

2012

SDCERA

Strength. Service. Commitment.

Health Insurance Plans
For Retired Members



This material is available in alternative formats upon request. Please contact 619.515.6800.

2012 health insurance plans for retired members

Thank you for your interest in SDCERA-sponsored health plans. SDCERA currently offers health insurance plans for retired members and their eligible dependents. If you are the surviving spouse/registered domestic partner or dependent of a deceased SDCERA member and you receive a monthly SDCERA retirement benefit, the plans are also available to you.

The 2012 SDCERA-sponsored health insurance plans are outlined on the following pages. Use this booklet as your resource to help with your initial enrollment or to change your coverage during the annual Open Enrollment period (November 1–November 21, 2011). We also encourage you to keep the booklet as a reference guide throughout the year.



Legal Notices

SDCERA-SPONSORED HEALTH INSURANCE PLANS

Access to SDCERA-sponsored health insurance plans is not a vested right or guaranteed benefit. The County Employees Retirement Law does not require SDCERA to provide any post-retirement health insurance plans. The Board of Retirement annually determines whether to continue the health insurance plans.

WOMAN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

Benefits for breast reconstruction may be subject to appropriate annual deductibles and co-insurance provisions that are consistent with those established for other benefits under the plan.

MEDICAL AND DENTAL PLAN DESCRIPTIONS CONTAINED IN THIS BOOKLET

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

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**My spouse is Medicare-eligible, but I'm not.
May I enroll my spouse in one of SDCERA's
Medicare-eligible plans?**

If you are currently participating in an SDCERA-sponsored medical plan, you may enroll your spouse in one of the Medicare plans with the same carrier. If you are not enrolled in an SDCERA-sponsored plan, you cannot enroll your spouse in an SDCERA-sponsored Medicare plan.



Medical plan options for members **not eligible** for Medicare

Who is eligible?

Retired members and eligible dependents not eligible for Medicare (usually under age 65) may enroll in the medical plans shown on Page 8. The HMO plans require you to live within the plan's California service area. (Before you enroll, contact the plan to confirm that you live within the plan's service area. Contact information for each plan is shown on the comparison chart in the center of this booklet.) If you elect the PPO plan, you are not limited to a specific service area as this plan provides coverage nationwide. SDCERA does not offer plans that provide coverage to members living outside of the United States.

Eligible dependents include your spouse or registered domestic partner and your children under age 26. If you choose to cover a dependent in an SDCERA-sponsored plan, premium(s) for all coverage will be deducted from your monthly retirement benefit. If your monthly benefit does not fully cover the cost of the plan(s) you select, SDCERA will contact you to set up automatic debit from your checking or savings account.

Domestic partners who are not registered with the California Secretary of State may become eligible dependents by submitting a completed *Affidavit of Domestic Partnership* form available from SDCERA.

Enrollment

You may enroll or make changes to your current plan selection during the Open Enrollment period each November. Enrollment outside of the annual Open Enrollment period is limited.

- If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in an SDCERA-sponsored plan if you or your dependents lose eligibility for the other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days of losing coverage (or losing the employer contribution toward the other coverage).

- If you have a new dependent as a result of marriage, domestic partner registration, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. However, you must request enrollment within 30 days.
- If you or a dependent loses eligibility (not due to termination for cause) for Medicaid or Medi-Cal coverage, Children’s Health Insurance Program (CHIP) or Healthy Families Program coverage, or Access for Infants and Mothers Program Coverage, you must request enrollment within 60 days of the prior coverage terminating or becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the plan.
- If you become eligible for Medicare you may enroll in an SDCERA-sponsored Medicare plan within 30 days.
- If you have medical insurance (either an SDCERA-sponsored plan or another plan) and move outside your plan’s service area, you may enroll in (or change) SDCERA-sponsored plans within 30 days.

You may cancel coverage for you or your dependents at any time.

The enrollment/disenrollment form and corresponding instruction page are in the back of this booklet, at www.sdcera.org, or available from SDCERA.

If you are not eligible for Medicare, but your dependent is (or if you are, but your dependent is not), and you both want to enroll in SDCERA-sponsored plans, you may enroll in separate group plans with the same carrier. *For example, if you enroll in the Health Net HMO plan, your dependent must enroll in a Medicare plan with Health Net.* Read more about SDCERA-sponsored Medicare plans beginning on Page 11 if this applies to your situation.

When you become eligible for Medicare (generally when you reach age 65) SDCERA will send correspondence to you regarding your SDCERA-sponsored plan enrollment choices. At that time, you may enroll in an SDCERA-sponsored plan for Medicare-eligible members as explained on Page 12.

Plans

SDCERA-sponsored plans available in 2012 and the corresponding monthly rates per person:

Health Net HMO	\$852.98
Kaiser Permanente HMO ¹	\$619.11
UnitedHealthcare (UHC) Choice Plus PPO ²	\$2,080.08
UnitedHealthcare (UHC) Signature Value HMO	\$975.01

1 A higher rate will apply if you enroll (or are currently enrolled) in this plan when you are eligible for Medicare. Refer to Page 13 for different plans available to members who are eligible for Medicare.

2 This is the only SDCERA-sponsored non-Medicare plan available nationwide.

The rates shown are per person, per month and include an administrative fee of \$4.12 per month. Premiums for 2012 (previous page) were reduced by \$12.32 per month as a result of the Early Retiree Reinsurance Program proceeds. SDCERA will deduct the amount of your premium(s) from your monthly retirement benefit payment. If you are (or your dependent is) covered by Medicare Part A only or Medicare Part B only, different rates may apply. Contact the SDCERA Call Center at 619.515.6800 or 888.4.SDCERA for the costs if this situation affects you.

Plan information is shown on the comparison chart in the center of this booklet. The chart includes additional detail and co-payment information for each plan.

Making your decision

When making your decision about which plan will provide the best coverage, be certain you consider the differences between an HMO (Health Maintenance Organization) plan and a PPO (Preferred Provider Organization) plan.

When you select an HMO, the plan contracts with its own network of hospitals, pharmacies and physician groups. All of your care is coordinated by your Primary Medical Group or the Primary Care Physician you choose from a list of doctors that the plan has contracted with to provide services.

When you choose a PPO plan, you have the flexibility to receive all covered services provided by the physician or facility of your choice, as long as your insurance is accepted. However, you will pay less if you select a physician or facility within the plan's Preferred Provider network. This is because: (1) the network physicians charge pre-negotiated discount rates to patients for services and (2) the plan reimburses network physicians a higher percentage of those costs.

When you are covered by a PPO plan, if you select an out-of-network physician, the charges may be higher than those from a network physician. In this case, the plan bases covered services and payment on reasonable and customary (R&C) charges. R&C charges for a service are the maximum amount the plan will pay for a service based on what providers in a geographic area charge for similar services. The balance of the R&C charges the plan will not pay, plus the amount over and above the R&C charges is what you will be responsible for paying. *For example, if you have an office visit and the plan pays 70% of the R&C cost for that visit, you are required to pay the remaining 30% plus any amount the provider charges above the R&C cost.*

After you have made your decision to enroll or to change plans, submit your completed *Medical & Dental Plan Enrollment/Disenrollment* form. SDCERA uses this form to process your enrollment, which includes enabling your premium deduction and updating your address. An enrollment form is available in the back of this booklet, at www.sdcer.org or from SDCERA.

When you select an HMO, the plan contracts with its own network of hospitals, pharmacies and physician groups.

When you choose a PPO plan, you have the flexibility to receive all covered services provided by the physician or facility of your choice, as long as your insurance is accepted.

I'm turning 65 in 2012 and will become eligible for Medicare. What forms do I submit?

SDCERA sends correspondence to your mailing address approximately 30–60 days prior to your 65th birthday. The letter will outline necessary steps to enroll in Medicare and give you information about enrolling in a Medicare plan with SDCERA. At that time, you need to submit the necessary enrollment forms for your new coverage. In addition, you must submit a copy of your signed Medicare card to SDCERA when you receive it. Generally, enrollment will be effective the first day of the month following the date SDCERA receives your signed enrollment forms. Your current SDCERA-sponsored coverage will continue until your SDCERA-sponsored Medicare coverage begins. However, if you are eligible for Medicare and choose to remain in a non-Medicare plan, your premium may increase.

Enrollment in an SDCERA-sponsored group plan provides prescription drug coverage. Therefore, if you enroll in an SDCERA-sponsored plan, your drug coverage will be provided through the SDCERA-sponsored plan you select and it is not necessary for you to enroll separately in a separate Medicare prescription drug plan.

Based on government rules, if you join an individual Medicare prescription drug plan (Medicare Part D), you and your dependents will lose your eligibility to continue (or initially enroll) in an SDCERA-sponsored medical plan.



Medical plan options for members **eligible** for Medicare

Who is eligible?

If you are eligible for Medicare, you may enroll in the health plans shown on Page 13. The HMO plan and the Medicare Advantage plans require you to live within the plan's service area. Before you enroll, contact the plan to confirm that you live within the plan's service area. Contact information for each plan is shown on the comparison chart in the center of this booklet. If you elect the UnitedHealthcare Senior Supplement plan, you are not limited to a specific service area as this plan provides coverage nationwide. SDCERA does not offer plans that provide coverage to members living outside of the United States.

Generally, when you reach age 65 you are eligible for Medicare through your work history, or the work history of a spouse. You may become eligible at an earlier age if you qualify for Social Security Disability benefits and have been receiving those benefits for at least 24 months.

SDCERA requires a copy of your signed Medicare identification card to confirm your eligibility for enrollment in an SDCERA-sponsored Medicare plan. If you have submitted a copy in the past, you do not need to submit another copy. If you are (or your dependent is) newly enrolled in Medicare Part A and Part B, or if you become eligible for Medicare in 2012, please submit a copy of the signed card to SDCERA when you receive it.

Eligible dependents include your spouse or registered domestic partner and your children up to age 26; no student status is required. If you choose to cover a dependent in an SDCERA-sponsored plan, premium(s) for all coverage will be deducted from your monthly retirement benefit. If your monthly benefit does not fully cover the cost of the plan(s) you select, SDCERA will contact you to set up automatic debit from your checking or savings account.

Domestic partners who are not registered with the California Secretary of State may become eligible dependents by submitting a completed *Affidavit of Domestic Partnership* form available from SDCERA.

Medicare information

Medicare coverage has historically been available in two parts: (1) Part A, which covers many major medical expenses including the costs of hospitalization and (2) Part B, which covers physician office visits and most out-patient hospital services. Generally, you will not be charged when you enroll in Medicare Part A; however, you will be charged a monthly premium for Medicare Part B.

Insurance companies and other private companies work with Medicare to offer prescription drug coverage through Medicare Part D. There are costs associated with enrolling directly in Part D and SDCERA encourages you to contact Medicare for additional information. However, SDCERA-sponsored plans include comprehensive medical coverage as well as the Medicare prescription drug coverage; therefore, if you enroll in an SDCERA-sponsored plan, your drug coverage will be provided through the SDCERA-sponsored plan you select. It is not necessary for you to enroll separately in an additional Medicare drug plan. If you enroll separately, you will be disenrolled from the SDCERA-sponsored plan.

Furthermore, as long as you are covered by an SDCERA-sponsored plan, you will always have the option of joining a Medicare drug plan in the future—without a penalty. SDCERA provides you with the documentation you need to prove that you have had creditable coverage through an SDCERA-sponsored plan, which protects you from penalty charges if you decide to enroll in a separate Medicare drug plan in the future. Read the notice of creditable coverage information beginning on Page 25.

Enrollment

When you are eligible, any delay in enrolling in Medicare may result in either delays in processing your SDCERA-sponsored plan enrollment, or higher plan rates for you. Usually, if you continue working after turning age 65, you should enroll in Medicare Part A, but it is not necessary to enroll in Medicare Part B until you terminate your employment. Contact your employer's benefits office for details if you are still working at age 65. You should contact the Social Security Administration at 800.772.1213 or visit www.medicare.gov 90 days prior to the month you will turn age 65 to obtain information about enrolling in Medicare.

You may enroll or make changes to your current SDCERA-sponsored plan selection during the Open Enrollment period each November. Enrollment outside of the annual Open Enrollment period is limited.

- If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in an SDCERA-sponsored plan if you or your dependents lose eligibility for the other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days of losing coverage (or losing the employer contribution toward the other coverage).
- If you have a new dependent as a result of marriage, domestic partner registration, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your eligible dependents. However, you must request enrollment within 30 days.
- If you or a dependent loses eligibility (not due to termination for cause) for Medicaid or Medi-Cal coverage, Children's Health Insurance Program (CHIP) or Healthy Families Program coverage, or Access for Infants and Mothers Program Coverage, you must request enrollment within 60 days of the prior coverage terminating or becoming eligible for assistance. Such coverage will be effective upon the date you enroll in the plan.
- If you become eligible for Medicare you may enroll in an SDCERA-sponsored Medicare plan within 30 days.

- If you have medical insurance (either an SDCERA-sponsored plan or another plan) and move outside your plan's service area, you may enroll in (or change) SDCERA-sponsored plans within 30 days.

You may cancel coverage for you or your dependents at any time.

The enrollment/disenrollment form and corresponding instruction page are in the back of this booklet, at www.sdcer.org, or available from SDCERA.

If you are eligible for Medicare, but your dependent is not (or you are not and your dependent is), and you both want to enroll in SDCERA-sponsored plans, you may enroll in separate plans with the same provider. *For example, if you enroll in Health Net Seniority Plus, your dependent must enroll in the Health Net HMO plan, which is the same carrier, although it is not a Medicare plan.* Read more about SDCERA-sponsored plans for members and dependents not eligible for Medicare on Page 7 if this applies to your situation.

Although you may be enrolled in Medicare Part A and Part B, you may still have medical expenses not covered by Medicare; therefore, you may enroll in an additional insurance plan to help pay expenses that Medicare does not cover. SDCERA offers three types of Medicare health plans for members covered by Medicare Part A and Part B. Read more beginning on Page 14.

Plans

SDCERA-sponsored Medicare plans available in 2012 and the corresponding monthly rates per person:

Medicare HMO	Health Net HMO	\$356.81
Medicare Advantage	Health Net Seniority Plus	\$243.96
Medicare Advantage	Kaiser Permanente Senior Advantage ¹	\$266.67
Medicare Advantage	UnitedHealthcare (UHC) Group Medicare Advantage ²	\$213.99
Medicare Supplement	UnitedHealthcare (UHC) Senior Supplement ³	\$365.16

- 1 A higher rate and the benefits of the traditional Kaiser Permanente HMO will apply if you enroll in this plan and do not assign your Medicare benefits to Kaiser Permanente.
- 2 Formerly known as Secure Horizons. This plan is available to residents in California, Arizona and Nevada.
- 3 This is the only SDCERA-sponsored Medicare plan available nationwide.

The rates shown are per person, per month and include an administrative fee of \$4.12 per month. Premiums for 2012 (above) were reduced by \$12.32 per month as a result of Early Retiree Reinsurance Program proceeds. If you are (or your dependent is) covered by Medicare Part A only or Medicare Part B only, different rates may apply. Contact the SDCERA Call Center at 619.515.6800 or 888.4.SDCERA to confirm your monthly rate if this situation affects you.

Contact the Social Security Administration at 800.772.1213 or visit www.medicare.gov 90 days prior to the month you will turn age 65 to obtain information about enrolling in Medicare.

Making your decision

When making your decision about which plan will provide the best coverage, it is important to consider the differences among the types of plans that coordinate with Medicare. SDCERA offers three types of Medicare health plans for members covered by Medicare Part A and Part B:

- 1. A Medicare supplement plan** allows you to keep your Medicare benefits and use any physician or facility that accepts Medicare. With this type of plan, you have the flexibility of using any physicians, hospitals, skilled nursing facilities, pharmacies or medical groups in the United States that accept Medicare. This type of plan also offers prescription drug coverage. When you receive treatment, Medicare pays first and the plan pays second (per Medicare guidelines). The plan pays fees that have been approved for coverage by Medicare as an eligible Medicare service or expense. You are responsible for paying outstanding balances of services that are determined to be ineligible Medicare services or expenses. *For example, you would pay costs for preventative care (except to the extent the charges or services are approved for coverage by Medicare).*

Certain procedures under Medicare supplement plans require pre-authorization such as inpatient hospitalization, transplant and transplant evaluations, outpatient surgery performed in a hospital or free-standing surgical center and home health care services. If you do not apply for the pre-authorization, your coverage will be significantly reduced or you may receive no benefits at all. *For example, there could be up to a \$500 penalty if you fail to receive pre-authorization for certain treatments.*

- 2. A Medicare HMO plan** coordinates its coverage with Medicare. When you select an HMO, the plan contracts with its own network of hospitals, pharmacies and physician groups. All of your care is coordinated by a Primary Medical Group or a Primary Care Physician that you choose from a list of doctors under contract with the plan. You may also use your Medicare card to obtain services outside your health plan. For these services, you are responsible for any co-payments or deductibles that Medicare does not cover. This type of plan also offers prescription drug coverage.
- 3. A Medicare Advantage plan** is also referred to as a Medicare assignment plan. This type of plan requires that your Medicare Part A and Part B be assigned to a health plan. If you enroll in this type of plan you may not enroll in an individual or group plan offered by another carrier.

When you enroll in a Medicare Advantage plan, you are making a Medicare assignment, which requires that your Medicare be assigned to a health plan. In this type of plan, you must use the plan's network of hospitals, skilled nursing facilities, pharmacies and physician groups at all times except for emergencies or urgent care out of the plan's service area. All of your care is coordinated by your Primary Medical Group or your Primary Care Physician, which you select from a list of doctors provided by the plan. This type of plan also offers prescription drug coverage.

The Medicare Advantage plans that SDCERA offers have been approved as Centers for Medicare and Medicaid Services (CMS) Medicare Advantage options. In addition, the plans may have some features not offered by the CMS-affiliated Medicare Advantage plans.

The plan rates are only effective after the plan verifies your coverage under Medicare Part A and Part B. The Medicare verification process can take up to 90 days; therefore, you may be charged higher, non-Medicare rates and/or a surcharge during this period. It is important that you provide SDCERA with a copy of your signed Medicare card or a letter from Social Security stating the effective dates of your enrollment in Medicare. Providing this information as soon as possible will help to eliminate delays in processing your enrollment. Generally, enrollment will be effective the first day of the month following the date SDCERA receives your signed enrollment forms and a copy of your signed Medicare card showing Part A and Part B coverage.

Plan Comparison Chart

Plan information is shown on the comparison chart in the center of this booklet. Note: In many places on the chart, you see a comment regarding coverage that explains the service or care is “Covered per Medicare guidelines.” This means that the plan coverage is the same as Medicare coverage. *For example, Medicare does not cover routine eye exams. Therefore, if the plan coverage is per Medicare guidelines for vision care, then the plan will not cover routine eye exams.*

The chart includes additional detail and co-payment information for each plan. After you have made your decision to enroll or change plans, submit your completed *Medical & Dental Plan Enrollment/Disenrollment* form. SDCERA uses this form to process your enrollment, which includes enabling premium deductions and updating your address. An enrollment form is available in the back of this booklet, at www.sdcera.org or from SDCERA. If you enroll in an SDCERA-sponsored Medicare Advantage plan, you will receive an additional form for the plan you select. You must complete and return the additional form to SDCERA to receive the rates shown on Page 13.

SDCERA encourages you to contact the health plan you choose and request their evidence of coverage booklets. The booklets can help you understand the plan’s covered and noncovered services and should also identify any limitations on your choice of providers.



Comparison chart of medical plan options for members **not eligible** for Medicare

There are many important considerations when choosing health care for you and your dependents. SDCERA encourages you to review the following to help you make the best decisions.

Think about how you access your regular care and whether or not it's important that your physician's office or medical facilities are near your home. Contact the plan's customer service center to find out if you live within the plan's service area and how far you'll need to travel if you need emergency care.

Consider how often you travel. You should find out what services will be available to you when you are out of the area.

Many plans offer health education programs and research materials.

It's a good idea to find out what is available from the plan you are considering.

Keep in mind that you or your family may have special medical needs—now, or in the future.

If you are making a change or choosing a provider for the first time, contact the physician's office you select to confirm that the office accepts new patients. Ask how referrals to specialists are handled and find out what specialists are available. Also confirm with which hospitals the office is affiliated.

non-Medicare plans

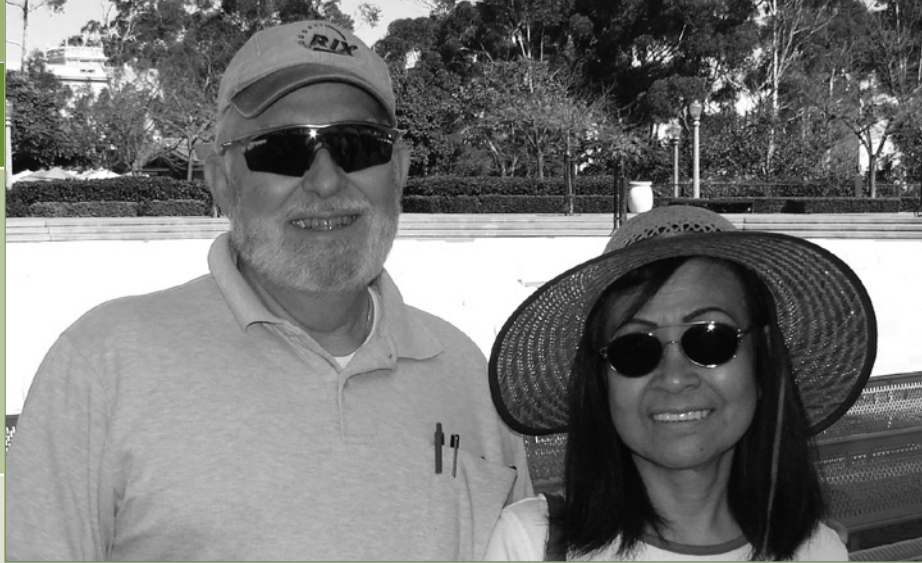
generally for those under 65

		HEALTH NET HMO	KAISER PERMANENTE HMO	UHC SIGNATURE VALUE HMO	UNITEDHEALTHCARE (UHC) CHOICE PLUS PPO	
		800.522.0088 Group 57358-A www.healthnet.com	800.464.4000 Group 104302 www.kp.org	800.624.8822 Group 004501 www.uhcwest.com	866.633.2446 Group 717697 www.myuhc.com	
		HMO plan	HMO plan	HMO plan	PPO plan	
		You are required to use the primary care physician you select from a list of providers.	You are required to use Kaiser Permanente physicians and facilities.	You are required to use the primary care physician you select from a list of providers.	IN-NETWORK If you select from an in-network list, your benefits will be greater than if you select from an out-of-network list. You may use any physician or facility that accepts this insurance.	OUT-OF-NETWORK You may use any physician or facility.
ANNUAL DEDUCTIBLE	Any applicable deductible must be met before coverage shown is effective.	None	None	None	\$500 individual / \$1,000 individual \$1,000 family / \$2,000 family	
AMBULANCE	Requires pre-authorization	Covered in full	Covered in full	Covered in full	(80% combined for in- and out-of network)	
ANESTHESIA		Covered in full	Covered in full	Covered in full	80%	60%
CHIROPRACTIC VISIT	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Pre-authorization may be required.	Not covered	\$10 per visit up to 20 visits	\$15 per visit up to 20 visits	100% (after \$20 co-pay) (24-visit annual maximum combined for in- and out-of network)	60%
DURABLE MEDICAL EQUIPMENT		Covered in full	Covered in full	Covered in full up to \$5,000 per year	80% (\$2,500 maximum combined for in- and out-of network)	60%
EMERGENCY CARE	Includes accidental injury and acute illness; the co-payment shown is when visiting an emergency room and is waived if you are admitted.	\$35	\$25	\$50	\$100 (\$100 maximum combined for in- and out-of network)	
HEARING CARE AND HEARING AIDS		\$20 per exam No coverage for hearing aids	\$20 per exam No coverage for hearing aids	\$20 per exam Hearing aids are covered in full up to \$5,000 every 36 months	\$20 per exam (\$2,500 per year, limited to a single purchase every three years)	60% per exam
HOME HEALTH CARE	Requires a physician's prescription	Covered in full up to 30 days; \$10 co-payment starts on the 31st day after the 1st visit	Covered in full	Covered in full up to 100 visits per year	80% (100 visits maximum combined for in- and out-of network)	60%
HOSPICE CARE		Covered in full	Covered in full	Covered in full	80%	60%
HOSPITAL ROOM AND BOARD	Coverage is for a semi-private room.	Covered in full	Covered in full	Covered in full	80%	60%
LABORATORY FEES		Covered in full	Covered in full	Covered in full	100% (deductible does not apply)	60%
PHYSICIAN CARE (DOCTOR VISITS) UNRELATED TO HOSPITALIZATION	The co-payments shown are for office visits unrelated to hospitalization.	\$20 per office visit	\$20 per office visit	\$20 per office visit	\$20 per office visit / \$30 per specialist	60%
PHYSICIAN CARE (DOCTOR VISITS) DUE TO HOSPITALIZATION	Coverage shown is for visits due to hospitalization.	Covered in full	Covered in full	Covered in full	80%	60%
PRESCRIPTION MEDICATIONS FROM A MAIL ORDER SPONSORED BY THE CARRIER	The co-payments in all cases are for the number of days shown.	\$20 generic, \$60 brand name \$90 non-formulary 90-day supply	\$15 generic, \$30 brand name 100-day supply	\$30 generic, \$60 brand name 90 day supply	\$25 generic, \$62.50 brand name, \$112.50 non-formulary 90-day supply through Medco. Information is available through www.myuhc.com.	
PRESCRIPTION MEDICATIONS FROM A PHARMACY	Unless noted, non-formulary prescriptions are covered by the same co-payments when deemed medically necessary.	\$10 generic, \$30 brand name \$45 non-formulary 30-day supply	\$15 generic, \$30 brand name 100-day supply	\$15 generic, \$30 brand name 30-day supply	\$10 generic, \$25 brand name \$45 non-formulary 30-day supply	\$10 generic, \$25 brand name \$45 non-formulary; 30-day supply Member responsible for cost difference between pharmacy charge and UHC coverage.
PSYCHIATRIC CARE (INPATIENT)	An asterisk (*) indicates the plan will cover this care in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full No limit on days	*Covered in full Unlimited visits	Covered in full No limit on days	80%	60%
PSYCHIATRIC CARE (OUTPATIENT)		\$20 per visit Unlimited visits	\$20 per visit; unlimited visits	\$20 per visit; unlimited visits	\$20	60%
SKILLED NURSING FACILITY		Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 consecutive calendar days from first treatment	80% (60 days maximum combined for in- and out-of network)	60%
SURGERY (INPATIENT)		Covered in full	Covered in full	Covered in full	80%	60%
SURGERY (OUTPATIENT)		Covered in full	\$20 co-payment	Covered in full	80%	60%
URGENT CARE	An asterisk (*) indicates non-emergency.	\$35	\$20*	\$50	\$50	60%
VISION CARE AND EYEWEAR		\$20 per exam No coverage for eyewear	\$20 per exam No coverage for eyewear	\$20 per exam No coverage for eyewear	\$20 per exam One exam every two years No coverage for eyewear	No coverage
X-RAYS		Covered in full	Covered in full	Covered in full	\$20 minor / 80% major	60%
MONTHLY RATE per person		\$852.98	\$619.11	\$975.01	\$2,080.08	

NON-MEDICARE PLANS GENERALLY FOR THOSE UNDER 65

IMPORTANT NOTES
SDCERA-sponsored medical plans do not have annual or lifetime limits. Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern in all cases.

Comparison chart of medical plan options for members **eligible** for Medicare



After you've selected your plan, calculate your monthly cost. Determine the monthly cost of the SDCERA-sponsored health plan coverage you are considering—both medical and dental—so you know how much you will pay for coverage. This planning will help you determine the amount you'll pay each month for your health insurance coverage.

Use the form in the back of this booklet (or available from SDCERA) to enroll or make changes to your existing coverage. Remember, there are limitations as to when you can enroll or make changes. Carefully read the instruction page (attached to the form) to be sure you complete the form correctly and timely.

Medicare eligibility usually changes a person's health care options. If you are eligible (or will soon become eligible), be certain you understand your options and have any questions answered in advance of making your decision.

Medicare plans

generally for those over 65

IMPORTANT NOTES

SDCERA-sponsored medical plans do not have annual or lifetime limits. Refer to each plan's coverage documents for exact terms and conditions of coverage. If there is a discrepancy between this summary chart and the plan documents, the plan documents will govern in all cases.

	HEALTH NET HMO	HEALTH NET SENIORITY PLUS	KAISER PERMANENTE SENIOR ADVANTAGE	UHC SENIOR SUPPLEMENT	UHC GROUP MEDICARE ADVANTAGE	
	800.522.0088 Group 57358-B www.healthnet.com	800.275.4737 Group 57358-S www.healthnet.com	800.464.4000 Group 104302-00 www.kp.org	Customer service—800.851.3802 Prospective member—800.698.0822 Group 05408 www.uhcretiree.com	Customer service—800.457.8506 Prospective member—877.714.0178 Group 004497 www.uhcretiree.com	
	Medicare HMO plan	Medicare Advantage plan	Medicare Advantage plan	Medicare Supplement	Medicare Advantage plan	
	This plan's benefit's are coordinated with Medicare. You are required to use the primary care physician you select from a list of providers.	Medicare benefit assigned to the plan. You are required to use the HealthNet physician you select from a list of providers.	Medicare benefit assigned to the plan. You are required to use Kaiser Permanente physicians and facilities.	You may use any physician or facility that accepts Medicare.	Medicare benefit assigned to the plan. You are required to use the primary care physician you select from a list of providers.	
ANNUAL DEDUCTIBLE	Any applicable deductible must be met before coverage shown is effective.	None	None	None	None	
AMBULANCE	Requires pre-authorization	Covered in full	Covered in full	Covered in full. No preauthorization required	Covered in full	
ANESTHESIA		Covered in full	Covered in full	Covered in full	Covered in full	
CHIROPRACTIC VISIT	If covered, services generally include initial examinations; additional visits for treatment; x-ray and laboratory fees when prescribed. Pre-authorization may be required.	Not covered	\$5 per visit up to 20 visits through American Specialty Health Network	\$10 per visit up to 20 visits	Generally not covered Limited to spinal manipulation	\$5 per visit up to 20 visits
DURABLE MEDICAL EQUIPMENT		Covered in full	Covered in full	Covered in full	Covered in full	
EMERGENCY CARE	Includes accidental injury and acute illness. The co-payment shown is when visiting an emergency room and is waived if you are admitted.	\$35	\$20	\$20	Covered in full in the U.S.	\$20
HEARING CARE AND HEARING AIDS		\$20 per exam No coverage for hearing aids	\$20 per exam, 2 standard hearing aids every 36 months covered in full	\$10 per exam No coverage for hearing aids	Generally not covered	\$0 per exam, hearing aids covered up to \$500 every 36 months
HOME HEALTH CARE	Requires a physician's prescription	Covered in full up to 30 days; \$10 co-payment starts on the 31st day after the 1st visit	Covered in full	Covered in full Refer to evidence of coverage from the plan	Covered in full	Covered in full
HOSPICE CARE		Covered in full	Covered per Medicare guidelines	Covered in full	Covered in full	Covered per Medicare guidelines
HOSPITAL ROOM & BOARD	Coverage is for a semi-private room	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
LABORATORY FEES		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
PHYSICIAN CARE (DOCTOR VISITS) UNRELATED TO HOSPITALIZATION	The co-payments shown are for office visits unrelated to hospitalization.	\$20 per office visit	\$20 per office visit	\$10 per office visit	Covered in full	\$20 per office visit
PHYSICIAN CARE (DOCTOR VISITS) DUE TO HOSPITALIZATION	Coverage shown is for visits due to hospitalization	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
PRESCRIPTION MEDICATIONS FROM A MAIL ORDER SPONSORED BY THE CARRIER	Coverage in all cases is for the number of days shown	\$30 generic, \$60 brand name \$100 non-formulary 90-day supply	\$30 generic, \$60 brand name \$90 non-formulary 90-day supply	\$10 generic, \$20 brand name 100-day supply	\$20 generic, \$70 brand name \$100 non-formulary 90-day supply	\$30 generic, \$60 brand name 90-day supply
PRESCRIPTION MEDICATIONS FROM A PHARMACY	Unless noted, non-formulary prescriptions are covered by same co-payments when deemed medically necessary.	\$15 generic, \$30 brand name \$50 non-formulary 30-day supply	\$15 generic, \$30 brand name \$45 non-formulary 30-day supply	\$10 generic, \$20 brand name 100-day supply	\$10 generic, \$35 brand name \$50 non-formulary 30-day supply	\$15 generic, \$30 brand name 30-day supply
PSYCHIATRIC CARE (INPATIENT)	An asterisk (*) indicates the plan will cover this in full for diagnoses covered under the Mental Health Parity Act.	*Covered in full	Covered in full	*Covered in full Unlimited visits	Covered in full up to 150 days	Covered per Medicare guidelines up to 190 days per lifetime
PSYCHIATRIC CARE (OUTPATIENT)		\$20 per visit	\$20 per visit	\$10 per visit Unlimited visits	Covered in full	\$20 per visit
SKILLED NURSING FACILITY		Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days	Covered in full up to 100 days
SURGERY (INPATIENT)		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
SURGERY (OUTPATIENT)		Covered in full	Covered in full	\$10 per procedure	Covered in full	Covered in full
URGENT CARE	An asterisk (*) indicates non-emergency	\$35	\$20	\$10*	Covered in full	\$10 co-pay in-network; \$10 co-pay out-of-network
VISION CARE AND EYEWEAR		\$20 per exam No coverage for eyewear	\$20 per exam \$100 paid for eyewear every 2 years	\$10 per exam \$150 allowance for eyewear every 2 years	Routine is not covered Eyewear is generally not covered	\$20 per exam \$75 per eyewear every 2 years
X-RAYS		Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
MONTHLY RATE per person	\$356.81	\$243.96	\$266.67	\$365.16	\$213.99	

MEDICARE PLANS GENERALLY FOR THOSE OVER 65

**I do not want to change my medical plan,
but want to enroll in an SDCERA-sponsored dental plan.
What do I do?**

During Open Enrollment, complete the dental enrollment section of the form and submit it to SDCERA. Your medical coverage will automatically continue.



Dental plan options

Retired members and eligible dependents may enroll in the following dental plans regardless of age or Medicare eligibility. Contact information for each plan is shown on the comparison chart on Page 20.

Eligible dependents include your spouse or registered domestic partner and your unmarried children up to age 25; no student status is required. The cost of dependent coverage is your responsibility. If you choose to cover a dependent in an SDCERA-sponsored plan, premium(s) for that coverage will be deducted from your monthly retirement benefit. If your monthly benefit does not fully cover the cost of the plan(s) you select, SDCERA will contact you to set up automatic debit from your checking or savings account.

Domestic partners who are not registered with the California Secretary of State may become eligible dependents by submitting a completed *Affidavit of Domestic Partnership* form available from SDCERA.

SDCERA-sponsored plans available in 2012 and the corresponding monthly rates per person:

CIGNA Dental Care DHMO	\$26.66
Delta Dental PPO ¹	\$44.07

¹ Provides PPO coverage in California and the majority of states nationwide.

The rates shown are per person, per month and include an administrative fee of \$4.12 per month.

Making your decision

When making your decision about which plan will provide the best coverage, be certain you consider the differences between a DHMO (Dental Health Maintenance Organization) plan and a dental PPO (Preferred Provider Organization) plan.

When you select a DHMO, the plan contracts with its own network of dentists and all care is coordinated by the dental office you select. You may change your dental office at any time. If you receive care (other than emergency services) that is not coordinated by your dental office, you are required to pay the full cost for the services you receive.

The cost of your out-of-pocket expense in a DHMO dental plan is based on a schedule of patient charges. There are no charges for many diagnostic and preventive services and most other types of service require you to pay a co-payment.

If you select a dental PPO, the plan gives you the flexibility to have all covered services provided by the dentist of your choice. However, you will pay less if you select a dentist within the network the plan has contracted with to provide services. This is because network dentists charge patients pre-negotiated discount rates for services.

If you choose to see an out-of-network dentist, the reimbursement amount will be based on the network's regional schedule of benefits for a geographic area. If your dentist charges more than a network dentist's allowed fee, you will be responsible for paying the difference.

Refer to the comparison chart below for the detail you need to help you make your decision. The chart shows some services provided by each plan, plus the required co-payments for those services. The chart is a summary only. For more details, including exclusions or limitations to coverage, contact the plan for specific information. After you have decided to enroll or change plans, submit your completed *Medical & Dental Plan Enrollment/Disenrollment* form (in the back of this booklet, at www.sdcera.org, or available from SDCERA). SDCERA uses this form to process your request, which includes enabling premium deductions and updating your address.

		CIGNA DENTAL CARE (DHMO)		DELTA DENTAL PPO	
		800.367.1037 Group number 3217340 www.cigna.com		800.765.6003 Group number 2472-1 www.deltadentalins.com	
		IMPORTANT NOTES			
ANNUAL DEDUCTIBLE	Any applicable deductible must be met before coverage shown is effective unless noted	None	IN-NETWORK	OUT-OF-NETWORK*	
			\$50 per person	\$50 per person	
ANNUAL MAXIMUM BENEFIT		None	\$1,500 per person	\$1,000 per person	
DIAGNOSTIC & PREVENTATIVE SERVICES	Emergency treatment for pain Oral exams Prophylaxis Space maintainers X-rays	100% for most services	100% of PPO dentist's approved fee with no deductible	100% of PPO dentist's approved fee with no deductible	
BASIC & RESTORATIVE SERVICES	Fillings Sealants Simple extractions	Co-payments vary by service; refer to the schedule of patient charges available from the plan	80% of PPO dentist's approved fee after deductible has been met	80% of PPO dentist's approved fee after deductible has been met	
OTHER BASIC & MAJOR SERVICES	Bridges Crowns Dentures Endodontics Implants Oral surgery Periodontal treatment	Co-payments vary by service; refer to the schedule of patient charges available from the plan. <i>Implants are not covered under the DHMO plan.</i>	50% of PPO dentist's approved fee after deductible has been met	50% of PPO dentist's approved fee after deductible has been met	
ORTHODONTIA for adults and eligible dependent children		Co-payments vary by service; refer to the schedule of patient charges available from the plan	50% of PPO dentist's approved fee; \$1,000 lifetime maximum, per person for Orthodontia services	50% of PPO dentist's approved fee; \$1,000 lifetime maximum, per person for Orthodontia services	
MONTHLY RATE per person**		\$ 26.66		\$ 44.07	

* If the dentist's fee exceeds the PPO dentist's approved fee, you are responsible for the difference. If you go out-of-network, visit a Delta Dental Premier dentist for lower cost.

**Different rates will apply if you enroll four or more people.



COBRA continuation coverage

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

Electing COBRA coverage

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

Qualifying events

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

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

- COBRA premiums are calculated based on current monthly medical, dental or vision plan rates plus a 2% administrative fee.
- You may only continue the coverage that was in effect on the date of the qualifying event.
- Coverage is extended only to those individuals covered at the time of the qualifying event.

To request continuation of coverage under COBRA, submit your request in writing to SDCERA. Upon receipt of your COBRA continuation coverage request, SDCERA will send you the enrollment materials.

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

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

Federal law places responsibility upon the member or the member's eligible dependent(s) to notify SDCERA within 60 calendar days of death, divorce, legal separation, annulment or dependent's ineligibility. If you or your eligible dependent(s) do not notify SDCERA of the qualifying event within the required time frame, you and your dependents will be ineligible for COBRA. You must also notify SDCERA of a second qualifying event or disability in order to extend the period of COBRA coverage. Other forms of notice will not bind the plan. If timely notice is not provided, COBRA continuation rights will expire on the date that your initial COBRA period expires.

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



Paying for COBRA

Initial COBRA Premium

You have 45 days from the date of your COBRA election to pay premiums for:

- Coverage provided between the date of the qualifying event and the end of the month in which the election is made; and
- Any premiums that become due during the 45-day period.

If your initial premium payment is not received in the allowed time frame, you will be ineligible for COBRA coverage.

Continuing Premiums

Monthly premiums are due the first day of each month following the initial premium due date. If you make your payment on or before the first day of each month, your coverage under the plan will continue for that month without any break.

You will be allowed a 30-day grace period. If your payment is received later than the first day of the month, any claims incurred will not be paid until coverage is paid through the current month. If the premium is not paid, you will be responsible for claims incurred.

Your COBRA coverage ends on the last day for which you paid your full COBRA premium on time. If your coverage ends due to nonpayment of premiums, it will not start again.

When COBRA coverage ends

COBRA coverage will end for you, your spouse/domestic partner, and dependent(s) when:

- You reach the maximum eligibility period (36 months)
- SDCERA ceases to sponsor a plan for any retiree
- You fail to make a timely premium payment
- You became covered under another group health plan, such as through your or your spouse's/domestic partner's employment. If this new group coverage contains limitations of coverage for pre-existing conditions, you may continue your COBRA coverage until the pre-existing condition limitation ends or your right to continue COBRA coverage terminates.
- You become covered by Medicare after electing COBRA.

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Important notice from SDCERA about your prescription drug coverage and Medicare

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

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

You should keep this notice with your important records. If you enroll in a Medicare prescription drug plan, you may need to provide a copy of this notice when you join as evidence that you have had creditable coverage and are not required to pay a higher premium amount.

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

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SDCERA and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. SDCERA has determined that the prescription drug coverage offered by the SDCERA-sponsored group insurance programs is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

RESOURCES

Your resources for more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the *Medicare & You* handbook for their telephone number.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY: 800.325.0778).

For more information about this notice or your current prescription drug coverage, contact the SDCERA Call Center at 619.515.6800 or 888.4.SDCERA.

2012

SDCERA

Strength. Service. Commitment.

Medical & Dental Plan
Enrollment/Disenrollment form

For Retired Members

Medical & Dental Plan Instructions for Enrollment/Disenrollment form

SECTION 1: EVENT TYPE

Select all options that apply to your situation. Review the following to determine which option(s) to select.

- During Open Enrollment each November, you may enroll or make changes/additions to your plan(s), which become effective January 1 of the following year.
- Enrollment outside of the annual Open Enrollment period is limited. See pages 7-8 and 12-13 for more information. Enrollment/changes outside of Open Enrollment become effective no sooner than the month after SDCERA receives the properly completed form.
- You may cancel your existing plan(s) at any time outside of Open Enrollment. If you are canceling your plan(s), make this selection and indicate the effective date of your cancellation.

SECTION 2: MEMBER INFORMATION

Make one selection and include your personal information—please print clearly.

SECTION 3: MEDICAL PLAN INFORMATION

Check the enrollment box next to your medical plan selection to enroll in the plan. If you are canceling your plan, check the cancel box next to your current plan to cancel your current coverage. You may check more than one box, if applicable.

All plans shown are available to all members who live within the plan's service area. Contact the plan first to determine if you live within the service area. Three plans are available to members who live outside of California: UnitedHealthcare Choice Plus PPO and UnitedHealthcare Senior Supplement are available nationwide; UnitedHealthcare Group Medicare Advantage (formerly known as Secure Horizons) is available to residents in California, Arizona and Nevada.

Medicare

Only complete the Medicare section if you are (or your dependent is) eligible for Medicare. SDCERA requires information about your enrollment date(s). In addition, you must submit a copy of your

signed Medicare card to SDCERA. If you are (or your dependent is) in the process of enrolling in Medicare, please submit a copy of your signed Medicare card as soon as you receive it.

Important: If you enroll (or your dependent enrolls) in Kaiser Permanente Senior Advantage, Health Net Seniority Plus or UnitedHealthcare Group Medicare Advantage (formerly known as Secure Horizons), you must complete and submit a Medicare assignment form to SDCERA prior to the month of your enrollment in Medicare. Health Net Seniority Plus and UnitedHealthcare Group Medicare Advantage enrollees, contact the SDCERA Call Center to request the form. Kaiser Permanente will automatically mail the form directly to Senior Advantage enrollees. If you do not submit this additional form to SDCERA, you may be charged a higher rate for your plan's coverage and in some cases a delay could cause loss of coverage. Additionally, disenrollment from a Medicare plan also requires a carrier disenrollment form.

SECTION 4: DENTAL PLAN INFORMATION

Check the enrollment box next to your dental plan selection to enroll in the plan. If you are canceling your plan, check the cancel box next to your current plan to cancel your coverage. You may check both an enrollment and a cancel box, if applicable.

All plans shown are available to all members regardless of whether or not you live in California; however, you must live within the plan's service area. Contact the plan first to determine if you live within the service area.

SECTION 5: COVERAGE INFORMATION

Please complete a line in this section for yourself and for each dependent you enroll. To enroll in a medical plan, mark an X in the medical column. To enroll in a dental plan, mark an X in the dental column. Mark an X in both columns if you are enrolling in both a medical and a dental plan. List yourself first. To enroll your eligible spouse or domestic partner, you must provide a copy of the original marriage certificate or Certificate of Registration of Domestic Partnership from the California Secretary of State or a completed *Affidavit of Domestic Partnership* from SDCERA. Or, to cover your dependent children, you must provide a copy of the birth certificate for each child. These documents do not need to be provided if previously submitted. If you need additional space, attach a separate sheet of paper and return it with your form.

SECTION 6: AUTHORIZATION

Sign and date in this section after you have read the authorization on the reverse side of the form.

Submit the completed form to SDCERA. If you are enrolling in a plan, the plan will send you an informational packet including a membership card.

SECTION 1: EVENT TYPE *Check all options that apply.*

Annual Open Enrollment **Canceling existing coverage** / Effective month/year: _____

Enrolling outside of Open Enrollment due to (please choose one) / Effective month/year: _____

Effective date cannot be sooner than the first day of the month following when SDCERA receives this form.

retirement* marriage* divorce* death* conclusion of COBRA or Cal-COBRA* domestic partnership*
 relocation out of area Medicare eligible* enrolling in SDCERA COBRA* *Attach supporting documentation

SECTION 2: MEMBER INFORMATION

First name	MI	Last name	Social Security number	
Street address	City	State	ZIP	Daytime telephone number ()

Retired, making a change or canceling current coverage Retired, enrolling for the first time / Retirement date: _____
 Surviving spouse/domestic partner or eligible child of a deceased member / Deceased member's SSN: _____

SECTION 3: MEDICAL PLAN INFORMATION

ENROLL	CANCEL	Kaiser Permanente	ENROLL	CANCEL	UnitedHealthcare	ENROLL	CANCEL	Health Net
		HMO (#104302)			Signature Value HMO (#004501)			HMO (#57358-A)
		Senior Advantage* (#104302-00)			UHC Medicare Advantage* (#004497)			HMO Medicare non-assignment (#57358-B)
		"M" Coverage (closed to new enrollees)			Choice Plus PPO (#717697)			
N/A					Senior Supplement (#05408)			Seniority Plus* (#57358-S)

Medicare (if eligible) *Medicare assignment form required. See instructions.

I am enrolled Medicare ID Number _____
 Part A effective date _____
 Part B effective date _____

My dependent is enrolled Medicare ID Number _____
 Part A effective date _____
 Part B effective date _____

I am in the process of enrolling

My dependent is in the process of enrolling

SECTION 4: DENTAL PLAN INFORMATION

ENROLL	CANCEL	CIGNA Dental	ENROLL	CANCEL	Delta Dental
		DHMO (#3217340)			Preferred PPO (#2472-1)

SECTION 5: COVERAGE INFORMATION

MEDICAL Mark with an 'X'	DENTAL Mark with an 'X'	Full name			Relationship	Sex (M/F)	Birth date	Social Security number
		First	MI	Last				
					Self	/ /		
						/ /		
						/ /		
						/ /		

SECTION 6: AUTHORIZATION

I have read, agree and understand the authorization section on the reverse side of this form. By signing below, I elect coverage as I have indicated above.

Signature X _____ Date _____

I elect to be covered under the medical and/or dental plan(s) I have indicated on the reverse side of this form in Sections 3 and 4, unless I make another selection during a future Open Enrollment period or revoke this choice in writing. I understand the provisions of the choice I have selected.

I agree to have my monthly retirement payment reduced by the required amount to pay my share of the cost for the medical and/or dental plan(s) I have selected and I authorize payment of medical and/or dental benefits to the plan or care provider I have chosen. I also authorize the plan or care provider to release any or all medical information for myself or covered dependents when information is needed to process claims.

I have read and understand the information contained in the SDCERA *Health Insurance Plans* booklet and I understand that the SDCERA Board of Retirement reserves the right to modify or terminate the health insurance plans for my insurance coverage.

FOR KAISER PERMANENTE PLANS ONLY

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation for any duty arising out of and related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by law suit or resort to court process, except as applicable law proves for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

FOR HEALTH NET OR UNITEDHEALTHCARE (INCLUDING PLANS FORMERLY KNOWN AS PACIFICARE AND SECURE HORIZONS)

Enrollment in a Health Net or UnitedHealthcare medical plan constitutes an agreement to have a dispute decided by neutral arbitration and a waiver of any injury or court trial. Refer to the enrollment information for the plan you enroll in to determine if and what types of disputes apply to the arbitration process. If this provision applies, your signature on the reverse side of this form means you agree to such arbitration for yourself and your enrolled dependents.

FOR CIGNA DENTAL OR DELTA DENTAL

Enrollment in CIGNA Dental or Delta Dental constitutes an agreement to have a dispute decided by neutral arbitration and a waiver of any injury or court trial. Refer to the enrollment information for the plan you enroll in to determine if and what types of disputes apply to the arbitration process. If this provision applies, your signature on the reverse side of this form means you agree to such arbitration for yourself and your enrolled dependents.



SDCERA

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