



THE SUPERIOR COURT OF CALIFORNIA
COUNTY OF SANTA BARBARA

2015 GUIDE TO COURT RETIREE HEALTH PLANS & OPEN ENROLLMENT

2015 HIGHLIGHTS

- ✓ Open Enrollment: Oct 6th – Oct 31st
- ✓ Plan Year: Jan 1, 2015—Dec 31, 2015
- ✓ Additional Prescription Benefit Option
- ✓ Change in Out-of-Pocket Maximums

Attending an Open Enrollment Meeting? Bring this book!

WHAT TO DO THIS YEAR—page 4
MEETING SCHEDULE—page 3
MEDICAL PLAN CHOICES—pages 6-7
RATE CHARTS—pages 26-27

Need help with healthcare expenses and don't have Court health insurance?

You do have money accumulating for health expenses, in conjunction with your retirement account. Retirees who do not participate in Court-sponsored health insurance can reimburse themselves for eligible health expenses using monies the Court contributes to a Health Reimbursement Arrangement (HRA) account for them. Learn how to obtain this money in "Health Subsidy and Health Reimbursement."

NEWS



MEDICARE® PRESCRIPTION DRUG PLAN AVAILABLE

There is a new Express Scripts Prescription Drug Plan (PDP) option for 2015. It's available to retirees who are enrolled in Medicare A & B who also elect to participate in most of the Blue Shield medical plans sponsored by the Superior Court. To find out more, go to "Introducing Express Scripts Medicare PDP."

OUT-OF-POCKET MAXIMUM & THE ACA

All co-pays, deductibles and coinsurance will now accumulate towards Out-of-Pocket maximums on non-Medicare plans, per the Affordable Care Act (ACA). Beginning 2015 Prescription drug benefits have Out-of-Pocket Maximums.

PLAN RATES

The Superior Court is again offering for 2015 the same insurance options that provide quality & accessibility. Rate increases were significantly contained for the new plan year due to the Court's continued participation in CSAC EIA. Blue Shield Medical plan rates increased approximately 7%. CareCounsel, Vision, and Dental HMO rates remain unchanged while Dental PPO rates decreased about 4%.

Employer Plan Sponsor

**SUPERIOR COURT OF CALIFORNIA,
SANTA BARBARA COUNTY**

.....

**DARREL E. PARKER
EXECUTIVE OFFICER**

**STEPHANIE ROBBINS
HUMAN RESOURCE MANAGER**

**CARLOS SILVAS
HUMAN RESOURCE ANALYST**

**CHELI HIDALGO
HUMAN RESOURCE ANALYST**

**VELIA McDONALD
HUMAN RESOURCE SPECIALIST**

**SAMANTHA OTERO
HUMAN RESOURCE SPECIALIST**

In This Issue

CareCounsel.....	5
Contact Information	Back Cover
Dates and Deadlines	3
Dental Plan Benefits	12-13
Dependent Eligibility Rules	20
Health Reform Disclosure	21
Health Subsidy and Health Reimbursement	25
Important Facts You Need to Know	15-18
Introducing Express Scripts Medicare PDP.....	8
Instructions (What To Do This Year).....	4
Legal Disclosures.....	20-21
Medical Plan Benefits	
Blue Shield EPO (Low and High Option).....	9
Blue Shield PPO	10
Blue Shield HDHP	11
Medical Plan Choices	6-7
Medicare Coordination of Benefit.....	24
Mid-Year Benefit Change Rules.....	19
Premium Rate Charts.....	26-27
Prescription Drug Coverage and Medicare	22-23
Vision Plan Benefits	14

NOTICE:

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 (Benefit Summaries) can be found online at www.sbcers.org.

If you (and/or your dependents) have or will have Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see "Prescription Drug Coverage and Medicare."

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.

Meeting Dates & Deadlines

Deadlines

Open Enrollment Period: October 6, 2014 through October 31, 2014

Forms Deadline: At SBCERS office no later than October 31, 2014

Forms Availability: Now (website, mail, email, fax)

Forms Submission Options: Mail, Email (scanned attachment), Fax

There are premium changes for some plans.

See "Instructions" for Required Actions.

Meeting Dates

Bring this book if you attend an Open Enrollment Meeting!

LOMPOC	Lompoc City Hall Council Chambers 100 Civic Center Plaza	Wednesday	Oct 8	1:30 pm – 3:30 pm
SANTA MARIA	Board of Supervisors' Hearing Room 511 E Lakeside Parkway	Thursday	Oct 9	9:30 am – 11:30 am
		Wednesday	Oct 15	2:00 pm – 4:00 pm
SANTA BARBARA	Planning Commission Hearing Room 123 E Anapamu Street	Tuesday	Oct 21	9:30 am – 11:30 am
	Public Health Auditorium 300 N San Antonio Rd	Thursday	Oct 23	1:30 pm – 3:30 pm

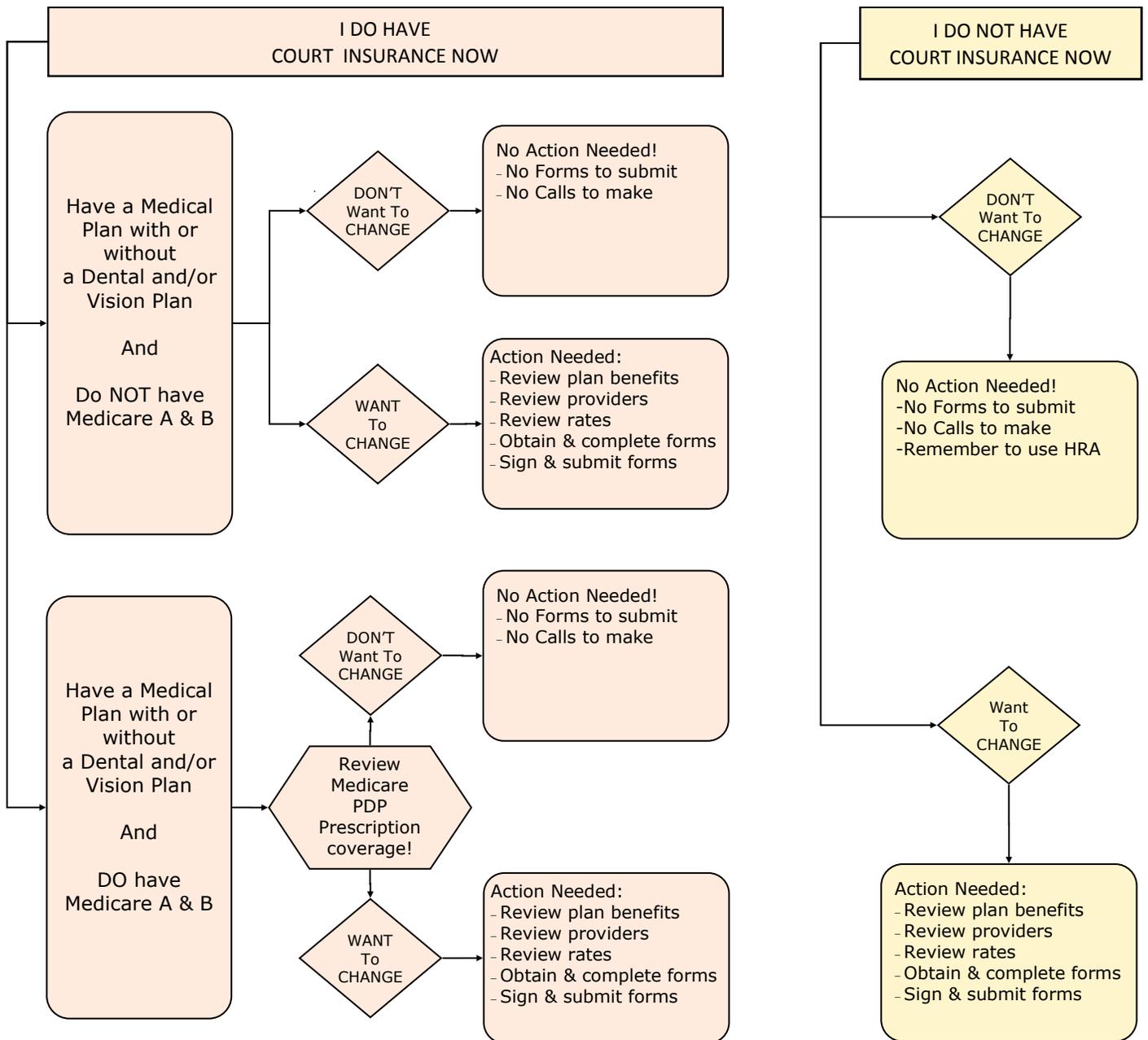
Meetings are open to both County and Court Retirees, although different plans apply. Insurance representatives will be available at these meetings. Guests are welcome.

If you need directions to any of these locations, please call the Retirement Office at (805) 568-2940. Please contact CareCounsel or your SBCERS Benefit Specialist to discuss any insurance needs or to make your elections and/or changes to your insurance plans.

Instructions— What To Do This Year

Open Enrollment is the one time each year you can enroll in the health insurance plans if you're not already participating or make changes to your coverage. For 2015:

- **Use** the decision tree **below to determine** your **steps** and **actions**.
- If you take no action, your current plans automatically continue in 2015, at the new rates.
- Turning 65 in 2015? Review insurance options and contact SBCERS 2 months before your 65th birthday!



FORMS TO BE IN SBCERS OFFICE NO LATER THAN OCTOBER 31, 2014

Changes made during Open Enrollment are effective January 1, 2015

Who Can Help You with Insurance Questions and Issues?

Make  CareCounsel Your First Call!
Your Personal Healthcare Advocate

Your Personal Healthcare Advocate

Sometimes health care and insurance issues can be confusing and frustrating. CareCounsel, a healthcare assistance program, is often your best resource for help. They are skilled, knowledgeable, experienced, friendly and ready to assist you.

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; they are not part of your health plan. Healthcare advocacy is all they do; their sole focus is 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
- ✓ Access to Stanford's Certified Medical Librarian

CareCounselors do not provide medical advice or treatment, but serve as advocates to help you get your health needs met.

Note — Enrollment in the CareCounsel program is mandatory for any retiree enrolled in a Court Medical plan.

For assistance, call and identify yourself as a COURT RETIREE*

(888) 227-3334

Or go to online to: www.carecounsel.com

Hours are 6:30 a.m. to 5:00 p.m., Pacific Time, Monday through Friday.

***COURT RETIREE benefits are different from COUNTY RETIREE benefits.**

When calling, please remember to let your CareCounselor know you retired from the COURT.

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 medical plans for the coming year:

All Blue Shield Medical Plans use the same (PPO) Provider Network.

Blue Shield EPO (Exclusive Provider Organization)

Under the EPO plans, the network of contracted physicians and hospitals are known as Preferred Providers. Under 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. There are two EPO plans offered:

- **EPO Low Option** – The Low Option plan has an annual deductible which must be met before Blue Shield begins to pay claims. A co-payment (“co-pay”) is a standard fee you have to give the physician or facility at the time of service. Co-pays are made by participants for services, some of which are not subject to the deductible. Participants may also be responsible for co-insurance in the form of a percentage of charges for some services.
- **EPO High Option** – The High Option plan has richer benefits than the Low Option, although the premium is higher. There is no annual deductible before Blue Shield pays claims. Co-pays are made by participants for services, some of which are not subject to the deductible. Participants are often also responsible for co-insurance in the form of a percentage of charges for some services.

Blue Shield PPO (Preferred Provider Organization)

The PPO plan is 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.

Medical and Prescription Plan Choices, continued

Prescription benefits under the Low EPO, High EPO and PPO plans are provided by EXPRESS SCRIPTS. Remember: 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. These plans have Out-of-Pocket Maximums; once the maximums have been met, the plan will pay 100% of medication costs.

New

Medicare Prescription benefits under the Blue Shield Low EPO, High EPO and PPO plans are provided by EXPRESS SCRIPTS. Medicare A and B enrolled retirees may choose the Express Scripts Medicare PDP instead of the regular Prescription plan to compliment their Low EPO, High EPO and PPO plans. See "Introducing 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.

Blue Shield HDHP (High Deductible Health Plan)

The HDHP plan provides choice and two levels of service: in-network and out-of-network. The HDHP plan uses the national PPO networks so you have a choice of using in-network preferred providers or any out-of-network physician that you choose. 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. This plan has a higher annual deductible that must be met before it begins to pay the appropriate co-insurance amount. Participants in this plan who do not have Medicare may be eligible to establish a Health Savings Account.

Prescription benefits under the HDHP plan are provided by BLUE SHIELD. Prescription and Medical have a combined Out-of-Pocket Maximum. You must use your Blue Shield ID card to obtain prescriptions. Participants in the HDHP plan are not eligible for the Express Scripts Medicare PDP benefit.

Did you know?

Retirees enrolled in Medicare A and B, may opt to enroll in any of the Court Blue Shield Plans as secondary insurance and still receive the insurance subsidy. This results in a *coordinated* benefit in which Medicare is the primary payer and Blue Shield the secondary payer. Note: Medicare Advantage plans and Medicare Supplement plans are not offered by the Court.

CSAC EIA Blue Shield Prescription Plan Benefits

Introducing Express Scripts Medicare® (PDP)



If you or your eligible dependent is enrolled in Medicare Part A and B and is also enrolled in the Blue Shield Low EPO, High EPO or PPO medical plans, you can choose from one of two Prescription Drug Plans (PDP) to accompany your medical plan. You can choose the new drug plan, Express Scripts Medicare® (PDP), or the current regular Prescription drug plan. The new plan is similar to your current Blue Shield regular Prescription plan but is through the Medicare Part D program so will use the Medicare D formulary. Some benefits to this prescription plan include a lower premium, no deductible and reduced out-of-pocket costs.

The Medicare PDP provides coverage across all stages of your benefit. 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.

Medicare A and B enrolled retirees that participate in Court insurance with dependents may elect Medicare PDP even when the enrolled dependent is not eligible for the Medicare PDP. If both the retiree and dependent(s) are Medicare A and B enrolled, they may choose either the Medicare PDP or regular Prescription Plan, however they must enroll in the same drug plan.

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.

If you wish to enroll in the new Express Scripts Medicare PDP for 2015, you must submit the appropriate form to SBCERS by October 31st, otherwise, you will remain in the standard prescription plan for 2015. Late enrollments cannot be accepted.

Blue Shield HDHP plan participants are not eligible for Express Scripts Medicare PDP.

Once enrolled and prior to your effective date¹, you will receive a member Medicare PDP ID card with a Welcome Kit from Express Scripts. You should use this card beginning January 1st when filling prescriptions but continue using your Blue Shield ID card for any other services. The kit will 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.

Express Scripts Medicare Customer Service
24 hours a day, 7 days a week
Toll-free: (844) 468-0428 — beginning October 1, 2014

¹ The effective date will be the first of the month after 45 days from your enrollment date, per CMS Rules.

CSAC EIA Blue Shield Plan Benefits

		BLUE SHIELD - EPO			
PLAN BENEFITS		LOW OPTION		HIGH 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		None	
PLAN LIFETIME MAXIMUM		Unlimited		Unlimited	
OUT-OF-POCKET MAXIMUM Individual/Family		\$1,500/\$3,000		\$1,500/\$3,000	
OFFICE VISITS Physician Specialist ²		\$20 Co-pay \$20 Co-pay		\$15 Co-pay \$15 Co-pay	
EMERGENCY SERVICES		\$100 Co-pay (waived if admitted)		\$50 Co-pay (waived if admitted)	
CHIROPRACTIC (30 visits/yr)		\$20 Co-pay		\$15 Co-pay	
ACUPUNCTURE (12 visits/yr)		\$20 Co-pay		\$15 Co-pay	
PREVENTIVE CARE		No Charge		No Charge	
OUTPATIENT LAB & X-RAY		No Charge		No Charge	
HOSPITAL SERVICES Inpatient Outpatient		\$250/Admit + 20% No Charge		\$100/Admit No Charge	
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient		\$250/Admit + 20% \$20 Co-pay		\$100/Admit \$15 Co-pay	
MENTAL HEALTH Inpatient Outpatient		\$250/Admit + 20% \$20 Co-pay		\$100/Admit \$15 Co-pay	
PRESCRIPTION DRUG <i>Plan Type →</i> <i>Administered by: Express Scripts</i> 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	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	\$10 \$30 \$45	\$5 \$20 \$50
MAIL ORDER (90-day supply) Generic Preferred Brand Non-Preferred Brand		\$20 \$70 \$100	\$10 \$40 \$100	\$20 \$60 \$90	\$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. For the PPO and HPDP plans, the out-of-network benefit applies to Usual and Customary allowable charges. You will be responsible for additional charges above the allowable charges.
2. Seek verification of what types of doctors are considered specialist, before obtaining specialist services.

CSAC EIA Blue Shield Plan Benefits, *continued*

		BLUE SHIELD - PPO			
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		\$500 Individual/\$1,500 Family		\$500 Individual/\$1,500 Family	
PLAN LIFETIME MAXIMUM		Unlimited		Unlimited	
OUT-OF-POCKET MAXIMUM Individual/Family		\$4,500/\$9,500		\$6,500/ \$13,500	
OFFICE VISITS Physician Specialist ²		\$30 Co-pay \$30 Co-pay		40% 40%	
EMERGENCY SERVICES		\$75/visit + 20% (waived if admitted)		\$75/visit + 20% (waived if admitted)	
CHIROPRACTIC (12 visits yr)		\$30 Co-pay		Not Covered	
ACUPUNCTURE (12 visits yr)		20%		20%	
PREVENTIVE CARE		No Charge		40%	
OUTPATIENT LAB & X-RAY		20%		40%	
HOSPITAL SERVICES Inpatient Outpatient		\$250/Admit + 20% 20%		40% 40%	
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient		\$250/Admit + 20% \$30 Co-pay		40% 40%	
MENTAL HEALTH Inpatient Outpatient		\$250/Admit + 20% \$30 Co-pay		40% 40%	
PRESCRIPTION DRUG <i>Plan Type →</i>		Regular	Medicare PDP	Regular	Medicare PDP
<i>Administered by: Express Scripts</i>					
Annual Deductible		Individual / Family \$25 / \$75	None	Individual / Family \$25 / \$75	None
Out-of-Pocket Maximum (Applies to Preferred & Non-Preferred Brand)		\$2,100 / \$3,700	\$4,700	\$2,100 / \$3,700	\$4,700
RETAIL (30 day supply)					
Generic		\$10	\$5	\$10	\$5
Preferred Brand		\$35	\$20	\$35	\$20
Non-Preferred Brand		\$50	\$50	\$50	\$50
MAIL ORDER (90-day supply)					
Generic		\$20	\$10	Not Covered	Not Covered
Preferred Brand		\$70	\$40		
Non-Preferred Brand		\$100	\$100		

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

1. For the PPO and HPDP plans, the out-of-network benefit applies to Usual and Customary allowable charges. You will be responsible for additional charges above the allowable charges.
2. Seek verification of what types of doctors are considered specialist, before obtaining specialist services.

CSAC EIA Blue Shield Plan Benefits, *continued*

		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%		40%	40%
EMERGENCY SERVICES	20%		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%		40%	40%
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	20%		40%	40%
MENTAL HEALTH Inpatient Outpatient	20%		40%	40%
PRESCRIPTION DRUG <i>Plan Type →</i> <i>Administered by: Blue Shield</i> Annual Deductible Out-of-Pocket Maximum (Applies to Preferred & Non-Preferred Brand)	Regular Individual / Family See Medical Deductible Combined with Medical Max	Medicare PDP No Medicare PDP for HDHP Participants	Regular Individual / Family See Medical Deductible Combined with Medical Max	Medicare PDP No Medicare PDP for HDHP Participants
RETAIL (30 day supply) Generic Preferred Brand Non-Preferred Brand	20%		20%	20%
MAIL ORDER (90-day supply) Generic Preferred Brand Non-Preferred Brand	20%		Not Covered	

*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 PPO and HPDP plans, the out-of-network benefit applies to Usual and Customary allowable charges. You will be responsible for additional charges above the allowable charges.
2. Seek verification of what types of doctors are considered specialist, before obtaining specialist services.

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 m.deltadentalins.com.

Plan Benefits	Delta Dental PPO (DPPO)	DentalCare® USA (DHMO)
Deductibles and maximums	<ul style="list-style-type: none"> • Deductibles and annual maximums apply to most plan designs 	<ul style="list-style-type: none"> • No annual deductible or annual dollar maximums
Copayments/ coinsurance	<ul style="list-style-type: none"> • Covered services paid at applicable percentage → for example, fillings are covered at 80% of allowed amount ; you pay the remaining 20% 	<ul style="list-style-type: none"> • Covered procedures have predetermined dollar copayments for services provided by network dentists (this means out-of-pocket costs are predictable)
Coverage	<ul style="list-style-type: none"> • Wide range of covered services • No exclusions for most pre-existing conditions 	<ul style="list-style-type: none"> • Plan covers nearly 300 procedures • No copayments or low copayments for most diagnostic and preventive services • No exclusions for pre-existing conditions or missing teeth
Dentist network	<ul style="list-style-type: none"> • Freedom to choose any licensed dentist • No referral required for specialty care • No balance billing with PPO dentist 	<ul style="list-style-type: none"> • You must select a dentist from a list of network dental facilities and you must visit this dentist to receive benefits • Easy referrals to a large specialty care network
Changing your dentist	<ul style="list-style-type: none"> • Change dentists any time without contacting Delta Dental 	<ul style="list-style-type: none"> • Ability to change selected or assigned network dentists via telephone or Internet
Authorization for specialty care treatment	<ul style="list-style-type: none"> • Preauthorization is not required in most cases 	<ul style="list-style-type: none"> • Preauthorization is required for treatment provided by a specialist • Your DeltaCare USA dentist will coordinate your specialty care treatment authorization
Out-of-area coverage	<ul style="list-style-type: none"> • Visit any licensed dentist 	<ul style="list-style-type: none"> • Limited to emergency care provision
Claims	<ul style="list-style-type: none"> • Delta Dental dentists file claim forms and accept payment directly from Delta Dental • Non-Delta Dental dentists may require payment up front, and require you to file a claim for reimbursement 	<ul style="list-style-type: none"> • No claim forms required • You only need to pay the specified copayment at the time of your visit

Dental Plan Benefits, *continued*



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

Plan Benefits	Delta Dental PPO Plan (DPPO)		DeltaCare® Plan (DHMO)
	In-Network PPO Providers	In-Network Premier Providers & Out-of-Network*	In-Network (Only)
Annual Deductible Maximum	\$50 Individual / \$100 Family Waived for Preventive Care		None
Annual Benefit Maximum	\$1500 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	\$1500 (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 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 <i>Reimbursements only</i>
Eye examination Once every 12 months	\$10 Co-pay	Up to \$45
Standard Lenses Once every 24 months <ul style="list-style-type: none"> • 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

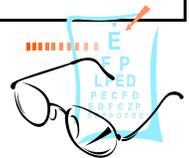
NOTE: It is possible that you may need to supply a Social Security Number to providers for purposes of eligibility and benefit verification.

VSP ID Number—Statement [as made] by Santa Barbara County Superior Court:

“When you call a provider to make an appointment, you will be asked to provide your social security number. The Court has chosen not to use your social security number as your ID number with VSP, instead the Court has chosen to use your employee ID number. Please give the provider your Court employee ID number (i.e. the number you used on your timesheet when you were still working) preceded by enough zeros to make a nine digit number.

Example: 1234 would be 000-00-1234. We advise that you do not give any provider your social security number.”

Call Court Human Resources at 805-882-4739 if you need assistance in obtaining your employee ID number.





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 affect 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 2015, your forms must be received by SBCERS no later than October 31, 2014; otherwise you will not be able to make changes until 2016 Open Enrollment.

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

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 PPO plan is open to all retirees. You are eligible

Important Facts You Need to Know, *continued*

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/

*The California Health Insurance Marketplace does not offer Medicare Plans.

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 Should 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 — If you are participating in a Court-sponsored medical insurance plan and will enroll in Medicare Parts A and B you may be eligible for a reduction of your Court medical insurance premium on or after your Medicare effective date. Be sure to let your SBCERS Benefits Specialist know at least 2-4 weeks before your Medicare effective date (usually this is the 1st of the month in which you turn 65) or as soon as possible. You will need to



Important Facts You Need to Know, *continued*

submit forms to indicate whether you are dropping Court insurance or wish to have your insurance benefits coordinated and receive a reduction in your monthly Court insurance premium. You will be asked to provide a copy of your signed Medicare card if you elect to keep the Court's insurance.

Retirees who have Medicare A & B and a Blue Shield plan may find, because of the coordination of benefit between Medicare and Blue Shield when services are obtained from providers that are Medicare assigned and Blue Shield contracted, that they ultimately may not be responsible for the Blue Shield co-pays and deductibles. Contact Blue Shield or CareCounsel for details. Adding Medicare and coordinating benefits between Medicare and your Court medical plan is not a qualifying event that entitles you to change plans outside of Open Enrollment. Upon receipt of your insurance change form and signed Medicare Card copy, we will reduce your premium prospectively only. During the following Open Enrollment you may be eligible to change to a different plan.

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 plans should always remember that there is NO coverage, except for emergencies, if you do not use a BlueCard Provider. Retirees traveling out of the country who need emergency services should contact Blue Shield as soon as possible. You will need to pay for the services out-of-pocket and submit a claim for reimbursement upon returning to the country. Only emergency services will be covered.

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,



Important Facts You Need to Know, *continued*

you will be responsible for benefit claims paid by the health plans and any associated premium costs. See “Dependent Eligibility Rules.”

Premium Payment — After the insurance subsidy is applied to the premium, any remaining balance is the retiree’s share of premium. This is paid through a deduction from your monthly retirement allowance on a post-tax basis in accordance with the Internal Revenue Code §402(a). A calculation box has been provided at the end of this guide 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 plan (s) 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, listing the retired spouse/partner as a dependent to participate in subsidy pooling. The option of pooling is only available to retirees who share the same employer plan sponsor. For example, a Court Retiree cannot pool with a County Retiree.



Mid-Year Benefit Change Rules

You will not be allowed to change your plan selections or add dependents until the next benefit year (2015 Open Enrollment) unless you have a qualified change in status (aka Qualifying Event). Two rules apply for making changes to your benefits during the year:

- 1. Any change must be consistent with the Qualifying Event.**
- 2. You must notify SBCERS and make the change within 31 calendar days of the date the event occurs. If your status change is your enrollment in Medicare A and B, you should contact SBCERS for instructions 1-2 months prior to your Medicare effective date.**

Contact SBCERS regarding the necessary forms and required documentation.

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, including a switch between part-time and full-time employment 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 place or 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 an individual's eligibility for Medicare or Medicaid:**
 - Enrolling in Medicare (A and B) is not a qualifying event for purposes of changing plans mid-year.
 - Enrolling in Medicare (A and B) is a qualifying event for a premium reduction in your current plan, if/when it is reported to SBCERS. Your premium will be reduced to the Medicare coordinated rate effective on the Medicare effective date -OR- the first of the month following receipt of a copy of your signed Medicare card and an appropriate insurance change form—*whichever is later*.

Dependent Eligibility Rules

Dependent Status Eligibility

- 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 and not be eligible for medical insurance through his or her employer.
- Your eligible physically or mentally handicapped children who depend on you for support, regardless of age. Eligibility is determined by Blue Shield or Kaiser Permanente. You must fill out a Disabled Form and submit it to Blue Shield or Kaiser for review and approval.
- A child of a covered domestic partner who satisfies the same conditions as listed above for natural children, stepchildren, or adopted children, and in addition is not a "qualifying child" (as that term is defined in the Internal Revenue Code) of another individual.

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

Legal Disclosures

Notice

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 (Benefit Summaries) can be found online at www.sbcers.org.

Legal Disclosures, *continued*

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 benefits 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.

Healthcare Reform Disclosure

Patient Protection and Affordable Care Act (PPACA) Disclosure Statement

This group health plan believes the Blue Shield Low Option EPO, High Option EPO, Preferred PPO and the High Deductible Health Plans 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.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the Santa Barbara Superior Court Human Resource Department, (805) 882-4739.

Prescription Drug Coverage and Medicare

IMPORTANT NOTICE FROM THE SANTA BARBARA COUNTY SUPERIOR COURT 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 2015 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.

PRESCRIPTION DRUG COVERAGE AND MEDICARE, continued

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 210, Santa Barbara, CA 93105 or call (805) 739-8686 or (805) 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).

Medicare Coordination of Benefit

When your Claims Administrator group plan provides benefits after Medicare, the combined benefits from Medicare and your Claims Administrator group plan will equal, but not exceed, what the Claims Administrator 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 Claims Administrator group plan deductible and Co-payments 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.

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	<u>-\$48.00</u>
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	<u>\$0.00</u>
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 Subsidy & Health Reimbursement

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 \times \$15 = \382.50) toward the cost of health insurance for his family:

Monthly Insurance Premium	\$1,500.00
Health Insurance Subsidy	<u>-\$382.50</u>
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 Arrangement

Eligible retirees and beneficiaries who are 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 by you and/or your qualified dependents. To obtain reimbursement you must submit claims to WageWorks for eligible expenses along with proof of the expense and proof of payment (e.g. Medicare statements and receipts).

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 their website at www.wageworks.com.

COURT RETIREE MONTHLY PREMIUM RATES

Effective January 1, 2015 through December 31, 2015

 NON-MEDICARE	BLUE SHIELD with regular Prescription Plan				BLUE SHIELD with Medicare Prescription Drug Plan			
	Low Option EPO	High Option EPO	PPO	HDHP	Low Option EPO	High Option EPO	PPO	HDHP
Non-Medicare Retiree Only	\$1,019.00	\$1,274.00	\$966.00	\$772.00	N/A	N/A	N/A	N/A
Non-Medicare Retiree + 1 Non-Medicare dependent	\$1,885.00	\$2,356.00	\$1,787.00	\$1,427.00	N/A	N/A	N/A	N/A
Non-Medicare Retiree + 2 Non-Medicare dependents	\$2,960.00	\$3,700.00	\$2,808.00	\$2,243.00	N/A	N/A	N/A	N/A
 MEDICARE	BLUE SHIELD with regular Prescription Plan				BLUE SHIELD with Medicare Prescription Drug Plan			
	Low Option EPO	High Option EPO	PPO	HDHP	Low Option EPO	High Option EPO	PPO	HDHP
Medicare Retiree Only	\$530.00	\$558.00	\$566.00	\$566.00	\$460.00	\$488.00	\$496.00	No
Medicare Retiree + 1 Medicare dependent	\$1,060.00	\$1,115.00	\$1,133.00	\$1,133.00	\$920.00	\$976.00	\$992.00	Medicare
Medicare Retiree + 2 Medicare dependents	\$1,591.00	\$1,674.00	\$1,699.00	\$1,699.00	\$1,380.00	\$1,464.00	\$1,488.00	PDP
 Medicare with Non-Medicare COMBINATION	BLUE SHIELD with regular Prescription Plan				BLUE SHIELD with Medicare Prescription Drug Plan <i>(all MC enrollees enrolled in MC PDP)</i>			
	Low Option EPO	High Option EPO	PPO	HDHP	Low Option EPO	High Option EPO	PPO	HDHP
Non-Medicare Retiree + 1 Medicare dependent	\$1,549.00	\$1,831.00	\$1,533.00	\$1,339.00	\$1,326.00	\$1,570.00	\$1,317.00	No Medicare PDP
Non-Medicare Retiree + 2 Medicare dependents	\$2,079.00	\$2,389.00	\$2,099.00	\$1,905.00	\$1,786.00	\$2,058.00	\$1,813.00	
Non-Medicare Retiree + 1 Medicare dependent, and 1 Non-Medicare dependent	\$2,415.00	\$2,913.00	\$2,354.00	\$1,994.00	\$2,401.00	\$2,914.00	\$2,338.00	
Medicare Retiree + 1 Non-Medicare dependent	\$1,396.00	\$1,640.00	\$1,387.00	\$1,221.00	\$1,326.00	\$1,570.00	\$1,317.00	
Medicare Retiree + 2 Non-Medicare dependents	\$2,471.00	\$2,984.00	\$2,408.00	\$2,037.00	\$2,401.00	\$2,914.00	\$2,338.00	
Medicare Retiree + 1 Medicare dependent, and 1 Non-Medicare dependent	\$1,926.00	\$2,197.00	\$1,954.00	\$1,788.00	\$1,786.00	\$2,058.00	\$1,813.00	

COURT RETIREE MONTHLY PREMIUM RATES

Effective January 1, 2015 through December 31, 2015

OPTIONAL



DENTAL	PPO	DHMO
Retiree	\$51.00	\$29.07
Retiree +1	\$98.00	\$47.79
Retiree +2	\$150.50	\$72.54

MANDATORY with Medical

CARECOUNSEL
\$2.80



CALCULATE YOUR SHARE OF PREMIUM

CareCounsel	\$	2.80
Medical Rate	\$	
Dental Rate	\$	
Vision Rate	\$	
SUB-TOTAL	\$	
Subtract Subsidy*	\$	
Your Share of Premium	\$	

*Monthly Subsidy = \$15 x Years of Service



VISION	
Retiree	\$7.00
Retiree +1	\$9.80
Retiree +2	\$17.30

IMPORTANT REMINDERS & NOTES

- ◆ Rates shown in this book are full monthly rates before any subsidy is applied.
- ◆ Rates shown do not include any premium for other insurance, such as Medicare B.
- ◆ If you join a private Medicare D Plan while enrolled in both a Court Medical plan with Prescription coverage AND Medicare, you may lose the Court coverage.
- ◆ Will you turn 65 this year? Will you become Medicare Eligible? Turning 65 or enrolling in Medicare A & B may require you to make changes to your Court insurance and could cause rates to increase or decrease. Review your entire health insurance profile for potential changes, then contact the retirement office, if necessary.

