San Diego County Employees Retirement Association

SDCERA

Strength. Service. Commitment.

2017

Health Insurance Plans

For Retired Members

2017 Health Insurance Plans for Retired Members

Who can enroll?

Retired Members, surviving spouses/ partners, and eligible dependents

When can I enroll?

Annually during Open Enrollment, or within 30 days of an eligible event such as retirement

Do I need to re-enroll every year?

Your current SDCERA-sponsored plan election(s) will renew automatically if you take no action during Open Enrollment

The 2017 SDCERA-sponsored health insurance plans are outlined on the following pages. Use this booklet as a resource to help with your initial enrollment or to change your coverage during the annual Open Enrollment period. If you are enrolled in an SDCERA-sponsored health plan, your current plan election(s) will automatically renew for the 2017 plan year, unless you request a change.

Eligibility

SDCERA offers group medical and dental insurance plans for all retired Members and their eligible dependents. If you are the surviving spouse/partner or dependent of a deceased SDCERA Member and you receive a monthly SDCERA retirement benefit, the plans are also available to you. Eligible dependents include your spouse or registered domestic partner and your children under age 26. Domestic partners who are not registered with the California Secretary of State may become eligible dependents by submitting a completed *Affidavit of Domestic Partnership* form available on the Health page of **www.sdcera.org**.

Premium(s) and applicable fees for all SDCERA-sponsored health plans, including coverage for your dependent(s), will be deducted from your monthly retirement benefit. If your monthly benefit does not fully cover the cost of the plan(s) you select, SDCERA will contact you to set up automatic debit from your checking or savings account.

Plans provide coverage in both California and out-of-state service areas, but service areas vary by plan. Please contact the plan to verify you live within its service area before enrolling. Premiums and types of medical plans vary based on Medicare eligibility. Dental plans are available to Members regardless of age and Medicare eligibility. SDCERA does not offer plans that provide coverage to Members living outside of the United States.

Enrollment in a plan

You may enroll or make changes to your current SDCERA-sponsored plan selection each November during Open Enrollment. Enrollment or changes outside of the annual Open Enrollment period are limited to qualifying life events (see Page 2). **If you wish to continue your current election(s), you do not need to do anything during Open Enrollment; your current plan election(s) will renew automatically**. If you change your plan, or enroll for the first time, allow 30 days from the effective date for the carrier to recognize your coverage. Plan ahead for any necessary prescriptions or care you may require.

Enrollment or changes outside of the annual Open Enrollment period are limited. You can cancel coverage for yourself or your dependents at any time. You may be eligible to enroll or make changes within 30 days if you have a qualifying life event noted below:

- retire
- become eligible for Medicare (or your dependent becomes eligible)
- add a dependent due to marriage, domestic partner registration, birth, adoption or placement for adoption
- move outside your plan's service area
- lose eligibility for coverage, such as conclusion of COBRA or Cal-COBRA
- lose eligibility for other coverage (or if the employer stops contributing toward your or your dependents' other coverage), or
- lose eligibility (not due to termination for cause) for Medicaid, Medi-Cal, Children's Health Insurance Program (CHIP), Healthy Families Program, or Access for Infants and Mothers Program (you must request enrollment within 60 days)

If you are a (or your dependent is) eligible for Medicare and the other is not, you can enroll in separate plans (Medicare and non-Medicare) with the same carrier.

If you are (or your dependent is) turning 65 in 2017 and will become eligible for Medicare, the SDCERA Health Plans Service Center will send correspondence to your mailing address approximately 90 days prior to your 65th birthday outlining necessary steps to enroll in Medicare and providing information about SDCERA-sponsored Medicare plans. In the meantime, you may enroll in a non-Medicare plan through SDCERA.

To enroll in medical and/or dental plans, please visit the Health page of **www.sdcera.org** and click on "enrollment information" for a copy of the *[SDCERA Health Insurance Plans Enrollment]* form. This form is used to process your request, which includes enabling premium deductions to cover the cost of plan premiums and using your address for health zone coverage verification purposes. You may submit your form requesting enrollment in an SDCERA-sponsored plan online or by mailing your completed form to the SDCERA Health Plans Service Center.

Medical plan coverage details and premiums begin on Page 4 of this booklet. Refer to Page 8 for dental coverage details and premiums. The premiums shown for medical and dental plans are per person, per month and include an administrative fee of $4.85.

Tier I and Tier II Members: Health Insurance Allowance

The Health Insurance Allowance (HIA) helps offset the cost of premiums for medical, dental and prescription plans. In addition to the allowance, $93.50 may be reimbursed to offset the cost of Medicare Part B. You are eligible for HIA if you are a retired Tier I or Tier II Member who has at least 10 years of SDCERA service credit or is receiving a disability retirement. Monthly allowance amounts range from $200 to $400. The HIA is not a vested SDCERA benefit and is not guaranteed. The allowance may be reduced or discontinued at any time. Refer to the *Health Insurance Allowance* fact sheet for more information on eligibility requirements and how this allowance can be used.

To use your HIA towards the cost of a medical, dental and/or prescription plan not sponsored by SDCERA, complete the *Health Insurance Reimbursement Request* form. You must enroll in the program each year to be reimbursed. Read the *Health Insurance Reimbursement* fact sheet for more information.

Medicare information for SDCERA-sponsored plans

SDCERA-sponsored Medicare plans

Although you may be enrolled in Medicare Part A and Part B, you may still have medical expenses not covered by Medicare; therefore, enrolling in an additional insurance plan such as an SDCERA-sponsored medical plan may help pay for expenses that Medicare does not cover.

As long as you are covered by an SDCERA-sponsored medical plan, you will have the option of joining a Medicare drug plan in the future—without a penalty. SDCERA-sponsored medical plans meet the Centers for Medicare and Medicaid Services (CMS) creditable coverage guidelines. The Notice of Creditable Coverage on Pages 9 and 10 of this booklet provides you with the documentation you need to prove that you have had creditable coverage through an SDCERA-sponsored plan. This notice protects you from penalty charges and allows you to join a Medicare drug plan in the future (if you so decide).

When deciding which plan will provide the best coverage for you, consider the differences among the types of plans that coordinate with Medicare. SDCERA offers three types of Medicare health plans for Members covered by Medicare Part A and Part B. SDCERA-sponsored plans include comprehensive medical coverage as well as the Medicare prescription drug coverage; therefore, if you enroll in an SDCERA-sponsored plan, your drug coverage will be provided through the SDCERA-sponsored plan you select. If you enroll in a separate Medicare prescription plan (Part D), you and your dependents will be disenrolled from the SDCERA-sponsored plan.

Medicare Supplement plans allow you to keep your Medicare benefits and use any physician or facility that accepts Medicare.

Medicare HMO plans coordinate their coverage with Medicare. You may also use your Medicare card to obtain services outside your health plan.

Medicare Advantage plans require your Medicare Part A and Part B to be assigned to a health plan.

Refer to the Medicare Information tab on the Health page of **www.sdcera.org** for more information about the types of Medicare health plans.

If you are eligible for Medicare, but your dependent is not (or if you are not eligible for Medicare and your dependent is), and you both want to enroll in SDCERA-sponsored plans, you may enroll in separate plans with the same provider.

You must submit a copy of both sides of your signed Medicare identification card to confirm your eligibility for enrollment in an SDCERA-sponsored Medicare plan. If you have submitted a copy in the past, you do not need to submit another copy. If you are (or your dependent is) newly enrolled in Medicare Part A and Part B, please submit a copy of the signed card to the SDCERA Health Plans Service Center when you receive it.

If you are (or your dependent is) covered by Medicare Part A only or Medicare Part B only, different premiums may apply. If this situation affects you, contact the SDCERA Health Plans Service center at 1.866.751.0256 to confirm your monthly premium.

For information about the Medicare program, enrollment deadline or to contact Medicare, visit **www.medicare.gov** or call 1.800.633.4227. You may also contact the Social Security Administration at 1.800.772.1213.

non-Medicare plans

generally for those **under age 65**

IMPORTANT NOTES		Health Net HMO **1.800.522.0088** Group 57358-A **www.healthnet.com**
SDCERA-sponsored medical plans do not have overall annual or lifetime limits. Service area varies by plan. Please confirm you live within a plan's service area before enrolling. Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern.		**HMO plan** You are required to use the primary care physician you select from a list of providers.
Annual deductible	Any applicable deductible must be met before coverage shown is effective.	None
Ambulance	Requires preauthorization.	Covered in full
Anesthesia		Covered in full
Chiropractic visit	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Preauthorization may be required.	Not covered
Durable medical equipment		Covered in full
Emergency care	Includes accidental injury and acute illness; the copayment shown is when visiting an emergency room and is waived if you are admitted.	$35
Fitness club membership		Discounts available
Hearing care and hearing aids		Preventive screening covered in full; all other $20 per exam. No coverage for hearing aids.
Home health care	Requires a physician's prescription.	Covered in full up to 30 days; $10 copayment starts on the 31st day after the 1st visit.
Hospice care		Covered in full
Hospital room and board	Coverage is for a semi-private room.	Covered in full
Laboratory fees		Covered in full
Physician care (doctor visits) unrelated to hospitalization	The copayments shown are for office visits unrelated to hospitalization.	$20 per office visit
Physician care (doctor visits) due to hospitalization	Coverage shown is for visits due to hospitalization.	Covered in full
Prescription medications from a mail order sponsored by the carrier	The copayments in all cases are for the number of days shown.	$20 generic, $60 brand name, $90 non-formulary. *90-day supply.*
Prescription medications from a pharmacy	Unless noted, non-formulary prescriptions are covered by the same copayments when deemed medically necessary.	$10 generic, $30 brand name, $45 non-formulary. *30-day supply.*
Psychiatric care (inpatient)	An asterisk (*) indicates the plan will cover this care in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full No limit on days
Psychiatric care (outpatient)		$20 per visit, unlimited visits
Rehabilitation therapy	Physical, speech, occupational, pulmonary, and cardiac	Covered in full
Skilled nursing facility		Covered in full up to 100 days
Surgery (inpatient)		Covered in full
Surgery (outpatient)		Covered in full
Urgent care	An asterisk (*) indicates non-emergency.	$35
Vision care and eyewear		$20 per exam; No coverage for eyewear.
X-rays		Covered in full
Monthly premium per person		$1,389.08

Kaiser Permanente HMO	UHC Signature Value HMO
1.800.464.4000 Group 104302 **www.kp.org**	**1.800.624.8822** Group 004501 **www.myuhc.com**
HMO plan	**HMO plan**
You are required to use Kaiser Permanente physicians and facilities. A higher premium will apply if you enroll in this plan when eligible for Medicare.	You are required to use the primary care physician you select from a list of providers.
None	None
Covered in full	Covered in full
Covered in full	Covered in full
$10 per visit, up to 20 visits	$15 per visit, up to 20 visits.
Covered in full	Covered in full
$25	$50
Discounts available	Discounts available
Preventive screening covered in full; All other $20 per exam. No coverage for hearing aids.	$20 per exam; Hearing aids are covered in full up to $5,000 every 36 months.
Covered in full up to 100 days	Covered in full up to 100 visits per year
Covered in full	Covered in full
Covered in full	Covered in full
Covered in full	Covered in full
$20 per office visit	$20 per office visit
Covered in full	Covered in full
$15 generic, $30 brand name. *Up to a 100-day supply.*	$30 generic, $60 brand name. *90-day supply.*
$15 generic, $30 brand name. *Up to a 100-day supply. Specialty drugs up to 30 days.*	$15 generic, $30 brand name. *30-day supply.*
*Covered in full Unlimited visits	*Covered in full No limit on days
$20 per visit, unlimited visits	$20 per visit, unlimited visits
$0 inpatient, $20 per visit outpatient	$20 copay
Covered in full up to 100 days	Covered in full up to 100 consecutive calendar days from first treatment
Covered in full	Covered in full
$20 copayment	Covered in full
$20*	$50
No charge for routine eye exams with a plan optometrist. $20/exam. No coverage for eyewear.	$20 per exam; No coverage for eyewear.
Covered in full	Covered in full
$837.54	$1,733.87

Medicare plans

generally for those **over age 65**

IMPORTANT NOTES		Health Net HMO **1.800.522.0088** Group 57358-B **www.healthnet.com**	Health Net Seniority Plus **1.800.275.4737** Group 57358-S **www.healthnet.com**
SDCERA-sponsored medical plans do not have overall annual or lifetime limits. Service area varies by plan. Please confirm you live within a plan's service area before enrolling. Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern.		**Medicare HMO plan** Benefits coordinated with Medicare (primary); may use Medicare outside of network. You must use a primary care physician from the providers list for HMO to cover services.	**Medicare Advantage plan** Medicare benefit must be assigned to the plan. You are required to use the Health Net physician you select from a list of providers.
Annual deductible	Applicable deductible must be met before coverage shown is effective.	None	None
Ambulance	Requires preauthorization.	Covered in full	Covered in full
Anesthesia		Covered in full	Covered in full
Chiropractic visit	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Preauthorization may be required.	Not covered	$5 per visit up to 20 visits through American Specialty Health Network
Durable medical equipment		Covered in full	Covered in full
Emergency care	Includes accidental injury and acute illness; the copayment shown is when visiting an emergency room and is waived if you are admitted.	$35	$20
Fitness club membership		Discounts available	Silver Sneakers Fitness Membership
Hearing care and hearing aids		Preventive screening covered in full; all other $20 per exam. No coverage for hearing aids.	$20 per exam, 2 standard hearing aids every 36 months covered in full
Home health care	Requires a physician's prescription.	Covered in full up to 30 days; $10 copayment starts on the 31st day after the 1st visit.	Covered in full
Hospice care		Covered in full	Covered per Medicare guidelines
Hospital room and board	Coverage is for a semi-private room.	Covered in full	Covered in full
Laboratory fees		Covered in full	Covered in full
Physician care (doctor visits) unrelated to hospitalization	Copayments shown are for office visits unrelated to hospitalization.	$20 per office visit	$20 per office visit
Physician care (doctor visits) due to hospitalization	Coverage shown is for visits due to hospitalization.	Covered in full	Covered in full
Prescription medications from a mail order sponsored by the carrier	Copayments are for the number of days shown. Copays may vary when the Medicare Part D Catastrophic Coverage stage is reached.	$30 generic, $60 brand name, $100 non-formulary. *90-day supply. Administered by SilverScript.*	$30 generic, $60 brand name, $90 non-formulary. *90-day supply.*
Prescription medications from a pharmacy before reaching Medicare Part D Catastrophic Coverage Stage	Unless noted, non-formulary prescriptions are covered by the same copayments when deemed medically necessary.	$15 generic, $30 brand name, $50 non-formulary. *30-day supply. Administered by SilverScript.*	$15 generic, $30 brand name, $45 non-formulary. *30-day supply.*
Psychiatric care (inpatient)	An asterisk (*) indicates the plan will cover this care in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full	Covered in full
Psychiatric care (outpatient)		$20 per visit	$20 per visit
Rehabilitation therapy	Physical, speech, occupational, pulmonary, and cardiac	Covered in full	No copay for Medicare-covered services
Skilled nursing facility		Covered in full up to 100 days	Covered in full up to 100 days
Surgery (inpatient)		Covered in full	Covered in full
Surgery (outpatient)		Covered in full	Covered in full
Urgent care	An asterisk (*) indicates non-emergency.	$35	$20
Vision care and eyewear		$20 per exam. No coverage for eyewear.	$20 per exam. $100 paid for eyewear every 2 years.
X-rays		Covered in full	Covered in full
Monthly premium per person		$565.45	$285.70

Kaiser Permanente Senior Advantage	UHC Group Medicare Advantage	UHC Senior Supplement
1.800.464.4000 Group 104302-00 **www.kp.org**	**Customer service—1.800.457.8506** **Prospective Member—1.877.714.0178** Group CA: 004497; AZ: 060499; NV: 667201 **www.uhcretiree.com**	**Customer service—1.800.851.3802** **Prospective Member—1.800.698.0822** Group 05408 **www.uhcretiree.com**
Medicare Advantage plan	**Medicare Advantage plan**	**Medicare Supplement plan**
Medicare benefit must be assigned to the plan, or a higher premium and traditional Kaiser HMO benefits apply. You are required to use Kaiser Permanente physicians and facilities.	This plan provides coverage in California, Arizona and Nevada. Medicare benefit must be assigned to the plan. You are required to use the primary care physician you select from a list of providers.	This plan is available nationwide. You may use any physician or facility that accepts Medicare.
None	None	None
Covered in full	Covered in full	Covered in full. No preauthorization required.
Covered in full	Covered in full	Covered in full
$10 per visit, up to 20 visits	$5 per visit, up to 20 visits	Spinal manipulation covered; $0 per visit. Other services generally not covered.
Covered in full	Covered in full	Covered in full
$20	$20	Covered in full in the U.S.; $250 deductible outside of the U.S., 20% thereafter.
Discounts available	Silver Sneakers Fitness membership	Silver Sneakers Fitness membership
$10 per exam No coverage for hearing aids.	$0 per exam; hearing aids covered up to $500 every 36 months.	Exams covered; $0 per visit for Medicare covered exams. Hearing aids not covered.
Covered in full. Refer to evidence of coverage from the plan.	Covered in full	Covered in full
Covered in full	Covered per Medicare guidelines	Covered in full
Covered in full	Covered in full	Covered in full
Covered in full	Covered in full	Covered in full
$10 per office visit	$20 per office visit	Covered in full
Covered in full	Covered in full	Covered in full
$10 generic, $20 brand name *Up to a100-day supply.*	$20 generic, $60 brand name, $60 non-preferred brand formulary. *90-day supply*.	$20 generic, $70 brand name; $100 non-preferred brand formulary. *90-day supply*.
$10 generic, $20 brand name *Up to a 100-day supply.*	$10 generic, $30 brand name, $30 non-preferred brand formulary. *30-day supply*.	$10 generic, $35 brand name; $50 non-preferred brand formulary. *30-day supply*.
*Covered in full Unlimited visits	Covered per Medicare guidelines up to 190 days per lifetime	Covered in full up to 150 days
$10 per visit, unlimited visits	$20 per visit	Covered in full
$0 inpatient; $10 per visit outpatient	$0 copay	Covered in full
Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days
Covered in full	Covered in full	Covered in full
$10 per procedure	Covered in full	Covered in full
$10*	$10 copay (in- and out-of-network)	Covered in full
$10 per exam. $150 allowance for eyewear every 2 years.	$20 per exam. $75 per eyewear every 2 years.	$0 per Medicare-covered exam. Medicare-covered eyewear is reimbursed. Non-Medicare is not covered.
Covered in full	Covered in full	Covered in full
$275.15	$260.29	$472.64

SDCERA-sponsored dental plans

When deciding which dental plan will provide the best coverage for you, consider the differences between a dental health maintenance organization (DHMO) plan and a dental preferred provider organization (PPO) plan.

DHMO plans contract with their own network of dentists and all care is coordinated by the dental office you select. You may change your dental office at any time. If you receive care (other than emergency services) that is not coordinated by your dental office, you are required to pay the full cost for the services you receive. The cost of your out-of-pocket expense in a DHMO dental plan is based on a schedule of patient charges. There are no charges for many diagnostic and preventive services, and most other types of service require you to pay a copayment.

Dental PPO plans give you the flexibility to have all covered services provided by the dentist of your choice; however, you pay less if you select a dentist within the network the plan has contracted with to provide services, because network dentists charge patients pre-negotiated discount rates for services. If you choose to see an out-of-network dentist, the reimbursement amount is based on the network's regional schedule of benefits for a geographic area. If your dentist charges more than a network dentist's allowed fee, you are responsible for paying the difference.

To enroll in a dental plan listed below and establish payment deductions to cover the cost of plan premiums, complete and submit the SDCERA *Health Insurance Plans Enrollment* form on the Health page of **www.sdcera.org.**

Dental plans

for retired Members and dependents

Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern.

	CIGNA Dental Care (DHMO)	Delta Dental PPO	
	1.800.244.6224 Group number 3217340 **www.cigna.com** This plan is available in 39 of 50 states. States without coverage: AK, HI, ME, MT, ND, NE, NM, RI, SD, VT and WY.	1.800.765.6003 Group number 02472-00001 **www.deltadentalins.com** This plan provides coverage nationwide.	
Annual deductible Any applicable deductible must be met before coverage shown is effective unless noted.	None	**IN-NETWORK** $50 per person	**OUT-OF-NETWORK*** $50 per person
Annual maximum benefit	No maximum	$1,500 per person	$1,000 per person
Basic and restorative services Fillings, sealants, simple extractions	Copayments vary by service; refer to the schedule of patient charges available from the plan.	80% of PPO contracted fee after deductible has been met	80% of PPO contracted fee after deductible has been met
Diagnostic and preventive services Emergency treatment for pain, oral exams, prophylaxis, space maintainers, x-rays	100% for most services	100% of PPO contracted fee with no deductible	100% of PPO contracted fee with no deductible
Other basic and major services Bridges, crowns, dentures, endodontics, implants, oral surgery, periodontal treatment	Copayments vary by service; refer to the schedule of patient charges available from the plan. *Implants are not covered under the DHMO plan; however, implant crowns are covered.*	50% of PPO contracted fee after deductible has been met	50% of PPO contracted fee after deductible has been met
Orthodontia For adults and eligible dependent children	Copayments vary by service; refer to the schedule of patient charges available from the plan.	50% of PPO contracted fee; $1,000 lifetime maximum, per person for orthodontia services.	50% of PPO contracted fee; $1,000 lifetime maximum, per person for orthodontia services.
Monthly premium per person†	**$22.09**	**$48.20**	

* If you go out-of-network, visit a Delta Dental Premier dentist for lower costs.

† Different premiums will apply if you enroll four or more people.

Notice of Creditable Coverage

Important notice from SDCERA about your prescription drug coverage and Medicare

The prescription drug coverage you have under your SDCERA-sponsored medical plan for retired Members is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay.

If you decide to join a Medicare drug plan, your current SDCERA-sponsored medical and prescription drug coverage will end for you and all covered dependents. If you decide to join a Medicare drug plan and drop your current SDCERA-sponsored coverage, be aware that you and your dependents will be unable to get this coverage back until the next Open Enrollment period.

You may receive this notice at other times in the future, such as before the next period during which you may enroll in Medicare prescription drug coverage, if SDCERA-sponsored plan coverage changes, or upon your request.

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SDCERA 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. **SDCERA has determined that the prescription drug coverage offered by the SDCERA-sponsored group insurance programs is, 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.**

   SDCERA-sponsored non-Medicare group insurance programs:
   Health Net HMO
   Kaiser Permanente HMO
   UHC Signature Value HMO

Notice of Creditable Coverage (cont.)

When can you join a Medicare drug plan?

When you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you are eligible for a two month Special Enrollment Period to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current SDCERA-sponsored medical and prescription drug coverage will end for the Member and all covered dependents. Please be aware that you and your dependents will be able to get this coverage back by enrolling during the next Open Enrollment period or if you experience a qualifying life event.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you drop or lose your current creditable SDCERA-sponsored coverage 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 one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent 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.

Medicare Prescription Drug Coverage Resources

Detailed information about Medicare plans that offer prescription drug coverage can be found in the *Medicare & You* handbook. You will receive a copy of the handbook in the mail each 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**
- Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the Medicare & You handbook for their telephone number.
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

Extra help paying for Medicare prescription drug coverage, for those with limited income and resources, is available. For information, visit Social Security on the web at **www.ssa.gov**, or call them at 1.800.772.1213 (TTY: 1.800.325.0778).

For more information about this notice or your current prescription drug coverage, contact the SDCERA Health Plans Service Center at 1.866.751.0256.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides retired Members, non-Member payees, and their dependents who lose SDCERA-sponsored coverage the right to continue medical and dental coverage for limited periods of time due to certain COBRA-qualifying events. These events include the death of a covered Member, divorce or legal separation from a retired Member, and a child's loss of dependent status (and therefore coverage) under the plan.

In addition to COBRA, there may be other coverage options available for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage or a tax credit through the Marketplace. For more information about the Health Insurance Marketplace (federal marketplace), visit **www.healthcare.gov** or call 1.800.318.2596. For information about Covered California (state marketplace), visit **www.coveredca.com** or call 1.800.300.1506.

Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse/registered domestic partner's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Electing COBRA coverage

If you are eligible to elect COBRA continuation coverage due to a qualifying event, you have 60 days (from the date of the COBRA election notice or the date you lose coverage, whichever is later) to elect COBRA continuation coverage.

Qualifying events

COBRA defines a qualifying event as the loss of health plan coverage that is attributable to death of the Member, divorce, legal separation, annulment or dependent(s) ineligibility (for instance, your dependent(s) no longer satisfies the requirements for coverage, such as attainment of age 26).

You will be ineligible for COBRA coverage if you do not notify the SDCERA Health Plans Service Center within 60 days of a qualifying event.

COBRA Continuation Coverage (cont.)

Each individual who is affected by the qualifying event may independently elect continuation coverage. This means that if you and your dependents are entitled to elect continuation coverage, you each may decide separately whether to do so. The covered Member or the spouse/registered domestic partner is allowed to elect on behalf of any dependent children or on behalf of all qualified beneficiaries; COBRA coverage is limited to a maximum of 36 months and the following terms and conditions apply:

- COBRA premiums are calculated based on current monthly medical or dental plan rates plus a two percent administrative fee.
- You may only continue the coverage that was in effect on the date of the qualifying event.
- Coverage is extended only to those individuals covered at the time of the qualifying event.

COBRA participants are subject to the same plan coverage levels and administrative rules (e.g., adding dependents and changing or canceling coverage) that apply to non-COBRA participants.

COBRA is provided subject to your eligibility for coverage under the law and the plan. SDCERA reserves the right to terminate your continuation coverage retroactively if you are later determined to be ineligible.

Federal law places responsibility upon the Member or the Member's eligible dependent(s) to notify within 60 calendar days of death, divorce, legal separation, annulment or dependent's ineligibility. If you or your eligible dependent(s) do not notify the SDCERA Health Plans Service Center of the qualifying event within the required time frame, you and your dependents will be ineligible for COBRA. Other forms of notice will not bind the plan.

Health administration program credits and fees

Health program administration fees

The administrative expenses of the health benefit program are paid by each plan participant. The health benefit program expenses are divided equally among all participants, resulting in a monthly fee per person for each plan in which they enroll (applicable to both medical and dental plans). This fee is applicable to SDCERA-sponsored plans and the Health Insurance Reimbursement program. The monthly administrative fee is $4.85 for the 2017 plan year.

Patient Centered Outcomes Research Institute (PCORI)

Federal law requires sponsors of self-funded health plans and insurers to pay the Patient Centered Outcomes Research Institute (PCORI) fee for each participant. This fee, paid to the Internal Revenue Service (IRS), is intended to fund a new federal research institute that will publish guidelines for improving public health. Tier I and Tier II members receiving Health Insurance Allowance, Health Insurance Reimbursement or Medicare Part B Reimbursement funds in 2016 will be charged this fee. The annual PCORI fee was $2.08 in 2014 and $2.17 in 2015. The federal government determines the current-year PCORI fee in October. Once the fee is determined, SDCERA will deduct the fee from your retirement benefit before December 31, 2016.

CHIP/Medicaid Notice

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you are not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, **visit www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1.877.KIDS NOW** or **www.insurekidsnow.gov**. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1.866.444.EBSA (3272)**.

Medicaid Contact List by State

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx Phone (Outside of Anchorage): 1-800-780-9972 / Phone (Anchorage): 907-465-2680
COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943
FLORIDA – Medicaid Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-342-6207
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid
CHIP: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-855-242-8282 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid Website: https://wyequalitycare.acs-inc.com/ Phone: 1-855-294-2127

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
wwww.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext. 61565

Physician Designation Notice

The SDCERA HMO retiree medical plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan's network and who is available to accept you or your family members. Until you make this designation, your HMO plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Health Net Non-Medicare HMO	1.800.522.0088
Health Net Medicare HMO	1.800.275.4737
UHC Non-Medicare HMO	1.800.624.8822
UHC Medicare HMO	1.800.457.8506

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Health Net or UHC or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the health plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan provider.

Legal notices

SDCERA-sponsored health insurance plans

Access to SDCERA-sponsored health insurance plans is not a vested right or guaranteed benefit. The County Employees Retirement Law of 1937 and the California Public Employees' Pension Reform Act of 2013 do not require SDCERA to provide any post-retirement health insurance plans. The Board of Retirement annually determines whether to continue the health insurance plans.

Woman's Health and Cancer Rights Act of 1998

Your (or your dependent's) health plan will not restrict benefits if you (or your dependent) received benefits for a mastectomy and elected breast reconstruction in connection with a mastectomy. Benefits will not be restricted provided the breast reconstruction is performed in a manner determined in consultation with your (or your dependent's) physician and may include: (1) reconstruction of the breast on which the mastectomy was performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance and (3) prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas. Benefits for breast reconstruction may be subject to appropriate annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan.

Medical and dental plan descriptions contained in this booklet

This booklet provides only a summary of the medical and dental plans offered to retired Members and their eligible dependents. Please refer to each plan's evidence of coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary and the plan documents, the plan documents will govern in all cases.

SDCERA

Strength. Service. Commitment.

SDCERA-sponsored Health Plans
PO Box 14464
Des Moines, IA 50306-3464

SDCERA Health Plans Service Center
1.866.751.0256, Monday - Friday 5:30 a.m. to 6:00 p.m. Pacific Time

www.sdcera.org

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