SBCERS
SANTA BARBARA COUNTY EMPLOYEES' RETIREMENT SYSTEM

Open Enrollment

Your Guide to Superior Court Retiree Health Plans & Open Enrollment **for the 2024 Calendar Year**

1 (877) 568-2940
www.sbcers.org

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

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

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

Employer Plan Sponsor:
Superior Court of California, County of Santa Barbara
- **Darrel E. Parker, Court Executive Officer**
- **Stephanie Robbins, Human Resources Manager**
- **Teri Carter, Human Resources Analyst**

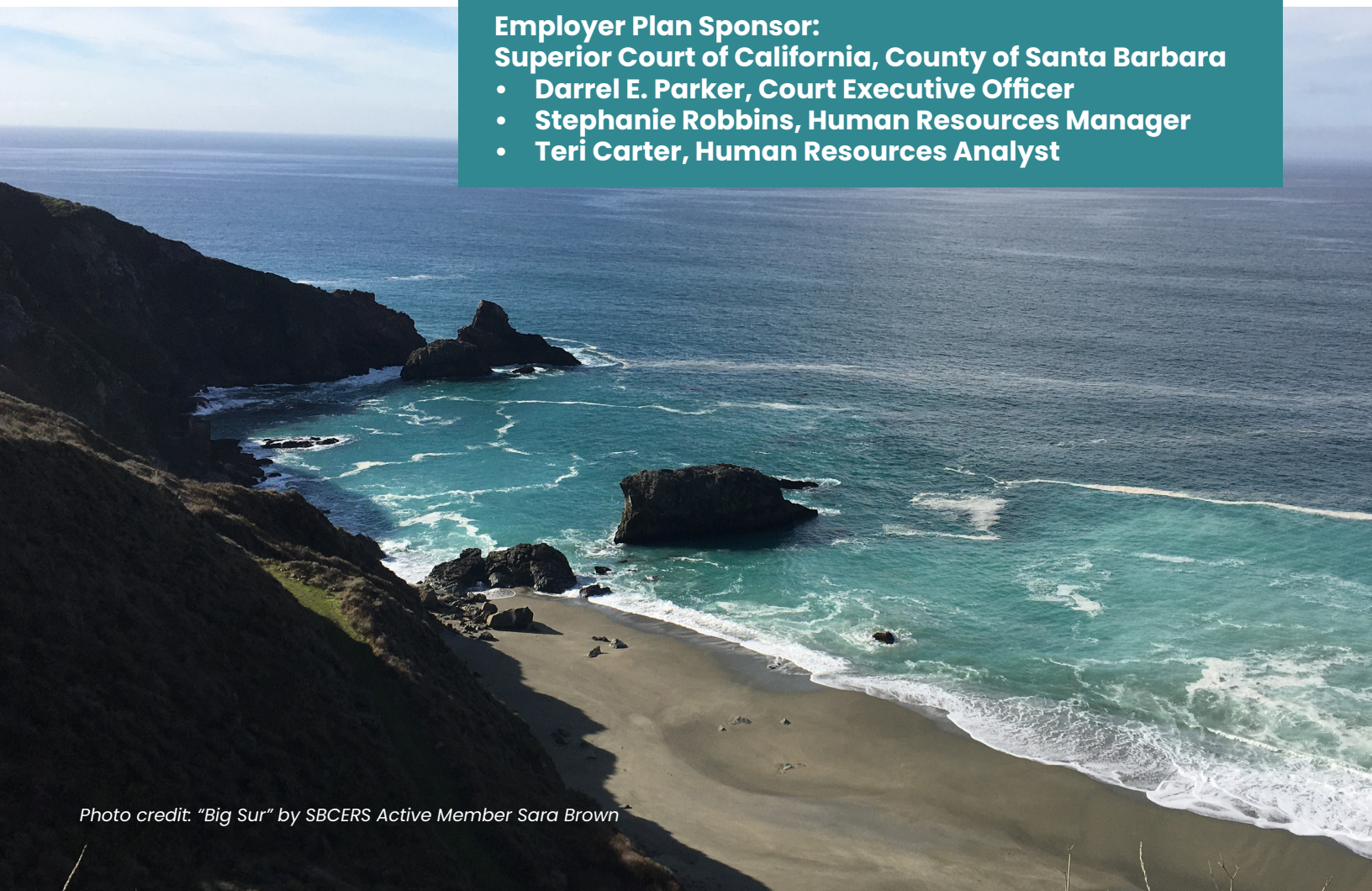
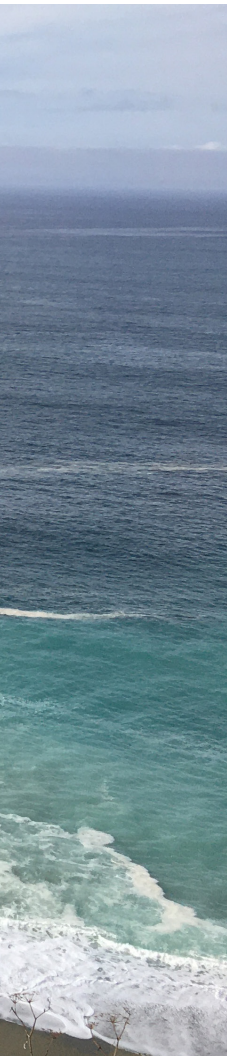


Photo credit: "Big Sur" by SBCERS Active Member Sara Brown

2024

HEALTH INSURANCE

FOR COURT RETIREES



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News, Highlights, and Instructions

The Court will continue the same insurance plans with the same benefits, including Domestic Medical Travel Benefits.

- Blue Shield Medical Plans will increase 8.9%.
- Dental HMO Plan rates remain the same and Dental PPO Plan rates will decrease 3.0%.
- Vision rates remain the same.
- CareCounsel rates will increase to $2.97.

How to Make Changes to Your Coverage

1. Review plan benefits, providers and rates.
2. Obtain and complete forms.
3. Sign and submit forms by Wednesday, November 1, 2023.

No changes to your coverage?

SBCERS will automatically continue your current coverage into 2024 at the new rates. You do not have to complete or submit any forms, or contact SBCERS.

Don't Have Court Health Insurance?

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

SBCERS will automatically continue your current HRA account into 2024.

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

Medicare and Important Notices

Turning 65 in 2024? Contact SBCERS three months before your 65th birthday to review options.

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

Deadlines and Meeting Dates

September
30
Forms Available

October
1
Open Enrollment Begins

October
13
In-Person Health Fair

October
31
Open Enrollment Ends

November
1
Form Submission Deadline

January
1
Changes Effective

Form Submission Options

Mail to an SBCERS office

Email scanned attachment to benefits@sbcers.org

Drop off in SBCERS Drop Box
(available at both office locations)

Fax to 805-695-2755

In-Person Health Fair

Friday, October 13 | 9:00 AM – 12:00 PM
SBCERS Board Room
130 Robin Hill Road, Goleta, CA 93117

The in-person event will have coffee, light breakfast snacks, free flu shots, and a raffle with free giveaways. Representatives from health plan providers and SBCERS will be on-site to answer any questions.

Can't make it in-person?

The Virtual Health Fair is available beginning Monday, October 16. All Open Enrollment resources and videos will be available for viewing throughout the year.

Access the Virtual Health Fair online at
www.sbcers.org/openenrollment2024

CareCounsel

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

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

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

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

Contacting CareCounsel

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

Phone: (888) 227-3334
Email: staff@carecounsel.com
Website: www.carecounsel.com

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

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

NOTE — Enrollment in the CareCounsel program is mandatory and automatic for any retiree enrolled in a Court medical plan.

CareCounsel

Stanford HEALTH CARE
STANFORD MEDICINE

Medical and Prescription Plan Choices

Santa Barbara County Superior Court offers a choice of medical plans through Blue Shield, all of which include prescription drug coverage. The medical plan comparison charts found in this guide show a brief summary of the benefits available. The Benefit Summaries (Official Plan Documents) provide the exact terms and conditions of coverage. Retirees may choose from the following plans for the coming year.

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

Blue Shield EPO

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

A co-payment ("co-pay") is a standard fee you have to give the physician or facility at the time of service. Co-pays are made by participants for services. Participants may also be responsible for co-insurance in the form of a percentage of charges for some services. Shield pays claims. Co-pays are made by participants for services. Participants are often also responsible for co-insurance in the form of a percentage of charges for some services.

Blue Shield EPO Prescription Benefits

Regular Prescription Benefit – Prescription benefits are provided by Express Scripts® through either retail (at a Pharmacy) or mail order service in accordance with the Express Scripts® Advanced Utilization Management program. 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.

Medicare Prescription Benefit – Prescription benefits are provided by Express Scripts® either retail (at a pharmacy) or through mail order service. Medicare A and B enrolled retirees may choose the Express Scripts® Medicare Prescription Drug Plan (PDP) or the regular prescription plan to complement their EPO plan. ID cards are issued to each enrolled individual. HDHP participants are ineligible for the Medicare PDP.

Medicare Prescription Benefit: Express Scripts® Medicare® PDP (Blue Shield EPO Plan)

Medicare Part D prescription program is one of two prescription plans available to Court retirees enrolled in Medicare A and B and the Court's Blue Shield EPO medical insurance. To be eligible[1] for this plan you and/or your eligible dependents must meet the following criteria:

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

How It Works

Because Express Scripts® Medicare PDP for EIA is an enhanced Medicare D plan, it provides coverage across all of Medicare's stages[2] of your benefit—even the coverage gap ("doughnut hole"). You pay co-pays for your covered drugs until your annual out-of-pocket costs reach $4,700. Once your costs reach $4,700, your cost share will decrease. Prescriptions may be filled at either in-network or out-of-network retail pharmacies or through Express Scripts® Mail Order service. Your co-pays will be the amounts shown on the table throughout all stages, however, they might be less during the Catastrophic Coverage stage.

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

Once enrolled and prior to your effective date[3], you will receive a member Medicare PDP ID card with a Welcome Kit from Express Scripts®. You should use this card when filling prescriptions but continue using your Blue Shield ID card for any other services. The kit may also include other important materials, such as a formulary and a pharmacy directory. Because Medicare is an individual benefit, you and your covered Medicare-enrolled dependent(s) will receive separate communications from Express Scripts® Medicare and each have your own PDP ID card with a unique member ID number.

Cost Share Co-Pays for EPO Plan

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

Late Enrollment Penalty (LEP)

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

Medicare Low Income Subsidies

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

You may be eligible if you:

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

Please contact Medicare at 800-633-4227 or **www.medicare.gov** for current eligibility rules.

If you are identified by the Centers for Medicare & Medicaid Services (CMS) as qualifying for Extra Help, you will receive plan cost information in your Express Scripts Welcome kit.

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

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

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

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

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

Blue Shield HDHP

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

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

Blue Shield HDHP Prescription Benefits

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

Medicare Prescription Benefit – Not available under the HDHP plan.

Blue Shield Benefit Programs

Carrum Health: Outpatient Surgeries Available and Two More Locations

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

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

Top-quality hospitals and doctors in Southern California – Learning that you need surgery is difficult enough - finding the right hospital and doctor for your individual needs is even more challenging. Not all medical providers deliver the same quality of care.

Carrum Health has done the research to find the top Southern California hospitals and identified regional Centers of Excellence demonstrate the best outcomes, fewest complications and highest level of personalized care - meaning patients experience smoother recoveries and get back to normal functionality sooner.

Costs, if any, are known beforehand – If you choose Carrum Health for your orthopedic, spinal, or cardiac surgery, you'll know exactly what it will cost beforehand, if anything at all. In most cases[2], the County's health insurance plan will cover 100% of the charges and your out-of-pocket costs[2] will be zero, saving you thousands of dollars. No medical bills, no travel expenses, no confusion, and no surprises.

Personal Care Concierge throughout the entire episode of care – Navigating the complexities of healthcare can be challenging when planning for surgery. Figuring out who to visit, how to prepare, and what to expect when transitioning from one care provider to the next isn't something you do very often.

Carrum assigns a personal Care Concierge to guide you through the entire episode of care. From selecting the right hospital and doctor, to gathering medical records, to assisting with travel (if needed) for you and a companion - your Care Concierge will be there to help every step of the way.

What It Means To You...

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

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

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

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

SOLERA: Lifestyle Change Program

Blue Shield is offering a free comprehensive 16-week program which will help qualified members lose weight, adopt healthy habits and significantly reduce their risk of developing type 2 diabetes. The program meets weekly for 16 weeks and then monthly for the balance of the year. You may choose from an array of national programs like Jenny Craig, Retrofit or HealthSlate. To find out if you qualify for this new preventive program, go to **www.solera4me.com** and take a one minute quiz.

This new program is available to Blue Shield early retirees and their dependents, and some Medicare retirees. This benefit is not available to Kaiser or United Healthcare retirees (excluding firefighters electing fire union plans). Medicare members should contact Solera Health at 1-877-486-0141 to find out if they're eligible.

Prescription Advanced Utilization Management[1]

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

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

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

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

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

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

Pharmacy Tips

Before you run out of a medication, you should work with your doctor, pharmacy, Express Scripts® and/or CareCounsel to determine whether the medication is affected by these changes.

Open mail from Express Scripts as soon as possible; it may be notification of a potential change to drugs you are taking. Drug formularies (list of drugs covered) change throughout the year.

Medicare Coordination of Benefit

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

When Covered by Medicare & Blue Shield

Before receiving services from new providers, always ask:

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

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

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

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

Example (under Blue Shield's PPO plan):

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

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

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

Example (under Blue Shield's PPO plan):

Chiropractic doctor's regular Office visit charge	$80.00
Medicare fee schedule allows	$0.00
Medicare pays 0% of the $80.00 charge	$0.00
Balance of bill	$80.00
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

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

Free Resource for Navigating the Medicare Maze

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

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

Introducing Alliant Medicare Solutions

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

Why Is This Important?

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

This enrollment period is your first opportunity to sign up for Medicare Part A and/or Part B. This is also your first chance to enroll in a Medicare Advantage plan (Part C) or Part D Prescription Drug plan.

If you don't enroll in Medicare during your initial enrollment period or do not provide proof of insurance under another eligible plan, you may pay more for Medicare later on when you do enroll.

How Does It Work?

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

Where Can I Find Out More?

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

For comprehensive information about Medicare, visit medicare.gov.

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

Medical Plan Comparison Charts

	Blue Shield			
	EPO	HDHP		
	You must use a Blue Shield contracted PPO provider or your care will not be covered (except in an emergency).	In-Network	Out-of-Network [2]	
		You may use 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	None	$1,500 / $3,000 (Combined)		
Plan Lifetime Maximum	Unlimited	Unlimited		
Annual Out-of-Pocket Maximum	$1,500 / $3,000	$4,500 / $9,000 (Combined)		
Office Visits				
Physician	$20 Co-pay	20%	40%	
Specialist[1]	$20 Co-pay	20%	40%	
Emergency Services	$100 Co-pay (waived if admitted)	20% (waived if admitted)	20% (waived if admitted)	
Chiropractic	$20 Co-pay (30 visits/yr)	20% (20 visits/yr)	40%	
Acupuncture	$20 Co-pay (12 visits/yr)	20% (12 visits/yr)	20%	
Physician Care				
Preventive Care	No Charge	No Charge	40%	
Outpatient X-Ray, Lab & MRI	No Charge	No Charge	40%	
Hospital Services				
Inpatient	$250/Admit + 20%	20%	40%	
Outpatient	No Charge	20%	40%	
Mental Health & Substance Abuse				
Inpatient	$250/Admit + 20%	20%	40%	
Outpatient	$20 Co-pay	20%	40%	
Prescription Drug Plan Type	**Regular** *Administered by Express Scripts*	**Medicare PDP**	**Regular** *Administered by Blue Shield*	
Annual Deductible	$25 / $75	None	See Medical Deductible	
Out-of-Pocket Maximum *(applies to preferred and non-preferred brand)*	$5,100 / $10,200	$4,700	Combined With Medical Maximum	
RETAIL (30-day supply)				
Generic *(EPO not subject to deductible)*	$10	$5	20%	
Preferred Brand	$35	$20	20%	
Non-Preferred Brand	$50	$50	20%	
MAIL ORDER (90-day supply)				
Generic *(EPO not subject to deductible)*	$20	$10	20%	Not covered
Preferred Brand	$70	$40	20%	
Non-Preferred Brand	$100	$100	20%	

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

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

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

[2] *For the HDHP plan, the out-of-network benefit applies to Usual and Customary allowable changes. You will be responsible for additional charges above the allowable charges.*

Creditable Coverage Notice

Important Notice from the Superior Court of California, County of Santa Barbara Regarding Prescription Drug Coverage and Medicare

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

You should read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with the Superior Court of California, County of Santa Barbara 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 Superior Court of California, County of Santa Barbara has determined that the prescription drug coverage offered for all Medical Insurance Plans for the 2024 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 Superior Court of California, County of Santa Barbara-sponsored Medical Insurance Plan and you do decide to enroll in a Medicare prescription drug plan, be aware that you are not permitted to opt out of the Court's prescription coverage plan that is "packaged" together with the Court's medical insurance. You should also be aware that if you join a private Medicare Prescription Drug Plan, you, your spouse, or your dependents may lose your employer or union health coverage.

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

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

You should also know that if you drop or lose your current coverage with the Superior Court of California, County of Santa Barbara and don't join

a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage visit **www.medicare.gov**.

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

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

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

Dental Plan Choices

There are two plans offered by Delta Dental:

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

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

Remember:

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

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

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

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

Plan Benefits	Delta Dental PPO Plan (DPPO)		DeltaCare® Plan (DHMO) *California Residents Only*
	In-Network Cost	**Out-of-Network Cost**	**In-Network (Only)**
Annual Deductible Maximum	$50 Individual / $100 Family Waived for Orthodontics and In-Network Diagnostic and Preventive Care.		None
Annual Benefit Maximum	$2,000 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% can be balance billed	$8 — $395 Refer to Delta Dental Description of Benefits & Co-payments Schedule
Major Services & Prosthodontic Benefits Crowns, bridges, inlays, onlays, dentures	40%	50% can be balance billed	$15 — $395 Refer to Delta Dental Description of Benefits & Co-payments Schedule
Orthodontia			
Dependent children (up to age 19)	50%		$1,900
Adults	50%		$2,100

Vision Plan

Vision Service Plan (VSP) is the provider for the Santa Barbara County Superior Court's optional vision coverage plan for eye exams and eyewear. The Medical plans may provide for only a basic screening exam to detect medical eye problems such as glaucoma or diabetic retinopathy. If you do have an ophthalmological medical condition, the medical plans do provide diagnosis, management and surgery of ocular diseases and disorders.

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

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

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

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

Retiree Monthly Premium Rates

Effective January 1, 2024 - December 31, 2024

ALL NON-MEDICARE (incl. dependents)	BLUE SHIELD with regular Prescription Plan		BLUE SHIELD with Medicare Prescription Drug Plan	
	EPO	HDHP	EPO	HDHP
Retiree Only	$1,686.50	$1,308.50	Not Applicable	
Retiree + 1 Dependent	$3,116.50	$2,418.50		
Retiree + 2 Dependents	$4,891.50	$3,800.50		

ALL MEDICARE (incl. dependents)	BLUE SHIELD with regular Prescription Plan		BLUE SHIELD with Medicare Prescription Drug Plan	
	EPO	HDHP	EPO	HDHP
Retiree Only	$876.50	$956.50	$781.50	No Medicare PDP
Retiree + 1 Dependent	$1,753.50	$1,919.50	$1,558.50	
Retiree + 2 Dependents	$2,631.50	$2,878.50	$2,337.50	

Medicare/Non-Medicare COMBINATIONS	BLUE SHIELD with regular Prescription Plan		BLUE SHIELD with Medicare Prescription Drug Plan *(all MC dependents enrolled in MC PDP)*	
	EPO	HDHP	EPO	HDHP
Non-Medicare Retiree + 1 Medicare Dependent	$2,563.50	$2,271.50	Available Upon Request	No Medicare PDP
Non-Medicare Retiree + 2 Medicare Dependents	$3,439.50	$3,227.50		
Non-Medicare Retiree + 1 Medicare Dependent + 1 Non-Medicare Dependent	$3,993.50	$3,381.50		
Medicare Retiree + 1 Non-Medicare Dependent	$2,306.50	$2,066.50	$2,211.50	
Medicare Retiree + 2 Non-Medicare Dependents	$4,081.50	$3,448.50	$3,986.50	
Medicare Retiree + 1 Medicare Dependent + 1 Non-Medicare Dependent	$3,183.50	$3,029.50	$2,988.50	

MANDATORY *(with Medical Plan Enrollment)*	CARECOUNSEL
	$2.97

OPTIONAL PLANS	DENTAL SERVICE PLAN		VISION SERVICE PLAN
	Delta Dental PPO	Delta Care USA HMO	
Retiree	$48.60	$40.33	$7.00
Retiree + 1 Dependent	$93.30	$66.31	$9.80
Retiree + 2 Dependents	$143.30	$100.64	$17.30

How to Calculate Your Share of the Premium

CareCounsel	$ 2.97
Medical Rate	$
Dental Rate	$
Vision Rate	$
SUBTOTAL	**= $**
SUBTRACT Monthly Subsidy *(Legacy Retirees, Not Plan 7 or 8)* $15 x Years of Service	- $
YOUR SHARE OF PREMIUM *The "insurance deduction" listed on your monthly benefit payment*	**= $**

Supplemental Information

Mid-Year Benefit Change Rules

You will not be allowed to change your plan selections or add dependents until the next benefit year (2025 Open Enrollment) unless you experience a qualified status change, known as a "qualifying event". If you qualify for a mid-year benefit change, you may be required to submit proof of change or evidence of prior coverage. Two rules apply for making changes to your benefits during the year:

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

Qualifying Events for Mid-Year Enrollment:

- **Change in legal marital status,** including marriage, divorce, court documented legal separation, annulment, death of spouse or termination of registered domestic partnership and establishment of registered domestic partnership.
- **Change in number of dependents,** including birth, adoption, placement for adoption, or death of a dependent child.
- **Change in employment status** that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child.
- **Change in work schedule,** including an increase or decrease in hours of employment by you, your spouse, or your dependent child, that affects eligibility for benefits.
- **Change in a child's dependent status,** either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in residence or worksite** that results in your change that affects the accessibility of network providers.
- **Change in your health coverage** or your spouse's coverage attributable to your spouse's employment.
- **A court order** resulting from a divorce, court ordered legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment"** under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, retirees have 60 days after the following events to request enrollment:
- **Retiree or dependent loses eligibility** for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
- **Retiree or dependent becomes eligible** to participate in a premium assistance program under Medicaid or CHIP.
- **Change in a covered individual's eligibility for Medicare or Medicaid:**
  - Enrolling in Medicare (A and B) is a qualifying event for purposes of changing plans mid-year.
  - Enrolling in Medicare (A and B) is a qualifying event for purposes of adding the Medicare PDP.
  - Enrolling in Medicare (A and B) is a qualifying event for any applicable premium reduction in your current plan, after it is reported to SBCERS. Your premium will be reduced to the Medicare coordinated rate effective the later of the Medicare effective date –OR– the first of the month following 45 days from receipt of a copy of your Medicare card and an appropriate insurance change form.

Dependent Eligibility Rules

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

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

Healthcare Subsidy

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

As an example, if a retiree has service credit of 25.5 years, they are eligible to receive $382.50/month (25.5 x $15 = $382.50) toward the Court health insurance premium for themself and their dependents:

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

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

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

If you and your spouse are both Court Retirees, you may be eligible to pool your subsidies together when one retiree carries the other as a dependent on the insurance. See "**Subsidy Combining**" and/or "**Subsidy Pooling**" under "**Important Facts You Need to Know**."

Health Reimbursement: If You Do Not Have Court Health Insurance

Eligible retirees and beneficiaries (not Plan 7 or 8) not enrolled in Court-sponsored health insurance, receive help with health expenses, through a Health Reimbursement Arrangement (HRA) benefit funded by the Court. You are automatically enrolled in the HRA when you drop Court-sponsored health insurance. An amount equal to $4-per-year-of-service is set aside monthly in a HRA account that is automatically set up for you when you decline or cancel 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. As a reminder, retirees from Plans 7 and 8 do not receive a Health Reimbursement Arrangement benefit.

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

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

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

COBRA Facts For Retirees

Qualifying Events for Mid-Year Enrollment:

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

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

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

1. SBCERS will enroll you in Retiree COBRA insurance with BCC. You do not need to complete nor mail forms or any form of payment to BCC or your Plan Sponsor's COBRA administrator.
2. SBCERS will deduct COBRA premiums from your monthly retiree benefit payment, and, as permitted by your retirement plan, apply your insurance subsidy to your monthly premiums. You do not need to pay BCC or your Plan Sponsor's COBRA administrator directly.
3. You will receive a cancellation notice from BCC or your Plan Sponsor's insurance administrator: please know that this notice is notifying you that your active employee coverage has been terminated due to your separation of employment, and that you have not enrolled directly in COBRA as a direct pay. It does not mean your Retiree COBRA has been cancelled.
    - After the 18 months of federal COBRA coverage expires, if you reside in California, you are permitted an additional 18 months of Extended COBRA, allowing 36 months of COBRA coverage.
    - Your spouse and dependent children are eligible for 36 months of initial coverage under federal law. There is no California state extension of this coverage. They have the option to enroll separately from your coverage. BCC can answer any questions you may have about your COBRA coverage.
    - Domestic partners do not have federal or state COBRA rights to continue health insurance coverage unless they otherwise meet the qualifications of a dependent.

If You Are A Recent Retiree With COBRA Coverage

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

Terminating COBRA Or Extended COBRA Coverage

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

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

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

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

Reminder About COBRA Eligibility

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

Important Facts You Need to Know

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

Annual Open Enrollment Periods are the annual period during which you have the opportunity to enroll in or change healthcare plans. If you are enrolling in or changing plans for 2024, your forms must be received by SBCERS no later than November 1, 2023; otherwise you will not be able to make changes until 2025 Open Enrollment. If changing carriers, you must submit a disenrollment form for the old plan as well as an enrollment form for the new plan.

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

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

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

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

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

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

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

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

Health Insurance Marketplace — Under the Affordable Care Act (ACA), if you are not covered under a health insurance plan, unless you are exempt, you may be assessed a penalty through your tax return. You have several ways to get insurance including through: SBCERS, your state's health insurance Marketplace (also called an Exchange), an insurance broker, or a public health group like Medicare, Medicaid, or the VA. For more information go online to:

www.healthexchange.ca.gov
www.healthinsurance.org/learn/
www.healthcare.gov
www.cahealthadvocates.org/

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

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

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

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

Medicare Advantage Plans (aka Part C) — Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. If you join a Medicare Advantage Plan, you still have Medicare. You'll get your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not Original Medicare. If you are enrolled in a UnitedHealthcare Medicare Advantage or Kaiser Senior Advantage plan, Medicare services are covered through those plans and not under Original Medicare. SBCERS' Medicare Advantage Plans include Part D (prescription drug coverage). Do not join any other Medicare Prescription Drug Plan while you are enrolled in a Medicare Advantage Plan, or Medicare will dis-enroll you from your Medicare Advantage Plan and return you to Original Medicare.

Medicare & Age 65 — See "Age 65 and Medicare" above.

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

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

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

monthly County insurance premium. You will also be asked to provide a copy of your Medicare card if you elect to keep the County's insurance.

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

Medicare Prescription Coverage Part D — The prescription coverage included in County sponsored medical plans is either Medicare D coverage or is considered creditable coverage because in most cases they offer a "richer" benefit than most Part D plans. If you are enrolled in a County-sponsored medical plan, you should not enroll in another Medicare Part D plan. See "**Prescription Drug Coverage and Medicare**."

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

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

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

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

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

Over-Age Dependents — Report and drop dependents as soon as they no longer qualify for coverage on your County insurance; this may entitle you to a decrease in your monthly premium. An annual certification is required by the carrier for each over-age dependent that is eligible to remain on your insurance. In the event that you do not drop a dependent who is ineligible for coverage under the County plans, you will be responsible for benefit claims paid by the health plans and any associated premium costs. See "**Dependent Eligibility Rules**."

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

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

To elect the self-pay option you must pre-pay your share of premium every month. After we apply your subsidy, the retirement office will apply all but $10 of your retirement allowance toward your health insurance premium cost. (The $10 amount is a "cushion" to ensure processing in

case of a minor tax modification or other payroll adjustment.) You must then remit payment of the remaining premium amount to SBCERS so that it arrives no later than the 15th of the month prior to the coverage month. There is no grace period. Please keep in mind that delinquent payments could cause the cancellation of insurance.

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

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

Legal Disclosures

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

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 lymphedema.

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

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

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

Patient Protection and Affordable Care Act (PPACA) Disclosure Statement

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

Contacts & Resources

SBCERS Santa Barbara Office
130 Robin Hill Road, Suite 100
Goleta, CA 93117

SBCERS Santa Maria Office
2236 South Broadway, Suite D
Santa Maria, CA 93454

Email: benefits@sbcers.org

Phone Number: 1-877-568-2940

Fax Number: 805-695-2755

Website: www.sbcers.org

Blue Shield (incl. prescriptions for HDHP)
Member Services: 1-855-256-9404
Website: **www.BlueShieldca.com/csac**

Blue Card (Network Providers outside of CA)
Member Services: 1-800-810-2583
Website: **www.bcbs.com**

Express Scripts (BS Prescriptions for EPO)
Member Services: 1-800-711-0917
Website: **www.express-scripts.com**

Express Scripts (Medicare PDP for BS EPO)
Member Services: 1-844-468-0428
Website: **www.express-scripts.com**

Carrum Health
Member Services: 1-888-855-7806
Website: **my.carrumhealth.com/cosb**

Alliant Medicare Solutions
Member Services: 1-888-312-1387

Delta Dental
Member Services (DPPO): 1-800-765-6003
Member Services (DHMO): 1-800-422-4234
Website: **www.deltadentalins.com/superiorcourtofcactyofsantabarbara**

Vision Service Plan (VSP)
Member Services: 1-800-877-7195
Website: **www.vsp.com**

Benefits Coordinators Corp (COBRA Admin)
Member Services: 1-800-685-6100
Website: **www.benXcel.com**

CareCounsel Healthcare Assistance
Member Services: 1-888-227-3334
Website: **www.carecounsel.com**

Health Equity/WageWorks
Member Services: 1-877-924-3967
Website: **www.wageworks.com**

Medicare & Medicare Prescription Drug Coverage
Member Services: 1-800-633-4227
Website: **www.medicare.gov**

SHIPs (State Health Insurance Assistance Programs)
Insurance Counseling and Assistance to Medicare Beneficiaries: 1-877-839-2675

Health Insurance Marketplace
Affordable Care Act (ACA) Info: 1-800-318-2596
Website: **www.healthcare.gov**

HICAP (Health Insurance Counseling & Advocacy)
Medicare Advocacy: 1-800-434-0222

Superior Court of California, County of Santa Barbara Human Resources
Phone: (805) 882-4739
Website: **www.santabarbara.courts.ca.gov**

Benefit Pay Days

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

	2024		2025	
Benefit for	**Check Mailing Date**	**Direct Deposit Date**	**Check Mailing Date**	**Direct Deposit Date**
January	1/31/2024	2/1/2024	1/31/2025	1/31/2025
February	2/29/2024	3/1/2024	2/28/2025	2/28/2025
March	3/30/2024	4/1/2024	3/31/2025	4/1/2025
April	4/30/2024	5/1/2024	4/30/2025	5/1/2025
May	5/31/2024	5/31/2024	5/31/2025	5/30/2025
June	6/29/2024	7/1/2024	6/30/2025	7/1/2025
July	7/31/2024	8/1/2024	7/31/2025	8/1/2025
August	8/31/2024	8/30/2024	8/30/2025	8/29/2025
September	9/30/2024	10/1/2024	9/30/2025	10/1/2025
October	10/31/2024	11/1/2024	10/31/2025	10/31/2025
November	11/30/2024	11/29/2024	11/29/2025	12/1/2025
December	12/30/2024	1/2/2025	12/31/2025	1/2/2026

SBCERS
SANTA BARBARA COUNTY EMPLOYEES' RETIREMENT SYSTEM
130 Robin Hill Road, Suite 100, Goleta, CA 93117
1 (877) 568-2940 | www.sbcers.org | benefits@sbcers.org

RETIREE OPEN ENROLLMENT HEALTH FAIR

Friday, October 13 | 9:00 AM – 12:00 PM
SBCERS Board Room
130 Robin Hill Road, Goleta, CA 93117

The in-person event will have coffee, light breakfast snacks, free flu shots, and a raffle with free giveaways. Representatives from health plan providers and SBCERS will be on-site to answer any questions.

Can't make it in-person?

The Virtual Health Fair is available beginning Monday, October 16. All Open Enrollment resources and videos will be available for viewing throughout the year.

Access the Virtual Health Fair online at
www.sbcers.org/openenrollment2024

SCAN ME

Register your MySBCERS member portal account.

Update your mailing address.
View your 1099-R.
Download forms for account changes.
Receive your Board of Retirement ballot via email.
Go to mysbcers.org or scan the QR code with your smartphone camera to enroll.

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