200 / $500
Monthly Rates (Area 1)			
Employee Only	$1,289	$1,408	$923
Employee + 2 or more dependents	$3,348	$3,660	$2,402

Medical Benefits Summary

DEDUCTIBLES / CO-INSURANCE / MAXIMUM	Gold PPO		Platinum PPO	
Calendar Year Deductible(s) (Individual / Family)	$500 / $1,000		$300 / $600	
Maximum Medical Out of Pocket (Individual / Family)	$2,000 / $4,000		$1,300 / $3,600	
Medicare Retiree Maximum Out of Pocket	$1,500 / $3,000		$1,000 / $3,000	
Services / Coverages	**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)	20%	50% up to $600 per day	10%	50% up to $600 per day
Ambulatory Surgery Center	Deductible Waived; 10% Coinsurance	50% up to $350 per day	Deductible Waived; No charge	50% up to $350 per day
Emergency Room Visit Results in Admission as Inpatient	20%		10%	
Visit Does Not Result in Admission	20%, $100 co-pay		10%, $100 co-pay	
Physician Benefits (Office visits)	$20 co-pay	50%	$20 co-pay	50%
Preventative Care	No Charge	Not Covered	No Charge	Not Covered
Rehabilitation Service (In an office location)	20%	50% up to $350 per day	10%	50% up to $350 per day
Acupuncture (26 Visits per calendar year / combined with Chiropractic)	20%		10%	50%
Durable Medical Equipment	20%	Not Covered	10%	Not covered
Hospice	20%	Not Covered without Prior Authorization	10%	Not Covered without Prior Authorization
Ambulance	20%		10%	
Home Health Care 100 visits / year (Prior authorization required)	20%	Not Covered without Prior Authorization	10%	Not Covered without Prior Authorization
Chiropractic Services (26 Visits per calendar year/combined with Acupuncture)	20% up to $50 per visit	50% up to $25 per visit	10% up to $50 per visit	50% up to $25 per visit
Prescription Drugs **Active / Early Retiree Plans Only***	**Express Scripts**		**Express Scripts**	
Prescription Maximum Out of Pocket	$4,600 / $9,200		$5,300 / $9,600	
(At Participating Pharmacies only)	Generic / Brand / Non-formulary / Specialty		Generic / Brand / Non-formulary / Specialty	
Retail - 30 day supply	$5 / $30 / $45 / 30% (max co-pay $150)		$5 / $30 / $45 / 30% (max co-pay $150)	
Mail Order - 90 day supply	$10 / $75 / $112.50 / 30% (max co-pay $300)		$10 / $75 / $112.50 / 30% (max co-pay $300)	
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	None		None	

**See Rx benefits for Medicare on page 12 under the "EGWP" pharmacy co-pay structure.*
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

Medical Benefits Summary

DEDUCTIBLES / CO-INSURANCE / MAXIMUM	Silver PPO		EPO
Calendar Year Deductible(s) (Individual / Family)	$2,000 / $4,000		$300 / $600
Maximum Medical Out of Pocket (Individual / Family)	$5,000 / $10,000		$1,300 / $2,600
Medicare Retiree Maximum Out of Pocket	$3,000 / $6,000		$1,000 / $2,000
Services / Coverages	**Participating Providers (You Pay)**	**Non-Participating Providers (You Pay)**	**Participating Providers (You Pay)**
Inpatient Hospital Room, Board & Support Services (Prior authorization required)	20%	50% up to $600 per day	No Charge
Ambulatory Surgery Center	Deductible Waived; 10%	50% up to $350 per day	Deductible Waived; No charge
Emergency Room Visit Results in Admission as Inpatient	20%		No Charge
Visit Does Not Result in Admission	20%, $100 co-pay		$100 co-pay
Physician Benefits (Office visits)	$30 co-pay	50%	$30 co-pay
Preventative Care	No Charge	Not Covered	No Charge
Rehabilitation Service (In an office location)	20%	50% up to $350 per day	$30 co-pay
Acupuncture (26 Visits per calendar year / combined with Chiropractic)	20%		$30 co-pay
Durable Medical Equipment	20%	Not Covered	20%
Hospice	20%	Not Covered without Prior Authorization	No Charge
Ambulance	20%		$50 Per Transport
Home Health Care 100 visits / year (Prior authorization required)	20%	Not Covered without Prior Authorization	$30 co-pay (100 Visits / year)
Chiropractic Services (26 Visits per calendar Year / combined with Acupuncture)	20% up to $50 per visit	50% up to $25 per visit	$30 co-pay
Prescription Drugs Active / Early Retiree Plans Only*	**Express Scripts**		**Express Scripts**
Prescription Maximum Out of Pocket	$1,600 / $3,200		$5,300 / $10,600
(At Participating Pharmacies only)	Generic / Brand / Non-formulary / Specialty		Generic / Brand / Non-formulary / Specialty
Retail - 30 day supply	$10 / $20 / $45 / 30% (max co-pay $150)		$10 / $20 / $45 / 30% (max co-pay $150)
Mail Order - 90 day supply	$20 / $40 / $90 / 30% (max co-pay $300)		$15 / $50 / $112.50 / 30% (max co-pay $150)
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	$200 / $500		$200

**See Rx benefits for Medicare on page 12 under the "EGWP" pharmacy co-pay structure.*

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Kaiser Summary

Coverages	Traditional HMO 15	Traditional HMO 20
Calendar Year Deductible	None	None
Maximum Medical Out of Pocket	$1,500 / $3,000	$1,500 / $3,000
Copay	$15	$20
Prescription Drugs (Express Scripts)		
Retail – 30 day supply Generic / Brand / Non-formulary / Specialty	$5 / $20 / $20	$10 / $25 / 20% (max co-pay $150)
Mail Order – 90 day supply	$10 / $40	$20 / $50
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	None	None
Monthly Rates (Area 1)		
Employee Only	$1,225	$1,180
Employee + 2 or more dependents	$3,136	$3,024

Medical Benefits Summary

Kaiser

DEDUCTIBLES / CO-INSURANCE / MAXIMUM	Traditional HMO 15	Traditional HMO 20
Calendar Year Deductible(s) (Individual / Family)	None	None
Maximum Medical Out of Pocket (Individual / Family)	$1,500 / $3,000	$1,500 / $3,000
Medicare Retiree Maximum Out of Pocket	No Applicable	No Applicable
Services / Coverages	**Participating Providers (You Pay)**	**Participating Providers (You Pay)**
Inpatient Hospital Room, Board & Support Services (Prior Authorization Required)	No Charge	$250 per admission
Non-Emergency Outpatient Services: Ambulatory Surgery Center Hospital Facility Outpatient Treatment	$15 / Surgery No charge $15 / Surgery	$20 / Surgery No charge $20 / Surgery
Emergency Room Visit Results in Admission as Inpatient	See inpatient hospital	See inpatient hospital
Visit Does Not Result in Admission	$50 Co-Pay	$100 Co-Pay
Preventative Care	No charge	No charge
Office visits	$15 Co-Pay	$20 Co-Pay
Rehabilitation Service (Outpatient)	$15 Co-Pay	$20 Co-Pay
Durable Medical Equipment	No charge	20%
Hospice	No Charge	No Charge
Ambulance	No Charge	$50 Co-pay
Home Health Care 100 visits / year (prior authorization required)	No Charge	No Charge
Chiropractic Services (Combined with Acupuncture)	$10 / up to 30 visits	$10 / up to 30 visits
Acupuncture (Combined with Chiropractic)	$10 / up to 30 visits	$10 / up to 30 visits
Prescription Drugs Active / Early Retiree Plans Only	**Kaiser**	**Kaiser**
(At Participating Pharmacies only)	Generic / Brand / Specialty	Generic / Brand / Specialty
Retail - 30 day supply	$5 / $20 / $20	$10 / $25 / 20% (max co-pay $150)
Mail Order - 100 day supply	$10 / $40	$20 / $50
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	None	None

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

Vision Plan Summary/Rates

Rates Guaranteed until December 31, 2025

Vision Plan – VSP

Vision Benefit	Option 3 – Plan B ($15) In –Network | Non-Network		Option 4 – Plan C ($25) In-Network | Non-Network		Option 5 – Plan C ($0) In-Network | Non-Network	
Copay	$15 for Exam and/or materials		$25 for Exam and/or materials		$0 for Exam and/or materials	
Exam	Covered after Co-Pay	Plan pays up to $50	Covered after Co-Pay	Plan pays up to $50	Covered after Co-Pay	Plan pays up to $50
Lenses						
Single Bifocal Trifocal	Covered after Co-Pay Covered after Co-Pay Covered after Co-Pay	$50 $75 $100	Covered after Co-Pay Covered after Co-Pay Covered after Co-Pay	$50 $75 $100	Covered after Co-Pay Covered after Co-Pay Covered after Co-Pay	$50 $75 $100
Frames	$130 Allowance 20% off amount over allowance	$70	$130 Allowance 20% off amount over allowance	$70	$130 Allowance 20% off amount over allowance	$70
Contact Exam and Fitting	Up to $60	$0	Up to $60	$0	Up to $60	$0
Contact Lenses – Elective Contact Lenses – Medically Necessary	$130 Allowance Covered after Co-Pay	$105 $210	$130 Allowance Covered after Co-Pay	$105 $210	$130 Allowance Covered after Co-Pay	$105 $210
Frequency of Services: Eye Examination Lenses Frames Contact Lenses[1]	12 Months 12 Months 24 Months 12 Months		12 Months 12 Months 12 Months 12 Months		12 Months 12 Months 12 Months 12 Months	

Option 3 – Plan B ($15)	
Vision Rates - Monthly	
Employee Only	$8.19
Employee + 1 Dependent	$15.75
Employee + 2 or More Dependents	$25.10

Option 4 – Plan C ($25)	
Vision Rates- Monthly	
Employee Only	$11.13
Employee + 1 Dependent	$21.84
Employee + 2 or More Dependents	$34.76

Option 5 – Plan C ($0)	
Vision Rates - Monthly	
Employee Only	$17.75
Employee + 1 Dependent	$34.86
Employee + 2 or More Dependents	$55.86

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

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.

Dental Plan Summary/Rates

Rates Guaranteed until December 31, 2024

Dental Plan PPO – Delta Dental

Program Highlights
- Largest dental network in California
- Dental PPO and Premier networks available

The PRISMHealth Dental Program was created to provide GSRMA members with comprehensive dental coverage and flexible benefits plan designs at the lowest possible rates.

Delta Dental is the nation's leading dental benefits system and offers the largest network of dentists in the U.S.A. The Delta Dental networks have more than 125,000 dentists nearly 61,000 more than the next closest national competitor.

Dental Benefits – Delta Dental	Low DPPO Plan		Med DPPO Plan		High DPPO Plan	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Maximum	$1,000	$750	$1,500	$1,250	$2,000	$1,500
Calendar Year Deductible	(Per patient per calendar year)		(Per patient per calendar year)		(Per patient per calendar year)	
Individual / Family	$50 / $150 (Waived for Preventive)		$50 / $150 (Waived for Preventive)		$50 / $150 (Waived for Preventive)	
Age Limitations	Dependents to Age 26		Dependents to Age 26		Dependents to Age 26	
Diagnostic and Preventive	100%		100%		100%	
Oral Exam						
Routine Cleaning						
X-Rays						
Fluoride Treatment						
Space Maintainers						
Specialist Consultations						
Basic Services	80%		80%		80%	
Fillings						
Endodontics (Root Canal)						
Periodontics (Gum Treatment)						
Tissue Removal (Biopsy)						
Extractions & Other Oral Surgery						
Sealants						
Major Services	50%		60%		80%	
Crown Repair						
Inlays, Onlays						
Cast Restorations						
Bridges						
Partial and Full Dentures						
Orthodontics	Not Covered		50%		50%	
Eligible for Benefit			Child & Adults		Child & Adults	
Lifetime Maximum			$500		$1,000	

Low Plan – Dental PPO

Employer Contributes 51-100% of dependent cost

Dental Rates - Monthly	
Employee Only	$30.14
Employee + 1 Dependent	$51.56
Employee + 2 or More Dependents	$83.16

Employer Contributes 0-50% of dependent cost

Dental Rates - Monthly	
Employee Only	$30.14
Employee + 1 Dependent	$54.92
Employee + 2 or More Dependents	$90.83

Medium Plan – Dental PPO

Employer Contributes 51-100% of dependent cost

Dental Rates - Monthly	
Employee Only	$40.95
Employee + 1 Dependent	$69.41
Employee + 2 or More Dependents	$108.78

Employer Contributes 0-50% of dependent cost

Dental Rates - Monthly	
Employee Only	$40.95
Employee + 1 Dependent	$73.71
Employee + 2 or More Dependents	$119.07

High Plan – Dental PPO

Employer Contributes 51-100% of dependent cost

Dental Rates - Monthly	
Employee Only	$52.50
Employee + 1 Dependent	$88.41
Employee + 2 or More Dependents	$134.40

Employer Contributes 0-50% of dependent cost

Dental Rates - Monthly	
Employee Only	$52.50
Employee + 1 Dependent	$93.56
Employee + 2 or More Dependents	$147.11

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Vision Summary – Option 4 – Plan C

Coverages	In-Network	Non-Network
Copay	$25 for Exam and/or materials	
Exam	Covered after Co-Pay	Plan pays up to $50
Copay	$15	$20
Lenses: Single, Bifocal & Trifocal	All covered after Co-Pay	$50 / $75 / $100
Frames	$130 Allowance 20% off amount over allowance	$70
Contact Exam & Fitting	Up to $60	$0
Contact Lenses: Elective Contact Lenses / Medically Necessary	$130 Allowance Covered after Copay	$150/210
Frequency of Services: Eye Exam, Lenses, Frames & Contact Lenses	12 Months	
Employee Only	$11.13	
Employee + 2 or more dependents	$34.76	

Delta Dental Summary – (May Choose1Plan)

Coverages	Low Plan	Medium Plan	High Plan
Calendar Year Maximum (Network / Non-Network)	$1,000 / $750	$1,500 / $1,250	$2,000 / $1,500
Calendar Year Deductible (Network / Non-Network) (Waived for Preventative)	$50 / $150	$50 / $150	$50 / $150
Employee Only	$30.14	$40.95	$52.50
Employee + 2 or more dependents	$83.16	$108.78	$134.40

GSRMA

Anthem/ Blue Shield Summary

Coverages	Gold PPO	Platinum PPO	Silver PPO
Calendar Year Deductible (EE / Family)	$500 / $1,000	$300 / $600	$2,000 / $4,000
Maximum Medical Out of Pocket (EE / Family)	$2,000 / $4,000	$1,300 / $3,600	$5,000 / $10,000
Copay / Co-Insurance	$20 / 20%	$10 / 20%	$30 / 20%
Prescription Drugs (Express Scripts)			
Maximum Out of Pocket / Yr	$4,600 / $9,200	$5,300 / $9,600	$1,600 / $3,200
Retail – 30 day supply Generic / Brand / Non-formulary / Specialty	$5 / $30 / 45 / 30% (max co-pay $150)	$5 / $30 / 45 / 30% (max co-pay $150)	$10 / $20 / $45 / 30% (max co-pay $150)
Mail Order – 90 day supply	$10 / $75 / $112.50 / 30% (max co-pay $300)	$10 / $75 / $112.50 / 30% (max co-pay $300)	$20 / $40 / $90 / 30% (max co-pay $300)
Brand / Non-Formulary / Specialty Deductible (Individual / Family)	None	None	$200 / $500
Monthly Rates (Area 1)			
Employee Only	$1,289	$1,408	$923
Employee + 2 or more dependents	$3,348	$3,660	$2,402