SBCERS
SANTA BARBARA COUNTY EMPLOYEES' RETIREMENT SYSTEM

2019 GUIDE TO COURT RETIREE HEALTH PLANS AND OPEN ENROLLMENT

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The information in this brochure is a general outline of the benefits offered by the Superior Court of California, County of Santa Barbara (Santa Barbara County Superior Court or Court). 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.

Employer Plan Sponsor

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SANTA BARBARA

DARREL E. PARKER, COURT EXECUTIVE OFFICER

STEPHANIE ROBBINS, HUMAN RESOURCES MANAGER

TERI CARTER, HUMAN RESOURCES ANALYST

News, Highlights and Instructions

PLANS AND RATES:

- The same insurance plans will continue to be offered with the same benefits, including the Express Scripts® Advanced Utilization Management Program.
- Medical Plans will increase 8.03%
- Dental HMO Plan remains the same and Dental PPO Plan decreased 3.4%
- Vision rates remain the same
- CareCounsel rates remain the same.

WHAT TO DO IF YOU ARE **MAKING CHANGES** TO YOUR COVERAGE:

1. Review plan benefits, providers and rates
2. Obtain and complete forms
3. **Sign and submit forms by WEDNESDAY, OCTOBER 31, 2018.**

WHAT TO DO IF YOU HAVE **NO CHANGES** TO YOUR COVERAGE:

1. You do not have to complete or submit any forms
2. You do not have to contact SBCERS
3. SBCERS will automatically continue your current coverage into 2019.

WHAT TO DO IF YOU DON'T HAVE COURT HEALTH INSURANCE:

1. Money will instead be deposited in your SBCERS Health Reimbursement Arrangement (HRA) account to use.
2. You do not have to contact SBCERS to set anything up, you contact WageWorks to seek reimbursement for eligible health expenses you pay out of your own pocket.
3. Learn how to collect this money in the "Health Insurance Subsidy" and "Health Reimbursement" sections of this booklet.
4. SBCERS will automatically continue your current HRA account into 2019.
5. You may opt back in to Court Health Insurance by completing and remitting forms.

MEDICARE AND IMPORTANT NOTICES:

1. Turning 65 in 2019? Contact SBCERS 3 months before your 65th birthday to review options.
2. If you (and/or your dependents) have or will have Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see "Prescription Drug Coverage and Medicare".

Deadlines and Meeting Dates

Open Enrollment Period:	**OCTOBER 1, 2018 - OCTOBER 31, 2018**
Forms Availability:	**After September 30th (website, mail, email, fax)**
Form Submission Deadline:	**At SBCERS office no later than October 31, 2018**
Forms Submission Options:	**Mail or;** **Email benefits@sbcers.org (scanned attachment) or;** **Fax (805) 560-1086 or;** **Drop Off at SBCERS office**
Changes effective:	**January 1, 2019**

Open Enrollment Meeting Dates

SANTA BARBARA

Where

Engineering Building
Planning Commission Hearing Room
123 E Anapamu Street
Santa Barbara, CA 93101

When

Monday, October 15, 2018 2:00 pm – 4:00 pm

SANTA MARIA

Where

County Administration Building
Board of Supervisors' Hearing Room
511 E Lakeside Parkway
Santa Maria, CA 93455

When

Thursday, October 18, 2018 2:00 pm – 4:00 pm

BRING THIS BOOKLET WITH YOU TO THE OPEN ENROLLMENT MEETING

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 Court medical plan.

CONTACTING CARECOUNSEL

Phone: (888) 227-3334

Email: staff@carecounsel.com

Note: Identify yourself as a Santa Barbara Court Retiree
Hours are 6:30 a.m. to 5:00 p.m., Pacific Time, Monday through Friday

For more information, visit — www.carecounsel.com

Medical and Prescription Plan Choices

Santa Barbara County Superior Court offers a choice of medical plans through Blue Shield, 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. Retirees may choose from the following plans for the coming year:

Blue Shield EPO (EPO = Exclusive Provider Organization)

Under an EPO plan, the network of contracted physicians and hospitals is known as Preferred Providers. On an EPO plan, you do not have an assigned Primary Care Physician (PCP). You are allowed to access medical services from any Blue Shield in-network PPO physician, specialist or facility without having to obtain a referral. For services to be covered, they must be provided by a Preferred Provider. There is no benefit for out-of-network service, except for Emergency Care which is covered at in-network rates.

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. Participants may also be responsible for co-insurance in the form of a percentage of charges for some services.

Regular Prescription Benefits

Under the EPO plan, regular prescription benefits are provided by Express Scripts® through either retail (at a Pharmacy) or mail order service in accordance with the Express Scripts' Pharmacy Management program. You must use your Express Scripts® prescription benefit ID card to obtain prescriptions for all covered family members; the Blue Shield ID card will not be valid for prescriptions. Only the primary subscriber's name is printed on the card. This plan has Out-of-Pocket Maximums; once the maximums have been met, the plan will pay 100% of medication costs.

Medicare Prescription benefits

Under the Blue Shield EPO plan, regular prescription benefits are provided by Express Scripts® either retail (at a Pharmacy) or through mail order service. Medicare A and B enrolled retirees may choose the Express Scripts® Medicare PDP instead of the regular prescription plan with their Blue Shield EPO plan. See "Express Scripts® Medicare PDP" for more information and review any material you may receive from Express Scripts. ID Cards are issued to each enrolled individual. HDHP participants are ineligible for the Medicare PDP.

Prescription Management Program[1]

Retail Refill Requirement

Maintenance drugs must be ordered through Express Scripts'® mail order service. You will be notified by Express Scripts® if medications you take are affected. If you continue to purchase maintenance drugs at retail pharmacies, you will pay 100% of the cost. You will be able to continue purchasing non-maintenance drugs at retail pharmacies using your Express Scripts® ID card.

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 second-line drugs. Second-line drugs can be prescribed as the second step if the first-line drug is not effective.

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 for the prescribed amount.

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

Blue Shield HDHP (High Deductible Health Plan, a Preferred Provider Organization)

This plan is a PPO plan designed to provide choice: two levels of service and flexibility. Participants have a choice of using preferred (In-Network) providers or going directly to any non-PPO provider (Out-of-Network) without a referral. Generally, there are annual deductibles to meet before benefits apply. Participants are also responsible for a certain percentage of the charges (co-insurance), and the plan pays the balance up to the agreed upon amount.

There are no co-payments; you pay a co-insurance amount for all services and prescriptions once the deductible is met. Your coverage for in-network providers is at a higher benefit level and lower cost to you. Participants in this plan who do not have Medicare may be eligible to establish a Health Savings Account.

Regular Prescription Benefits

Under the HDHP plan, regular prescription benefits are provided by Blue Shield. Prescription and Medical coverage have a combined Out-of-Pocket Maximum. You must use your Blue Shield ID card to obtain prescriptions.

Medicare Prescription benefits

Not available under the HDHP plan.

Blue Shield Medicare Prescription Benefits for CSAC EIA

Express Scripts® Medicare® PDP for Blue Shield EPO Plan

This Medicare Part D prescription drug program (PDP) is one of two prescription plans available to Court retirees enrolled in Medicare A and B and the Court's Blue Shield EPO medical insurance. To be eligible[1] 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 Court's Blue Shield EPO plan
- Not enrolled in any other Rx plan

How the Medicare Prescription Drug Plan works

Because Express Scripts® Medicare PDP for EIA is an enhanced Medicare D plan, it provides coverage across all of Medicare's stages[2] 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 $4,700. Once your costs reach $4,700, your cost share will decrease. Prescriptions may be filled at either in-network or out-of-network retail pharmacies or through Express Scripts® 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.

Cost Share Co-Pays For EPO Low Option Plan

	Retail 31 day	Retail 60 day	Retail 90 day	Mail Order 90 day
Generic Drug	**$5.00**	**$10.00**	**$15.00**	**$10.00**
Preferred Brand Drug	**$20.00**	**$40.00**	**$60.00**	**$40.00**
Non-Preferred Brand Drug	**$50.00**	**$100.00**	**$150.00**	**$100.00**

Your medical plan coverage through Blue Shield of California will be the same regardless of which PDP plan you select. You should check with Express Scripts® Medicare to be sure your medications are covered before making your choice.

Once enrolled and prior to your effective date[3], you will receive a member Medicare PDP ID card with a Welcome Kit from Express Scripts. 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 Express Scripts® Medicare and each have your own PDP ID card with a unique member ID number.

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. CSAC EIA has chosen to cover the LEP on the member's behalf.

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 75% 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 eligible who qualify for both Medicare & Medicaid), or they may apply through Social Security
- Meet asset/income thresholds as defined by CMS

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 enrollment Welcome packet.

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 benefit 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.

For more information, premium amounts, etc. visit www.medicare.gov or call Medicare at **800-MEDICARE (800-633-4227).**

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.

IMPORTANT NOTICE FROM THE SUPERIOR COURT OF CALIFORNIA, COUNTY OF SANTA BARBARA REGARDING PRESCRIPTION DRUG COVERAGE AND MEDICARE

CREDITABLE COVERAGE NOTICE

Keep this Creditable Coverage notice. You may be charged a penalty in the form of a life-time higher premium IF you are unable to show when joining a Medicare drug plan, whether or not you have maintained creditable coverage.

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 the Santa Barbara County Superior Court 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 Superior Court has determined that the prescription drug coverage offered for all Medical Insurance Plans for the 2019 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 Superior Court 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 Court's prescription coverage plan that is "packaged" together with the Court'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 Court health insurance, you should also be aware that if you drop your Court 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 Superior Court 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 3916 State Street, Suite 100, Santa Barbara, CA 93105 or call (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 Superior Court 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 (800) MEDICARE (800-633-4227). TTY users should call (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 (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 (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 (800) 772-1213 (TTY 800-325-0778).

Medical Travel Benefits – Carrum Health

The Santa Barbara County Superior Court offers a Medical Travel Benefit to early retirees[1]. A special Centers of Excellence program through Carrum Health is being made available to eligible Blue Shield medical plan early retirees and their dependents who are facing orthopedic, spinal, cardiac or bariatric surgery.

TOP QUALITY hospitals and doctors in 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. In fact, going to low-quality hospital for surgery – even if it is the most convenient location – can be life threatening. At Carrum Health we've done all the research to find the top California hospitals and doctors and give you peace of mind. We have identified regional "**Centers of Excellence**" demonstrating the best results, fewest complications and highest level of personalized care– meaning patients experience a smoother recovery and get back to health sooner.

ZERO out of pocket costs*

Medical bills are confusing and can seem never-ending – especially for surgery. Determining if they are accurate, when they will stop and how much you'll end up paying is incredibly frustrating. If you choose Carrum Health for your surgery, you'll know exactly what it will cost beforehand, if anything at all. In most cases*, the Court's health insurance plan will cover 100% of charges and your out-of-pocket costs* will be zero, saving you thousands of dollars. No medical bills, no travel expenses, no confusion and no surprises.

PERSONALIZED support throughout your journey

Navigating the complexities of healthcare becomes even more challenging and important 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. That's why Carrum Health lends a helping hand. 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.

[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.*

For additional information on this new medical travel benefit visit

my.carrumhealth.com/sbcourts or call (888) 855-7806.

Plan Benefits	BLUE SHIELD - EPO LOW OPTION	
How it Works >	You ***must*** use a Blue Shield contracted PPO provider OR your care will not be covered (except in an emergency).	
DEDUCTIBLE **Individual/Family**	None	
PLAN LIFETIME MAXIMUM	Unlimited	
OUT-OF-POCKET MAXIMUM Individual/Family	$1,500/$3,000	
OFFICE VISITS Physician Specialist [1]	 $20 Co-pay $20 Co-pay	
EMERGENCY SERVICES	$100 Co-pay (waived if admitted)	
CHIROPRACTIC (30 visits/yr)	$20 Co-pay	
ACUPUNCTURE (12 visits/yr)	$20 Co-pay	
PREVENTIVE CARE	No Charge	
OUTPATIENT LAB & X-RAY	No Charge	
HOSPITAL SERVICES **Inpatient** **Outpatient**	 $250/Admit + 20% No Charge	
SUBSTANCE ABUSE PROGRAM **Inpatient** **Outpatient**	 $250/Admit + 20% $20 Co-pay	
MENTAL HEALTH **Inpatient** **Outpatient**	$250/Admit + 20% $20 Co-pay	
PRESCRIPTION DRUG *Plan Type* → ***Administered by: Express Scripts*** Annual Deductible Out-of-Pocket Maximum (Applies to Preferred & Non-Preferred Brand)	Regular Individual / Family $25 / $75 $5,100 / $10,200	Medicare PDP None $4,700
RETAIL (30 day supply) Generic Preferred Brand Non-Preferred Brand	 $10 $35 $50	 $5 $20 $50
MAIL ORDER (90-day supply) Generic Preferred Brand Non-Preferred Brand	 $20 $70 $100	 $10 $40 $100

Note: CSAC EIA Health programs use the Blue Shield of California networks and plans. The medical health plans are insured by CSAC. 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.

	BLUE SHIELD - HDHP			
Plan Benefits	**In-Network**		**Out-of-Network[1]**	
How it Works >	You may see any provider when you need care. Each time you need care you decide whether to see a PPO network or an out-of-network provider. When you use PPO network providers, you typically pay less.			
DEDUCTIBLE **Individual/Family**	$1,500 Individual/$3,000 Family (Combined)			
PLAN LIFETIME MAXIMUM	Unlimited			
OUT-OF-POCKET MAXIMUM **Individual/Family**	$4,500/$9,000 (Combined)			
OFFICE VISITS Physician Specialist [2]	20% 20%		40% 40%	
EMERGENCY SERVICES	20% (waived if admitted)		20% (waived if admitted)	
CHIROPRACTIC (20 visits / yr)	20%		40%	
ACUPUNCTURE (12 visits / yr)	20%		20%	
PREVENTIVE CARE	No Charge		40%	
OUTPATIENT LAB & X-RAY	No Charge		40%	
HOSPITAL SERVICES **Inpatient** **Outpatient**	20% 20%		40% 40%	
SUBSTANCE ABUSE PROGRAM **Inpatient** **Outpatient**	20% 20%		40% 40%	
MENTAL HEALTH **Inpatient** **Outpatient**	20% 20%		40% 40%	
PRESCRIPTION DRUG *Plan Type* → ***Administered by: Blue Shield***	Regular	Medicare PDP	Regular	Medicare PDP
Annual Deductible	Individual / Family See Medical Deductible Combined with Medical Max	No Medicare PDP for HDHP Participants	Individual / Family See Medical Deductible Combined with Medical Max	No Medicare PDP for HDHP Participants
Out-of-Pocket Maximum (Applies to Preferred Brand and Non-Preferred Brand)				
RETAIL (30 day supply)				
Generic	20%		20%	
Preferred Brand	20%		20%	
Non-Preferred Brand	20%		20%	
MAIL ORDER (90-day supply)				
Generic	20%		Not Covered	
Preferred Brand	20%			
Non-Preferred Brand	20%			

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] For the HPDP plan, the out-of-network benefit applies to Usual and Customary allowable changes. 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.

Dental Plan Benefits

There are two plans offered by Delta Dental. The DPPO Plan gives you freedom to choose any dentist and the opportunity for cost savings on treatment when you use a provider from either of the two Delta Provider networks. 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/superiorcourtofcactyofsantabarbara

Plan Benefits	Delta Dental PPO (DPPO)	DentalCare® USA (DHMO) [1] (California Residents Only)
Deductibles and maximums	• Deductibles and annual maximums apply to most plan designs	• No annual deductible or annual dollar maximums
Copayments and 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 copayments for services provided by network dentists (this means out-of-pocket costs are predictable)
Coverage	• Wide range of covered services	• Plan covers nearly 300 procedures
	• No exclusions for most pre-existing conditions	• No copayments or low copayments for most diagnostic and preventive services
		No exclusions for pre-existing conditions or missing teeth
Dentist network	• Freedom to choose any licensed dentist	• You must select a dentist from a list of network dental facilities[1] and you must visit this dentist to receive benefits
	• No referral required for specialty care	• Easy referrals to a large specialty care network
	• No balance billing with PPO dentist	
Changing your dentist	• Change dentists any time without contacting Delta Dental	• Ability to change selected or assigned network dentists via telephone or Internet
Authorization for specialty care treatment	• Preauthorization is not required in most cases	• Preauthorization is required for treatment provided by a specialist
		• Your DeltaCare USA dentist will coordinate your specialty care treatment authorization
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	• No claim forms required
	• Non-Delta Dental dentists may require payment up front, and require you to file a claim for reimbursement	• You only need to pay the specified copayment at the time of your visit

In order to be eligible for dental coverage, you and your dependent must be enrolled in a medical plan offered by the Court.

Participation in medical coverage without dental coverage constitutes a waiver of dental benefits. You will be asked to sign an acknowledgement of this waiver when you decline dental coverage; 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)
	In-Network PPO Providers	In-Network Premier Providers and Out-of-Network*	In-Network (Only)
Annual Deductible Maximum	$50 Individual / $100 Family Waived for Preventive Care		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	10%	20%	$8 — $395 Refer to Delta Dental Description of Benefits & Copayments Schedule
Major Services - Crowns, bridges, inlays, onlays, dentures	40%	50%	$15 — $395 Refer to Delta Dental Description of Benefits & Copayments Schedule
Orthodontia -			
Child	50%	50%	$1,900
Adult (19 & Up)	50%	50%	$2,100
Lifetime Maximum	$1,500 (Deductible does not apply)		Discounted Plan Benefits

**Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 80th percentile for non-Delta dentists.*

Vision Plan Benefits

Vision Service Plan (VSP) is the provider for the Santa Barbara County Superior Court'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, the medical plans do provide diagnosis, management and surgery of ocular diseases and disorders.

VSP features a broad provider network with substantial access across the United States in a variety of settings. All VSP network providers are independent optometrists or ophthalmologists in private practice who provide full service. To receive the best benefit when using VSP, select a Network Provider for your services and eyewear purchase. You do have the option of using a non-network provider under the VSP plan but you pay out-of-pocket, file claims for reimbursement, and the benefit allowances are lower.

To use your vision coverage, simply tell your eye care provider that you have VSP. No ID card is necessary. VSP is a paperless company and does **not** issue ID cards, however a "Member Vision Card" is accessible online or from your smartphone at http://mobile.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 Court in order to participate in the vision plan. Retirees who cancel vision insurance are permitted to re-enroll during Open Enrollment.

Plan Benefits	In-Network	Out-of-Network *Reimbursements only*
Eye examination **Once every 12 months**	$10 Co-pay	Up to $45
Standard Lenses **Once every 24 months** • Single • Bifocal • Trifocal	 $10 Co-pay $10 Co-pay $10 Co-pay	 Up to $30 Up to $50 Up to $65
Frame **Once every 24 months**	$120 allowance at contracted provider $70 allowance at Costco 20% off amount over your allowance	Up to $70
Contact Lenses (in lieu of eye-glasses)	$120 Allowance	Up to $105
Discounts & Extra Savings	20% off additional glasses or non-prescription sunglasses	Not Covered

NOTE: It is possible that you may need to supply a Social Security Number to providers for purposes of eligibility and benefit verification.

Important Facts You Need to Know

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 Court insurance premiums.

Annual Open Enrollment Periods — are usually your only opportunity each year to enroll in or change healthcare plans. If you are enrolling in or changing plans for 2019, your forms must be received by SBCERS no later than October 31, 2018, otherwise you will not be able to make changes until 2019 Open Enrollment for 2020 coverage.

Blue Shield ID Cards for EPO Plan — 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.

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. **Enrolling in Medicare while you have COBRA coverage** disqualifies 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

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 Court 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 open only to California residents. The dental 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 Court medical plan.

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.

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 (see "Who Can Help You…"). Check your local community for resources and assistance with your Insurance, Medicare and other "Senior" needs.

Medicare Advantage Plans (aka Part C) — A health plan offered by an insurance carrier that contracts with Medicare to provide you with all of your Part A and Part B benefits. Medicare services are covered through those plans and not under Original Medicare. The Court does not offer any Medicare Advantage plans.

Medical Exchanges — See "Important Facts… Health Insurance Marketplace."

Medicare and Age 65 — See "Age 65 and Medicare" in "Important Facts You Need to Know."

Medicare Coordination with Other Coverage — If you participate in a SBCERS' Blue Shield plan with Medicare, the Blue Shield plan provides full comprehensive 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 "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 Court insurance premium. You may wish to contact Medicare for information about enrolling in either.

Medicare Parts A & B — New enrollment in Medicare Parts A and B is considered a qualifying event that entitles you to change your plan mid-year and/or receive a premium reduction on or after your Medicare effective date. Let your SBCERS Benefits 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 must submit forms to drop Court

insurance, change plans or have your Court insurance benefits coordinated with a current Blue Shield EPO plan and/or participate in the Medicare Prescription Drug Plan (PDP) for Blue Shield EPO plan, and/or receive a reduction in your monthly Court insurance premium. If you continue to participate in Court-sponsored insurance you must also provide a copy of your signed Medicare card with your change form(s).

The effective date of Court insurance plan and/or premium changes will be determined by SBCERS based on several factors including, the Medicare effective date, CMS rules and the date SBCERS received your insurance change form with signed Medicare card copy, and will be no earlier than two weeks after receipt but may be as late as the first of the month following 45 days from receipt.

Retirees who have Medicare A & B and a Blue Shield EPO plan may find, because of the coordination of benefit between Medicare and Blue Shield that 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 EPO co-pays and deductibles. Blue Shield HDHP participants will still have to meet deductibles.

Medicare Prescription Coverage Part D — The prescription coverage included in the Court 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 Court-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 copayments, coinsurance, and deductibles. The Court 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 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 plan 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.

Over-Age Dependents — Report and drop dependents as soon as they no longer qualify for coverage on your Court 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 Court plans, you will be responsible for benefit claims paid by the health plans and any associated premium costs. See "Dependent Eligibility Rules."

PPACA (Patient Protection and Affordable Care Act) — Was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. Starting in 2019, plans with annual premiums exceeding $10,200 for individuals or $27,500 for a family will have an excise tax imposed by to be paid by insurers. The excise tax, also known as the "Cadillac" tax, was created as part of the Patient Protection and Affordable Care Act largely as a way to reduce overall health care costs and help fund benefits to the uninsured under the law.

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 to help you calculate your insurance premium and deduction.

Premium is More than Retirement Allowance ("Self-Pay" Option) — You might be eligible to participate in Court 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. The retirement office will apply your retirement allowance toward your health insurance cost. As a result, you are required to pay only the difference between the cost of your insurance and your monthly retirement benefit, plus $10.

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 this 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, 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, and list 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.

Mid-Year Benefit Change Rules

You will not be allowed to change your plan selections or add dependents until the next benefit year (2019 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:

- Any change must be consistent with the qualifying event.
- 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.

The events that qualify for mid-year enrollment are:

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 results in your change 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 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 signed 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 the you are 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.
- 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.

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 copayments will be waived.

Getting the Best Benefit: When Covered by Medicare & Blue Shield

Before receiving services from new providers, always ask:

1) Are you a "Medicare Assigned" doctor? and
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
Chiropractic doctor's regular Office visit charge	$80.00
Blue Shield pays 80% of the charge	-$64.00
Balance of bill	$16.00
Patient Responsibility	$16.00

Health Care Subsidy

Retired members of SBCERS who participate in Court-sponsored health plans currently receive a health insurance subsidy (aka 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 Court's 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 Court 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 …" and/or "Subsidy Pooling..." under "Important Facts You Need to Know."

Health Reimbursement: if you don't have Court health insurance

Eligible retirees and beneficiaries not enrolled in Court-sponsored health insurance, receive help with health expenses, through a Health Reimbursement Arrangement (HRA) benefit funded by the Court. 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 Court-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.

This benefit is administered by WageWorks. 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 WageWorks along with proof of the expense and proof of payment (e.g. Medicare statements and receipts) or beginning in 2018, use a pre-paid debit card issued to you by WageWorks.

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.

Legal Disclosures

The information in this brochure is a general outline of the benefits offered by the Santa Barbara County Superior Court. 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.

Notice of 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 lymph edema.

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 Blue Shield EPO 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 Court's Human Resources Department.

COURT RETIREE MONTHLY PREMIUM RATES

Effective January 1, 2019 through December 31, 2019

NON-MEDICARE	BLUE SHIELD with regular Prescription Plan		BLUE SHIELD with Medicare Prescription Drug Plan	
	EPO	HDHP	EPO	HDHP
Non-Medicare Retiree Only	$1,302.00	$1,010.00	N/A	N/A
Non-Medicare Retiree + 1 Non-Medicare dependent	$2,405.00	$1,866.00	N/A	N/A
Non-Medicare Retiree + 2 Non-Medicare dependents	$3,777.00	$2,934.00	N/A	N/A
MEDICARE	**BLUE SHIELD with regular Prescription Plan**		**BLUE SHIELD with Medicare Prescription Drug Plan**	
	EPO	HDHP	EPO	HDHP
Medicare Retiree Only	$677.00	$739.00	$602.00	No Medicare PDP
Medicare Retiree + 1 Medicare dependent	$1,354.00	$1,482.00	$1,203.00	
Medicare Retiree + 2 Medicare dependents	$2,031.00	$2,222.00	$1,805.00	
Medicare/ Non-Medicare COMBINATIONS	**BLUE SHIELD with regular Prescription Plan**		**BLUE SHIELD with Medicare Prescription Drug Plan *(all MC enrollees enrolled in MC PDP)***	
	EPO	HDHP	EPO	HDHP
Non-Medicare Retiree + 1 Medicare dependent	$1,979.00	$1,753.00	Available Upon Request	No Medicare PDP
Non-Medicare Retiree + 2 Medicare dependents	$2,656.00	$2,492.00	Available Upon Request	
Non-Medicare Retiree + 1 Medicare dependent, and 1 Non-Medicare dependent	$3,082.00	$2,609.00	Available Upon Request	
Medicare Retiree + 1 Non-Medicare dependent	$1,780.00	$1,595.00	$1,705.00	
Medicare Retiree + 2 Non-Medicare dependents	$3,152.00	$2,663.00	$3,077.00	
Medicare Retiree + 1 Medicare dependent, and 1 Non-Medicare dependent	$2,457.00	$2,338.00	$2,307.00	

COURT RETIREE MONTHLY PREMIUM RATES

Effective January 1, 2019 through December 31, 2019

OPTIONAL

DENTAL	Delta Dental PPO	DeltaCare USA
Retiree	$45.60	$40.33
Retiree +1	$87.50	$66.31
Retiree +2	$134.50	$100.64

VISION SERVICE PLAN	
Retiree	$7.00
Retiree +1	$9.80
Retiree +2	$17.30

MANDATORY (with Medical)

CARECOUNSEL
$3.25

HOW TO CALCULATE YOUR SHARE OF PREMIUM

CareCounsel	$	3.25
Medical Rate	$	
Dental Rate	$	
Vision Rate	$	
SUB-TOTAL	$	
SUBTRACT Monthly SUBSIDY[1]	$	
YOUR SHARE OF PREMIUM		
the "insurance deduction" listed on your monthly benefit payment	**$**	

[1] *Monthly Subsidy = $15 x Years of Service*

COBRA Facts for Retirees

If you are retiring in 2019, or if you are a recent retiree with COBRA coverage.

If you retire in 2019, 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.

Health Insurance - 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 Court's COBRA administrator, **Workterra** will send you an election notice detailing your rights to re-enroll with no lapse in coverage and 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 **Workterra**. You do not need to complete nor mail forms or any payment to **Workterra**.

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 **Workterra** directly.

3. You will receive a cancellation notice from **Workterra**, the Court'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 has expired, if you continue to reside in California, you are permitted an additional 18 months under 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. **Workterra** 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.

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.

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 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 disqualifies 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.

You are responsible for coordinating your Medicare enrollment. SBCERS does not deduct Medicare premiums from your retiree benefit payment, nor do we coordinate your enrollment with the Center for Medicare Services. It is your responsibility to contact Social Security Administration directly to coordinate your Social Security and Medicare enrollment.

CONTACT AND RESOURCE INFORMATION

SBCERS Toll Free Number: **877-568-2940**
Website: www.sbcers.org
Send Insurance Forms to: benefits@sbcers.org

SBCERS Santa Barbara Office: **805-568-2940**
3916 State Street, Suite 100
Santa Barbara, CA 93105
FAX: 805-560-1086

SBCERS Santa Maria Office: **805-739-8686**
2400 Professional Parkway, Suite 150
Santa Maria, CA 93454
FAX: 805-739-8689

Blue Shield (including prescriptions for HDHP)
Member Services: 855-256-9404
Website: www.blueshieldca.com/csac

BlueCard (Network Providers outside of California)
Member Services: 800-810-2583
Website: www.bcbs.com

Express Scripts (BS Prescriptions for EPO, PPO)
Member Services: 800-711-0917
Website: www.express-scripts.com

Express Scripts (Medicare PDP for BS EPO, PPO)
Member Services: 844-468-0428
Website: www.express-scripts.com

Carrum Health
Member Services: 888-855-7806
Website: my.carrumhealth.com/cosb

Delta Dental
Member Services (DPPO): 800-765-6003
Member Services (DHMO): 800-422-4234
Website:
www.deltadentalins.com/countyofsantabarbara

Vision Service Plan (VSP)
Member Services: 800-877-7195
Website: www.vsp.com

Benefits Coordinators Corp (Cobra Admin)
Member Services: 800-685-6100
Website: www.benXcel.com

CareCounsel Healthcare Assistance
Member Services: 888-227-3334
Website: www.carecounsel.com

WageWorks
Member Services: 877-924-3967
Website: www.wageworks.com

HELPFUL RESOURCES

Medicare and Medicare Prescription Drug Coverage
Member Services: 800-MEDICARE (800-633-4227)
Website: www.medicare.gov

SHIPs (State Health Insurance Assistance Programs)
Insurance Counseling and Assistance to Medicare Beneficiaries: 877-839-2675

Health Insurance Marketplace
ACA Affordable Care Act Info: 800-318-2596
Website: www.healthcare.gov

HICAP (Health Insurance Counseling and Advocacy)
Medicare Advocacy: 800-434-0222

County of Santa Barbara
Human Resources: 805-568-2800
Website: www.sbcountyhr.org

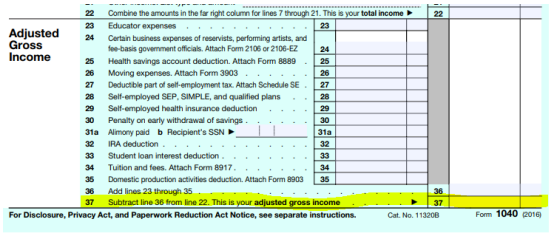
IMPORTANT INFORMATION ABOUT MEDICARE

You may be eligible to have your Medicare premium reduced for calendar year 2018 and the proceeds refunded to you.

SBCERS Staff has worked diligently with the Social Security Administration to advocate for our members and request consideration of Medicare IRMAA premium adjustments made for the 2018 calendar year as a result of the IRS 1099-R correction put in place by SBCERS. Recently, significant progress has been made with the Social Security Administration and SBCERS may be able to assist you to have your Medicare premiums reduced. This process does not require that you have previously appealed your Medicare premium and received a denial.

To tell if you might be eligible for a refund please follow these 3 easy steps:

1. Review your Calendar Year 2016 Tax Return to locate your Adjusted Gross Income (1040 line 37):



2. If the amount included on line 37 of your tax return is less than **10%** over the amount applicable for your filing status in the chart below, you may be eligible to appeal to have your premiums reduced to the lower premium tier and receive a refund for the amounts paid over the lower tier.

If your yearly income in 2016 (for what you pay in 2018) was:			
File individual tax return	**File joint tax return**	**File married & separate tax return**	**You pay each month (in 2018)**
$85,000 or less	$170,000 or less	$85,000 or less	$134
above $85,000 up to $107,000	above $170,000 up to $214,000	Not applicable	$187.50
above $107,000 up to $133,500	above $214,000 up to $267,000	Not applicable	$267.90
above $133,500 up to $160,000	above $267,000 up to $320,000	Not applicable	$348.30
above $160,000	above $320,000	above $85,000	$428.60

3. If you think you might be eligible or need help performing this calculation, call us at 1-877-568-2940 or email us at benefits@sbcers.org and we will explain to you how to file an appeal with the Social Security Administration.

Please note that SBCERS cannot provide tax advice nor can it represent you before the Social Security Administration.

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.

2019

Benefit For	*Check Mailing Date*	*Direct Deposit Date*
January	1/31/2019	2/1/2019
February	2/28/2019	3/1/2019
March	3/30/2019	4/1/2019
April	4/30/2019	5/1/2019
May	5/31/2019	5/31/2019
June	6/29/2019	7/1/2019
July	7/31/2019	8/1/2019
August	8/31/2019	8/30/2019
September	9/30/2019	10/1/2019
October	10/31/2019	11/1/2019
November	11/30/2019	11/29/2019
December	12/31/2019	1/2/2020

2020

Benefit For	*Check Mailing Date*	*Direct Deposit Date*
January	1/31/2020	1/31/2020
February	2/29/2020	2/28/2020
March	3/31/2020	4/1/2020
April	4/30/2020	5/1/2020
May	5/30/2020	6/1/2020
June	6/30/2020	7/1/2020
July	7/31/2020	7/31/2020
August	8/31/2020	9/1/2020
September	9/30/2020	10/1/2020
October	10/31/2020	10/30/2020
November	11/30/2020	12/1/2020
December	12/31/2020	1/4/2021

2019 GUIDE TO COURT RETIREE HEALTH PLANS AND OPEN ENROLLMENT

Santa Barbara County Employees' Retirement System

3916 State Street, Suite 100

Santa Barbara, CA 93105

WWW.SBCERS.ORG

RETURN SERVICE REQUESTED