2026 Employee Benefits Booklet

SUPERIOR COURT of SANTA BARBARA
SANTA MARIA • LOMPOC • SANTA BARBARA

Open Enrollment October 1 – 31, 2025

Benefits for All Seasons

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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage.

Cover Photo Credit: Daisy Gonzalez.

GETTING STARTED

The Santa Barbara County Superior Court has a benefits program that provides you with great coverage that is simple and comprehensive. We offer programs that protect your health, your money, your family and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage so that you know how to get care, when you need it, at the lowest cost. With the tools and information in this booklet and related resources, we hope to help you be well today and work towards a healthy and secure future.

The Court understands that comparing benefit plans, features and costs can be complicated. This booklet provides information that will help simplify your decision-making process. It is a summary of your benefits and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your Evidence of Coverage documents (EOCs). The Evidence of Coverage documents determine how all benefits are paid and are available on the Court's benefits website. Visit the Court Intranet Benefits Page.

You can also contact CareCounsel to help you navigate and assist you with your health issues. Contact a CareCounsel representative at (888) 227-3334, Monday – Friday 6:30am – 5:00pm.

The benefits in this summary are effective:

January 1, 2026 - December 31, 2026

Open Enrollment Period: October 1 to October 31, 2025

OPEN ENROLLMENT & WHATS NEW

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, and enroll or re-enroll in the Flexible Spending Accounts. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2026, unless you experience a qualifying life event. Include your spouse or partner in the review if they have input into your family's benefits decisions.

Do I need to enroll?

If you do not have any changes to make to your 2026 benefits and you do not want to enroll in a 2026 Flexible Spending Account, **no action is required.**

What's New!

At the Santa Barbara Superior Court, we are committed to continuously reevaluating our benefits program to offer you and your family comprehensive and affordable options. Below is a summary of the changes for the new 2026 plan year:

Benefits Administration Platform

- We are moving from Workterra to BRMS for benefits administration. Log onto the benefits system at: **MyHealthBenefits.com** see page 7 for log-in instructions.

Medical

Based on IRS regulations, the Blue Shield HDHP plan will have a deductible increase, to $1,700 individual and $3,400 family.

Pharmacy Benefits Manager

- Starting January 1, 2026, Navitus will replace Express Scripts as the Pharmacy Benefits Manager for both medical Rx plans, see pg. 13 for more details. Members will receive a welcome packet in the mail with more information in December 2025.

New Value-Added Program

- Digbi Health (Digestible Bites) is a new chronic condition and disease management program available to members with diabetes, hypertension, hyperlipidemia, obesity and gastrointestinal issues. Digbi will replace Livongo for diabetes care.

HSA Flexible Spending Account

- The HSA limit will increase to $4,400 for individuals and $8,750 for family.

OPEN ENROLLMENT MEETINGS

We hope you join us at one of our 2025 Open Enrollment meetings. It's a great opportunity for you to obtain benefit information.

Lompoc
October 14
Lompoc Superior Court, Dept. 2
115 Civic Center Plaza, Lompoc, CA
3:30pm – 5:00pm
Santa Maria
October 15
Santa Maria Superior Court, Jury Building F
312 E. Cook Street, Santa Maria, CA
3:00pm – 5:00pm
Santa Barbara
October 16
Santa Barbara, Jury Services Building
1108 Santa Barbara St, Santa Barbara, CA
3:00pm – 5:00pm

BENEFIT PLAN INFORMATION FOR 2026

During Open Enrollment, remember that:

- You must enroll in an FSA account every year; your account does not roll over.
- The Court will continue to contribute $900 ($37.50 per 24 pay periods) to a Health Savings Account for all employees enrolled in the Blue Shield HDHP.
- Health premium information is on page 23-24. Most deductions are taken twice monthly rather than every paycheck. For those benefits, there are no deductions in pay period 15 and 26.

All plan changes must be made online at BRMS: **https://www.myhealthbenefits.com/MyHealthBenefits/Home/Login/**
You may add, delete, or change benefit elections online. Instructions on how to use BRMS can be found on pg. 7 or the Human Resources web page. All changes must be completed by October 31, 2025.

brms

To view the Open Enrollment presentation, please go to **https://alliantbenefits.cld.bz/2025SBCourtsOEPresentation** or click on the picture below.

MyHealthBenefits.com

New User Registration

With MyHealthBenefits® through BRMS, you can enroll in benefits, view plan and cost comparisons, access an all-inclusive resource library, and more! Log into myhealthbenefits.com to take advantage of these tools.

Registering for your new MyHealthBenefits account is required in order to view and manage your benefits. This reference guide will walk you through how to register for an account. Follow the steps below to complete your registration.

REGISTERING FOR A NEW ACCOUNT

1. In your web browser, enter www.myhealthbenefits.com.
2. You will be directed to the benefits system login page. All users will be required to go through the registration process to create a new username and password.
3. To register for an account, click Create New Account.
4. Complete the registration process. You will be required to validate your account with an active email address.
5. Once your email address has been validated, your account will be successfully verified.
6. Click Log In to enter your account.
7. Enter your username and password, and the system will prompt you to validate your identity by entering a code (sent via phone call, text message or email). *Note: This second step in the authentication process will be required every time an attempt to access your account is made from a device the system does not recognize.*
8. Upon completing the multi-factor verification, you will be taken to your MyHealthBenefits dashboard.

Scan the QR Code to login to your MyHealthBenefits account, or visit brmsonline.com for more information

WHO'S ELIGIBLE FOR BENEFITS?

When You Can Enroll

Coverage for new employees begins on the 1st of the month following their date of hire.

Open enrollment for current employees is held in October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 31 days to make your change.

Employees

You are eligible for the benefits outlined in this overview, if you are a regular Court employee working 20 or more hours per week.

Eligible Dependents

- Legally married spouse (includes same-sex spouse)
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing coverage for your domestic partner. Any premiums for your domestic partner paid for by the Santa Barbara County Superior Court are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to Pg. 51 of this booklet for Eligibility Documentation.

Who is Not Eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

Please refer to the Appendix section on page 46 to obtain detailed information on eligibility requirements and documentation needed.

QULAYFING LIFE EVENTS & CHANGING YOUR BENEFITS

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 31 days of their eligibility:

- Marriage or Domestic partners Certification or License and portion of your joint State Tax return
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 31 day period, you will not be able to add the dependent(s) until the next open enrollment period. For a full list of documents, please see page 51.

You must submit your change within 31 days after the event.

Click to play video

CARECOUNSEL HEALTHCARE AVOCATE

Have Questions About Your Benefits? Get Help From Your Healthcare Advocate

Are you getting married and not sure how and when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? CareCounsel can help answer these questions and more.

CareCounsel is your dedicated advocate with any healthcare benefit issue. All services are confidential and dedicated to your best interest in reducing hassle and headaches with your healthcare experience.

A CareCounsel trained benefits expert can help you understand and use your healthcare and other coverage.

Contact CareCounsel for issues such as:

- Benefits Education
- Open Enrollment Support & Plan Comparisons
- Making Sense of Medicare
- Locating Providers In Your Network
- Coordinating Multiple Party Interactions
- Troubleshooting Claims, Eligibility, And Billing Discrepancies
- Grievance And Appeal Support
- Coordinate Access To Clinical Information Via Stanford Health Care

CONTACT CARECOUNSEL

Phone:

(888) 227-3334

Hours:

6:30 AM – 5:00 PM
Monday - Friday

Website:
carecounsel.com

CareCounsel | Stanford HEALTH CARE STANFORD MEDICINE

MEDICAL

OUR PLANS

- Blue Shield Medical EPO
- Blue Shield Medical High-Deductible Health Plan (HDHP)

We offer two medical plans through Blue Shield. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and understand how the plan works.

Play the Health Lingo Game!

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Consider an EPO (Exclusive Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral as long it is in-network
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network

Consider a HDHP (High-Deductible Health Plan) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. Santa Barbara County Superior Court gives you a choice between two medical plans through Blue Shield of California.

	Blue Shield Medical EPO Plan	**Blue Shield High-Deductible Health Plan (HDHP)**	
	In-Network Only	**In-Network**	**Out-of-Network**
Annual Deductible Individual Family	$0 $0	$1,700 $3,400	$1,700 (combined w/ in-network) $3,400 (combined w/in-network)
Annual Out-of-Pocket Maximum Individual Family	$1,500 $3,000	$4,500 $9,000	$4,500 (combined w/in-network) $9,000 (combined w/in-network)
HSA Employer Contribution	None	$900 over 24 pay periods	
Office Visit Primary Care Specialist	$20 copay $20 copay	Plan pays 80% after deductible Plan pays 80% after deductible	Plan pays 60% after deductible Plan pays 60% after deductible
Online Visit (Teladoc)	$20 copay	$40 copay after deductible	Not Covered
Preventive Services	Plan pays 100%	Plans pays 100%	Plans pays 100%
Chiropractic	$20 copay (combined outpatient rehab up to 30 visit/year)	Plan pays 80% after deductible (up to 20 visits per year)	Plan pays 60% after deductible (combined with in-network limit of 20 visits/year)
Lab and X-ray	Plan pays 100%	Plan pays 100% after deductible	Plan pays 100% after deductible
Urgent Care	$20 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	$100 copay then plan pays 100% (copay waived if admitted)	Plan pays 80% after deductible	Plan pays 80% after deductible
Inpatient Hospitalization	$250/admission then plan pays 80%	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)
Outpatient Surgery	Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per day)
PRESCRIPTION DRUGS	**Administered by Navitus**	**Administered by Blue Shield**	
Prescription Drug Deductible Individual Family	$25 (preferred and non-preferred brand) $75 (preferred and non-preferred brand)	Combined with medical	Combined with medical
Out-of-Pocket Maximum	$5,100 individual; $10,200 family	Combined with medical	Combined with medical
Retail- 30 Day Supply Tier 1 (generic) Tier 2 (preferred brands) Tier 3 (non-preferred brands) Tier 4 (Specialty)	$10 copay $35 copay after Rx deductible $50 copay after Rx deductible Plan pays 80% with $100 copay max	Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible with $100 copay max	Plan pays 80% deductible Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible with $100 copay max
Mail Order- 90 Day Supply Tier 1 (generic) Tier 2 (preferred brands) Tier 3 (non-preferred brands) Tier 4 (Specialty)	$20 copay $70 copay after Rx deductible $100 copay after Rx deductible Plan pays 80% w/ $100 copay max	Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible with $100 copay max	Not covered Not Covered Not Covered Not Covered

NEW! INTRODUCING NAVITUS PHARMACY

Filling Your Prescriptions

Blue Shield members have access to prescription drug coverage through Navitus.

- **Network Pharmacy –** Most independent and all major chain pharmacies, are part of your benefit network.
- **Costco Mail Order –** A 90-day supply of maintenance medications can be mailed right to your door. You don't need to be a Costco member to use their pharmacies. Just register online at pharmacy.costco.com or call (800) 607-6861 to get started.
- **Specialty Pharmacy -** Lumicera Health Services, our specialty pharmacy partner, provides a high level of personalized care for members with complex conditions. Their clinical team will help you manage side effects and reduce complications, so you can focus on the things that matter most. Visit lumicera.com/patients/ or call (855) 847-3553 for more information.

Member Portal & App

Go to navitus.com/members to access the member portal or download the Navitus mobile app. Register for your account, if you haven't already done so. Log into the Navitus member portal and app with the same username and password. Once registered, click Sign In, then enter your login details and password. From here you can:

- View or print your member ID card
- Perform a Drug Search for coverage details
- Find drug prices and pharmacy locations
- Easily track your medication history

Simplifying Prior Authorization, Step Therapy & Exception to Coverage

There are certain conditions and medications which require extra steps to gain approval to fill the prescription, but Navitus tries to make it as easy as possible.

- **Prior Authorization (PA) –** Some prescriptions require prior authorization to be filled, which your health care provider will need to help facilitate. Drugs that need prior authorization are listed on your formulary with a PA. Most prior authorization requests are reviewed within two business days and urgent requests within one business day.
- **Step Therapy –** When there's an effective alternative available that's less expensive for you, you may be asked to try that before a more expensive prescription is authorized.
- **Exception to Coverage (ETC) –** If a drug isn't approved, you and your doctor can submit an ETC request showing alternative medications aren't effective or suitable for your personal situation.
- **Coverage Details -** If there are any limits or requirements on your medications like the ones listed above, a Coverage Details button will appear on the medicine's description page in the portal. Clicking on that button will outline what's needed to get the prescription filled.

Navitus Customer Care

Phone: (866) 333-2757

Website: navitus.com

Available 24 hours a day, 7 days a week
Closed Thanksgiving & Christmas

Important Note: You will continue to have access to RXnGo.

NEW! INTRODUCING DIGBI HEALTH & GI CARE

Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Blue Shield through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

GLP-1 Eligibility

Eligibility requirements for accessing GLP-1s for weight management:

- 18 years or older and enrolled in Blue Shield (Mandatory).
- BMI 40 or higher without any comorbidity (OR)
- BMI 35 - 39 with at least one related comorbidity (OR)
- Mandatory: If you're on a GLP-1 for weight management, you should have lost 5% weight within 90 days of starting them.
- Digbi to be the sole prescriber for all weight loss medications.

Get Started

1. Check your eligibility and sign up for the program at digbihealth.com/prism.
2. If you are eligible, download mobile app - onelink.to/digbi.
3. On the app, please confirm shipping address and answer onboarding questions - your kits will be ordered to your address, automatically.
4. Starting January 1, 2026, you will have 90 days to go through Digbi Health's Reauthorization for weight management GLP-1 medication based on the new eligibility criteria.

Digbi Health App

- **Get at-home Test Kits -** Within a week, you'll receive a comprehensive testing kit including a Genetic Test, a Gut Microbiome Test, and an Abbott Libre Continuous Glucose Monitor. Please follow instructions to collect samples and return kits using pre-labeled shipping.
- **Sync your Health Apps -** Connect Apple or Google Health Apps with the Digbi App. Navigate to settings, choose "Health", then connect by tapping "Refresh" under "Apple Health".
- **Say hi to your Coach! -** Tap the 'Coach' button at the bottom to start engaging with your health coach on the app and upload meal pictures for scoring while you await test results.

HEALTH SAVINGS ACCOUNT (HSA)

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future. Available to employees who participate in the Blue Shield High-Deductible Health Plan, this is a tax-advantaged savings account through Sterling HSA that allows you to save pre-tax dollars to pay for qualified health expenses.

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Blue Shield High-Deductible Health Plan (HDHP).
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

Click to play video

How the Sterling HSA works

- You can contribute up to the 2026 annual limit set by the IRS:
  Individual: $4,400 per year
  Family: $8,750 per year
  Are you age 55 **or over?** You can contribute an additional $1,000 per year
- To help you get started, The Courts will contribute to your HSA (this is included in the IRS maximums noted above):
  Individual/Family: $900 annually over 24 pay periods
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the court.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

Find out more

- Eligible Expenses
- Ineligible Expenses

NOTE: *you are not eligible to elect an HSA if you are covered by another health plan, such as a health plan sponsored by your spouse's employer (unless it is another HDHP plan), Medicare, Tricare or if an employee is claimed as a dependent on another's tax return.*

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Santa Barbara County Superior Court offers you the opportunity to participate in a Healthcare and/or Dependent Care Flexible Spending Account (FSA). BRMS is the administrator for these accounts. To access your accounts, visit, https://www.myhealthbenefits.com/MyHealthBenefits/Home/Login/.

Set aside healthcare dollars for the coming year.

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through BRMS.

Click to play video

Find out more

- Eligible Expenses– now include more over-the-counter items!
- Ineligible Expenses

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How the Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,300, the 2025 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- The FSA plans have an added feature (Grace Period) that allows you to continue to incur new claims up to 03/15/27, with any remaining funds from your 2026-elected amount. Expenses must be submitted for reimbursement no later than 05/30/27.
- If you don't spend all the money in your account, you forfeit the leftover balance. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

DEPENDENT CARE FSA & TRANSIT & PARKING FSA

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $7,500 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by BRMS.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. For 2026, you can set aside up to $7,500 per household for eligible dependent care expenses.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

TRANSIT & PARKING FLEXIBLE SPENDING ACCOUNT (FSA)

Santa Barbara County Superior Court allows you to participate in a Parking/Transit Flexible Spending Account. Use the money in our BRMS Commuter Program for all of your eligible work-related transit and parking expenses. Ineligible expenses include tolls, car maintenance, carpools and gasoline.

Work related transit - these consist of vouchers, passes, tokens and fare cards for transportation via bus, commercial vanpool or train.

Parking expenses – these include parking at or near work, parking at or near a transportation site and Park and Ride expenses.

The maximum IRS allowed amount for 2025 is $325 per month. You will be notified if the limit changes for 2026.

To learn more about the FSA and Transit/Parking FSA visit: www.myhealthbenefits.com.

DENTAL

OUR PLANS

We offer two dental plans through Delta Dental.

- Delta Dental DHMO DeltaCare USA
- Delta Dental PPO

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth

Important: Delta Dental does not issue ID Cards. Please refer to the Court's custom Delta Dental website to download and print your ID card. Members can also view their plan coverage and benefits, locate a provider, and more at www.deltadentalins.com/superiorcourtofcactyofsantabarbara.

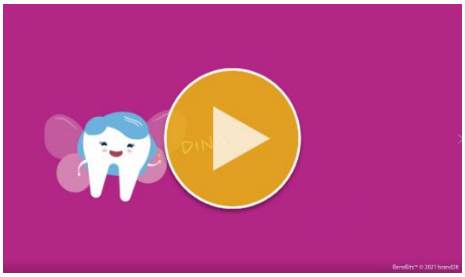
Dental

The Santa Barbara County Superior Court gives you a choice between two dental plans through Delta Dental.

	Delta Dental DHMO – DeltaCare USA	Delta Dental PPO	
	In-Network	**In-Network***	**Delta Dental Premier or Out-of-Network***
Annual Deductible Individual Family	$0 $0	$50 $100	$50 (combined with in-network) $100 (combined with in-network)
Annual Plan Maximum	N/A	$2,000 per person	$2,000 per person (combined with in-network)
Waiting Period	None	None	None
Diagnostic & Preventive	Plan Pays 100%	Plan pays 100%	Plan Pays 100%
Basic Services Fillings Root Canals Periodontics	Various copays apply Various copays apply Various copays apply	Plan pays 90% after deductible Plan pays 90% after deductible Plan pays 90% after deductible	Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible
Major Services	Various copays apply	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontia	Plan pays 100% up to Lifetime Maximum	Plan pays 50% up to $1,500 Lifetime Maximum (Calendar deductible does not apply)	Plan pays 50% up to $1,500 Lifetime Maximum (Calendar deductible does not apply)
Ortho Lifetime Max Adults Children (up to age 26)	$2,100 $1,900	$1,500 $1,500	$1,500 (combined with in-network) $1,500 (combined with in-network)

Important information you need to know about these plans

- Delta Dental does not issue ID Cards. Please refer to the Court's custom Delta Dental website to download and print your ID card. Members can also view their plan coverage and benefits, locate a provider, and more at www.deltadentalins.com/superiorcourtofcactyofsantabarbara.
- If you elect the DHMO plan, you must select a DeltaCare USA primary dentist, otherwise, you will be auto assigned a dentist near your home zip code.
- *For the PPO Plan, reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for out of network dentists and program allowance for non-Delta dentists.



Click to play video

VISION

OUR PLANS

We offer two vision plans through VSP.

- VSP Vision Core Plan
- VSP Choice Buy-Up Plan

Quality Vision Care You Need

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Shop Online And Connect Your Benefits

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

Value And Savings You Love

Save on eyewear and eye care when you see a VSP network doctor. Plus take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands up to over $3,000 in savings.

Click to play video

VSP Vision Core Plan

Your vision checkup is fully covered after your exam copay. After any materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision	
	In-Network	**Out-of-Network***
Exams Wellvision Exam Contact Lens Exam Frequency	$10 copay for exam and glasses Up to $60 Once every 12 months	Plan pays up to $45 exam only Up to $60 In-network limitations apply
Essential Medical Eye Care Retinal screening Additional Exams Frequency	Up to $39 copay or $0 per screening for members with diabetes $20 per exam Available as needed	Up to $39 copay or $0 per screening for members with diabetes $20 per exam Available as needed
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Lens Enhancements Frequency	Combined with exam Combined with exam Combined with exam From $0 up to $175 (standard, premium, and custom + 30% savings on other lens enhancements) Once every 24 months	Up to $30 Up to $50 Up to $65 Up to $50 In-network limitations apply
Frames Benefit Frequency	Up to $120 Up to $70 at Costco/Walmart/Sam's Club 20% off amount over your allowance Once every 24 months	Up to $70 In-network limitations apply
Contacts (In lieu of glasses) Frequency	Up to $120 Once every 24 months	Up to $105 Once every 24 months

VSP Choice Buy-up Plan

Your vision checkup is fully covered after your exam copay. After any materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision	
	In-Network	**Out-of-Network***
Exams Wellvision Exam Contact Lens Exam Frequency	 $10 copay $10 copay Once every 12 months	 Plan pays up to $45 exam only Once every 12 months
Essential Medical Eye Care Retinal screening Additional Exams Frequency	Up to $39 copay or $0 per screening for members with diabetes $20 per exam Available as needed	Up to $39 copay or $0 per screening for members with diabetes $20 per exam Available as needed
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Lens Enhancements Frequency	 $10 $10 $10 From $0 up to $175 (standard, premium, and custom + 30% savings on other lens enhancements) Once every 12 months	 $30 $50 $65 Up to $50 In-network limitations apply
Frames Benefit Frequency	$150 Allowance (Plus 20% Discount) Once every 24 months	$70 (Plus 20% Discount) Once every 24 Months
Contacts (In lieu of glasses) Frequency	$150 Allowance Every 12 Months	Up to $105 Every 12 Months

Important Information For Both Core and Buy-Up Plans

Using Your VSP Benefit Is Easy!

- Find a VSP doctor and/or sign up at **www.vsp.com** under the VSP Signature network.
- At your appointment, say you have VSP. No ID card required, but you can print one online.
- Need help? Contact VSP at **800-877-7195**.

Extra Savings! Receive an extra $20 to spend on featured frame brands on glasses and sunglasses. You can also save 20% on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision exam. Members also can save up to $1,000 off LASIK at a VSP Laser VisionCare in-network provider. For more information visit **vsp.com/offers**.

***The Out-of-Network** amounts are reimbursement amounts not copayment amounts.

YOUR BENEFIT COSTS

The amount that you pay for your coverage is outlined below and depends on whether you have employee only coverage or cover dependents.

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. Please note that domestic partner contributions are regulated by the IRS and generally must be made on an after-tax basis. Similarly, the company contribution toward the cost of domestic partner coverage and his/her dependents is taxable income to you. Contact your tax advisor for more details on how this tax treatment applies to your specific situation.

Rates noted below are twice monthly.

MEDICAL	Medical Premium	Court Contribution*	Employee Cost*
Blue Shield EPO Medical Plan Group #W0052121			
Employee Only	548.50	(548.50)	$0.00
With 1 Dependent	1,016.50	(1,016.50)	$0.00
Two + Dependents	1,595.00	(1,595.00)	$0.00
Blue Shield HDHP Medical Plan Group #W0052151			
Employee Only	485.00	(485.00)	0.00
With 1 Dependent	896.00	(896.00)	0.00
Two + Dependents	1,409.00	(1,409.00)	0.00

*Court contribution will be pro-rated for part-time employees.

YOUR BENEFIT COSTS CONTINUED

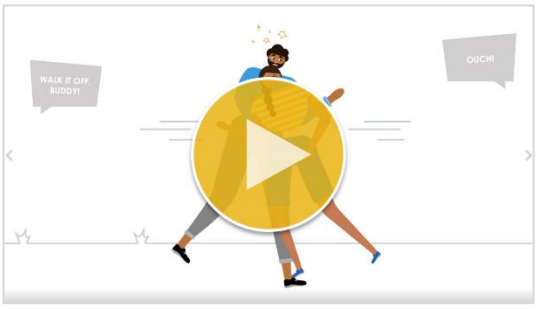
DENTAL	Medical Premium	Court Contribution*	Pre-Tax Employee Cost
Delta Dental PPO, Group #16479			
Employee Only	$23.45	(23.45)	0.00
With 1 Dependent	$45.00	(38.25)	0.00
Two + Dependents	$69.15	(58.78)	0.00
Delta Dental HMO DeltaCare USA, Group #76836			
Employee Only	$20.17	(20.17)	0.00
With 1 Dependent	$33.16	(28.18)	0.00
Two + Dependents	$50.32	(42.77)	0.00

VISION	Vision Premium	Pre-Tax Employee Cost	After-Tax Employee Cost
VSP Core			
Employee Only	$3.65	0.00	$3.65
With 1 Dependent	$5.20	0.00	$5.20
Two + Dependents	$9.30	0.00	$9.30
VSP Buy Up			
Employee Only	$5.15	0.00	$5.15
With 1 Dependent	$7.30	0.00	$7.30
Two + Dependents	$13.05	0.00	$13.05

*Court contribution will be pro-rated for part-time employees.

ENGAGE WITH YOUR WELLNESS RESOURCES

Click to play video



Urgent Care vs ER

Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Understanding preventive care benefits
- Enjoy learning about health, medicine, fitness and nutrition.

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

- **New Digbi** Health – Chronic Conditions and Disease Management
- **Concern Employee Assistance Program -** Confidential counseling and other resources
- **Wellvolution –** A personalized digital platform for health and well-being
- **Teladoc Health** – Virtual office visits 24/7
- **Carrum** – Surgical and Cancer benefit
- **Hinge Health** – MSK and Pelvic health support
- **And more!**

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack ▪ Stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

PREVENTIVE CARE SCREENING BENEFITS

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **https://www.cdc.gov/index.html** for recommended guidelines.

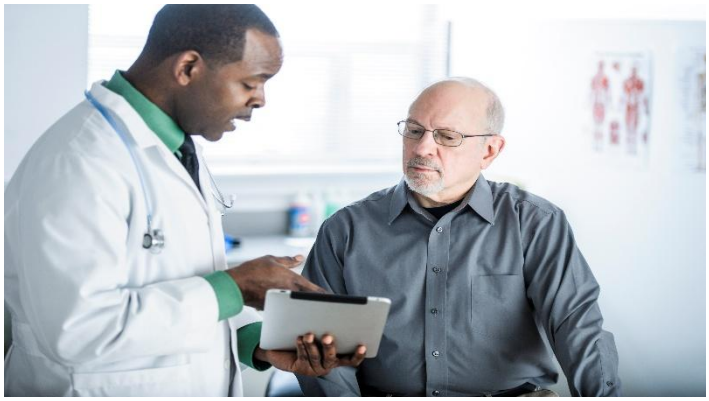
Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.



TYPICAL SCREENINGS FOR ADULTS

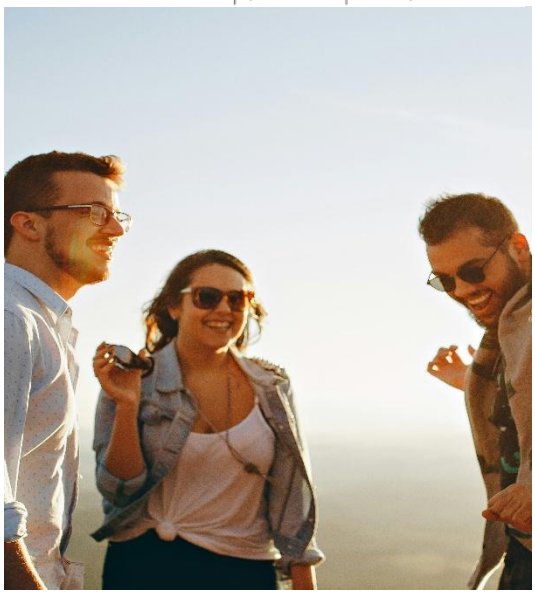
- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

LEARN ABOUT PREVENTIVE CARE FOR YOU AND YOUR FAMILY WITH BLUE SHIELD

Find out what screenings, services, and immunizations we recommend for you and your family. Visit blueshieldca.com/preventive.

CONCERN EMPLOYEE ASSISTANCE PROGRAM (EAP)

Concern
Real help, real experts, real fast.



CONTACT THE EAP

Phone
800-344-4222

Website
https://employees.concernhealth.com/employee-portal

Company Code:
Santabarbaracourts

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through CONCERN can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources. Best of all, contacting the EAP is completely confidential, free and available to all employees, your spouse/domestic partner, and dependent children up to age 26. Check out this video* for a brief introduction to Concern.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3 visits per issue, per 12-month period.

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING : Free 30-minute phone consultation

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION : Free 30-minute consultation with 25% discount on hourly rate

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

*You may need to use your company code to access the video.

BLUE SHIELD RESOURCES

BLUESHIELDCA.COM & MOBILE APP

Register at blueshieldca.com or download the Blue Shield app from the App Store℠ or Google Play® to access tools to help you improve your health, make informed decisions about your care, and find options to save you money.

BLUE SHIELD MEMBER SERVICES

Call Blue Shield for representatives that will provide answers to questions regarding claims, authorizations, determinations, general plan information, and coverage.
(855) 599-2650
7 a.m. to 7 p.m. Pacific Time
Monday – Friday

24/7 NURSE LINE

Health issues can arise at the most inconvenient times and places for you and your loved ones. Whether it's 3 a.m. at home or 10 a.m. while you're in the office. You have access to a nurse you can talk to any time, day or night, 365 days a year. Just call the number on the back of your ID card.

Teladoc

Teladoc's U.S. board-certified doctors or mental health professional are available 24/7/365 to resolve many non-emergency medical issues through phone or video consults. Contact Teladoc online at teladoc.com/bsc, on the phone at 800-teladoc (835-2362).

Wellvolution

Wellvolution is a digital platform for health and well-being. It offers over 50 tested apps and programs to help you achieve your health goals – at no extra cost. Areas of focus include disease prevention and reversal, nutrition, sleep, stress, smoking and more. Members also have access to mental health resources such as Ginger and Headspace.

Ginger can help with anything you're struggling with—from stress and depression to issues with work and relationships. Need to chat on the weekend? Or at 3 AM on a holiday? Ginger coaches are around 24/7/365.

Headspace is a well-being solution that fosters healthier employees and more productive teams by developing mental health & wellness routines that last a lifetime. Headspace holds a rich, diverse, library of on demand content to help navigate daily stress, sleep, movement, and focus.

Learn more at wellvolution.com.

Bluecard Program – Stay Covered While Traveling

Your family has access to urgent and emergency care through the BlueCard® and Blue Shield Global Core programs almost everywhere in the U.S. and in 170 countries and territories around the world. To find a provider in the U.S. visit provider.bcbs.com or call (800) 810-2583. To find a provider outside the U.S. visit bcbsglobalcore.com .

LifeReferrals℠

Call LifeReferrals℠ 24/7 anytime and talk with experienced professionals ready to help you with personal, family, and work issues. Get referrals for three face-to-face or telephone visits in a six-month period with a licensed counselor. Legal and financial consultations are also available. For more information, visit lifereferrals.com and enter the access code: BCS or, call (800) 985-2405.

BLUE SHIELD RESOURCES CONTINUED

Maven Maternity Program

Maven offers 24/7 virtual access to one-on-one maternity and postpartum support. Blue Shield members who are expecting and their partners can get access to virtual care for pregnancy, postpartum, and returning to work after parental leave. Plus, they'll enjoy 24/7 access to Care advocates, specialists, and coaches – as well as content tailored to your experience.

With Maven you can get access to:

- On-demand virtual appointments with Maven OB-GYNS, lactation consultants, doulas, mental health specialists, nutritionists, career coaches, and many more
- Your own Care Advocate who can help you find care, navigate your health benefits, find the right in-network providers, and more
- Expert resources including virtual classes, helpful articles, and community forums

To learn more, go to blueshieldca.com/maven.

Care Management Program

Get support managing your health needs for conditions such as diabetes, depression, chronic pain, cancer, as well as other conditions. Services include personalized health coaching, care plan development, provider coordination, plus more. To learn more, go to https://www.blueshieldca.com/en/home/be-well and click on Conditions and care programs, and then select Shield Support. You can also call (877) 455-6777 to find out if you're eligible.

Save On Fitness Club Memberships With Fitness Your Way

This program gives you access to more than 800 fitness centers in California and more than 10,000 nationwide for as low as $10 per month. Get access to virtual classes, gyms with no long-term contracts, and more. Visit https://bsca.fitnessyourway.tivityhealth.com/ to check if you're eligible today!

blue california

PRISM VALUE ADDED SERVICES

Take advantage of these value-added services available to The Court's PRISM Blue Shield plan members to help you get and stay healthy.

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
Physical Therapy for Back, Joint, or Pelvic Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Available for preventative, acute, and chronic needs at no cost. Must be 18+ to qualify for this benefit.	*EPO & HDHP members* **Call:** (855) 902-2777 **Email:** help@hingehealth.com **Visit** hingehealth.com/prism/ Hinge Health
Hip, Knee, Bariatric, and Spine Surgical Benefit and Breast Cancer Treatment Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel for patient and companion, and medical bills. Oncology benefit also available; guidance for all cancers; treatment for Breast Cancer through the City of Hope.	*EPO & HDHP* members* **Call:** (888) 855-7806 **Visit** carrumhealth.com *Due to IRS regulations on HDHP plans, the deductible applies but the coinsurance is waived. carrumhealth
New! Chronic Condition & Disease Management Program **Digbi Health** Access personalized digital care programs that utilize genetic and gut microbiome analysis to address obesity, diabetes, digestive disorders, and related conditions. Services include at-home DNA (optional) and gut biome testing, continuous glucose monitoring, nutrition and lifestyle recommendations, access to health coaches, plus medically managed weight loss programs.	**EPO & HDHP members** **Call:** (866) 344-2189 **Visit** digbihealth.com/prism digbi health

LIFE & DISABILITY

BASIC LIFE

Basic Life insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

Basic Life Amount	$50,000

SUPPLEMENTAL LIFE AND AD&D

Supplemental Life and AD&D Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya Financial.

Employee Supplemental Life Amount	Can elect from **$20,000** to **$500,000** in increments of **$10,000** ($10,000 of AD&D is included for a minimal fee)
Spouse or Domestic Partner Supplemental Life Amount	Can elect from **$20,000** to **$500,000** in increments of **$10,000** not to exceed 100% of Employee's Supplemental Life Insurance amount. Employee must have coverage.
Child(ren) Supplemental Life Amount	Can elect **$5,000 or $10,000** (unmarried child from birth up to age 26). Employee must have coverage.

NOTE: Rates for this plan can be found on page 36.

LONG – TERM DISABILITY

The Courts cover all regular employees working 20 hours or more with a Long-Term Disability Insurance plan. The plan pays 60% of your monthly earnings with a minimum of $100 to a maximum amount which is dependent on your job classification. You must be disabled for 60 days before the plan begins to pay benefits.

NOTE: Your amount of Supplemental Life and AD&D will decrease to 65% on your 65th birthday, to 50% of original coverage on your 70th birthday and 30% of the original coverage at age 75.

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

VOYA FINANCIAL

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

VOLUNTARY ACCIDENT AND CRITICAL ILLNESS INSURANCE

VOLUNTARY COMPASS ACCIDENT

Voluntary Compass Accident Insurance is offered by Voya Financial. This policy helps you pay for the out-of-pocket costs you may experience after an accident. The policy pays a lump sum amount depending on the type of injuries you have sustained such as broken bones, torn ligaments or burns, as well as for expenses from hospitalizations, the ER, office visits or physical therapy. You may use this amount to pay for everyday living expenses or to pay healthcare costs.

The policy also has an annual Wellness Benefit that pays you $100 for completing a screening, an additional $100 for a covered spouse and $50 for a child.

VOLUNTARY PERSONAL ACCIDENT

Voluntary Personal Accident Insurance (PAI) allows you to purchase additional life insurance for yourself or Family (Spouse/Domestic Partner and Child coverage). Coverage is provided by Voya Financial. Evidence of Insurability (EOI) is not required. Rates for this plan can be found on page 36.

Employee Voluntary Personal Accident	Can elect from $25,000 to $300,000 in $25,000 increments not to exceed 10 times annual salary
Family Voluntary Personal Accident	• Spouse/Domestic Partner – receives 50% of Employee's Personal Accident Insurance • Child (each) – receives 10% of Employee's Personal Accident Insurance

VOLUNTARY CRITICAL ILLNESS

Critical Illness Insurance is an affordable way to protect against the financial stress of a serious illness. It pays a lump-sum benefit if you are diagnosed with a covered illness or condition. This policy is in addition to your health coverage. You may use this benefit to pay:

- Medical expenses
- Child Care
- Home health costs
- Mortgage payment/rent and home maintenance
- Any other everyday expenses

This policy offers an annual Wellness benefit that provides a $150 reimbursement for each covered employee and spouse who completes a covered health screening. Child benefit is 50% of employee amount with a maximum of $300 in child wellness benefit.

Coverage is provided by Voya Financial.

Employee Voluntary Critical Illness	Can elect from $5,000 to $20,000 in $5,000 increments.
Spouse Voluntary Critical Illness	Can elect $5,000 or $10,000. Must have employee coverage.
Child Voluntary Critical Illness	Can elect $1,000. $2,500. $5,000 or $10,000. Must have employee coverage.

VOLUNTARY HOSPITAL INDEMNITY PLAN

Voluntary Hospital Confinement Indemnity Plan

Voya is offering their Hospital Confinement Indemnity plan which provides a benefit for a hospital stay. This voluntary benefit is separate from your Blue Shield hospital benefit. This Voya plan pays a daily benefit if you have a covered stay in a hospital, critical care unit or rehabilitation facility. The benefit is determined by the type of facility and the number of days you stay. You can use the lump sum payment for any purpose such as deductible, copays or everyday expenses like utilities and groceries. Plan rates are noted on page 36.

Plan highlights:

- Guarantee issue – no medical question or tests required
- Flexible – you can use the benefit payments for any purpose you like
- Portable – you can take the policy with you if you leave your employer or retire

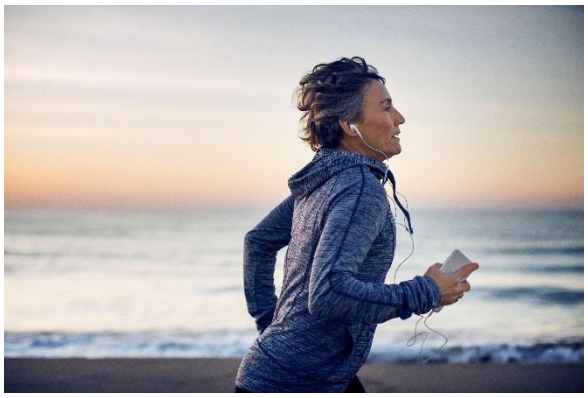
Benefit	
Initial Hospital admission	$1,000
Hospital	$100 per day up to 30 days per confinement
Critical Care Unit	$200 per day up to 15 days per confinement
Rehabilitation Facility	$50 per day up to 30 days per confinement
Pre-existing condition limitation	None
Age reduction	None
Portability	You can take this policy with you if you leave the Court
Wellness Benefit	
Employee	$50, once a year
Spouse	$50, once a year
Child	$25 per child, to a maximum of $100, once a year

The Wellness benefit provides an annual amount if you complete a preventive health screening test. Refer to page 35 for information on what are Preventive health screening tests.

VOYA FINANCIAL

If viewing electronically, click on the icon to view a video on the Hospital Indemnity Plan or go to our website where you will find an electronic copy of this booklet.

WELLNESS BENEFIT AT A GLANCE



What is a Wellness Benefit?

A Wellness benefit is a rider that is included on your Voluntary Compass Accident, Critical Illness and Hospital Indemnity Plan. It provides an annual payment if you complete a preventive health screening test. You only need to complete one preventive health screening test. This one test can be used for any or all three benefit plans. The Accident, Critical Illness and Hospital Indemnity plan each has a Wellness benefit. Your spouse and/or dependents covered under your plan also have a Wellness benefit.

What type of preventive health screening tests are eligible?

Preventive health screening tests include but are not limited to:

If viewing electronically, click on the icon to view a video on How To File A Claim or go to our website where you will find an electronic copy of this booklet.

Blood test for triglycerides	Serum Protein Electrophoresis	Fasting blood glucose test	Annual physical exam
Pap smear	Breast ultrasound, sonogram, MRI	Thermography	CA 125 (ovarian cancer)
Sigmoidoscopy	Chest x-ray	PSA Prostate Cancer	Tests for STIs
CEA (blood test for colon cancer)	Mammography	Hearing test	Ultrasounds for abdominal aortic aneurysms
Bone marrow testing	Colonoscopy	Routine eye exam	Hemoglobin A1C
Cholesterol test	CA 15-3 (breast cancer)	Routine dental exam	Bone density
Hem occult stool analysis	Stress test on bicycle or treadmill	Well child/preventive exam to age 18	Electrocardiogram (EKG)

Don't forget to claim your Wellness dollars every year!

Make it a habit to do so right after your annual physical exam.

How do I file a claim?

You can easily file a claim online.

1. Go to voya.com/claims
2. Scroll down to the "Have a Wellness Benefit Claim?" section and click the "Submit your claim" button.
3. Check all products that apply – Accident, Critical Illness, Hospital Indemnity
4. Click "Continue" and follow the screen prompts. Once all questions are answered, click "Submit"

Your Group Name is Santa Barbara Superior Court

Your Group Number is: 00680974

VOLUNTARY INSURANCE RATES

Supplemental Insurance Rates

Employee and Spouse Supplemental Life Insurance Rates	
Age	**Cost per $1,000 of Coverage**
Under 25	$0.03
25-29	$0.03
30-34	$0.045
35-39	$0.05
40-44	$0.06
45-49	$0.09
50-54	$0.165
55-59	$0.26
60-64	$0.405
65-69	$0.775
70+	$1.255

Semi-Monthly (24) Rates

Child Life Insurance Rates	
Coverage Levels	**Cost of Coverage**
$5,000 each child	$0.525
$10,000 each child	$1.05

Supplemental Accidental Death and Dismemberment (AD&D) Insurance Rates	
Coverage Type	**Cost of Coverage**
Employee Supplemental AD&D	$0.13

Personal Accident Insurance (PAI) Rates

Semi-Monthly (24) Rates

Coverage Type	Cost per $1,000 of Coverage
Employee Only	$0.02
Employee + Family	$0.028

Voluntary Compass Accident Insurance Rates

Semi-Monthly (24) Rates - Includes Wellness Benefit

Employee	Employee and Spouse	Employee and Children	Family
$4.57	$7.58	$8.10	$11.10

Voluntary Hospital Confinement Indemnity Insurance Rate

Semi-Monthly (24) Rates- Includes wellness Benefit.

Coverage Type	
Employee Only	$13.59
Employee + Spouse	$26.52
Employee + Child(ren)	$20.15
Employee + Family	$33.08

Voluntary Critical Illness Insurance Rates

Employee Coverage - Semi-Monthly (24) Rates - Includes Wellness Benefit

Non-Tobacco					Tobacco				
Issue Age	$5,000	$10,000	$15,000	$20,000	Issue Age	$5,000	$10,000	$15,000	$20,000
Under 20	$3.70	$5.45	$7.20	$8.95	Under 20	$4.95	$7.95	$10.95	$13.95
20-24	$3.70	$5.45	$7.20	$8.95	20-24	$4.95	$7.95	$10.95	$13.95
25-29	$3.98	$6.00	$8.03	$10.05	25-29	$5.50	$9.05	$12.60	$16.15
30-34	$4.05	$6.15	$8.25	$10.35	30-34	$5.85	$9.75	$13.65	$17.55
35-39	$4.78	$7.60	$10.43	$13.25	35-39	$7.33	$12.70	$18.08	$23.45
40-44	$6.18	$10.40	$14.63	$18.85	40-44	$10.10	$18.25	$26.40	$34.55
45-49	$8.08	$14.20	$20.33	$26.45	45-49	$13.85	$25.75	$37.65	$49.55
50-54	$10.25	$18.55	$26.85	$35.15	50-54	$18.13	$34.30	$50.48	$66.65
55-59	$12.33	$22.70	$33.08	$43.45	55-59	$22.15	$42.35	$62.55	$82.75
60-64	$15.18	$28.40	$41.63	$54.85	60-64	$27.50	$53.05	$78.60	$104.15
65-69	$21.30	$40.65	$60.00	$79.35	65-69	$38.98	$76.00	$113.03	$150.05
70+	$29.58	$57.20	$84.83	$112.45	70+	$54.88	$107.80	$160.73	$213.65

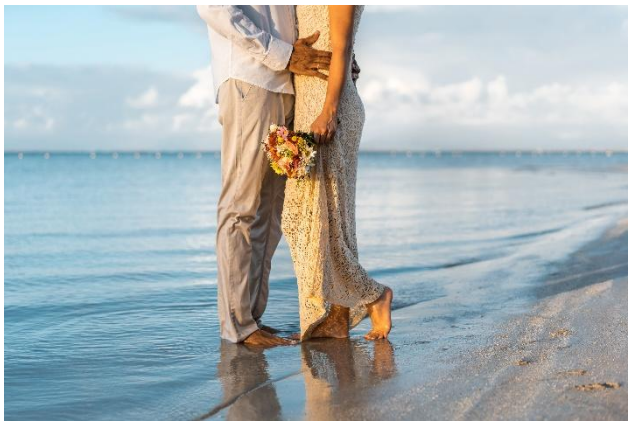
Spouse Coverage -Semi-Monthly (24) Rates - Includes Wellness Benefit

Non-Tobacco			Tobacco		
Issue Age	**$5,000**	**$10,000**	**Issue Age**	**$5,000**	**$10,000**
Under 20	$3.28	$4.60	Under 20	$4.23	$6.50
20-24	$3.28	$4.60	20-24	$4.23	$6.50
25-29	$3.60	$5.25	25-29	$4.93	$7.90
30-34	$4.60	$7.25	30-34	$6.73	$11.50
35-39	$5.50	$9.05	35-39	$8.45	$14.95
40-44	$7.23	$12.50	40-44	$11.88	$21.80
45-49	$9.88	$17.80	45-49	$17.10	$32.25
50-54	$13.48	$25.00	50-54	$24.33	$46.70
55-59	$17.45	$32.95	55-59	$32.20	$62.45
60-64	$22.45	$42.95	60-64	$42.18	$82.40
65-69	$30.93	$59.90	65-69	$58.60	$115.25
70+	$35.98	$70.00	70+	$67.60	$133.25

Children Coverage - Semi-Monthly (24) Rates - Includes Wellness Benefit

Coverage Amount	Rate
$1,000	$1.84
$2,500	$2.34
$5,000	$3.18
$10,000	$4.85

VOLUNTARY LIFE INSURANCE WITH LONG-TERM CARE (LTC)



Nearly 70% of people turning age 65 will need some type of Long Term Care.[1]

$93,075 average annual cost for nursing home care in 2020.[2]

Contact your HR Benefits Representative on how to enroll

Using Your Benefit

The LifeTime Benefit Term benefit plan protects your family with money that can be used any way they choose. It is most often used to pay for mortgage or rent, education for children and grand children, retirement, family debt, and final expenses. Cash benefits can also be paid directly to you for Long Term Care (LTC) expenses while you are living. This benefit works by providing you Term Life Insurance and a Long Term Care benefit.

What is Long Term Care?

Long term care is the type of care received either at a nursing home or in an assisted living setting to assist with Activities of Daily Living (ADL's) due to an accident, illness or advancing age. Long term care insurance pays benefits when a physician certifies that you are unable to perform two of six ADL's for a period that is expected to last at least 90 days. ADL's are: bathing, dressing, toileting, transferring, continence, eating or (2) cognitive impairment. Insurance premiums are waived while this benefit is being paid.

Term Life Insurance

- Life insurance premiums will never increase and are guaranteed to age 100. Thereafter no additional premium is due while the coverage can continue to age 121.
- Death Benefit is guaranteed 100% when it is needed most – during your working years when your family is relying on your income. While the policy is in force, the death benefit is 100% guaranteed for the longer of 25 years or age 70.
- Even after age 70, the full death benefit is designed to last through age 99 for non-tobacco user and age 95 for tobacco users.
- After 10 years, paid-up benefits begin to accrue. At any point thereafter, if you stop paying the premium, a reduced paid-up benefit is issued and can never lapse. This means that when you retiree, you can stop paying the premium and have a death benefit for the rest of your life.
- Terminal illness – after your coverage has been enforced for two years, you can receive 50% of your death benefit, if you are diagnosed with a terminal illness.

LONG-TERM CARE (LTC) Rates

Carrier	CHUBB Lifetime Benefit Term	CHUBB Lifetime Benefit Term
Death Benefit	$75,000	$50,000
Max Policy Benefit	$150,000	$100,000
Monthly LTC	$3,000	$2,000
LTC Duration	50 Months	50 Months
	Non-Tobacco	
25	$41	$27
35	$60	$40
45	$99	$66
55	$184	$123
65	$398	$265
	Tobacco	
25	$54	$36
35	$78	$52
45	$133	$88
55	$248	$166
65	$522	$348

METLIFE PET INSURANCE

Protect Your Fur Family From the Unexpected

More than ever, pets play a huge role in our lives. We want to do everything to keep them safe and healthy. Help make sure your furry family members are protected against unplanned vet expenses for covered accidents or illnesses with MetLife Pet Insurance.

Pet insurance can help reimburse you for covered vet visits, accidents, illness and more. Plus it can help keep your pet safe and healthy with preventive care like X-rays and ultrasounds.

Coverage Highlights:

Flexible Coverage	Choose the plan that works for you and your pet. Options include: • Levels of coverage from $500 – unlimited. • $0 -$2,500 deductible options. • Reimbursement percentages from 50%-90%.
What is Covered	• Accidental injuries • Illnesses • Exam fees • Surgeries • Medications • Ultrasounds • Hospital stays • X-rays and diagnostic tests
Coverage also includes	• Hip dysplasia • Hereditary conditions • Congenital conditions • Chronic conditions • Alternative therapies • Holistic care • And much more
Additional Value	• Take your pet to any licensed veterinarian, specialist or emergency clinic in the U.S. • If you're claim-free in a policy year, we'll automatically decrease your deductible by $25 or $50.

Why MetLife Pet Insurance?

- Flexible coverage with up to 90% reimbursement.
- Optional preventive care coverage.
- 24/7 access to Telehealth concierge services.
- Discounts up to 30% and additional offers on per care, where available.
- Coverage of previously covered pre-existing conditions when switching providers.
- MetLife Pet mobile app to submit and track claims and manage your pet's health and wellness.

How to Get Started - Get a quote by calling 800.438.6388 or visiting www.metlife.com/getpetquote.

FOR ASSISTANCE

Plan Type	Provider	Phone Number	Website
Medical	Blue Shield EPO and HDHP	855.256.9404	https://myoptions.blueshieldca.com/prism
Pharmacy	Navitus	866.333.2757	navitus.com
Surgery **Cancer**	Carrum Health	888.855.7806	carrum.me/prism
Dental	Delta Dental DHMO DeltaCare USA	800.422.4234	www.deltadentalins.com/superiorcourtofcactyofsantabarbara
Dental	Delta Dental PPO & Premier	800.765.6003	www.deltadentalins.com/superiorcourtofcactyofsantabarbara
Vision	Vision Service Plan (VSP)	800.877.7195	www.vsp.com
FSA	BRMS	888.326.2555	https://www.myhealthbenefits.com/MyHealthBenefits/Home/Login/
HSA	Sterling HSA	800.617.4729	www.sterlinghsa.com
EAP	Concern	800.344.4222	Employees.concernhealth.com To register, use company code: Santabarbaracourts
Human Resources		805.882.4739	Visit the Court Intranet Benefits Page Email: Humanresources@sbcourts.org

CARECOUNSEL CAN ALSO HELP: 888.227.3334 6:30am – 5:00pm, M-F

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is Physically incapable of self-care.

E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Spending Account (HSA) An account funded by an employer and or yourself with tax-free dollars, for qualified medical expenses up to a maximum amount per year.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High-Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high-deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on our benefits website the Court Intranet Benefits Page.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Grandfathered Plan Status:** Notifies you that a plan is grandfathered and does not include all Affordable Care Act (ACA) provisions
- **ACA 1557 Notice:** Notifies you that the Court complies with Federal civil rights laws and does not discriminate on basis of race, color, national origin, age, disability, or sex.

CURRENT PLAN DOCUMENTS

Important documents for our health plans can be found on our benefits website, Court Intranet Benefits Page.

and include:

Evidence of Coverage (EOCs)

An Evidence of Coverage, or EOC, is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The following EOC plan descriptions is/are available:

- Blue Shield EPO Plan
- Blue Shield HDHP Plan

Summary of Benefits and Coverage (SBCs)

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available:

- Blue Shield EPO Plan
- Blue Shield HDHP Plan

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources at 805.882.4739.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

APPENDIX

Eligibility Rules

Eligible Employees and Retirees

You are eligible to enroll in Court medical, dental, vision and applicable voluntary benefits plans if:

- You are a regular employee of the Court working at least 20 hours per week, or
- You are an extra-help employee working in a grant funded position working 20 or more hours per week and are expected to be employed for six or more months (medical, dental and vision only), or
- You are an extra-help employee who has worked an average of 30 hours per week in the measurement period (medical, dental and vision only; see below for terms),
- You are a qualified retiree who is currently receiving a retirement allowance from the Court.

The following terms and periods (as defined by the IRS) apply to extra-help employees:

- Upon Hire:
    - Initial Measurement Period = 12 months from date of hire.
    - Administration Period = from the end of the initial measurement period to the end of the first calendar month beginning on or after the end of the initial measurement period.
    - Stability Period = 12 months beginning on the first day after the Administration Period.

    - Ongoing Employees (an employee who has been employed by the Court for at least one complete standard measurement period.
    - Standard Measurement Period = October 15th of the previous year to October 14th of the current year.
    - Administration Period = October 15th through December 31st.
    - Stability Period = January 1st to December 31st.

Example: An extra help employee is hired on July 15 year 1.

- Initial Measurement period = July 15 year 1 to July 14 year 2.
- Administration period = July 14 year 2 to August 31 year 2.
- Stability period = September 1 year 2 to August 31 year 3.

This employee's hours will be measured again in year 2 using the same dates as the initial measurement period as they have not yet been employed through one full measurement period. In the third year they will move to the standard measurement period in October.

If they meet the eligibility requirements, coverage will continue from August 31 year 4 to December 31 year 4 at which time they will become an ongoing employee.

Eligible Dependents

Eligible employees and retirees who enroll in Court benefits plans may also enroll their eligible dependents in the Plan. Eligible dependents include:

- The employee's or retiree's lawful spouse as defined by applicable law, or legally registered domestic partner.
- The employee's or retiree's natural children, stepchildren, foster children, or adopted children of which the employee is the legal guardian who are under the age of 26, or your eligible physically or mentally handicapped children who depend on you for support, regardless of age.
- The child of a covered domestic partner who satisfies the same conditions as listed above for natural children, stepchildren, foster children or adopted children, and in addition is not a "qualifying child" (as that term is defined in the Internal Revenue Code) of another individual.
- Any child named in a qualified medical child support order for which an eligible employee or retiree is required to provide health coverage.

Eligible dependents do not include any person on active duty in the Armed Forces of the United States or any person covered as an employee or retiree under the Medical or Dental Plan. If both partners in a marriage or domestic partnership are eligible to be participants, then they may both be eligible for dependent benefits. Their children may be eligible to be enrolled as a dependent of both parents.

Documentary proof of dependent eligibility must be provided to Human Resources at the time of enrollment. Examples of types of documentation accepted may be requested from the Human Resources Department.

Waiver of Coverage

If an eligible employee chooses to waive health insurance coverage, they must do so by indicating their intention to waive coverage through the normal enrollment procedures.

Enrollment Requirements

New Hires: Eligible employees who want coverage under the Court's benefits plans must enroll through the normal enrollment procedures prior to their 30th day of employment.

Retirees: Retirees must enroll by completing the applicable enrollment form and submitting it when they complete and return the Court's Application for Retirement form.

Dependents: If an eligible employee or retiree wants their eligible dependents covered under the Court's benefits plans at the same time their initial coverage begins, the eligible dependents must be included in the initial enrollment process. If an eligible employee or retiree acquires eligible dependents after his initial enrollment, the dependent(s) must be enrolled within 31 days of the date they are acquired. A newborn dependent child is automatically covered from birth for 31 days. In order for coverage to be continued beyond the first 31 days, the enrollment process must be completed within 31 days following birth. 60 days are allowed for an event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.

Late enrollment: If enrollment does not take place as provided above, the eligible employee or retiree may enroll himself and/or his eligible dependents in the Court's benefits plans only during the Court's annual open enrollment period except as provided below under "special enrollment."

Special enrollment: If an eligible employee or retiree does not enroll himself and/or eligible dependents in the Medical or Dental Plan because he or they were covered under another group health plan or had other health insurance coverage at the time enrollment in the Medical or Dental Plan was declined, the eligible employee or retiree may enroll himself and/or his eligible dependents in the Medical or Dental Plan if there is a qualifying status change.

Qualified Status Changes include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment, that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in place of residence or worksite, including a change that affects the accessibility of network providers.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.

When Coverage Begins

If enrollment takes place during the Court's annual open enrollment period, coverage will begin on January 1. If enrollment is delayed because of other health coverage, coverage will begin on the date the other coverage is lost provided you enroll in the Court's plan within 31 days from the loss of coverage.

Following are the date coverage begins when enrollment takes place when a person is first entitled to enroll:

New Hires:

- Regular Employees: When enrollment requirements are met, coverage begins on the first day of the month after the employee's first day of employment.

- Extra Help Employees: As determined by initial measurement period (page 43).

New Retirees:

- When the enrollment requirements are met, coverage beings on the first day of the month following retirement or, if coverage has been extended under COBRA, on the date that coverage ends.

- Dependents: When enrollment requirements are met, coverage for eligible dependents begins on the date the eligible employee's or retiree's coverage begins or, if acquired after that date, the date the dependent becomes an eligible dependent.
- For marriage or domestic partnership, the effective date will be the first day of the first month following receipt of your request for enrollment.
- For birth, the effective date will be the date of birth.
- For a child placed for adoption, the effective date will be the date the Member, spouse, or Domestic Partner has the right to control the child's health care.

When Coverage Ends

Unless a special extension applies, coverage under the Court's benefits plans will end on the earliest of the following dates:

- For eligible employees and their eligible dependents only, the last day of the month during which the eligible employee's employment terminates or otherwise ceases to meet the requirements of an eligible employee.
- For retirees and their eligible dependents only, the last day of the month a retiree no longer qualifies for coverage because his retirement allowance from the Court ceases.
- For dependents only, on the last day of the month during which the dependent no longer qualifies as an eligible dependent.
- The date of complete termination of the Court's benefits plans or upon the effective date of an amendment to the Court's benefits plans which excludes the covered person from such status.
- The last day of the month following the date the Court receives written authorization from the eligible employee or retiree to terminate his health coverage. Important note to retirees: if dental coverage is voluntarily terminated by a retiree, it cannot be reinstated or added at a later date, even during an annual open enrollment period.
- The last day of the month for which any required self-payment was made for this coverage if the next self-payment is not paid when due.

Special Extensions:

Physical or Mentally Handicapped Child: If a dependent child is physically or mentally handicapped on the date coverage would otherwise end because of age, the child's coverage will be continued for as long as the eligible employee or retiree is covered under the plan provided the handicap continues and the child continues to qualify as an eligible dependent in all aspects except age. The Court may require from time to time a physicians' statement certifying the physical or mental handicap.

Leave of Absence: Eligible employees may continue coverage during a leave of absence provided they continue twice monthly contributions as agreed upon with the Court and they comply with the applicable provisions of the Court's Leave of Absence Policy. If the Leave of Absence extends for greater than 18 months, the employee will be responsible for the full benefits' premium payment beginning in the 19th month of the leave of absence.

Employees entering the Armed Forces of the United States: If an eligible employee goes into active military service (including periodic reserve training) for any of the Armed Forces of the United States for up to 31 days, coverage may continue during the period of that leave, if such employee continues to pay his required contribution for coverage, if any. The Court will continue its contribution for coverage during such military leave.

If an eligible employee goes into active military service for any of the Armed Forces of the United States for more than 31 days, coverage may continue for up to 18 months or the period of such military leave, whichever is shortest, if such employee pays the full cost of the coverage during the military leave.

Whether or not an eligible employee elects to continue coverage, coverage will be reinstated on the first day they return to active employment with the Court if they are released under honorable conditions and they return to work on whichever of the following dates is applicable:

- On the first full business day following completion of their military service for a leave of 30 days or less,
- Within 14 days of completing their military service for a leave of 31 to 180 days,
- Wthin 90 days of completing their military service for a leave of more than 180 days.

When coverage under the Medical & Dental Plan is reinstated, all provisions, limitations and exclusions of the Plan will apply to the extent that they would have applied if he had not taken military leave and his coverage had been continuous under the Plan. The foregoing, however, does not apply to coverage for any illness or injury caused or aggravated by military service, as determined by the Veterans Administration.

For further information see the individual plan Evidence of Coverage documents which are the controlling source of eligibility information.

Eligibility Documentation

Dependent Type	Required Documentation	Resources to Obtain Documentation
Spouse (same or opposite gender)	Marriage Certificate **and** the portion of your most recent joint Federal or State Tax Return that lists filing status and includes the name(s) of the dependent spouse and/or children OR a current utility bill showing the spouse's name and employee's address.	• County office that issued original marriage certificate. • Personal tax records/IRS/CA Franchise Tax Board. • Utility companies. • **www.vitalchek.com**
Registered Domestic Partner	State of California, County or City issued Declaration/Certificate of Domestic partnership **and** the portion of your most recent joint State Tax Return that lists filing status and includes the name of the domestic partner OR a current utility bill showing the spouse's name and employee's address.	• County/City office that issued original certificate. • Personal tax records/CA Franchise Tax Board. • Utility companies.
Dependent child by birth, related to employee or dependent stepchild(ren)	Birth Certificate-must include parent's name, **and/or** copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage or income tax exemptions.	• County office that issued original birth certificate. • Hospital in which child was born. • US Department of State (for children born outside of the US) • **www.vitalchek.com**
Dependent child by adoption	Final adoption papers, **and/or** copies of any court orders, divorce decrees or other legal documents relating to custody, health coverage or income tax exemptions.	• State agency that issued final adoption papers. • Adoption agency that issued placement papers.

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SUPERIOR COURT of SANTA BARBARA

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Alliant

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