

SBCERS

SANTA BARBARA COUNTY EMPLOYEES' RETIREMENT SYSTEM

County Retiree Guide to
**OPEN ENROLLMENT &
HEALTH PLANS**
for 2026

The information in this booklet is a general outline of the benefits offered by the County of Santa Barbara Plan Sponsors.



Specific details, provisions and plan limitations are provided in the official Plan Documents (Benefit Summaries or Evidence of Coverage). In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Plan documents (Benefit Summaries) can be found online at www.sbcers.org.

In this Health Plan Guide, any reference to “Retiree” in most cases refers also to other recipients of monthly SBCERS benefits. References to “spouse” are also applicable to Registered Domestic Partners.

Participating Employers:

- County of Santa Barbara
- Air Pollution Control District
- Santa Maria Cemetery District
- Carpinteria Cemetery District
- Goleta Cemetery District
- Summerland Sanitary District
- Carpinteria-Summerland Fire Protection District
- Local Agency Formation Commission District
- Superior Court of California*

****A separate Open Enrollment booklet is available for Court members due to different plan coverage.***

TABLE OF CONTENTS

News, Highlights, and Instructions.....4

Medicare & Important Notices 5

A Note for Firefighters.....5

Deadlines and Meeting Dates..... 6

CareCounsel.....7

Medical and Prescription Plan Choices.....8

Blue Shield Plans 9

Blue Shield EPO, PPO, and Tandem Prescription Benefits: Navitus 10

Blue Shield Benefit Programs 13

United Healthcare Medicare Advantage PPO Plans - *New in 2026*..... 18

Kaiser Permanente Plans 18

Alliant Medicare Solutions 19

Medical Plan Comparison Charts..... 20

Creditable Coverage Notice 25

Dental Plan Choices 27

Vision Plan 29

Retiree Monthly Premium Rates..... 30

How to Calculate Your Share of the Premium..... 32

Supplemental Information33

Mid-Year Benefit Change Rules..... 33

Dependent Eligibility Rules..... 34

Healthcare Subsidy 34

Health Reimbursement: If You Do Not Have County Health Insurance 35

COBRA Facts For Retirees 35

Important Facts..... 37

Legal Disclosures 40

Contacts & Resources 41

Benefit Pay Days 42

NEWS, HIGHLIGHTS, AND INSTRUCTIONS

Blue Shield and Kaiser plans will continue with the same benefits. United Healthcare HMO options are changing to PPO. Blue Shield Pharmacy benefits will transition from Express Scripts to Navitus.

- **Blue Shield Medical Plans** will increase 14%.
- **Kaiser Traditional** premiums will increase 14%. **Kaiser Senior Advantage** premiums will increase 9%.
- **United Healthcare** HMO options are transitioning to PPO, resulting in a 30% premium increase. Despite the increase, UHC remains the lowest-cost premium option compared to Blue Shield plans.
- **Alliant Medicare Solutions**, a white glove, concierge Medicare assistance service continues to be offered with agents licensed in all 50 states. There is no charge for Medicare Solutions services.
- **Digbi Health** launches January 1, 2026—a highly personalized program for obesity, diabetes, cardiometabolic, and digestive health. At-home testing pinpoints root causes and guides your nutritional plan. Digbi is also the starting point for weight-management medications, handling prior authorization, being the sole Prescriber, and lifestyle support.
- **Pharmacy benefits will transition from Express Scripts to Navitus.** Retirees will be receiving Navitus Welcome Packets in the mail from Navitus, including an ID card to be used when ordering prescriptions. All prescriptions previously filled through Express Scripts will need to be re-authorized with Navitus.

How to Make Changes to Your Coverage

- Review plan benefits, providers and rates.
- Obtain and complete forms.
- Sign and submit forms by Friday, October 31, 2025.

No Changes to Your Coverage?

SBCERS will automatically continue your current coverage into 2026 at the new rates. You do not have to complete or submit any forms, or contact SBCERS.

Don't Have County Health Insurance?

Instead, you have money in your SBCERS Health Reimbursement Arrangement (HRA) account. You do not have to contact SBCERS to set anything up! Just contact WageWorks to seek reimbursement for eligible health expenses you pay out of your own pocket. Learn how to collect this money in "[Health Care Subsidy](#)" and "[Health Reimbursement](#)".

SBCERS will automatically continue your current HRA account into 2026.

You may opt back in to County Health Insurance by completing and remitting forms.



Medicare & Important Notices

Turning 65 in 2026? Contact SBCERS three months before your 65th birthday to review options.

If you (and/or your dependents) have or will have Medicare in the next 12 months, Federal law provides choices for prescription drug coverage. See "[Prescription Drug Coverage and Medicare](#)".



A Note for Firefighters

Open Enrollment materials for the Firefighters Union insurance will be sent to retired Santa Barbara County firefighters prior to Open Enrollment, which occurs October 1 - 31, 2025. Otherwise, to get 2026 plan information, rates, forms, Open Enrollment deadlines or to make plan changes, firefighters should contact Benefit Service Center at (800) 842-6635 or www.mybenefitchoices.com/local2046.

This year, Local 2046 is offering a Retiree Firefighters Open Enrollment session. More information will be coming from Local 2046. Representatives from the insurance broker, Benefit Service Center, and UHC will be there to answer questions.

It is important that you also notify SBCERS by October 31, 2025 of any Union plan changes you make for the 2026 plan year as well as each time insurance-related changes occur during the plan year to ensure that the correct premiums are deducted from your benefit payments.

You should also be aware that retired County firefighters may participate in Santa Barbara County-sponsored insurance. Open Enrollment is your opportunity to enroll in the County-sponsored insurance. See "[Don't Have County Health Insurance?](#)" if you are considering this option.

Deadlines and Meeting Dates

Forms due Friday, October 31 by 5 pm:

- Mail to an SBCERS office.
- Fax to 805-695-2755.
- Drop in SBCERS Drop Box (available at both office locations).
- **RECOMMENDED & MOST SECURE: Upload to your account directly through mySBCERS.**

How to Submit Forms Online

Step 1 - Login to your account at mysbcers.org. If you do not have an account yet, please call 1-877-568-2940 and a staff member will assist in registering you.

Step 2 - Under the left navigation menu, click "Message Center".

Step 3 - Click "Send a New Message". Type in the subject line (i.e., "Insurance Change") and click the "Add Attachment(s)" button to upload your completed form(s). Click send button when complete.

In-Person Health Fairs

Wednesday, September 24, 2025 | 3 to 5 PM
Hearing Room, Betteravia Government Center
511 E Lakeside Pkwy, Santa Maria, CA 93454

Friday, September 26, 2025 | 9 to 11 AM
SBCERS Board Room
130 Robin Hill Road, Goleta, CA 93117

Representatives from health plan providers and SBCERS will be on-site to answer any questions.

RSVP for an in-person health fair at www.sbcers.org/openenrollment or by scanning the QR code to the right.



United Healthcare Webinar: New PPO Offerings

Thursday, October 2, 2025 | 10 AM to 11:30 AM

Join UHC for a brief webinar explaining the 2026 transition from HMO to PPO plans, including what it means for your coverage and provider access. A recording will be available online after the event. Access the webinar online at www.sbcers.org/uhc.

Navitus Webinar: Blue Shield Pharmacy Benefit Change

Tuesday, October 7, 2025 | 10 AM to 11 AM

Monday, October 27, 2025 | 10:30 AM to 11:30 AM

In 2026, Blue Shield members have access to prescription drug coverage through Navitus (previously Express Scripts). Join Navitus for a brief webinar explaining the 2026 transition from Express Scripts. Access either webinar online at www.sbcers.org/navitus.

Virtual Health Fair

Monday, October 20 - Sunday, October 26

Can't make it in-person? The Virtual Health Fair is available beginning Monday, October 20. Access the Virtual Health Fair online at www.sbcers.org/openenrollment.

CARECOUNSEL

CareCounsel's goal is for your healthcare experience to be as stress-free as possible. They'll listen to your concerns, ask questions, guide you to the right resources and intervene on your behalf when needed. Their only agenda is you and your family; they'll always look out for your best interests.

CareCounsel, a wholly owned subsidiary of Stanford Health Care, is an independent organization. The CareCounsel advocacy program is not part of your health insurance; it is a special benefit sponsored by your former employer to help you understand and navigate the complexities of your health benefits.

Some of the areas for which CareCounsel provides in-depth support:

- Choosing the best health plan for you and your family during Open Enrollment.
- Helping you find doctors, seeking second opinions and accessing care.
- Obtaining necessary authorizations.
- Troubleshooting claims/bills.
- Navigating Medicare (when you turn 65 and onward).
- Grievances and appeals.
- Becoming a proactive health consumer and maximizing healthcare dollars.
- Accessing the Stanford Health Library and educational webinars.

Member Care Specialists do not provide medical advice or treatment. As a subsidiary of Stanford Health Care, they are committed to providing exceptional service and can draw on world-class medical expertise, cutting-edge research and technology and extensive resources to help you.

NOTE – *Enrollment in the CareCounsel program is mandatory and automatic for any retiree enrolled in a County medical plan.*

Contacting CareCounsel

Monday - Friday
6:30 a.m. - 5:00 p.m. PST

P: (888) 227-3334

E: staff@carecounsel.com

W: www.carecounsel.com

** Identify yourself as a Santa Barbara County Retiree.*

MEDICAL AND PRESCRIPTION PLAN CHOICES

The County of Santa Barbara offers a choice of medical plans, all of which include prescription drug coverage. The medical plan comparison charts found in this guide show a brief summary of the benefits available. The Benefit Summaries (Official Plan Documents) provide the exact terms and conditions of coverage.

Blue Shield Plans

All Blue Shield medical plans use the same (PPO) Provider Network. A provider finder, ID card and benefit information are accessible online or from your smartphone. Visit www.blueshieldca.com/csac where you can also download the mobile app.

Blue Shield EPO

An Exclusive Provider Organization (EPO) insurance plan that allows access to health care only from a Blue Shield PPO network physician, facility or other healthcare professional, including specialists, without designating a Primary Physician or obtaining a referral. Under the EPO plan, you must use contracted Blue Shield PPO providers or your care will NOT be covered; there are no benefits for out-of-network services, except in the event of an emergency. Two types of EPO plans are offered:

Low Option – The Low Option plan has an annual deductible which must be met before Blue Shield begins to pay claims. A co-payment (“co-pay”) is a standard fee you have to give the physician or facility at the time of service. Co-pays are made by participants for services, some of which are not subject to the deductible. Participants may also be responsible for co-insurance in the form of a percentage of charges for some services.

High Option – The High Option plan has richer benefits than the Low Option, although the premium is higher. There is no annual deductible to meet before Blue Shield pays claims. Copays are made by participants for services. Participants are often also responsible for coinsurance in the form of a percentage of charges for some services.

Blue Shield PPO

A Preferred Provider Organization (PPO) insurance plan that offers flexibility by allowing you to see any provider when you need care and to choose between receiving services from in-network or out-of-network providers. You have an annual deductible you must meet before Blue Shield begins to pay claims and you are also responsible for a certain portion of the charges, i.e., co-insurance, co-pays, etc. When you use contracted Blue Shield in-network PPO providers, you pay less for services and will not have to file claim forms. When using out-of-network providers you may need to file claims, and you may pay more out-of-pocket.

Blue Shield Tandem (Narrow) Network EPO

Blue Shield’s Tandem EPO Network extends throughout California. It offers you access to a quality network of providers that includes all specialties and levels of care. Like other PPO plans, Tandem PPO offers you the flexibility to choose any in network doctor or specialist. However, you will save money when you see a doctor in the Tandem network.

Your Primary Care Physician – After enrolling in a Tandem PPO plan, you will be matched with a primary care physician (PCP) in the Tandem PPO Network. Having a PCP means you have a doctor you can turn to for healthcare advice. You don’t need to visit your PCP first to receive care. And you can see any doctor or specialist that you want without a referral. If you prefer a different PCP, you can easily change it online.

Find a network doctor – Check if your preferred doctors are in the Tandem PPO Network at www.blueshieldca.com/networkTandemPPO. You’ll find the latest listing of PCPs, specialists, mental health providers, hospitals, dentists, vision care providers, and pharmacies. Tandem includes about 58% of doctors and 93% of hospitals from our broader PPO network.

Blue Shield EPO, PPO, and Tandem Prescription Benefits: Navitus

Regular Prescription Benefit – Under the Low EPO, High EPO and PPO plans, prescription benefits are provided by Navitus through either retail (at a Pharmacy) or mail order service in accordance with the Advanced Utilization Management program. **Remember, you must use your Navitus prescription benefit ID card to obtain prescriptions for all covered family members; the Blue Shield ID card will not be valid for prescriptions.** These plans have Out-of-Pocket Maximums; once the maximums have been met, the plan will pay 100% of medication costs.

Medicare Prescription Benefit – Under the Blue Shield Low EPO, High EPO and PPO plans, prescription benefits are provided by Navitus either through retail (at a pharmacy) or mail order service. Medicare A and B enrolled retirees may choose the Navitus Medicare Prescription Drug Plan (PDP) or the regular prescription plan to complement their Low EPO, High EPO and PPO plans. ID cards are issued to each enrolled individual. HDHP participants are ineligible for the Medicare PDP. See below for more information.

Navitus – New in 2026

In 2026, Blue Shield members have access to prescription drug coverage through Navitus (previously through Express Scripts).

Understanding Your Pharmacy Benefits - Members who take stabilized doses of covered long-term maintenance medications – like those used to treat an ongoing condition such as high blood pressure or high cholesterol – can save money by ordering them through Navitus’ mail service partner, Costco Pharmacy, instead of using a retail pharmacy. With the Costco Home Delivery Pharmacy, a 90-day supply of maintenance medications can be mailed right to your door. You don’t need to be a Costco member to use their pharmacies. Just register online at pharmacy.costco.com or call (800) 607-6861 to get started.



Lumicera Health Services, is Navitus’ specialty pharmacy partner. Lumicera provides a high level of personalized care for members with complex conditions. Their clinical team will help you manage side effects and reduce complications, so you can focus on the things that matter most. Visit www.lumicera.com/patients/ or call (855) 847-3553 for more information.

Navitus Formulary - You can find a list of formulary and preventive medications on or the website: <https://navitus.com/>.

Navitus Customer Care - Available 24 hours a day, 7 days a week; Closed Thanksgiving & Christmas

Carrier ID: NVPSM

Phone: (855) 847-1035

Website: <https://navitus.com/>

Prescription Advanced Utilization Management Program¹

If you participate in a Blue Shield plan and your doctor prescribes brand name or specialty drugs for you, you may be required to obtain prior authorizations, try other drugs first, or have quantities limited to 30-day supplies when your pharmacy or mail order service is filling your future prescriptions. This Utilization Program applies to Navitus pharmacy benefits for Blue Shield EPO Low Option, EPO High Option and PPO plans.

Prior Authorization – Some prescribed drugs must be authorized before they can be covered.

Step Therapy – The first step of this two-step process is the use of a first-line or generic drug before a second-line drug is approved. Usually, these drugs are preferred over secondline drugs. Second-line drugs can be prescribed as the second step if the first-line drug is not effective.

¹ Does not apply to the Blue Shield HDHP Prescription Benefit or the Medicare PDP benefit available to Medicare A & B enrolled retirees.

Quantity Management – Some drugs have quantity limits, meaning you can get only a certain amount at one time. If the pharmacy sees that a prescription was written for a larger amount than the plan covers, they can fill the amount that the plan covers or the doctor can contact the plan for approval of the prescribed amount.

Clinical Plan Expansions will mean an addition of medications to step therapy plans. Please see Navitus documentation for included medications.

Pharmacy Tips

- Before you run out of a medication, you should work with your doctor, pharmacy, Navitus and/or CareCounsel to determine whether the medication is affected by these changes.
- Open mail from Navitus as soon as possible; it may be notification of a potential change to drugs you are taking. Drug formularies (list of drugs covered) change throughout the year.

Medicare Prescription Benefit: Navitus Medicare PDP (Blue Shield EPO & PPO Plans)

Medicare Part D prescription program is one of two prescription plans available to County retirees enrolled in Medicare A and B and the County's Blue Shield EPO Low Option, EPO High Option and PPO medical insurance. To be eligible¹ for this plan you and/or your eligible dependents must meet the following criteria:

- Enrolled in Medicare Part A and Part B.
- A retiree (or dependent) of the plan sponsor.
- A permanent resident of the United States.
- A participant in the County's Blue Shield EPO Low Option, EPO High or PPO plans.
- Not enrolled in any other Rx plan.

How It Works

Because Navitus Medicare PDP for EIA is an enhanced Medicare D plan, it provides coverage across all of Medicare's stages² of your benefit—even the coverage gap ("doughnut hole"). You pay co-pays for your covered drugs until your annual out-of-pocket costs reach \$2,000. Once your costs reach \$2,000, your cost share will decrease. Prescriptions may be filled at either in-network or out-of-network retail pharmacies or through Navitus Mail Order service. Your co-pays will be the amounts shown on the table throughout all stages, however, they might be less during the Catastrophic Coverage stage. Your medical plan coverage through Blue Shield of California will be the same regardless of which PDP plan you select. You should check with Navitus Medicare to be sure your medications are covered before making your choice.

Once enrolled and prior to your effective date³, you will receive a member Medicare PDP ID card with a Welcome Kit from Navitus. You should use this card when filling prescriptions but continue using your Blue Shield ID card for any other services. The kit may also include other important materials, such as a formulary and a pharmacy directory. Because Medicare is an individual benefit, you and your covered Medicare-enrolled dependent(s) will receive separate communications from Navitus Medicare and each have your own PDP ID card with a unique member ID number.

¹ If one Medicare A & B enrolled individual elects to participate in the Medicare PDP, all Medicare A & B enrolled individuals must also participate in the Medicare PDP.

² Medicare's stages of benefits are: Initial Coverage Stage, Coverage Gap Stage and Catastrophic Coverage Stage.

³ The effective date will be the first of the month after 45 days from your enrollment date, per CMS Rules. When first reporting Medicare A & B you may be able to elect to also enroll in Medicare PDP, however, all applicable rate changes will take effect on the same effective date, no earlier than the first of the month after 45 days from your enrollment date.

Cost Share Co-Pays for EPO Low, EPO High & PPO Option Plans

	Retail - 31 Day	Retail - 60 Day	Retail - 90 Day	Mail Order - 90 Day
Generic Drug	\$5	\$10	\$15	\$10
Preferred Brand Drug	\$20	\$40	\$60	\$40
Non-Preferred Brand Drug	\$50	\$100	\$150	\$100

Late Enrollment Penalty (LEP)

You may owe an LEP if you didn't join a Medicare prescription drug plan when you were first eligible for Medicare Part A and/or Part B, and you didn't have other prescription drug coverage that met Medicare's minimum standards, or you had a break in coverage of at least 63 days. If it is determined that you owe an LEP or have an existing penalty that needs to be adjusted, you will be notified. The EIA has chosen to cover the LEP on behalf of retirees of County sponsored plans.

Medicare Low Income Subsidies

People with limited incomes may qualify for "Extra Help" to pay for their Medicare prescription drug costs. Medicare could pay up to seventy-five (75) percent or more of your drug costs, including monthly prescription drug premiums, annual deductibles and co-pays.

You may be eligible if you:

- Are eligible for Medicare Part A and Part B.
- Beneficiaries may be deemed automatically eligible (Dual Eligibles who qualify for both Medicare & Medicaid), or they may apply through Social Security.
- Meet asset/income thresholds as defined by CMS.

Please contact Medicare at 800-633-4227 or www.medicare.gov for current eligibility rules. If you are identified by the Centers for Medicare & Medicaid Services (CMS) as qualifying for Extra Help, you will receive plan cost information in your Navitus Welcome kit.

Medicare Part D Income Related Adjustment Amount (D-IRMAA)

You may be required to pay a Part D income-related monthly adjustment amount (Part D-IRMAA) in addition to your monthly Part D plan premium if your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain limit. This extra amount is not paid to your plan or deducted by SBCERS, it is either deducted from your Social Security check automatically or you are billed and pay this directly to Medicare. If Social Security notifies you about paying a higher amount for your Part D coverage, you're required by law to pay the Part D-IRMAA or you'll lose your Part D coverage.

Blue Shield HDHP

A High Deductible Health Plan (a Preferred Provider Organization plan) that allows services from any provider. This plan has a high annual deductible. You do not have co-pays under this plan; you pay a coinsurance amount for all services as well as prescriptions once the deductible is met. Coverage for in-network providers has a higher benefit level and lower co-insurance. Participants in this plan who do not have Medicare may be eligible to establish a Health Savings Account.

The Amino Member Tool assists members on the HDHP in finding lower cost, high quality providers. The tool assists in booking medical appointments. This tool is available online at www.amino.com/register or in the App store.

Blue Shield HDHP Prescription Benefits

Regular Prescription Benefit – Under the HDHP plan, prescription benefits are provided by Blue Shield. Prescription and Medical have a combined Out-of-Pocket Maximum. You must use your Blue Shield ID card to obtain prescriptions at the Pharmacy or by mail. Participants in the HDHP plan do not have an option for the Medicare PDP benefit.

Creditable Prescription Drug Coverage – See [“Prescription Drug Coverage and Medicare”](#) for important information about whether the prescription drug benefits through Navitus and Blue Shield are considered by Medicare to be creditable coverage.

Blue Shield Benefit Programs

In addition to core medical benefits, members enrolled in a Blue Shield PPO, EPO, or HDHP plan have access to several value-added programs designed to support health and well-being. The following pages explain each program in detail.

Program	Description	Eligibility
Digbi Health	Digital platform for managing chronic conditions like obesity, diabetes, and digestive issues	Blue Shield PPO, EPO, and HDHP
Rx'nGo	Pharmacy Discount Benefit plan	Blue Shield PPO, EPO, and HDHP
Carrum Health	Surgery benefit with Oncology guidance	Blue Shield PPO, EPO, and HDHP
Hinge Health	Digital musculoskeletal PT program	Blue Shield PPO, EPO, and HDHP
Accolade PPO Navigator	Employee PPO Navigator	Blue Shield PPO, EPO, and HDHP

Digbi Health – New in 2026

Digbi Health is a chronic-illness management program designed to meet you where you are and personalize care to your biology. Digbi supports members managing obesity, diabetes, cardiometabolic conditions, and digestive health.

Using at-home testing, Digbi identifies the root causes affecting your health and turns those insights into a personalized nutrition plan—making it easier to choose foods and habits that work for your body. Your plan adapts over time with guidance from the Digbi team.

Beginning in 2026, Digbi will also serve as the starting point for all weight-management medications under PRISM. The program will administer prior authorization, act as the sole prescriber for weight-management medications within this benefit, and provide the lifestyle support needed to help you get the most from treatment.

If you're ready for a clearer path and coordinated support, explore what Digbi can do for you at [DigbiHealth.com](https://www.digbihealth.com).



Rx 'n Go: Mail Order Pharmacy Benefit

The County of Santa Barbara offers a voluntary mail order pharmacy benefit program called Rx 'n Go. You have the option to receive up to a 90-day supply of generic prescription maintenance medications by mail at no cost to you through Rx 'n Go. Only generic medications on the Rx 'n Go covered drug list will be provided to you at no cost. *This program is available to all early retirees and their dependents that are enrolled on a Blue Shield medical plan. Retirees that are 65 and over or any retiree on a Kaiser or United Healthcare plan are not eligible for this voluntary program.*



Over 1,200 generic medications to treat ongoing medical conditions are available for free to you via Rx 'n Go! View available medications at www.rxngo.com.

It's your choice! The voluntary Rx 'n Go pharmacy program is in addition to your current pharmacy benefit through Navitus or Blue Shield. Now you have a choice for generic mail order medications. You must still use Navitus or Blue Shield for medications that are not on the Rx 'n Go drug list.

What about diabetic supplies? You have the option of receiving up to a 90-day supply of Prodigy® diabetic test strips and lancets by mail at no cost to you. The initial diabetic test strip order includes a new Prodigy® diabetic monitor!

What about current mail order prescriptions? If you are receiving a maintenance medication that is on the Rx 'n Go drug list through another pharmacy, Rx 'n Go will help you obtain a new prescription from your doctor. Prescriptions cannot be transferred. Rx 'n Go will call your physician to obtain a new prescription for you. Call our Customer Service and they will do the work for you.

NOTE – Members on the HDHP plan are only eligible for preventive generic medications at no cost due to IRS guidelines.

How to Get Started

Complete a Pharmacy Profile Form online at www.rxngo.com or call Customer Service at 1-888-697-9646 to set up an account. You then have two easy options for submitting new prescription(s):

Instructions for your physician:

Have your physician/licensed health care practitioner E-Scribe, phone, or fax your prescription(s) directly to Rx 'n Go:

- E-Scribe: use the name of Rx 'n Go's fulfillment pharmacy "Specialty Medical Drugstore."
- Phone: (888) 697-9646. Must come from your physician's office.
- Fax: (888) 697-0646. Must come from your physician's office.

Instructions for you:

1. Complete the Pharmacy Profile Form.
2. Include the original prescription(s) from your physician/licensed health care practitioner.
3. Mail the completed form and original prescription(s) to Rx 'n Go at the following address:

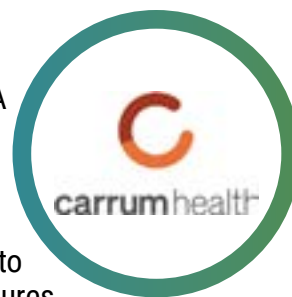
Rx 'n Go c/o Specialty Medical Drugstore
525 Alexandria Pike, Suite 100
Southgate, KY 41071

Watch a short video to learn more about the program at www.vimeo.com/109917892.

Need help? Have questions? Call Rx 'n Go at (888) 697-9646.

Carrum Health

The County of Santa Barbara offers a Medical Travel Benefit to early retirees¹. A special Centers of Excellence program through Carrum Health is available to eligible Blue Shield medical plan early retirees and their dependents who are facing orthopedic, spinal, cardiac, or bariatric surgery.



Carrum Health, your voluntary surgery benefit, has also added outpatient surgeries to your benefit plan and two additional medical centers. The 80 new outpatient procedures will be available at Hoag Orthopedic Institute in Orange County.

- **Top-quality hospitals and doctors in Southern California** – Learning that you need surgery is difficult enough - finding the right hospital and doctor for your individual needs is even more challenging. Not all medical providers deliver the same quality of care. Carrum Health has done the research to find the top Southern California hospitals and identified regional Centers of Excellence demonstrate the best outcomes, fewest complications and highest level of personalized care - meaning patients experience smoother recoveries and get back to normal functionality sooner.
- **Costs, if any, are known beforehand** – If you choose Carrum Health for your orthopedic, spinal, or cardiac surgery, you'll know exactly what it will cost beforehand, if anything at all. In most cases², the County's health insurance plan will cover 100% of the charges and your out-of-pocket costs will zero, saving you thousands of dollars. No medical bills, no travel expenses, no confusion, and no surprises.
- **Personal Care Concierge throughout the entire episode of care** – Navigating the complexities of healthcare can be challenging when planning for surgery. Figuring out who to visit, how to prepare, and what to expect when transitioning from one care provider to the next isn't something you do very often. Carrum assigns a personal Care Concierge to guide you through the entire episode of care. From selecting the right hospital and doctor, to gathering medical records, to assisting with travel (if needed) for you and a companion - your Care Concierge will be there to help every step of the way.

What It Means To You...

- Highest quality surgeons.
- No medical bills! Coinsurance and deductible waived.
- Travel expenses covered 100% for two.
- Your own personal Concierge that will:
 - Help with forms
 - Gather medical records
 - Schedule surgery
 - Make travel arrangements
 - Coordinate post-discharge care

For additional information on this medical travel benefit, text "COSB" to 555888, visit my.carrumhealth.com/cosb or call (888) 855-7806.

¹ Early retirees are those not enrolled in Medicare A & B.

² Due to IRS regulations, Blue Shield HDHP enrollees are subject to their deductible but co-insurance is waived.

Hinge Health

Hinge Health offers free, innovative digital programs to help you reduce back, muscle & joint pain, recover from injuries, prepare for surgery, or stay healthy and pain free. Their programs are available to members and their eligible dependents on a Blue Shield medical plan at no cost.

Hinge Health goes above and beyond traditional physical therapy to help you take control of back and joint pain. Your custom Hinge Health plan may include:

- **App-guided exercise therapy:** 15-minute sessions to reduce pain and increase strength and mobility.
- **No cost wearable sensors:** Wearable sensors give you live feedback on your form in the Hinge Health app.
- **Personal care team:** Connect with your personal health coach or physical therapist at any time.

Your Hinge Health care plan can be done from anywhere, and whenever works best for your schedule in their convenient app. That means never rushing to an appointment or worrying about copays!

To learn more about Hinge Health, visit www.hingehealth.com/sbcountyforyou.



Accolade PPO Navigator

County of Santa Barbara benefit eligible members on a County Blue Shield plan has access to Accolade. Your Accolade care team is here to provide an exceptional healthcare experience through their web portal and mobile app.

Health and Benefits Support

Accolade Health Assistance and nurses are your first place to turn whenever you have a healthcare need or benefits question. Available by phone or secure messaging through the web portal and mobile app. Through Accolade you can:

- Get Benefits Guidance – health assistants can help you learn more about the benefits available to you and your family.
- Virtual Care – Accolade Care gives you 24/7 access to primary care and mental health support. Accolade care doctors can also prescribe medications.
- Finding In-Person Care – Accolade Health assistants can help find and schedule appointments with high quality, in network doctors, specialists or healthcare facilities. They can also help you understand your options for care (e.g. PCP, urgent care, emergency room).
- Understand Coverage and Costs – Accolade can help you understand your health plan coverage and costs, and make sense of confusing medical bills.
- Nurse Support – get connected to a nurse who can help you understand symptoms, learn about a conditions or explore treatment options. You can also connect with clinical programs that are specific to your health conditions and offer enhanced support.
- Expert Medical Opinion – 2nd MD is Accolade’s expert medical opinion service. They can arrange for a second opinion from a world renowned doctor about a diagnosis, treatment option, surgery or medication that you may be feeling unsure about at no cost to you.
- And so much more!

For additional information, contact Accolade by calling 1 (866) 417-0167 or visit their website at <http://member.accolade.com>.



Medicare Coordination of Benefit

When your group plan provides benefits after Medicare, the combined benefits from Medicare and your group plan will equal, but not exceed, what they would have paid if you were not eligible to receive benefits from Medicare (based on the lower of the Claims Administrator’s Allowable Amount or the Medicare allowed amount). Your group plan deductible and co-payments will be waived.

When Covered by Medicare & Blue Shield

Before receiving services from new providers, always ask:

1. Are you a “Medicare Assigned” doctor?
2. Are you a Blue Shield contracted PPO Provider?

If the provider answers yes to both questions, you can feel secure about receiving the best benefits from your coordinated plans.

When Charge for Retiree is Covered by Medicare, Doctor Accepts Medicare’s Fee Schedule & Blue Shield is Secondary

When Blue Shield receives a Medicare claim from Medicare where Medicare has paid a portion, Blue Shield processes the claim as the secondary payer and pays allowable amounts up to 100% of charges.

Example (under Blue Shield’s PPO plan):

Office visit charge	\$80.00
Medicare fee schedule allows.....	\$60.00
Medicare pays 80% of the \$60.00 charge.....	\$48.00
Balance of bill	\$12.00
Blue Shield pays.....	\$12.00
Patient Responsibility	\$0.00

When Charge Not Covered by Medicare, Blue Shield Acts as Primary

When Blue Shield receives a Medicare claim from Medicare with a denial of charges because it is a non-covered service, Blue Shield processes the claim as if they were the primary payer.

Example (under Blue Shield’s PPO plan):

Chiropractic doctor’s regular Office visit charge	\$80.00
Medicare fee schedule allows.....	\$0.00
Medicare pays 0% of the \$80.00 charge.....	\$0.00
Balance of bill	\$80.00
Blue Shield pays 80% of the charge.....	\$64.00
Balance of bill	\$16.00
Patient Responsibility	\$16.00

United Healthcare Medicare Advantage PPO Plans - New in 2026

The United Healthcare Medicare Advantage Plan (MAP) is transitioning from a Health Maintenance Organization (HMO) to a Preferred Provider Organization (PPO) plan in 2026. This new PPO plan will continue to offer comprehensive benefits for retirees enrolled in Medicare Parts A and B, including Part D prescription drug coverage, but will no longer require members to select a Primary Care Physician (PCP) or obtain referrals for specialist care. Members will have greater flexibility to see both in-network and out-of-network providers, though using in-network providers will result in lower out-of-pocket costs. Emergency services remain covered nationwide.

- Low Option – Lower premium, higher co-pays.
- High Option – Higher premium, lower co-pays

Effective January 1, 2026, retirees currently enrolled in the UHC Medicare Advantage HMO Low or HMO High plans will be automatically transitioned to the corresponding PPO Low or PPO High plan. No action is required to maintain coverage, and members will receive updated plan materials before the change takes effect. However, if you wish to change your plan option, you must submit a completed change form by October 31, 2025.

Kaiser Permanente Plans

Are you turning 65 this year and enrolled in a Kaiser Traditional HMO Plan? Are you for any reason NOT enrolling in Medicare A & B? If you are 65 or older and do not enroll in Medicare A & B, higher rates for the Kaiser HMO plan will apply.

Kaiser Permanente HMO

The Kaiser Permanente Health Maintenance Organization (HMO) traditional plan is for individuals who do not have Medicare and who reside in a Southern California Kaiser service area. You must choose a Primary Care Physician (PCP) and exclusively use Kaiser facilities and providers for all healthcare services except in emergencies. These plans may require co-pays for services.

- Low Option – Lower premium, higher co-pays.
- High Option – Higher premium, lower co-pays.

Kaiser Permanente Senior Advantage

The Kaiser Permanente Senior Advantage plan is an HMO that offers more benefits than original Medicare, including Part D prescription drug coverage and built-in wellness programs that promote your total health. You are only eligible for these plans if you are enrolled in Medicare Part A and Part B and reside in a Kaiser service area in Southern California. You must choose a Primary Care Physician (PCP) and exclusively use Kaiser facilities and providers for all healthcare services except in emergencies. These plans may require co-pays for services.

- Low Option – Lower premium, higher co-pays.
- High Option – Higher premium, lower co-pays.

Medicare Advantage Plans (Medicare Part C)

See "[Important Facts](#)" for explanation when considering these plans.

Alliant Medicare Solutions

Medicare Enrollment Help for You, Family, and Friends Nearing Age 65



Free Resource for Navigating the Medicare Maze

Most people become eligible for Medicare at age 65. Medicare is the government run health insurance for people age 65 and older, younger people with disabilities, and people with End Stage Renal Disease.

Medicare can look like a complicated maze of choices, between Medicare Parts A–D, Medicare Advantage plans, and Medicare Supplement (Medigap) policies. That’s why we are introducing a resource to help you understand the different parts of Medicare, what is and isn’t covered, how Medicare works with employer coverage, and how to choose the best coverage for your situation.

Introducing Alliant Medicare Solutions

Alliant Medicare Solutions is a free resource for you, or any family members and friends who are nearing age 65. Alliant Medicare Solutions’ Licensed Insurance Agents can help you navigate the Medicare maze to find a plan that is right for you. Agents are contracted and certified in all 50 states to provide Medicare advice and an “A-rated” or better insurance carrier at competitive rates.

Why Is This Important?

There is a seven-month window to enroll in Medicare for the first time. This Initial Enrollment Period starts three months before you turn age 65 and ends three months after your birthday month.

This enrollment period is your first opportunity to sign up for Medicare Part A and/or Part B. This is also your first chance to enroll in a Medicare Advantage plan (Part C) or Part D Prescription Drug plan. If you don’t enroll in Medicare during your initial enrollment period or do not provide proof of insurance under another eligible plan, you may pay more for Medicare later on when you do enroll.

How Does It Work?

1. Call Alliant Medicare Solutions at (888) 312-1387 to speak to a Licensed Insurance Agent (Alliant Medicare Solutions is managed by Insuractive).
2. Discuss with Alliant Medicare Solutions:
 - Your current insurance coverage
 - Types of coverage including Original Medicare, Medigap, Medicare Advantage, and prescription drug plans
 - Which plans might work the best for you
3. Alliant Medicare Solutions helps you enroll immediately or emails the policy materials for you to review and enroll at a later date.

Where Can I Find Out More?

- Watch “Medicare 101” for an introduction to Medicare and some important considerations in choosing the right plan.
- Download “Your Guide to Medicare” for more information about Medicare and services from Alliant Medicare Solutions.

For comprehensive information about Medicare, visit www.medicare.gov.

Decisions related to healthcare and an individual's enrollment in Medicare should be based on the specific circumstances of the individual and made in consultation with his or her own advisors. Alliant Medicare Solutions shall not have any liability for direct, indirect, incidental, special, exemplary, or consequential damages, under any theory of liability, whether in contract or tort, arising out of the use of Alliant Medicare Solutions. Alliant Medicare Solutions is not connected with or endorsed by the United States government or the federal Medicare program.

Medical Plan Comparison Charts

Blue Shield Plan Benefits

Blue Shield EPO <i>You must use Blue Shield's EPO provider OR your care will not be covered (except in an emergency).</i>				
	Low Option		High Option	
Annual Deductible	\$300 Ind / \$600 Family		None	
Annual Out-of-Pocket Maximum	\$2,000 Ind / \$4,000 Family		\$1,500 Ind / \$3,000 Family	
Lifetime Maximum	Unlimited		Unlimited	
Hospital Care				
Inpatient	\$500 Co-pay/Admit + 20%		\$300 Co-pay/Admit + 20%	
Outpatient	\$500 Co-pay/Admit + 20%		No Charge	
Emergency Svc (Co-pay waived if admit)	\$250 Co-pay		\$150 Co-pay	
Urgent Care	\$25 Co-pay (in-network only)*		\$20 Co-pay (in-network only)*	
Skilled Nursing (100 days/year)	20%		20%	
Physician, Inpatient Benefit	No Charge		No Charge	
Physician Care				
Office Visit	\$25 Co-pay (not subject to deduct.)		\$20 Co-pay	
Specialist Visit ¹	\$40 Co-pay (not subject to deduct.)		\$30 Co-pay	
Preventive Care ²	No Charge (not subject to deductible)		No Charge	
Outpatient X-Ray, Lab & MRI	No Charge (after deduct.)		No Charge	
Outpatient Rehabilitation Therapy ³	\$25 Co-pay, 26 visits/yr		\$20 Co-pay, 26 visits/yr	
Immunizations	No Charge		No charge	
Accupuncture	Not Covered		\$20 Co-pay, 12 visits/yr	
Chiropractic ³	Not Covered		\$20 Co-pay, 26 visits/yr	
Mental Health / Substance Abuse				
Inpatient	\$500/Admit + 20%		\$300/Admit + 20%	
Outpatient	\$25 Co-pay (not subject to deduct.)		\$20 Co-pay	
Other				
Ambulance	\$50 Co-pay, per transport		\$50 Co-pay, per transport	
Durable Medical Equipment	20% (after deductible)		No Charge	
Hospice	No Charge		No Charge	
Hearing Aid, \$700 max every 24 mos	No Charge		No Charge	
Home Health Care Services	20% (after deduct.), 100 visits/yr		20%, 100 visits/yr	
Pharmacy (see also: page 10)				
	Regular	MC PDP	Regular	MC PDP
Annual Brand Deductible⁴	\$100 Ind / \$300 Fam	None	\$25 Ind / \$75 Fam	None
Annual Out-of-Pocket Maximum	\$4,600 Ind / \$9,200 Fam	\$4,700	\$5,100 Ind / \$10,200 Fam	\$4,700
	Generic (not subj. to deduct.) / Preferred Brand / Non-Preferred Brand			
RETAIL (30-day supply)	\$15 / \$35 / \$50	\$5 / \$20 / \$50	\$10 / \$35 / \$50	\$5 / \$20 / \$50
MAIL ORDER (90-day supply)	\$30 / \$70 / \$100	\$10 / \$40 / \$100	\$20 / \$70 / \$100	\$10 / \$40 / \$100

* Co-payment or co-insurance applies only to in-network Blue Shield facility. If facility is not part of the Blue Shield network, you may be subject to additional charges and/or out-of-network benefit amounts.

1 Seek verification of what types of doctors are considered specialist, before obtaining specialist services.

2 Due to Health Care reform, 8 additional preventive services for non-Medicare women are now covered at no charge and have \$0 copay on EPO & PPO plans: well-woman visits, gestational diabetes screening, domestic & interpersonal violence screening & counseling, breastfeeding support, supplies & counseling, HPV DNA testing for women 30 or older, sexually transmitted infections counseling, HIV screening and counseling, and FDA-approved contraceptive methods and contraceptive education counseling.

3 Outpatient Rehabilitation Therapy/Chiropractic have combined maximum number of visits (26) per year.

4 Pharmacy deductible does not apply to the Medical deductible.

COUNTY RETIREE OPEN ENROLLMENT & HEALTH PLANS FOR 2026

	Blue Shield PPO				Blue Shield HDHP ¹	
	In-network		Out-of-Network ¹		In-network	Out-of-Network ¹
<i>For PPO and HDHP plans, you may see any provider when you need care. Each time you need care, you decide whether to see a network or an out-of-network provider. When you use network providers, you typically pay less.</i>						
Annual Deductible	\$750 Ind / \$2,250 Family				\$1,600 Ind / \$3,200 Family	
Annual Out-of-Pocket Max	\$4,750 Ind / \$10,250 Fam		\$6,750		\$4,500 Ind / \$9,000 Family	
Lifetime	Unlimited		Unlimited		Unlimited	
Hospital Care						
Inpatient	\$250 Co-pay/Admit + 20%		40%		20%	40%
Outpatient	20%		40%		20%	40%
Emergency Svc (co-pay waived if admit)	\$75/visit + 20%		\$75/visit + 20%		20%	20%
Urgent Care	\$30 Co-pay		40%		20%	40%
Skilled Nursing (100 days/yr)	20%		40%		20%	20%
Physician, Inpatient Benefit	20%		40%		20%	40%
Physician Care						
Office Visit	\$30 Co-pay		40%		20%	40%
Specialist Visit ²	\$30 Co-pay		40%		20%	40%
Preventive Care ³	No Charge		40%		No Charge	40%
Outpatient X-Ray, Lab & MRI	20%		40%		No Charge	40%
Outpatient Rehabilitation Therapy ⁴	20%		40%		20%	Not covered
Immunizations	No Charge		40%		No charge	40%
Accupuncture	20%, 12 visits/yr		20%, 12 visits/yr		20%, 12 visits/yr	20%, 12 visits/yr
Chiropractic ⁴	20%, 26 visits/yr		Not covered		20%, 26 visits/yr	Not covered
Mental Health / Substance Abuse						
Inpatient	\$250/Admit + 20%		40%		20%	40%
Outpatient	\$30 Co-pay		40%		20%	40%
Other						
Ambulance	20%		20%		20%	20%
Durable Medical Equipment	20%		40% (after deduct.)		20% (after deduct.)	40% (after deduct.)
Hospice	No Charge		Not Covered		No Charge	Not Covered
Hearing Aid, \$700 max every 24 mos	20%		20%		20%	20%
Home Health Care Services	20%, 100 visits/yr		Not covered		20%, 100 visits/yr	Not covered
Pharmacy	Regular	MC PDP	Regular	MC PDP	Regular	
Annual Brand Deductible⁵	\$25 Ind / \$75 Fam	None	\$25 Ind / \$75 Fam	None	All drugs subject to & accrue to Deductible. No Medicare PDP. Pharmacy & Medical: combined Max	
Annual Out-of-Pocket Maximum	\$1,850 Ind / \$2,950 Fam	\$4,700	No Limit	\$4,700		
Generic / Preferred Brand / Non-Preferred Brand						
RETAIL (30-day supply)	\$10 / \$35 / \$50	\$5 / \$20 / \$50	\$10 / \$35 / \$50	\$5 / \$20 / \$50	20%	20%
MAIL ORDER (90-day supply)	\$20 / \$70 / \$100	\$10 / \$40 / \$100	Not Covered		20%	Not Covered

1 For the PPO and HDHP plans, the out-of-network benefit applies to allowable charges. You will be responsible for additional charges above the allowable charges.

2 Seek verification of what types of doctors are considered specialist, before obtaining specialist services.

3 Due to Health Care reform, 8 additional preventive services for non-Medicare women are now covered at no charge and have \$0- copay on EPO & PPO plans: 1) well-woman visits, 2) gestational diabetes screening, 3) domestic & interpersonal violence screening & counseling, 4) breastfeeding support, supplies & counseling, 5) HPV DNA testing for women 30 or older, 6) sexually transmitted infections counseling, 7) HIV screening and counseling, and 8) FDA-approved contraceptive methods and contraceptive education counseling.

4 Outpatient Rehabilitation Therapy/Chiropractic have combined maximum number of visits (26) per year.

5 Pharmacy deductible does not apply to the Medical deductible.

6 Generic drugs not subject to deductible.

Blue Shield Tandem (Narrow) Network PPO <i>When Using a Participating Employer</i>	
Calendar Year Deductible	\$500 Ind / \$1,000 Family
Annual Out-of-Pocket Maximum When Using a Participating Provider	\$3,000 Ind / \$6,000 Family
Lifetime Maximum	None
Major Medical	
Physician Office Visit	\$25 (not subject to deductible)
Specialist Copay	\$40 (not subject to deductible)
Preventive Care	\$0 (not subject to deductible)
Lab and X-Ray	20%
Hospitalization	
Inpatient	\$500 per admit + 20% (after deductible)
Carrum Contracted Procedures	\$0 (using Carrum Health Program)
Outpatient	\$500 per admit + 20% (after deductible)
Carrum Contracted Procedures	\$0 (using Carrum Health Program)
Emergency Room	\$250 (after deductible, waived if admitted)
Urgent Care	\$25 (not subject to deductible)
Chiropractic Care	\$15 visit (20 visits per member, including Acupuncture)
Acupuncture Care	\$15 visit (20 visits per member, including Chiropractor)
Pharmacy	
Deductible	\$100 Ind / \$300 Family
EIA Pharmacy Maximum	\$4,600 Ind / \$9,200 Family
Generic/Brand/Non-Formulary	
Retail (30 day supply)	\$15 / \$35 / \$50
Mail Order (90 day supply)	\$30 / \$70 / \$100
Rx and Go (Generics)	\$0 (up to 90 day supply)
Specialty Medications	20% up to \$100 copay maximum

United Healthcare Plan Benefits

Only available to Retirees with Medicare Parts A & B.

	MAPD Low PPO	MAPD High PPO
Calendar Year Deductible	None	
Annual Out-of-Pocket Maximum	\$6,700 (combined for in and out of network)	
Life-Time Maximum	Unlimited	
Physician Office Visit	\$15	\$5
Specialist Co-pay	\$25	\$5
Preventive Care	No charge	No charge
Hospitalization		
Inpatient	\$500 per admit	\$0 per admit
Outpatient	\$250	\$0
Emergency Room	\$50 (waived if admitted)	\$50 (waived if admitted)
Lab & X-Ray	\$0 (office visit copay applies if performed during physician visit)	\$0 (office visit copay applies if performed during physician visit)
Ambulance	\$50	\$0
Urgent Care	\$15	\$5
Prescription Drugs		
	Generic / Brand / Non-formulary / Specialty	
Retail - 30 day supply	\$10 / \$25 / \$40 / \$40	\$7 / \$14 / \$14 / \$14
Mail Order-90 day supply	\$20 / \$50 / \$80 / \$80	\$14 / \$28 / \$28 / \$28

Kaiser Permanente Plan Benefits

Only available to Retirees who reside in Southern California qualifying service areas.

	NON-MEDICARE RETIREE (Traditional Plans) <i>Different rates apply to enrollees who are age 65 or older and do not have Medicare</i>		MEDICARE RETIREE (Senior Advantage Plans) <i>Only available to retirees enrolled in Medicare A and B who also assign their Medicare to Kaiser Permanente.</i>	
	Low Option	High Option	Low Option	High Option
Annual Out-of-Pocket Maximum	\$1,500 Ind/ \$3,000 Fam	\$1,500 Ind / \$3,000 Family	\$1,000	\$1,000
Physician Office Visit	\$20/visit	\$15/visit	\$20/visit	\$15/visit
Routine physical exams	No charge	No charge	No charge	No charge
Routine eye exams with a Plan Optometrist	No charge	No charge	\$20/visit	\$15/visit
Urgent care consultations, evaluations, and treatment	\$20/visit	\$15/visit	\$20/visit	\$15/visit
Physical, occupational, and speech therapy	\$20/visit	\$15/visit	\$20/visit	\$15/visit
Hospital Inpatient Services	\$500/admit	\$100/admit	\$500/admit	\$100/admit
Telehealth Visits	No charge	No charge	No charge	No charge
Outpatient Services				
Outpatient surgery and certain other outpatient procedures	\$20/procedure	\$15/procedure	\$50/procedure	\$50/procedure
Most immunizations (including the vaccine)	No charge	No charge	No charge	No charge
Most X-rays and laboratory tests	No charge	No charge	No charge	No charge
Manual manipulation of the spine			\$20/visit	\$15/visit
Emergency Department visits	\$100/Visit	\$100/Visit	\$50/Visit	\$50/Visit
Ambulance Service	\$50/Trip	\$50/Trip	\$100/Trip	\$50/Trip
Mental Health Services				
Inpatient psychiatric hospitalization	\$500/admit	\$100/admit	\$500/admit	\$100/admit
Individual outpatient mental health evaluation and treatment	\$20/visit	\$15/visit	\$20/visit	\$15/visit
Group outpatient mental health treatment	\$10/visit	\$7/visit	\$10/visit	\$7/visit
Substance Use Disorder Treatment				
Inpatient detoxification	\$500/admit	\$100/admit	\$500/admit	\$100/admit
Individual outpatient substance use disorder evaluation and treatment	\$20/visit	\$15/visit	\$20/visit	\$15/visit
Group outpatient substance use disorder treatment	\$5/visit	\$5/visit	\$5/visit	\$5/visit
Home health care (part-time, intermittent)	No charge	No charge	No charge	No charge
Skilled nursing facility care (up to 100 days per benefit period)	No charge	No charge	No charge	No charge
External prosthetic and orthotic devices	No charge	No charge	No charge	No charge
Durable Medical Equipment	No charge	No charge	No charge	No charge
Eyewear (every 24 months)			\$150 Allowance	\$150 Allowance
Hearing Aid(s) (every 36 months)			\$500 per Aid	\$500 per Aid
Prescription Drug - Retail	\$20 (100-day supply, Generic) \$70 (100-day supply, Brand)	\$10 (30-day supply, Generic) \$60 (100-day supply, Brand)	\$10 (100-day supply, Generic) \$35 (100-day supply, Brand)	\$10 (100-day supply, Generic) \$25 (100-day supply, Brand)

Creditable Coverage Notice

Important Notice from the County of Santa Barbara Regarding Prescription Drug Coverage and Medicare

Keep this Creditable Coverage notice. You may be charged a penalty in the form of a lifetime higher premium if you are unable to show whether or not you have maintained creditable coverage when joining a Medicare drug plan. You should read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with Santa Barbara County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Santa Barbara County has determined that the prescription drug coverage offered for all Medical Insurance Plans for the 2026` Plan Year are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from

October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you are enrolled in a Santa Barbara County sponsored Medical Insurance Plan and you do decide to enroll in a Medicare prescription drug plan, be aware that you are not permitted to opt out of the County's prescription coverage plan that is "packaged" together with the County's medical insurance. You should also be aware that if you join a private Medicare Prescription Drug Plan, you, your spouse, or your dependents may lose your employer or union health coverage.

If you are enrolled in both Medicare and County health insurance, you should also be aware that if you drop your County medical insurance you will also be losing your creditable prescription drug coverage for yourself and any covered dependents. You will be permitted to get your prescription coverage back for yourself and any eligible dependents, during a future annual Open Enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the Santa Barbara County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month

that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact Santa Barbara County Employees' Retirement System office at 130 Robin Hill Road, Suite 100, Goleta, CA 93117 or call 1-877-568-2940. You'll get this notice each year. You will also get it at other times, for instance, if this coverage through the Santa Barbara County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage visit www.medicare.gov.

Contact your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number). For personalized help call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Additional information, counseling and assistance may be available within your local community. In California, HICAP (Health Insurance Counseling and Advocacy Program) provides trained volunteer counselors who can answer your questions and help you understand your Medicare rights and benefits. Check your local community or contact the HICAP office at 1-800-434-0222 for assistance. Nationally, contact the U.S. Administration on Aging for programs and help at www.aoa.gov or the Eldercare Locator 1-800-677-1116 or www.eldercare.gov.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Dental Plan Choices

There are two plans offered by Delta Dental:

1. The DPPO Plan gives you freedom to choose any dentist but also gives you the opportunity for cost savings on treatment when you use a provider from either of the two Delta Provider networks (PPO and Premier).
2. The DHMO Plan has no annual benefit maximum and provides the convenience of knowing your co-pay before your visit, when you receive treatment from your assigned dentist. The DHMO plan is open to California Residents only.

Treatment authorizations are needed and referrals are required to obtain coverage for specialty care. A provider finder, ID Card and benefit information are accessible online or from your smartphone at www.deltadentalins.com.

Remember, in order to be eligible for dental coverage, you and your dependent must be enrolled in an employer-sponsored medical plan offered by the County.

The County has a special DHMO network with Delta Dental and you must go to www.deltadentalins.com/countyofsantabarbara for a full selection of DHMO providers. Please refer to this website when selecting a new dentist.

Participation in medical without dental constitutes a waiver of dental benefits. You will be asked to sign an acknowledgement of this waiver when you decline dental; you will not be eligible to re-enroll at any time in the future. If you signed a waiver in the past, you are precluded from enrolling now or in the future.

Plan Benefits	Delta Dental PPO Plan (DPPO)	DeltaCare® Plan (DHMO) <i>California Residents Only</i>
Deductibles/Maximums	Deductibles and annual maximums apply.	No annual deductible or annual maximums.
Co-payments/Coinsurance	Covered services paid at applicable percentage. For example, fillings are covered at 80% of allowed amount; you pay the remaining 20%.	Covered procedures have predetermined dollar co-payments for services provided by network dentists (this means out-of-pocket costs are predictable).
Coverage	Wide range of covered services. No exclusions for most pre-existing conditions.	Plan covers nearly 300 procedures. No co-payments or low co-payments for most diagnostic and preventative services.
Dentist Network	Freedom to choose any licensed dentist. No referral required for specialty care.	You must select a dentist from a list of network dental facilities and you must visit this dentist to receive benefits. Easy referrals to a large specialty care network.
Changing Your Dentist	Change dentists at any time without contacting Delta Dental.	Ability to change dentists by contacting Delta Dental.
Out-of-Area Coverage	Visit any licensed dentist.	Limited to emergency care provision.
Claims	Delta Dental dentists file claim forms and accept payment directly from Delta Dental. Non-Delta Dental dentists may require payment up front, and require you to file a reimbursement claim.	No claim forms required. You only need to pay the specified co-payment at the time of your visit.

Plan Benefits	Delta Dental PPO Plan (DPPO)		DeltaCare® Plan (DHMO) <i>California Residents Only</i>
	In-Network Cost	Out-of-Network Cost	In-Network (Only)
Annual Deductible Maximum	\$50 Individual / \$100 Family Waived for Diagnostic and Preventive Care and Orthodontics		None
Annual Benefit Maximum	\$1,500 per person		None
Preventive / Diagnostic Exams, Cleanings, X-rays, fluoride treatments.	No Charge	No Charge	No Charge
Basic Services Basic restorative, endodontic, periodontal, oral surgery, emergency treatment.	20%	20% can be balance billed	\$8 – \$395 Refer to Delta Dental Description of Benefits & Co- payments Schedule
Major Services Crowns, bridges, inlays, onlays, dentures	40%	40% can be balance billed	\$15 – \$395 Refer to Delta Dental Description of Benefits & Co- payments Schedule
Orthodontia			
Child		40%	\$1,900
Adult (19 & Up)		40%	\$2,100
Lifetime Maximum	\$1,200 (Deductible does not apply)		Discounted Plan Benefits

Vision Plan

Vision Service Plan (VSP) is the provider for the County of Santa Barbara’s optional vision coverage plan for eye exams and eyewear.

The Medical plans may provide for only a basic screening exam to detect medical eye problems such as glaucoma or diabetic retinopathy. If you do have an ophthalmological medical condition, these medical plans do provide diagnosis, management and surgery of ocular diseases and disorders.

VSP has a broad provider network with substantial access across the country in a variety of settings, including some Costco Warehouses. All VSP network providers are independent optometrists or ophthalmologists in private practice who provide full service. To receive the best benefit use a VSP Network Provider for your services and eyewear purchase. However, you do have the option of using a non-network

provider under the VSP plan but the benefit allowances are lower.

To use your vision coverage, simply tell your eye care provider that you have VSP. VSP is a paperless company and does not issue ID cards, however a “Member Vision Card”, provider finder and benefit information are accessible online or from your smartphone at www.vsp.com. The card is a summary of your benefits and includes information to help you manage your vision service.

You and your dependent must be enrolled in a medical plan offered by the County in order to participate in the vision plan. Retirees who cancel vision insurance are eligible to re-enroll during a future Open Enrollment.

Plan Benefits	In-Network	Out-of-Network
Eye examination (once every 12 months)	\$10 Co-pay	Up to \$51 Allowance
Standard Lenses (once every 24 months)		
• Single	Covered in full	Up to \$41 Allowance
• Bifocal	Covered in full	Up to \$63 Allowance
• Trifocal	Covered in full	Up to \$82 Allowance
Frames (once every 24 months)	Up to \$150 Allowance 20% off amount above allowance	Up to \$70 Allowance
Contact Lenses (in lieu of eyeglasses, once every 24 months)	Up to \$150 Allowance	Up to \$105 Allowance
Low Vision Benefit (for severe vision problems)	\$500, maximum benefit every two years	Not Covered
Laser Vision Correction	15% fee discount	Not Covered
Discounts & Extra Savings	20% off additional glasses or non-prescription sunglasses	Not Covered

RETIREE MONTHLY PREMIUM RATES

ALL NON-MEDICARE (incl. dependents)	BLUE SHIELD with Regular Prescription Plan					BLUE SHIELD with Medicare Prescription Drug Plan				UHC MEDICARE ADVANTAGE	
	Narrow Network	EPO Low	EPO High	PPO	HDHP	Narrow Network	EPO Low	EPO High	PPO	PPO Low	PPO High
Retiree Only	\$2,192.25	\$2,319.25	\$2,689.25	\$2,363.25	\$1,810.25						
Retiree + 1 Dependent	\$4,053.25	\$4,291.25	\$4,976.25	\$4,371.25	\$3,348.25						
Retiree + 2 Dependents	\$6,366.25	\$6,740.25	\$7,813.25	\$6,873.25	\$5,263.25						
ALL MEDICARE (incl. dependents)	BLUE SHIELD with Regular Prescription Plan					BLUE SHIELD with Medicare Prescription Drug Plan				UHC MEDICARE ADVANTAGE	
	Narrow Network	EPO Low	EPO High	PPO	HDHP	Narrow Network	EPO Low	EPO High	PPO	PPO Low	PPO High
Retiree Only	\$1,045.25	\$1,239.25	\$1,280.25	\$1,410.25	\$1,430.25	\$941.25	\$1,115.25	\$1,155.25	\$1,286.25	\$610.18	\$756.96
Retiree + 1 Dependent	\$2,086.25	\$2,483.25	\$2,560.25	\$2,817.25	\$2,851.25	\$1,880.25	\$2,226.25	\$2,308.25	\$2,575.25	\$1,220.36	\$1,513.96
Retiree + 2 Dependents	\$3,132.25	\$3,722.25	\$3,843.25	\$4,225.25	\$4,280.25	\$2,823.25	\$3,345.25	\$3,464.25	\$3,858.25	Available Upon Request	
Medicare/ Non-Medicare COMBINATIONS	BLUE SHIELD with Regular Prescription Plan					BLUE SHIELD with Medicare Prescription Drug Plan (all MC dependents enrolled in MC PDP)					
	Narrow Network	EPO Low	EPO High	PPO	HDHP	Narrow Network	EPO Low	EPO High	PPO		
Non-Medicare Retiree + 1 Medicare Dep.	\$3,233.25	\$3,563.25	\$3,969.25	\$3,770.25	\$3,231.25	\$2,802.25	\$3,087.25	\$3,422.25	\$3,294.25		
Non-Medicare Retiree + 2 Medicare Dep.	\$4,278.25	\$4,802.25	\$5,249.25	\$5,180.25	\$4,661.25	Call Alliant for Rates					
Non-Medicare Retiree + 1 Medicare Dep. + 1 Non-Medicare Dep.	\$5,094.25	\$5,535.25	\$6,256.25	\$5,778.25	\$4,769.25	\$5,115.25	\$5,536.25	\$6,279.25	\$5,796.25		
Medicare Retiree + 1 Non-Medicare Dep.	\$2,906.25	\$3,211.25	\$3,567.25	\$3,418.25	\$2,968.25	\$2,805.25	\$3,087.25	\$3,422.25	\$3,294.25		
Medicare Retiree + 2 Non-Medicare Dep.	\$5,219.25	\$5,660.25	\$6,404.25	\$5,920.25	\$4,883.25	\$5,115.25	\$5,536.25	\$6,279.25	\$5,796.25		
Medicare Retiree + 1 Medicare Dep. + 1 Non-Medicare Dep.	\$3,947.25	\$4,455.25	\$4,847.25	\$4,825.25	\$4,389.25	\$3,947.25	\$4,202.25	\$4,597.25	\$4,583.25		

ALL NON-MEDICARE (incl. dependents)	KAISER, Under Age 65 <i>Not Enrolled in Medicare</i>		KAISER, Age 65 & Over <i>Not Enrolled in Medicare</i>	
	HMO Low	HMO High	HMO Low	HMO High
Retiree Only	\$1,356.25	\$1,411.25		
Retiree + 1 Dependent	\$2,554.25	\$2,658.25	Rates Available from Alliant Upon Request	
Retiree + 2 Dependents	\$3,886.25	\$4,046.25		
ALL MEDICARE (incl. dependents)	KAISER SENIOR ADVANTAGE <i>Medicare Enrolled</i>		KAISER SR ADVANTAGE <i>Age 65 & Over Not Enrolled in Medicare</i>	
	HMO Low	HMO High	HMO Low	HMO High
Retiree Only	\$214.25	\$246.25		
Retiree + 1 Dependent	\$413.25	\$477.25	Only Medicare A & B enrolled retirees are eligible for this plan.	
Retiree + 2 Dependents	Rates Available from Alliant Upon Request			
MEDICARE/NON-MEDICARE COMBINATIONS	KAISER Medicare Enrolled <i>with Non-Medicare Under Age 65</i>		KAISER SR ADVANTAGE <i>Age 65 & Over Not Enrolled in Medicare with Medicare Enrolled</i>	
	HMO Low	HMO High	HMO Low	HMO High
Non-Medicare Retiree + 1 Medicare Dependent	\$1,570.25	\$1,657.25		
Non-Medicare Retiree + 2 Medicare Dependents	\$2,744.25	\$2,881.25		
Non-Medicare Retiree + 1 Medicare Dependent + 1 Non-Medicare Dependent	\$2,768.25	\$2,904.25	Rates Available from Alliant Upon Request	
Medicare Retiree + 1 Non-Medicare Dependent	\$1,412.25	\$1,493.25		
Medicare Retiree + 2 Non-Medicare Dependents	\$2,744.25	\$2,881.25		
Medicare Retiree + 1 Medicare Dependent + 1 Non-Medicare Dependent	\$1,745.25	\$1,865.25		

MANDATORY <i>(with Medical Plan Enrollment)</i>	CARECOUNSEL
	\$3.45

OPTIONAL PLANS	DENTAL SERVICE PLAN		VISION SERVICE PLAN
	Delta Dental PPO	Delta Care USA HMO	
Retiree	\$50.27	\$32.88	\$6.36
Retiree + 1 Dependent	\$82.67	\$54.04	\$9.14
Retiree + 2 Dependents	\$125.62	\$82.05	\$16.40

How to Calculate Your Share of the Premium

CareCounsel \$ 3.45

Medical Rate \$

Dental Rate \$

Vision Rate \$

SUBTOTAL = \$

SUBTRACT Monthly Subsidy

(Legacy Retirees, Not Plan 7 or 8)

\$15 x Years of Service - \$

YOUR SHARE OF PREMIUM

*The "insurance deduction" listed on
your monthly benefit payment = \$*

SUPPLEMENTAL INFORMATION

Mid-Year Benefit Change Rules

You will not be allowed to change your plan selections or add dependents until the next benefit year (2027 Open Enrollment) unless you experience a qualified status change, known as a “qualifying event”. If you qualify for a mid-year benefit change, you may be required to submit proof of change or evidence of prior coverage. Two rules apply for making changes to your benefits during the year:

1. Any change must be consistent with the qualifying event.
2. You must notify SBCERS and make the change within 30 calendar days of the date of the event, however if your status change is your enrollment in Medicare A and B, you should contact SBCERS for instructions 3 months prior to your Medicare effective date and must submit necessary documents and forms at least 60-90 days before your Medicare effective date.

Qualifying Events for Mid-Year Enrollment:

- **Change in legal marital status**, including marriage, divorce, court documented legal separation, annulment, death of spouse or termination of registered domestic partnership and establishment of registered domestic partnership.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child.
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child.
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, that affects eligibility for benefits.
- **Change in a child’s dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in residence or worksite** that affects the accessibility of network providers.
- **Change in your health coverage or your spouse’s coverage attributable to your spouse’s employment.**
- **A court order resulting from a divorce, court-ordered legal separation, annulment, or change in legal custody** (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a “special enrollment” under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children’s Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, retirees have 60 days after the following events to request enrollment:
 - Retiree or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
 - Retiree or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.
- **Change in a covered individual’s eligibility for Medicare or Medicaid:**
 - Enrolling in Medicare (A and B) is a qualifying event for purposes of changing plans mid-year.
 - Enrolling in Medicare (A and B) is a qualifying event for purposes of adding the Medicare PDP.

- Enrolling in Medicare (A and B) is a qualifying event for any applicable premium reduction in your current plan, after it is reported to SBCERS. Your premium will be reduced to the Medicare coordinated rate effective the later of the Medicare effective date –OR– the first of the month following 45 days from receipt of a copy of your Medicare card and an appropriate insurance change form.

Dependent Eligibility Rules

- Your legal spouse or legally registered domestic partner; same gender/opposite gender.
- Your natural children, stepchildren, children who are either legally adopted by you or placed in your custody during the adoption process, children for whom you are the legal guardian, and any child named in a qualified medical child support order for which you are required to provide health coverage. Dependent children must be under the age of 26 and not be eligible for medical insurance through his or her employer.
- Your eligible physically or mentally handicapped children who depend on you for support, regardless of age. Eligibility is determined by Blue Shield or Kaiser Permanente. You must fill out a Disabled Form and submit it to Blue Shield or Kaiser for review and approval.
- A child of a covered domestic partner who satisfies the same conditions as listed above for natural children, stepchildren, or adopted children, and in addition is not a “qualifying child” (as that term is defined in the Internal Revenue Code) of another individual.

NOTE – You will be responsible for benefit claims paid by the health plans and County-paid premium costs for any ineligible dependents enrolled in plans.

Healthcare Subsidy

Retired members of SBCERS Legacy Plans (not Plan 7 or 8) who participate in County-sponsored health plans currently receive a health insurance subsidy (also known as an insurance offset) of \$15-per-month-per-year-of service toward their premium costs.

As an example, if a retiree has service credit of 25.5 years, he is eligible to receive \$382.50/month (25.5 x \$15 = \$382.50) toward the County health insurance premium for him and his dependents:

Monthly Insurance Premium	\$1,500.00
Health Insurance Subsidy	– \$382.50
Retiree Share of Premium	\$1,117.50

Surviving spouses and other beneficiaries receive an amount proportionate to their benefit continuance percentage. Members receiving a disability retirement allowance currently receive a health insurance subsidy of at least \$187 per month.

If you receive multiple monthly benefit payments, your insurance subsidies from all accounts may be added together, so that the combined subsidy is applied to the total premium amount.

If you and your spouse are both County Retirees, you may be eligible to pool your subsidies together when one retiree carries the other as a dependent on the insurance. See [“Subsidy Combining for Recipients of Multiple Benefits”](#) and/or [“Subsidy Pooling for Married Retirees”](#) under [“Important Facts.”](#)

Health Reimbursement: If You Do Not Have County Health Insurance

Eligible retirees and beneficiaries (not Plan 7 or 8) not enrolled in County-sponsored health insurance, receive help with health expenses, through a Health Reimbursement Arrangement (HRA) benefit funded by the County. You are automatically enrolled in the HRA when you drop County-sponsored health insurance. An amount equal to \$4-per-year-of-service is set aside monthly in a HRA account that is automatically set up for you when you decline or cancel County-sponsored health insurance. This tax free money is available for reimbursement of eligible post-tax health expenses for which you paid out-of-pocket during your coverage period. Unused balances roll over from year-to-year. As a reminder, retirees from Plans 7 and 8 do not receive a Health Reimbursement Arrangement benefit.

This benefit is administered by Health Equity, formerly known as WageWorks. WageWorks was acquired by Health Equity in 2020. You may be reimbursed for eligible health expenses incurred and paid by you and/or your qualified dependents. To receive reimbursement you must either complete and submit claims to Health Equity along with proof of the expense and proof of payment (e.g. Medicare statements and receipts) or use a pre-paid debit card issued to you by Health Equity.

HRA account balances transfer to an eligible monthly benefit recipient upon the death of a retiree (e.g. spouse). If no continuing monthly benefit is payable, HRA funds remain available to the estate for up to 12 months after a retiree's death for reimbursement of eligible health expenses, after which the coverage period ends.

For additional information about this benefit and the reimbursement process, call WageWorks at 877-924-3967 or visit www.wageworks.com.

COBRA Facts For Retirees

It is important to know that you may be eligible for the continuation of your active employment insurance through COBRA, with premium deductions from your monthly retirement benefit payments.

Your medical, dental, and vision coverage will end on the last calendar day of the month in which your separation from employment occurs. Once your last employment payroll is processed, the County's COBRA administrator, Benefits Coordinators Corporation (BCC), or your Plan Sponsor's COBRA administrator, will send you an election notice detailing your rights to re-enroll with no lapse in coverage, no pre-existing conditions, and what your premium cost will be.

If you have elected and completed Retiree COBRA enrollment forms with your SBCERS Member Services Specialist during your retirement counseling:

1. SBCERS will enroll you in Retiree COBRA insurance with BCC. You do not need to complete nor mail forms or any form of payment to BCC or your Plan Sponsor's COBRA administrator.
2. SBCERS will deduct COBRA premiums from your monthly retiree benefit payment, and, as permitted by your retirement plan, apply your insurance subsidy to your monthly premiums. You do not need to pay BCC or your Plan Sponsor's COBRA administrator directly.
3. You will receive a cancellation notice from BCC or your Plan Sponsor's insurance administrator: please know that this notice is notifying you that your active employee coverage has been terminated due to your separation of employment, and that you have not enrolled directly in COBRA as a direct pay. It does not mean your Retiree COBRA has been cancelled.

- After the 18 months of federal COBRA coverage expires, if you reside in California, you are permitted an additional 18 months of Extended COBRA, allowing 36 months of COBRA coverage.
- Your spouse and dependent children are eligible for 36 months of initial coverage under federal law. There is no California state extension of this coverage. They have the option to enroll separately from your coverage. BCC can answer any questions you may have about your COBRA coverage.
- Domestic partners do not have federal or state COBRA rights to continue health insurance coverage unless they otherwise meet the qualifications of a dependent.

If You Are A Recent Retiree With COBRA Coverage

Open Enrollment is an opportunity for you to elect different coverage, including a different carrier, within the COBRA tier. Your 18 month COBRA or 18 month Extended COBRA period will not reset, the COBRA coverage termination date will remain the same as if you had not changed coverage or carrier.

Terminating COBRA Or Extended COBRA Coverage

Terminating COBRA or Extended COBRA Coverage terminates the COBRA period permanently, it cannot be placed on hold and continued at a later time.

If You Turn 65 or Otherwise Become Eligible for Medicare During Your COBRA Period

It is important to know that your COBRA eligibility does not change the Medicare enrollment date. You are strongly encouraged to sign up for Medicare when you are eligible at age 65. Medicare will not consider your COBRA conclusion date as a Qualifying Event to enroll in Medicare outside the normal timeframe. If you do not sign up for Medicare when you are eligible, you will be penalized when you do enroll: you will pay a higher premium for life, and you will be subject to the Medicare Open Enrollment period, which may delay your enrollment in Medicare for up to a year.

- **Newly enrolling in Medicare while you have COBRA coverage** does not disqualify you from continuing your COBRA coverage. You may be responsible for reimbursement of claims paid incorrectly after your Medicare effective date. Continuation of COBRA benefits might be available in some cases for a COBRA-covered spouse. Extended COBRA is only available to California residents. Reaching the end of your COBRA eligibility period (18 months or three years) is a qualifying event enabling you to make insurance changes outside of Open Enrollment.
- **You are responsible for coordinating your Medicare enrollment.** SBCERS does not deduct Medicare premiums from your retiree benefit payment, nor coordinate your enrollment with the Centers for Medicare and Medicaid Services. It is your responsibility to contact Social Security Administration directly to coordinate your Social Security and Medicare enrollment.

Reminder About COBRA Eligibility

If you do not have active employee insurance at the time of retirement, you are unable to elect COBRA. You must have active employee insurance to convert to COBRA. You would be eligible for early retiree insurance, Medicare retiree insurance, or, if your retirement plan provides it, the Health Reimbursement Account.

Important Facts

Age 65 and Medicare – If you are turning 65 during the plan year, you should re-examine your insurance profile. Reaching age 65 could entitle you to enrollment in Medicare. Choosing whether or not to enroll or being ineligible for Medicare, may have an effect on your County insurance premiums.

Annual Open Enrollment Periods are the annual period during which you have the opportunity to enroll in or change healthcare plans. If you are enrolling in or changing plans for 2025, your forms must be received by SBCERS no later than October 31, 2024; otherwise you will not be able to make changes until 2026 Open Enrollment. If changing carriers, you must submit a disenrollment form for the old plan as well as an enrollment form for the new plan.

Blue Shield ID Cards for EPO Plans may show the plan type as “PPO” even if you are enrolled in an EPO plan. Blue Shield listed “PPO” on the ID cards as a way of identifying the Provider Network that the subscriber may use. In cases where the EPO plan designation is not shown on the card, the Group # does identify your specific EPO plan. All Blue Shield cards list the Retiree’s name only; they do not show dependents’ names.

Centers for Medicare and Medicaid Services (CMS) – The Centers for Medicare and Medicaid Services (CMS), is a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program (SCHIP), and health insurance portability standards.

COBRA Covered Retirees who are in the COBRA covered insurance period have the opportunity to change plans and dependent coverage during Open Enrollment. Please follow the process described in this book to make any plan and/or coverage changes; you must submit your changes to SBCERS. Newly enrolling in Medicare while you have COBRA coverage does not disqualify you from COBRA coverage. You may be responsible for reimbursement of claims paid incorrectly after your Medicare effective date. Continuation of COBRA benefits might be available in some cases for a COBRA-covered spouse. Extended COBRA is only available to California residents. Reaching the end of your COBRA eligibility period (18

months or three years) is a qualifying event enabling you to make insurance changes outside of Open Enrollment.

California State Association of Counties Excess Insurance Authority (CSAC-EIA) – California State Association of Counties Excess Insurance Authority (CSAC-EIA) Health Program is a Joint Powers Authority (JPA) for cities, counties and special districts. The founding principle of EIA Health is to provide a stable and cost effective health insurance option for public entities. EIA Health has created value and long-term rate stability by combining the risks of participating employer groups with similar risk profiles.

Eligibility – You are eligible for health insurance coverage offered by the County and may enroll at retirement, during any Open Enrollment period or if you experience a qualifying event outside of Open Enrollment. You must be enrolled in a medical plan in order to enroll in a dental and/or a vision plan. Even though you may decline insurance at any time, you will be eligible to enroll in the future, with one exception. Participation in a medical plan without a dental plan constitutes a lifetime waiver of dental benefits. You will be required to sign an acknowledgement of that waiver upon declination of dental coverage. Insurance and insurance benefits are not guaranteed benefits.

Eligibility for Dental Plans – The dental HMO plan is only open to California residents. The PPO plan is open to all retirees. You are eligible to participate in a dental plan only if you never cancelled or waived coverage while maintaining enrollment in a County medical plan.

Eligibility for Kaiser Permanente Plans – These plans are only open to California residents who live in qualifying areas. Different rates apply to age 65 retirees or dependents enrolled in a Kaiser plan who are not also enrolled in Medicare A and B.

Eligibility for UnitedHealthcare Plans – These plans are only open to California residents who live in qualifying areas.

Health Insurance Marketplace – Under the Affordable Care Act (ACA), if you are not covered under a health insurance plan, unless you are exempt, you may be assessed a penalty through your tax return. You have several ways to get insurance including through:

SBCERS, your state's health insurance Marketplace (also called an Exchange), an insurance broker, or a public health group like Medicare, Medicaid, or the VA. For more information go online to:

www.healthexchange.ca.gov

www.healthinsurance.org/learn/

www.healthcare.gov

www.cahealthadvocates.org/

Health Savings Accounts – If you enroll in the High Deductible Health Plan (HDHP) and you are not enrolled in Medicare, you are eligible to establish a Health Savings Account (HSA). An HSA is a tax-free savings account that you can use to pay qualified medical expenses, and can be established at most banks offering tax-free savings accounts. If you discontinue an HDHP, remember to use any monies remaining in the HSA account in accordance with IRS rules. SBCERS does not offer HSA's and is unable to provide information about or assist with these accounts. Once enrolled in Medicare A and B, you can no longer contribute to your HSA.

Insurance Advocacy and Senior Resources – Organizations such as Area Agency on Aging and Health Insurance Counseling and Advocacy Program (HICAP) may be available for health insurance assistance and/or Senior resources in your area, in addition to advocacy offered by CareCounsel.

Medical Exchanges – See "[Health Insurance Marketplace](#)."

Medical Travel – This is also referred to as medical tourism, health tourism, and medical vacation, refers to the travel of people to another country for medical treatment. Traditionally, people would travel to major medical centers in highly developed countries for medical treatment that was unavailable in their own communities. More recently, people travel from highly developed countries with high quality, state-of-the-art Centers of Excellence for medical treatments because of cost consideration, though the traditional pattern still continues.

Medicare Advantage Plans (aka Part C) – Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. You'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not Original Medicare. If you are enrolled

in a UnitedHealthcare Medicare Advantage or Kaiser Senior Advantage plan, Medicare services are covered through those plans and not under Original Medicare. SBCERS' Medicare Advantage Plans include Part D (prescription drug coverage). Do not join any other Medicare Prescription Drug Plan while you are enrolled in a Medicare Advantage Plan, or Medicare will dis-enroll you from your Medicare Advantage Plan and return you to Original Medicare.

Medicare Coordination with Other Coverage – If you participate in a Blue Shield plan and you are enrolled in Medicare A and B, the Blue Shield plan provides comprehensive secondary insurance. When there is more than one payer, "coordination of benefits" rules decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. See also "[Medicare Coordination of Benefit](#)."

Medicare Part A or Medicare Part B Only – If you participate in Medicare, but only in Part A or only Part B, you are not eligible for a reduced County insurance premium. You may wish to contact Medicare for information about enrolling in either.

Medicare Parts A & B and County Insurance – If you are participating in a County-sponsored medical insurance plan and enroll in Medicare Parts A and B, you may be eligible for a reduction of your County medical insurance premium on or after your Medicare effective date and/or you may change your medical plan. Be sure to let your SBCERS Member Services Specialist know 3 months before your Medicare effective date (usually this is the 1st of the month in which you turn 65) or as soon as possible. You will need to submit forms to indicate whether you are dropping County insurance or wish to change plans or keep your current plan and have your insurance benefits coordinated and receive a reduction in your monthly County insurance premium. You will also be asked to provide a copy of your Medicare card if you elect to keep the County's insurance.

Retirees who have Medicare A & B and a Blue Shield plan may find that, because of the coordination of benefit between Medicare and Blue Shield when services are obtained from providers that are Medicare assigned and Blue Shield contracted, that they ultimately may not be responsible for the Blue Shield co-pays and deductibles. Contact Blue Shield or CareCounsel for details. Upon receipt of your insurance change form and Medicare Card copy, we will reduce your premium prospectively only.

Medicare Prescription Coverage Part D – The prescription coverage included in County sponsored medical plans is either Medicare D coverage or is considered creditable coverage because in most cases they offer a “richer” benefit than most Part D plans. If you are enrolled in a County-sponsored medical plan, you should not enroll in another Medicare Part D plan. See [“Prescription Drug Coverage and Medicare.”](#)

Medicare Supplement Plans – A Medicare supplement (Medigap) insurance, sold by private companies, can help pay some of the health care costs that Original Medicare doesn’t cover, like co-payments, coinsurance, and deductibles. The County does not offer Medicare supplement Plans.

Office Visits & Preventive Services – You should be aware that office visit co-pays and charges may vary based on the type of service received during the visit. Some “special” office visit services may fall outside of what is considered part of a normal office visit and therefore incur higher charges and/or change the way coverage works for that service.

You should also be aware that preventive services billed as preventive with a preventive diagnosis code will not be subject to a deductible or co-pay/co-insurance. However, if a claim has a medical diagnosis code, services will be subject to the deductible or co-pay/co-insurance.

Out-of-Area Coverage by Blue Shield for non-California Residents and for Retirees While Traveling – Retirees who reside and/or travel outside California will have access to care through Blue Shield’s BlueCard Network. You are still responsible for the usual payments (deductibles, co-pays, etc.). Retirees on the EPO plans should always remember that there is no coverage, except for emergencies, if you do not use a BlueCard Provider. Retirees traveling out of the country who need emergency services should contact Blue Shield as soon as possible. You will need to pay for the services out-of-pocket and submit a claim for reimbursement upon returning to the country. Only emergency services will be covered.

Out-of-Area Coverage for Kaiser and United Healthcare Participants – No matter where you are in the world, you should be covered for emergency and urgently needed services. Co-pays will apply and may vary. You must notify your carrier within 48 hours of receiving out-of-area services.

Over-Age Dependents – Report and drop dependents as soon as they no longer qualify for coverage on your

County insurance; this may entitle you to a decrease in your monthly premium. An annual certification is required by the carrier for each over-age dependent that is eligible to remain on your insurance. In the event that you do not drop a dependent who is ineligible for coverage under the County plans, you will be responsible for benefit claims paid by the health plans and any associated premium costs. See [“Dependent Eligibility Rules.”](#)

Premium Payment – After the insurance subsidy is applied to the premium, any remaining balance is the retiree’s share of premium. This is paid through a deduction from your monthly retirement allowance on a post-tax basis in accordance with the Internal Revenue Code §402(a). A calculation box has been provided at the end of this guide.

Premium is More than Retirement Allowance (“Self-Pay” Option) – You might be eligible to participate in County sponsored insurance even if your share of premium is more than the amount of your net retirement allowance.

To elect the self-pay option you must pre-pay your share of premium every month. After we apply your subsidy, the retirement office will apply all but \$10 of your retirement allowance toward your health insurance premium cost. (The \$10 amount is a “cushion” to ensure processing in case of a minor tax modification or other payroll adjustment.) You must then remit payment of the remaining premium amount to SBCERS so that it arrives no later than the 15th of the month prior to the coverage month. There is no grace period. Please keep in mind that delinquent payments could cause the cancellation of insurance.

Subsidy Combining for Recipients of Multiple Benefits – If you receive multiple monthly SBCERS benefit allowance payments from the same employer plan sponsor, your insurance subsidies from all accounts may be added together so that the combined subsidy is applied to the total premium amount.

Subsidy Pooling for Married Retirees – If two retirees are married to each other (or are registered domestic partners) and are both eligible for a health insurance subsidy, they may “pool” their subsidy amounts toward the premium cost for two-party or family coverage. One of the retirees must enroll in medical, dental and/or vision coverage, listing the retired spouse/partner as a dependent to participate in subsidy pooling. The option of pooling is only available to retirees who share the same employer plan sponsor. For example, a Court Retiree cannot pool with a County Retiree.

Legal Disclosures

The information in this brochure is a general outline of the benefits offered by the County of Santa Barbara. Specific details, provisions and plan limitations are provided in the official Plan Documents (Benefit Summaries or Evidence of Coverage). In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Plan documents can be found online at www.sbcers.org.

Availability of HIPAA Privacy Notice

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician for:

All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.

Premium Assistance Under Medicaid & the Children's Health Insurance Program (CHIP)

You may find a copy of this Notice at www.sbcers.org. If you do not have internet access and would like a paper copy, contact SBCERS.

Patient Protection and Affordable Care Act (PPACA) Disclosure Statement

This group health plan believes the Kaiser Traditional (non-Medicare) Low Option HMO, Kaiser Traditional (non-Medicare) High Option HMO and the Blue Shield High Deductible Health Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. For any questions please contact the County of Santa Barbara Human Resources.

Contacts & Resources

SBCERS Goleta Office:

130 Robin Hill Road, Suite 100
Goleta, CA 93117

SBCERS Santa Maria Office:

2236 South Broadway, Suite D
Santa Maria, CA 93454

Office Hours: Monday - Friday, 8am - 4pm

Business Hours: Monday - Friday, 8am - 5pm

Email for Questions: benefits@sbcers.org

Phone Number: 1-877-568-2940

Fax Number: 805-695-2755

Website: www.sbcers.org

Blue Shield (incl. prescriptions for HDHP)

Member Services: 1-855-256-9404

Website: myoptions.blueshieldca.com/prism

Blue Card (Network Providers outside of CA)

Member Services: 1-800-810-2583

Website: www.bcbs.com

Navitus (BS Prescriptions for EPO, PPO)

Listed on your pharmacy benefit member ID card
or call 1-844-268-9789

Website: www.navitus.com

Rx 'n Go

Member Services: 1-888-697-9646

Website: www.rxngo.com

Carrum Health

Member Services: 1-888-855-7806

Website: my.carrumhealth.com/cosb

Alliant Medicare Solutions

Member Services: 1-888-312-1387

Kaiser Permanente

Member Services: 1-800-464-4000

Senior Advantage Members: 1-800-443-0815

Website: www.kp.org

UnitedHealthCare Medicare Advantage

Member Services: 1-800-457-8506

Website: www.uhcretiree.com

Delta Dental

Member Services (DPPO): 1-800-765-6003

Member Services (DHMO): 1-800-422-4234

Website: <https://www1.deltadentalins.com/group-sites/countyofsantabarbara.html>

Vision Service Plan (VSP)

Member Services: 1-800-877-7195

Website: www.vsp.com

Benefits Coordinators Corp (COBRA Admin)

Member Services: 1-800-685-6100

Website: www.benXcel.com

CareCounsel Healthcare Assistance

Member Services: 1-888-227-3334

Website: www.carecounsel.com

Health Equity/WageWorks

Member Services: 1-877-924-3967

Website: www.wageworks.com

Medicare & Medicare Prescription Drug Coverage

Member Services: 1-800-633-4227

Website: www.medicare.gov

SHIPs (State Health Insurance Assistance Programs)

Insurance Counseling and Assistance to Medicare

Beneficiaries: 1-877-839-2675

Health Insurance Marketplace Affordable Care Act (ACA)

Info: 1-800-318-2596

Website: www.healthcare.gov

HICAP (Health Insurance Counseling & Advocacy)

Medicare Advocacy: 1-800-434-0222

County of Santa Barbara Human Resources:

Phone: 805-568-2800

Website: www.sbcountyhr.org

Benefit Pay Days

Benefits are paid at the beginning of the month for the previous month’s benefits. For tax reasons, the December benefit is dated the first business day of the new year. Checks will be delivered to post office on the mailing day. Direct deposits will be sent to bank with the settlement date provided below, please contact your financial institution to see when funds are placed in your account.

2026		
Benefit Month	Check Mailing Date	Direct Deposit Date
December <i>*2026 premiums made effective</i>	12/31/2025	1/2/2026
January	1/30/2026	1/31/2026
February	2/27/2026	2/28/2026
March	3/31/2026	4/1/2026
April	4/30/2026	5/1/2026
May	5/30/2026	6/1/2026
June	6/30/2026	7/1/2026
July	7/31/2026	7/31/2026
August	8/31/2026	9/1/2026
September	9/30/2026	10/1/2026
October	10/30/2026	10/31/2026
November	11/30/2026	12/1/2026
December	12/31/2026	1/4/2027

SBCERS

SANTA BARBARA COUNTY EMPLOYEES' RETIREMENT SYSTEM

130 ROBIN HILL ROAD, SUITE 100
GOLETA, CA 93117

 Phone:
1-877-568-2940

 Email:
benefits@sbcers.org

 Website:
www.sbcers.org



To view Open Enrollment forms and materials online, or RSVP for an in-person health fair, go to www.sbcers.org/openrollment

or scan the QR code above with your smartphone.

MAKING CHANGES TO YOUR HEALTH INSURANCE FOR 2026?

Confirm you have a mySBCERS account.

Go to mysbcers.org to register, if you haven't already. You can securely submit change forms electronically through your account via the "Message Center".

Attend an in-person or virtual health fair.

Speak directly with representatives from health plan providers and SBCERS.

- Santa Maria Retiree Health Fair: Wednesday, September 24
- Goleta Retiree Health Fair: Friday, September 26
- Virtual Health Fair: Monday, October 20 - Sunday, October 26.

View and download materials beginning September 24.

All change forms must be submitted to SBCERS by Friday, October 31, 2025.