2007 SBCERS Retiree Health Plan Open Enrollment Guide

Calendar of OE Meetings

Spouses are welcome, too!

Santa Maria: Monday, May 21
9:30 a.m. – 11:30 a.m.
Board of Supervisors’ Hearing Room
511 E. Lakeside Parkway

Lompoc: Tuesday, Jun 5
9:30 a.m. – 11:30 a.m.
Veterans Memorial Building Auditorium
100 Locust Street

Lompoc: Monday, May 21
2 p.m. – 4 p.m.
Veterans Memorial Building Auditorium
100 Locust Street

Santa Maria: Tuesday, Jun 5
2 p.m. – 4 p.m.
Board of Supervisors’ Hearing Room
511 E. Lakeside Parkway

Santa Barbara: Friday, May 25
9:30 a.m. – 11:30 a.m.
Board of Supervisors’ Conference Room
105 E. Anapamu St., Fourth Floor

Santa Barbara: Friday, Jun 8
2 p.m. – 4 p.m.
Board of Supervisors’ Conference Room
105 E. Anapamu St., Fourth Floor

If you need directions to any of these locations, please call the Retirement Office at: 805-568-2940. This year’s Open Enrollment starts May 21 and ends June 13, 2007.

There are changes in the medical plan designs and rates are changing, in some cases significantly. Your medical and dental needs may also have changed. This is your chance to think about your coverage, consider your options, and make changes for the upcoming year.

For more information, contact:
Santa Barbara County Employees’ Retirement System
(805) 568-2940
Oscar Peters, Administrator
www.countyofsb.org/sbcers
What’s New for 2007

New in July! Continued Health Subsidies for Husband/Wife and Domestic Partner Retirees

If two SBCERS retirees are married to each other or are domestic partners and are both eligible for a health insurance subsidy, they may now combine their subsidy amounts toward the premium cost for two-party or family coverage. This program is modeled after the County’s combined health insurance contribution program and works in much the same way. One retiree becomes a dependent on their spouse/partner’s insurance, and “donates” his/her service credit to the spouse/partner for the purpose of calculating the health insurance subsidy.

Currently, each retiree uses his/her own subsidy to purchase individual health coverage:

Retiree Spouse A with 30 years of service
$450 subsidy
$400 individual premium
$50 unused subsidy

Retiree Spouse B with 15 years of service
$225 subsidy
$400 individual premium
$175 paid from retirement allowance

Now, both retirees can enroll in two-party coverage and combine subsidies to pay the premium:

Retirees A&B with 45 years combined service
$675 combined subsidy
$700 2-party premium
$25 paid from retirement allowance

Both spouses/partners must enroll in the same medical, dental and/or vision coverage to participate. If you want to take advantage of this program, please telephone the Retirement Office to request an “Election to Combine Health Insurance Subsidies” form or come to one of the Open Enrollment meetings listed on Page 1.

Board of Retirement

Bernice James
Chair – County Treasurer-Tax Collector & ex-officio member

Joni Gray
Vice Chair – Fourth District Supervisor

Donald Kendig
Secretary – elected
General Member representative

George Bobolia
elected Retiree representative

Paul Doré
appointed member

Joseph Gallas
appointed member

Julie McCammon
elected Safety Member representative

Harriet Miller
appointed member

Shawn Terris
elected General Member representative

Ronald Bruns
alternate Safety Member representative

Vacant
alternate Safety Member representative

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Overall Costs

The biggest change this Open Enrollment is the significant increase in all medical premiums for early (non-Medicare) retirees, and for Medicare retirees enrolled in the Blue Shield PPO. In recent years, early retiree costs have been subsidized by premiums paid by active County employees and Medicare retirees. This year the County’s Health Oversight Committee made a major decision to redistribute premium costs among Active Employees, Early Retirees and Medicare Retirees in order to rate each group based on its own claims experience. This will result in very large medical premium increases (approximately 40%-60%) for early retirees. Premiums for Medicare retirees in the HMO and POS plans will decrease as a result, but PPO premiums for this group will increase by almost 45% as well.

Dental and vision premiums are not changing for 2007-08.

Blue Shield Plan Design Changes

While all of the same plans are available this year, several Blue Shield medical plan design changes are being made effective July 1, 2007. These changes are being made in order to reduce the overall premium cost of each plan.

Low Option HMO Copayments
- Office visit - $20
- Prescription drugs - $10 generic; $35 brand formulary; and $50 brand non-formulary after a $50 annual deductible
- Emergency Room - $100

High Option HMO Copayments
- Office visit - $15
- Prescription drugs - $10 generic; $30 brand formulary; and $45 brand non-formulary after a $50 annual deductible
- Emergency Room - $50
- Hospital Admission - $100

PPO Copayments
- Prescription drugs - 15 generic; $25 brand formulary; and $40 brand non-formulary after a $50 annual deductible

Point of Service Copayments
- Office visit - $15
- Prescription drugs - $10 generic, $20 brand formulary, and $35 brand non-formulary
- Emergency Room - $50
- Hospital Admission - $200
Open Enrollment

During Open Enrollment, you have the opportunity to enroll in or change coverage under the SBCERS sponsored health and dental plans for the next plan year. Before you enroll or change coverage, review your current benefit elections, assess your medical coverage needs, calculate your available health plan subsidy, and carefully consider your choices for 2007.

A Few Points to Remember

• Attend one of the Open Enrollment meetings near you. Insurance representatives will be available to answer your questions. Complete any necessary forms and submit them – right on the spot!

• Compare premium costs and plans on page 18 and calculate your available subsidy – Your subsidy is $15 for every year of service

• Self-Pay Option. If your subsidy and retirement allowance are insufficient to cover your monthly premium you must elect the Self-Pay Option to cover the monthly difference in premium to keep your medical/dental plan; your payment is due to the retirement system by the 15th of the month prior to the coverage month. Contact your Benefits Specialist for details.

• You must be continuously enrolled in a medical plan offered by SBCERS to be eligible for dental coverage; if you drop your dental coverage you waive your right to reenroll

• In order to enroll in PacifiCare Secure Horizons plans, all subscribers must be Medicare participants.

• Medicare participants also have the option of choosing any medical plan with the exception of the High Deductible Health Plan. If you choose one of the Blue Shield plans, Medicare will be your primary coverage and the other plan will provide secondary coverage

• Send in a copy of your and your dependent’s Medicare card as soon as you receive it from Social Security Administration

• Telephone your Benefits Specialist for assistance if you cannot attend an Open Enrollment meeting – see contact information on the back cover

Enrollment in PacifiCare Secure Horizons

Enrollment in PacifiCare Secure Horizons (an option only for individuals enrolled in Medicare) is on a calendar-year schedule rather than the July 1 – June 30 schedule like the other health insurance plans.

If you are currently in PacifiCare Secure Horizons and you want to change to one of the other plans, you may take advantage of Open Enrollment to do so, for coverage effective July 1. Make sure you disenroll in Secure Horizons simultaneously.

If you are interested in changing to PacifiCare Secure Horizons, please contact your Benefits Specialist for an enrollment kit.
Open Enrollment Instructions

Step 1:
Review the medical/dental plan choices, premiums described on pages 10 - 11, 12, and on page 18. Then calculate your available subsidy and possible premium deduction to determine if these choices are still right for you. Then decide whether you want to change or keep your plans. If you like the plans you’re in, and you have no new dependents to enroll, or other changes to make, you can stop here. You will be automatically enrolled for coverage effective July 1, 2007.

Step 2:
If you have questions about your choices, you can attend an Open Enrollment Meeting (see schedule on front cover). During Open Enrollment, all retirees are invited to explore their healthcare options.

Step 3:
Review your Open Enrollment materials carefully. If you want more specific information regarding the different plans, please use the websites and the phone numbers on the back page of this guide to see which doctors and other healthcare providers you can use under the different plan choices. If your retirement lifestyle includes a lot of travel, check on provisions for coverage when you are away from home.

Step 4:
You want to choose a different medical, dental or vision plan, you must:
Complete the appropriate enrollment/change request form for the plan you are choosing. Changes between carriers (PacifiCare to Blue Shield or vice versa) require that you disenroll with the prior carrier. Please note that you may not add dental coverage if you have previously waived dental coverage.

You want to add/change dependent coverage and . . .

• you are changing your medical or dental plan, simply enter the new dependent information on the enrollment form you are completing.

• you are not changing plans, put the new dependent information on a change form for your plan.

Step 5:
Make your selections on the appropriate form(s) and submit the completed and signed form(s) to your Benefits Specialist no later than June 13, 2007.

Enrollment forms must be received in the Retirement Office by June 13, 2007. Changes made during Open Enrollment are effective on July 1, 2007.
Changes During the Calendar Year

You may enroll in or change your medical or dental account elections during the year if you or your eligible spouse or eligible dependents experience a qualified change in family status affecting your eligibility for coverage under our retiree health plans. Qualified changes in family status allow you to add or drop health or dental coverage. Qualified changes in family status allow you to change from single to retiree + 1 or family coverage and vice versa. You are not allowed to change from one health plan option to another option. Changing your address may also be a qualifying event to make changes to your health plan.

Qualifying Events
The following events qualify as changes in family status or eligibility:

- change in marital status due to marriage, divorce, or legal separation
- change in domestic partnership
- change in the number of dependents due to birth, adoption, or placement for adoption
- death of spouse, domestic partner, or dependent
- your dependent child becomes ineligible for coverage (age 19 and no longer full-time student or age 24)
- your address changes and you no longer reside within an HMO zip code service area

You Acquire New Dependents
If you acquire any new eligible dependents during the year and you wish to add them to your coverage, you must enroll them within 31 days of the event (marriage, birth, adoption, etc.). Telephone your Benefits Specialist to get the necessary form.

You or Your Spouse Becomes Eligible for Medicare
If you or your spouse becomes eligible for Medicare after Open Enrollment, contact your benefits specialist for the required Medicare Part D application and enrollment instructions. Your medical benefits (and the amount you are being charged each month) will be adjusted accordingly.

You Change Your Address
If you change your address, you are required to submit that information to the retirement office within 31 days of the event. If you or your eligible dependent(s) no longer reside within an HMO service area for the plan in which you are enrolled, you may not be eligible for that plan. Telephone your Benefits Specialist for assistance.
A Reminder About CareCounsel

Your personal healthcare advocate

Sometimes health care and insurance issues can be confusing. CareCounsel, a healthcare assistance program, is available to help. When you call CareCounsel, you get confidential support, benefits assistance, claims troubleshooting, health plan issues resolution, help locating quality healthcare resources, and healthcare advocacy. CareCounsel is an independent organization and is not part of your health plan. They are here to help you navigate the complexities of your health plan benefits.

Some of the areas where CareCounsel can help are:

• Choosing a health plan for your family
• Understanding your benefits
• Selecting doctors and hospitals
• Troubleshooting claims problems
• Obtaining care or referrals
• Addressing quality-of-care concerns
• Communicating effectively with doctors
• Getting the most from your healthcare dollars
• Finding resources for a health condition

CareCounsel is different from your health plan. They do not provide medical advice or treatment, but serve as advocates to help you get your needs met.

For more information, call 1-888-227-3334, or go to www.carecounsel.com.

Have You Heard About Health Savings Accounts?

If you enroll in the Blue Shield High Deductible Health Plan (HDHP), you are eligible to establish a Health Savings Account (HSA). An HSA is a tax-free savings account that you can use to pay for qualified medical expenses, and can be established at most banks offering tax-free savings accounts.

Only individuals enrolled in a High Deductible Health Plan are eligible for a Health Savings Account. In accordance with federal tax law, the HDHP and HSA are available only to individuals under 65 years of age and not enrolled in Medicare.

A Health Savings Account offers several benefits. You can claim a tax deduction for the after-tax contributions you make to an HSA even if you do not itemize your income tax deductions. The interest on the assets in the account is tax free. You can make tax-free withdrawals to pay for qualified medical expenses, and the unused balance in your HSA carries over from one year to the next. Once you reach age 65 and can no longer contribute to the HSA, you can use your savings for any purpose.
Dependent Eligibility

Eligible retirees who enroll in healthcare coverage may also enroll their eligible dependents. Eligible dependents include:

- **Your legal spouse**

- **Your domestic partner if he or she:**
  - is your sole spousal equivalent (this means that you cannot be married to someone else or have another domestic partner)
  - is 18 years old or older
  - is mentally competent to enter into contracts
  - resides with you and intends to do so indefinitely
  - is jointly responsible with you for common financial obligations
  - is unmarried and not related to you by blood to a degree that would bar marriage in the state of residence
  - and, the domestic partnership is registered with a state, county or city, and the domestic partner has not terminated another domestic partnership within the last 6 months

- **Your natural children, stepchildren, foster children** placed with you by an authorized agency or by court order, and children who, before reaching the age of 18, are either adopted by you or placed in your home for adoption. In addition, such children must:
  - be under age 23
  - be unmarried
  - be over 50% supported by you (except as noted below under “Special Rule for Divorce/Separation”)

- **not be a “qualifying child”** (as that term is defined in the Internal Revenue Code) of another individual.

- **Your disabled children age 23 or older.**

- **A child of a domestic partner** who satisfies the same conditions as listed above for natural children, stepchildren, adopted children, or foster children, and in addition:
  - is not a “qualifying child” (as that term is defined in the Internal Revenue Code) of another individual

**Special Rule for Divorce/Separation.**

The requirement that you provide over 50% of a child’s support does not apply if (1) you and the child’s other parent are divorced or legally separated under a decree of separate maintenance, are separated under a written separation agreement, or currently live apart and lived apart at all times during the last six months of the previous calendar year; (2) the child receives over 50% of his or her support during the calendar year from you and the other parent; and (3) the child is in the custody of one or both of you and the other parent more than 50% of the calendar year.

This is only a summary of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents, and the plan documents will govern in the event of any conflict between this summary and the plan documents.
Your Medical Plan Choices

All Medical Plans include prescription drug coverage but the coverage differs under each plan – refer to medical plan comparison charts for coverage details. The medical plan comparison charts show only a brief summary of the benefits available. The health plan contracts must be consulted to determine the exact terms and conditions of coverage.

Retirees may choose from the following medical plans for the coming year.

**Blue Shield HMO/Low Option** – A comprehensive HMO plan with a $20 office visit co-pay, inpatient hospital co-pays of $250 plus 20% of hospital charges.

**Blue Shield HMO/High Option** – A second comprehensive HMO plan with lower co-pays than the low option HMO plan. There’s a $15 office visit co-pay and a $100 co-pay for inpatient hospital services.

**High Deductible Health Plan/Blue Shield Preferred Savings PPO** – A high deductible preferred provider organization plan (PPO) that includes benefit coverage for all physicians and hospitals with coverage for in-network providers at a higher benefit level and with lower co-pays. In exchange for lower premiums, this plan has a high annual deductible of $1,500 for single coverage and $3,000 for family coverage (2 or more family members). This plan is not available to Medicare participants.

**Blue Shield Point of Service** – A point-of-service (POS) option that combines the reduced cost of an HMO with the in-network and out-of-network coverage of a preferred provider (PPO) plan. For Tiers 1 and 2, there is no deductible and there are significantly reduced co-pays.

**Blue Shield PPO** – A preferred provider organization plan (PPO) that has lower deductibles and co-payment maximums than the High Deductible Health Plan. Includes benefit coverage for all physicians and hospitals with coverage for in-network providers at a higher benefit level and with lower co-pays.

**Blue Shield PPO Plan for Out-of-State Retirees** – A PPO plan that allows you to use the healthcare providers of your choice. You and the plan each pay a percentage of covered expenses. This plan is available only to retirees who live outside of California.

**PacifiCare Secure Horizons** – Retirees enrolled in Medicare also have a choice of two Medicare Advantage plans designed to coordinate with Medicare benefits. These plans feature all of the health coverage services offered by Medicare, plus some extra services Medicare does not offer.
<table>
<thead>
<tr>
<th>Medical Plan Co-Pays/Limits</th>
<th>Blue Shield HMO Low Option (H53907)</th>
<th>Blue Shield HMO High Option (H53905)</th>
<th>Blue Shield Preferred Savings PPO (HDHP) (977749)</th>
<th>Blue Shield Point-of-Service (POS) (ZH5743)</th>
<th>Blue Shield PPO (977737)</th>
<th>Blue Shield Out of State PPO (977736)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>None</td>
<td>None</td>
<td>$1,500 / $3,000 (combined)</td>
<td>None</td>
<td>None</td>
<td>$250/$750</td>
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<tr>
<td>Lifetime Maximum</td>
<td>None</td>
<td>None</td>
<td>$6 million (combined)</td>
<td>None</td>
<td>None</td>
<td>$2 million (combined)</td>
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<tr>
<td>Annual Co-Pay Maximum</td>
<td>$1,500 individual $3,000 two-party $4,500 family</td>
<td>$1,500 Individual $3,000 two-party $4,500 family</td>
<td>$1,500 Individual $3,000 two-party $4,500 family</td>
<td>$2,000 Individual $4,000 two-party $6,000 family</td>
<td>$3,000 Individual $6,000 two-party $9,000 family</td>
<td>$4,000 / $8,000 $6,000 / $18,000 $1,000 / $2,000</td>
</tr>
<tr>
<td>Hospital Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (room)</td>
<td>$250 + 20% per admission</td>
<td>$100 per admission</td>
<td>$200 per admission</td>
<td>$200 per admission+10%</td>
<td>$200/per admission</td>
<td>$250/admit +20%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>No charge</td>
<td>No charge</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>40% +20%</td>
</tr>
<tr>
<td>Emergency Room Co-Pay</td>
<td>$100</td>
<td>$50</td>
<td>20% (+$50 if not directly admitted)</td>
<td>20% (+$50 if not directly admitted)</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$20 In service area OR $50 out-of-area</td>
<td>$15 In service area OR $50 out-of-area</td>
<td>$15 In service area OR $50 out-of-area</td>
<td>10% In service area, 10% out-of-area</td>
<td>20% or 30% depending on services</td>
<td>20%</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$50 per day</td>
<td>No charge</td>
<td>20%</td>
<td>10%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Physician Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20, $30 self-referral</td>
<td>$15, $30 self-referral</td>
<td>20%</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Hospital Visits</td>
<td>No charge</td>
<td>No charge</td>
<td>20%</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Periodic Health Evaluation</td>
<td>$20 per exam</td>
<td>$15</td>
<td>20%</td>
<td>20%</td>
<td>Not covered</td>
<td>$25 Not covered</td>
</tr>
<tr>
<td>X-Ray &amp; Lab Services</td>
<td>No charge</td>
<td>No charge</td>
<td>20%</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>$20 per visit</td>
<td>$15</td>
<td>20% max, unlimited</td>
<td>$15</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>$20 per visit</td>
<td>$15</td>
<td>20% max, unlimited</td>
<td>20% max, unlimited</td>
<td>20% max, unlimited</td>
<td>20%</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>$20, 100 visits/year</td>
<td>$15, 100 visits/year</td>
<td>20% w/ prior authorization</td>
<td>10%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Blue Shield HMO Low Option</td>
<td>Blue Shield HMO High Option</td>
<td>Blue Shield Preferred Savings PPO (HDHP)</td>
<td>Blue Shield Point-of-Service (POS)</td>
<td>Blue Shield PPO</td>
<td>Blue Shield Out of State PPO</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>In Network</td>
<td>Out-of-Network</td>
<td>POS Tier 1 HMO</td>
<td>POS Tier 2 PPO</td>
<td>POS Tier 3</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Not Covered</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>$15/visit</td>
<td>$25/visit</td>
</tr>
<tr>
<td>Prosthetics/Orthotics</td>
<td>$20/visit</td>
<td>$15/visit</td>
<td>20%</td>
<td>Not covered</td>
<td>$20/visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$20, up to $2,000/year</td>
<td>No charge</td>
<td>20%</td>
<td>Not covered</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not covered</td>
<td>Not covered</td>
<td>50%</td>
<td>Not covered</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Mental Health**

| Severe Disorders-                  | $250 + 20% per admission | $100/admission | $100/admission | See HMO Tier | See HMO Tier | $250/admit | 20% |
| Inpatient                        |                            | 20%            | 40%            | No charge    | 20%          | 40%        | 20% |
| Severe Disorders-                 | $20 per visit              | $15 per visit  | $15 per visit  | See HMO Tier | See HMO Tier | $20 per visit | 20% |
| Outpatient                       |                            | 20%            | 40%            | No charge    | 20%          | 40%        | 20% |
| Non-Severe Disorders-Inpatient   | $250 + 20% per admission   | $100/admission | $100/admission | See HMO Tier | See HMO Tier | $250/admit | 20% |
|                                |                            | 20%            | 40%            | No charge    | 20%          | 40%        | 20% |
| Non-Severe Disorders-Outpatient  | $25/visit, 20 visits/year  | $15/visit      | $20/visit      | See HMO Tier | See HMO Tier | $25/visit | 20% |
|                                | (combined with             | 20%            | 40%            | Not covered  | 20%          | 20%        | 20% |
|                                |chem dep visits)            | 20%            | 40%            | Not covered  | 20%          | 20%        | 20% |
| Chem. Dependency               | $25/visit, 20 visits/year  | $15/visit      | $15/visit      | See HMO Tier | See HMO Tier | $25/visit | 20% |
| Rehab-Outpatient               | (combined with             | 20%            | 40%            | Not covered  | 20%          | 20%        | 20% |
|                                | non-severe c/p)            | 20%            | 40%            | Not covered  | 20%          | 20%        | 20% |
| Detoxification-Inpatient        | $250 + 20% per admission   | $100 per admit | $100 per visit | See HMO Tier | See HMO Tier | $250/admit | 20% |
|                                |                            | 20%            | 40%            | No charge    | 20%          | 40%        | 20% |

**Prescription Drugs**

| Retail: Generic/Brand Non-Formulary | $10 / $35 / $50 with a $50 annual deductible (30-day limit) | $10 / $30 / $45 with a $50 annual deductible (30-day limit) | $10 / $20 / $35 (30-day limit) | See HMO Tier | Not covered | $15 / $25 / $40 with a $50 annual deductible (30-day limit) | $15 / $25 / $40 +25% with a $500/yr deductible (30-day limit) | $5/$10/not covered (30 day limit) |
| Mail Order: Generic/Brand Non-Formulary | $20 / $70 / $100 with a $50 annual deductible (90-day limit) | $20 / $60 / $90 with a $50 annual deductible (90-day limit) | $20 / $40 / $70 (90-day limit) | See HMO Tier | Not covered | $30 / $50 / $80 With a $50/yr deductible (90-day limit) | Not covered | $10/$20/not covered (90 day limit) |

**Vision**

| Screening & Eyewear | Not covered* | Not covered* | Not covered | Not covered | Not covered* | Not covered* | Not covered | Not covered | Not covered |

*See Evidence of Coverage document for more details. 1 For POS and PPO plans, the out-of-network benefit applies to allowable charges. You will be responsible for additional charges above the allowable charges. * Some co-pays do not apply to the Annual Co-Pay Maximum. Check your Evidence of Coverage for details. 3 Emergency Room copays do not apply if admitted to the hospital. 4 Vision screening by PCP for children allowed.
### PacifiCare Secure Horizons Plan Benefits

<table>
<thead>
<tr>
<th></th>
<th>PacifiCare Secure Horizons Low Option</th>
<th>PacifiCare Secure Horizons High Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Co-pay Maximum</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Hospital Inpatient</strong></td>
<td>$500 per admission</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Hospital Outpatient</strong></td>
<td>$250 for surgery</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$50 copay, if not admitted</td>
<td>$50 copay, if not admitted</td>
</tr>
<tr>
<td><strong>Urgent Care Centers</strong></td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td><strong>Skilled Nursing</strong></td>
<td>No charge first 20 days, $50 per day thereafter, 100 days max per year</td>
<td>No charge, 100 days max per year</td>
</tr>
<tr>
<td><strong>Primary Care Office Visit</strong></td>
<td>$15 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td><strong>Lab Services</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Standard X-rays</strong></td>
<td>$15 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy</strong></td>
<td>$25 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td><strong>Home Health Visit</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>$500 per admission</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Renal Dialysis</strong></td>
<td>$25 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Severe Mental Health Disorders</strong></td>
<td>Inpatient: $500 per admission, 190 days lifetime (combined with non-severe mental health) Outpatient: $25 copay</td>
<td>Inpatient: $0 copay, 190 days lifetime (combined with non-severe mental health) Outpatient: $5 copay</td>
</tr>
<tr>
<td><strong>Non-Severe Mental Health Disorders</strong></td>
<td>Inpatient: $500 per admission, 190 days lifetime (combined with severe mental health disorders) Outpatient: $25 copay</td>
<td>Inpatient: No charge, 190 days lifetime (combined with severe mental health disorders) Outpatient: $5 copay</td>
</tr>
<tr>
<td><strong>Inpatient Detoxification</strong></td>
<td>$500 per admission</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Medicare Required Chiropractic</strong></td>
<td>$25 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td><strong>Routine Eye Exam (annual)</strong></td>
<td>$15 PCP copay, $25 for specialist</td>
<td>$5 copay</td>
</tr>
<tr>
<td><strong>Eyewear</strong></td>
<td>Not covered</td>
<td>$125 frame allowance/24 months</td>
</tr>
</tbody>
</table>
Your Dental Plan Choices

There are no changes in dental benefits or rates for 2007-08. Your choices for dental coverage are as follows:

**County Self-Funded Dental Plan** – This is a fee-for-service plan that allows you to use the dentist of your choice. However, the plan does offer you a preferred provider network ("the True Advantage PPO network"). The County plan is administered by Golden West, and you can find more information on preferred providers on the Golden West website (see the "Contacts" list on the back page).

**Golden West Pacesetter HMO Dental Plan** – This is a comprehensive dental HMO with no deductibles or calendar-year maximums. Preventive services are provided at no charge, and there is no limit on approved specialty services. Most basic and major services have co-pays.

### Dental Plan Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>County Self-Funded Dental Plan</th>
<th>Golden West Pacesetter Dental HMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>None for preventive services; $50 individual, $100 family maximum for all other services</td>
<td>None</td>
</tr>
<tr>
<td><strong>Annual Maximum Benefit</strong></td>
<td>$1,500 per person (excluding orthodontics)</td>
<td>No maximum</td>
</tr>
<tr>
<td><strong>Diagnostic &amp; Preventive Services</strong></td>
<td>Plan pays 100% of reasonable and customary rates.</td>
<td>No charge, except $20 per tooth for sealants</td>
</tr>
<tr>
<td><strong>Restorative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fillings</strong></td>
<td>20% charge for covered expenses</td>
<td>Co-pays: from $8</td>
</tr>
<tr>
<td><strong>Crowns &amp; Bridges</strong></td>
<td>40% charge for covered expenses</td>
<td>Co-pays: from $200* + lab fees</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td>20% charge for covered expenses</td>
<td>Co-pays: from $150*</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td>20% charge for covered expenses</td>
<td>Co-pays: from $100*</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td>40% charge for covered expenses</td>
<td>Co-pays: from $250*</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>20% charge for covered expenses</td>
<td>Co-pays: from $10 to $70*</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>40% charge for dentist’s fee. Lifetime maximum benefit: $1,200 per person</td>
<td>Child: $1845+ $350 Diagnostic Adult: $2045+ $250 Diagnostic</td>
</tr>
<tr>
<td><strong>Cosmetic Services</strong></td>
<td>Not covered</td>
<td>Generally not covered</td>
</tr>
</tbody>
</table>

* Specific co-pay amounts under the Golden West Pacesetter Dental HMO Plan will depend on the type of service.

This comparison shows only a brief summary of the benefits available. The health plan contracts define the exact terms and conditions of coverage.
Vision Care Coverage Provided Through Vision Service Plan (VSP)

Except for those covered by PacifiCare Secure Horizons high option plan (which has its own vision care coverage), if you want vision care coverage you must enroll in the VSP plan. If you are (or will be) covered by PacifiCare Secure Horizons low option plan, you may want to consider enrolling in VSP since the Secure Horizons low option plan does not include eyewear coverage.

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. However, you do have the option of using a non-network provider under the VSP plan but the benefit allowances are lower.

VSP Benefit Plan Summary

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Examination, once every 12 months</strong></td>
<td>$10 co-pay</td>
<td>$37 benefit allowance</td>
</tr>
<tr>
<td><strong>Standard Lenses, once every 24 months (or 12 months if change in prescription)</strong></td>
<td>No charge</td>
<td>$34 benefit allowance</td>
</tr>
<tr>
<td>• Single Vision</td>
<td>No charge</td>
<td>$51 benefit allowance</td>
</tr>
<tr>
<td>• Lined Bifocal</td>
<td>No charge</td>
<td>$68 benefit allowance</td>
</tr>
<tr>
<td>• Lined Trifocal</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td><strong>Frame, once every 24 months</strong></td>
<td>No charge up to $100 retail allowance</td>
<td>$40 benefit allowance</td>
</tr>
<tr>
<td><strong>Contact Lenses (in lieu of eyeglasses)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Elective/Convenience</td>
<td>$100 allowance</td>
<td>$100 allowance</td>
</tr>
<tr>
<td>• Medically Necessary</td>
<td>25% charge</td>
<td>$126 allowance</td>
</tr>
<tr>
<td><strong>Low Vision Benefit (for severe visual problems)</strong></td>
<td>$500 maximum benefit every two years</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Laser Vision Correction</strong></td>
<td>15% fee discount</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

This comparison shows only a brief summary of the benefits available. The health plan contracts must be consulted to determine the exact terms and conditions of coverage.
Today patients take a more active role in their health care. Although some of us want our doctor to take charge of our case, we are each ultimately responsible for our own health care. Establishing communications that are open, consistent, and candid provide the greatest opportunity for health success. Think of your relationship with your doctor as a partnership in achieving the best level of health.

Here are some things to consider in establishing good communications with physicians.

Your comfort level is important to your care. Speak to your doctor immediately if you feel you are not being listened to or you believe the doctor is not spending enough time with you.

You have a right to be treated with dignity and respect. Understand that doctors are not counselors. You may require a lot of guidance and attention about life problems over and above the medical issues. Ask your doctor to refer you to a trained counselor if you feel you need it.

Be realistic about your expectations. Your doctor will not always have the answer or know ‘why.’ However, your doctor should have a good working knowledge of and sensitivity to normal aging processes versus illness and how they may impact your health in particular. Be prepared when you go to your doctor visit. Keep a diary or journal of medical visits that include dates, medical complaints, medications and therapies prescribed, etc.

Here are some questions to ask.

About Your Disease or Disorder

• What is the diagnosis?
• What caused the condition?
• Can the condition be treated?
• Should I watch for any particular symptoms and notify you if they occur?

About Your Treatment

• What is the treatment for the condition?
• How long will it last? When does it start?
• What are the risks and side effects associated with this treatment?

About the Tests

• What kinds of tests will I be taking and what do expect to find out?
• When will the results be available?
• Are there any side effects from these tests?
• Will I need more tests later?

Understand Your Doctor's Answers. Ask questions until you do understand. Or ask your doctor to write down his/her instructions to you.
BlueCard Nationwide Coverage for Retirees

Almost 90% of the physicians in the United States contract with Blue Shield plans. If you enroll in the Blue Shield PPO or Blue Shield POS plan, all of them will be considered network providers for you, thanks to the BlueCard benefits included in those options. That could be a useful feature if you live outside California, are planning to move, have a second residence out of state, or spend significant amounts of time traveling. BlueCard users are still responsible for the usual payments (deductibles, co-pays, etc.).

Questions?

If you have questions, here’s where to turn. See the “Contacts” list on the back page for the applicable telephone numbers and website addresses.

| Medical, dental or vision coverage or the providers you can use | Contact the carriers (Blue Shield, Golden West, PacifiCare Secure Horizons or VSP) |
| General information about enrollment | Contact your Benefits Specialist |
| Problems filling out enrollment forms | Contact your Benefits Specialist |

Please keep this booklet for reference throughout the year.

The information and descriptions provided in this booklet are brief summaries intended to provide you with a general overview of the benefits involved in Open Enrollment. The information is not intended to be exhaustive or definitive, nor does it constitute an entitlement or any right to benefits. If there is any discrepancy between this booklet and the plan documents, the plan documents will control.

REMEMBER

ALL Enrollment Forms must be returned to the Retirement Office by June 13, 2007.
### SBCERS
**2007 - 2008**
**HEALTH INSURANCE PREMINS**

**SECURE HORIZONS**
- **PACIFICARE**
  - **HMO** Current
  - **Low Option**

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

**BLUE SHIELD**
- **LOW Option**
  - **HMO**
  - **PPO**
  - **POS**

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>H53907</th>
<th>H53905</th>
<th>977737</th>
<th>ZH5743</th>
<th>977736</th>
<th>977749</th>
</tr>
</thead>
</table>

#### MEDICAL for RETIREE

**RETIREE NO MEDICARE**
- **Single Retiree Only**
  - N/A

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

#### DEPENDENTS NO MEDICARE
- **2 Party Retiree +1 dependent**
  - N/A

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

- **Family Retiree +2 or more dependents**
  - N/A

#### DEPENDENTS WITH MEDICARE
- **2 Party Retiree +1 dependent with MC**
  - N/A

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

- **Family Retiree +2 dependents/1 with MC**
  - N/A

#### MEDICAL for MEDICARE RETIREE

**RETIREE WITH MEDICARE**
- **Single Medicare Retiree Only**
  - $264.32

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

#### DEPENDENTS NO MEDICARE
- **2 Party MC Retiree +1 dependent**
  - N/A

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

- **Family MC Retiree +2 or more dependents**
  - N/A

#### DEPENDENTS WITH MEDICARE
- **2 Party MC Retiree +1 dependent with MC**
  - $528.64

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>144274</th>
<th>523345</th>
</tr>
</thead>
</table>

- **Family MC Retiree +2 dependents/1 with MC**
  - N/A

### VISION (optional)

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>12-287740-0003</th>
</tr>
</thead>
</table>

#### DENTAL (optional)

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>NP8059-02</th>
<th>561902</th>
</tr>
</thead>
</table>

#### CARE COUNSEL (mandatory)

<table>
<thead>
<tr>
<th>Group Number &gt;</th>
<th>Monthly Rate</th>
</tr>
</thead>
</table>

All rates are subject to approval by Santa Barbara County Board of Supervisors.

*Secure Horizons premiums ONLY are valid thru 12/31/07 due to January 1 renewal schedule.
All other vendor rates remain in effect through June 30, 2008.*

| N/A = NOT APPLICABLE |
Contact Information

Santa Barbara Office
3916 State Street, Suite 210
Santa Barbara, CA 93105 • 805-568-2940

Last Name A-K
Barbara Gordon (805) 568-2942

Last Name L-Z
Scott Dunlap (805) 568-2943

Santa Maria Office
2400 Professional Parkway, Suite 150
Santa Maria, CA 93458 • 805-739-8686

Last Name A-K
Doreen Miller (805) 739-8668

Last Name L-Z
Reneé Lynn (805) 739-8667

Website: www.sbcers.org

Blue Shield
Customer Service: 800-424-6521
LifePath Advisors: 800-543-3728
Website: www.my lifepath.com
Blue Card Customers: 800-810-BLUE (2583)
Website: www.bluecard.com

Golden West Dental
Customer Service: 800-995-4124
Website: www.goldenwestdental.com

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

CareCounsel Healthcare Assistance Program
Customer Service: 888-227-3334
Website: www.carecounsel.com

PacifiCare Secure Horizons
Customer Service: 800-228-2144
Website: www.securehorizons.com