SUPERIOR COURT OF CALIFORNIA
COUNTY OF KERN

RETIREE BENEFIT GUIDE
Effective January 1, 2024

Smart Decisions

Getting the most value from your Superior Court benefits means making smart decisions, by knowing how the plans work and how they impact you and your family.

Introduction

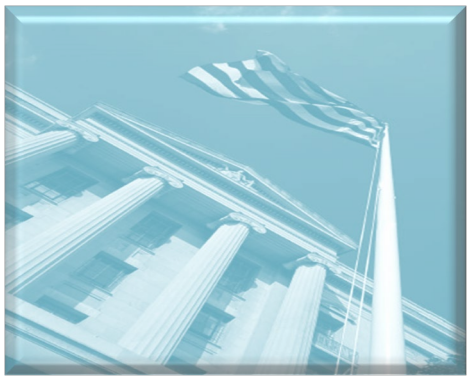
We believe every retired employee at the Superior Court has contributed his or her part to our commitment to service. We provide our retirees with access to a comprehensive and competitive benefits package, including Medical/RX and Dental coverage. This Benefit Resource Guide addresses all these benefits. We encourage you to read this guide carefully, so you understand your benefits and how they affect you. If you have additional questions, please contact Human Resources.

The information contained in this Benefit Guide does not provide complete details on the Court's Benefit Programs. Complete details are contained in the plan documents and policies. If there is a conflict between what is presented here and the official documents, the documents will govern. The Court reserves the right to alter, modify, amend, or terminate, in whole or in part, any benefit plan for retired employees and/or beneficiaries, or any provisions of the plans, at any time, without prior notification.

Important Contact Information

For information about the Court's Medical/RX and Dental benefits, you may also contact the companies that help manage our plans. Below is a list of our vendors' phone numbers and websites. If you need further assistance, please contact the Human Resources Department.

Benefit	Company	Phone No.	Web Address
Medical Dental & COBRA (self-funded)	HealthComp	(800) 442-7247	www.healthcomp.com
Prescription Drugs (Court's Medical plan)	Express Scripts	(800) 988-1913	www.express-scripts.com
Medical PPO Provider Network (self-funded Medical Plan)	Anthem Blue Cross (Inquiries should be directed to HealthComp)	(800) 442-7247	www.anthem.com/ca
Dental PPO Provider Networks (self-funded Dental Plan)	**Anthem Dental PPO**	**(877) 567-1804**	**www.anthem.com/ca**
Other Court-approved Medical/Rx Plans for **Medicare-Eligible** Enrollees (through the County of Kern)	Blue Cross Senior Secure	(800) 225-2273	www.anthem.com
	Anthem Blue Cross Gold/Silver	(800) 288-2539	www.anthem.com
	Kaiser Senior Advantage	(800) 464-4000	www.KP.org
	Health Net Seniority Plus	(800) 275-4737	www.HealthNet.com
	Health Net COB Point of Service	(800) 676-6976	www.HealthNet.com
	Blue Shield 65 Plus HMO	(800) 776-4466	www.blueshieldca.com
Other Court-approved Medical/Rx Plans for **Non-Medicare-Eligible** Enrollees (through County of Kern)	Kaiser Permanente	(800) 464-4000	www.KP.org
	Health Net	(800) 522-0088	www.HealthNet.com
Court-approved Vision Plan	Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
Human Resources	Superior Court of California, County of Kern	(661) 610-6211	CourtBenefits@kern.courts.ca.gov
KCERA	Kern County Employees' Retirement Association	(661) 381-7700	www.kcera.org



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Eligibility and Enrollment

Retired Employees

You are eligible to enroll for coverage in the Court's self-funded Medical/Rx and Dental plans, or another Court-approved plan through the County of Kern, if

1. You have taken either a service retirement or a disability retirement on or after September 1, 2008; or
2. You have taken either a service retirement or a disability retirement between January 1, 2001 and August 31, 2008 AND you were covered by the County of Kern's self-insured Point-of-Service PPO medical plan on December 31, 2010.

Service retirement means:

1. You have 10 years of retirement service credit and are age 50 or older; or
2. You have 30 years of retirement service credit regardless of your current age; or
3. You are age 70, regardless of your years of service credit.

Disability retirement means you are disabled and permanently unable to perform your normal job duties and that your disability has been approved by, and meets the requirements of, the Board of Directors of the Kern County Employees' Retirement Association (KCERA).

Are You Both Retired from The Superior Court?

If you and your spouse are both retired employees of the Court, there are unique rules that apply for coordination of dependent Medical, Rx, and Dental coverage. Neither you nor your spouse are permitted to elect duplicate coverage for yourselves – and no two parents can elect to cover the same dependent children under any Court-sponsored Medical, Rx, or Dental program.

Dependents of Retired Employees

Dependent coverage will be effective on the same date as yours, if you enroll your eligible dependents at the same time that you enroll and you authorize any necessary pension deduction(s). You can add newly acquired eligible dependents to your coverage within 31 days of any qualifying event.

Eligible dependents include your legally married spouse and your children under age 26. Dependent children over age 26 are also eligible if they are dependent on you because of a physical or mental disability and are incapable of sustaining employment at the time they reach the maximum age for coverage as a dependent.

The Court may require documentation proving a legal marital relationship.

The term "children" shall include natural children of the retiree or adopted children. Stepchildren who reside in the retiree's household may also be included as long as a natural parent remains married to the retiree and resides in the retiree's household. If a covered retiree is the legal guardian of a child or children, such child(ren) may be enrolled as covered Dependents.

Beneficiaries of Retired Court Employees

A beneficiary of a retiree is defined as: A person who was married to a covered retiree when the covered retiree died. Former (divorced) spouses and children of deceased retirees are specifically excluded from the definition of a beneficiary of a retiree for purposes of retiree health plan eligibility.

Frequently Asked Questions

The one thing you can count on in life is change. Whatever the events in your life, certain changes can affect your benefits. Please review these FAQ's carefully and contact Human Resources should you have any questions.

Can I enroll in any Medical/Rx plan?

Retirees and beneficiaries who are not yet Medicare-eligible, may enroll in the Court's self-funded Medical/ Rx and Dental plans, administered by HealthComp or in a Court-approved Medical/Rx plan (for non-Medicare eligible subscribers) through the County of Kern.

Retirees and beneficiaries who are Medicare-eligible (regardless of age) may only enroll in one of the Court approved Medical/Rx plans, through the County of Kern.

What is a Court-approved Medical/Rx plan?

A Court-approved Medical/Rx plan is any fully insured plan available to retirees and beneficiaries, through the County of Kern. Court-approved County of Kern Medical/Rx plans include:

Non-Medicare Eligible Subscribers

- Health Net "Under 65" HMO
- Kaiser Permanente

Medicare Eligible Subscribers

- Kaiser Senior Advantage HMO
- Anthem Blue Cross Senior Secure HMO
- Blue Shield 65 Plus HMO
- Health Net Seniority Plus HMO
- Health Net COB Point-of-Service Plan (POS)
- Anthem Blue Cross Gold
- Anthem Blue Cross Silver

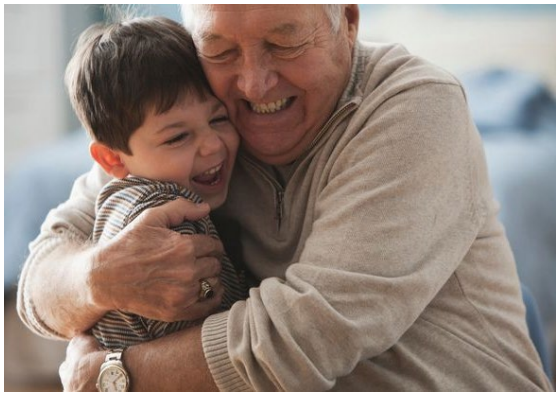
If you do not enroll for coverage in the Court's self-funded Medical/Rx and Dental plans or another Court-approved plan through the County of Kern, for which you are eligible to enroll, within 31 days following the date of your retirement, you will be disqualified from participating in any Court plan in the future.

Can I enroll for coverage at any time?

Enrollment in plans will ONLY be allowed:

1. Within 31 days following, and consistent with, your date of retirement; and
2. For dependents, within 31 days following a change in family status.

Enrollment in a Court plan means that you have completed all necessary paperwork required for plan participation and returned such paperwork to Human Resources within the 31-day period immediately following your retirement.



What happens to my beneficiary's coverage in the event of my death?

Should you die, coverage may be continued for your beneficiary, provided the beneficiary is receiving a contingent pension benefit from KCERA. A beneficiary of a retiree is defined as: A person who was married to a covered retiree when the covered retiree died. Former (divorced) spouses and children of deceased retirees are specifically excluded from the definition of a beneficiary of a retiree for purposes of retiree health plan eligibility.

If a beneficiary is not covered as the dependent of a Court retiree, at the time of the retiree's death, he/she must enroll for coverage within 31 days following the death of the retiree. Failure to enroll for coverage within this 31-day period will disqualify a beneficiary from future enrollment in any Court Medical/Rx or Dental plans.

What if my beneficiary re-marries?

Benefits for a covered beneficiary will not cease upon the beneficiary's re-marriage. However, newly acquired dependents, resulting from such re-marriage, are not eligible to be covered as dependents of a beneficiary, under any Court plan.

If I am enrolled in a Court-approved Medical/Rx plan, through the County of Kern, can I transfer from one plan to another?

Transfers between Court-approved plans, through the County of Kern, will ONLY be allowed:

1. During the annual open enrollment period; or
2. When a participant changes his/her permanent place of residence to a location outside of his/her current plan's service area

Under item two above, the effective date of the change will be the first day of the following month, provided proper documentation is received by the County of Kern's Health and Wellness Department, as long as the requested change is received prior to the 10th day of the current month.

What if I am eligible for Medicare, but I have not enrolled in Medicare Parts A & B?

To participate in a Court-approved Medical/Rx plan for Medicare-eligible subscribers, through the County of Kern, you must be enrolled for both Medicare Parts A and B. Failure to enroll will disqualify you from eligibility in a Court-approved plan, through the County of Kern.

When can I cancel my coverage?

Cancellations of coverage are allowed at any time during the plan year. If you wish to cancel coverage, you must complete a change form and return it to Human Resources in advance of cancelling your coverage. The cancellation will be effective as of midnight on the last day of the month following the date identified on the Enrollment/Change Form, provided the form is received by the Court's Human Resources Department prior to this date.

Stipend

The Court provides a monthly stipend, to Court retirees, to help defray the premium cost for Medical/Rx insurance under the Court's self-funded Medical/Rx plan or another Court-approved Medical/Rx plan, through the County of Kern.

Eligibility

To be eligible to receive the stipend, you must be enrolled in the Court's self-funded Medical/Rx plan or another Court-approved Medical/Rx plan, through the County of Kern. If you discontinue coverage under the Court's self-funded Medical/Rx plan or another Court- approved Medical / Rx plan, through the County of Kern, your stipend will immediately end.

Should you die while receiving a Court stipend, the stipend will continue for the lifetime of your covered spouse (also referred to as your beneficiary), provided the covered spouse is receiving a contingent pension benefit from KCERA and remains enrolled in the Court's self-funded plan, or another Court-approved plan offered through the County of Kern.

Current Benefit

The monthly amount of the stipend is based on how many people are covered by the Court's self-funded Medical/Rx plan or another Court-approved Medical/Rx plan, through the County of Kern. The monthly stipend for calendar year 2024 is:

2024 STIPEND	
Retiree Only	$39.75
Retiree and One Dependent	$53.69
Retiree and Two or More Dependents	$61.50

Retiree Health Premium Supplement Program

While the stipend assists in paying for the cost of retiree Medical/Rx insurance, the Court recognizes the need for additional assistance for those retirees who are not yet Medicare-eligible (generally under age 65). To be eligible to receive the supplement, you must:

1. Choose retiree Medical/Rx coverage through the Court's self-funded plan, administered by HealthComp, or another Court-approved Medical/Rx plan, through the County of Kern, immediately upon retirement;
2. Have worked for the Court for at least 20 continuous* years of service;
3. Take active retirement from service (separating from service and deferring your retirement to a later date will make you ineligible for the program);
4. Be at least 50 years of age, but less than 65 years of age at retirement; and
5. Have contributed to the program, by payroll deduction, during the qualified years of employment.

NOTE: You are not eligible to participate in the Retiree Health Premium Supplement Program if:

1. You began working for the Court at age 45 or older; or
2. You were hired by the Court on or after March 12, 2011 (regardless of your age on your date of hire).

* Continuous service means consecutive years worked for the Court, during which the employee was earning retirement credit. Years worked prior to a break in service will not be counted towards this program unless the break in service is less than one year in length or occurred after July 1, 1994. In other words, a break in service over one year in length prior to July 1,1994 will cause all time worked, prior to the break in service, to be ineligible time.

Years of Service

Years of Service is calculated in accordance with the policies of KCERA, except that the only years counted for this program are years of actual Court-benefited service (i.e., certain types of retirement service credit, such as prior public service, military time, Golden Handshake credit, are NOT counted). Service begins at the date of entry into the retirement system, so years of service for this program will not exceed years of service for retirement credit.

Retirement for work-related disability: If you are granted a work-related disability retirement by KCERA, you will qualify for the full benefit under this program, if you:

a) Have five years of qualified Court service;
b) Have applied for the disability retirement prior to separating from Court service;
c) Contributed to the program by payroll deduction during employment; and
d) Enroll in the Court's self-funded Medical/Rx plan, administered by HealthComp, upon retirement.

Court employees, who worked for the County of Kern immediately prior to commencing employment with the Court, will receive credit for continuous service earned while an employee of the County of Kern.

Benefit Amount

The supplement that the Court will contribute is calculated at the time of retirement and does not change after that, even though premiums may increase. The base amount of the supplement is equal to the then current non-Medicare retiree Medical/Rx premium under the Court's self-funded Medical/Rx plan, at the time of retirement. The base amount is multiplied by a percentage, depending on years of service (refer to the chart below). In no event will this amount, in combination with the stipend, exceed 100% of the monthly Medical/Rx premium.

Years of Service Retirement	Monthly Retiree Health Premium Supplement
less than 20	0%
20	50%
21	60%
22	70%
23	80%
24	90%
25	100%

NOTE: If you terminate employment, retire before age 50 or after age 65, you will not be reimbursed for any amount you may have paid into this program.

Premium Rates (calendar year 2024)

Medical/Rx

The following are monthly premium rates for non-Medicare eligible retirees and their beneficiaries who are covered under the Court's self-funded Medical/Rx plan, administered by HealthComp, or by a Court-approved Medical/Rx plan, offered through the County of Kern during the 2024 calendar year:

	NON-MEDICARE ELIGIBLE		
	Courts Self-Funded PPO Medical/RX Plan	Health Net "Under 65" HMO	Kaiser HMO
Single	$1,181.50	$1,432.56	$1,263.15
2-Party	$2,262.24	$2,864.99	$2,526.10
Family	$3,067.10	$3,459.99	$3,574.94

The following are monthly premium rates for Medicare-eligible retirees and their beneficiaries who are covered by a Court-approved Medical/Rx plan, offered through the County of Kern during the 2024 calendar year:

	MEDICARE ELIGIBLE						
	Kaiser Senior Advantage HMO	Anthem Blue Cross Senior Secure HMO	Blue Shield 65 Plus HMO	Health Net Seniority Plus HMO	Health Net COB Point of Service (POS)	Anthem Blue Cross Gold	Anthem Blue Cross Silver
Single	$207.00	$643.60	$212.92	$304.19	$964.02	$933.13	$210.67
2-Party	$413.79	$1,287.20	$425.84	$608.38	$1,928.03	1,866.38	$422.78

Dental

The following are monthly premium rates for retirees and beneficiaries who are covered by the Court's **self-funded Dental plan**, administered by HealthComp:

DENTAL	
Single	$45.00
2-Party	$82.00
Family	$119.00

Vision

The following are monthly premium rates for retirees and beneficiaries who enroll in the Vision plan during the 2024 calendar year. This benefit is offered through the County of Kern and administered by Vision Services Plan (VSP). All Court retirees are eligible to enroll in this benefit.

VISION	
Single	$11.28
2-Party	$22.57
Family	$28.46

VISION BENEFITS	
Vision Exam (every 12 months)	$20 copay
Lenses/Frame (every 24 months)	$20 copay
Other Copays	Please contact Kern County Health and Wellness at (661) 868-3182

Things You Should Know

Out-of-Pocket (OOP) Maximum

What is an OOP Maximum?

An Out-of-Pocket (OOP) Maximum refers to the maximum amount that you will have to pay for expenses covered under the Medical and Prescription Drug plans (the Medical and Prescription Drug Plans have separate OOP Maximums). The maximum is the sum of all paid deductibles and coinsurance. The OOP maximum for in-network benefits also includes plan copays.

Deductible

What is a Deductible?

A Deductible is the amount of eligible plan expense that must be incurred by you before medical or dental benefits are payable. You are responsible for the deductible amount, unless the benefit specifically notes that the deductible is waived.

Recognized Charges

Recognized Charges (RC) Example

Sally's laboratory is an Out-of-Network provider. She recently had tests done which cost $400.00. Her insurance company said it would pay only 90% of $360.00, which was the amount considered as a recognized charge. Sally was responsible for:

$ 36.00 (10% of the $360.00 RC amount)
$ 40.00 (the amount over RC: $400.00 - $360.00)
$ 76.00

Sally paid a total of $76.00. Had she gone to an In-Network provider, Sally would have only been responsible for $36.00 (10% of the contract amount) since network providers will not bill the member any amount over RC.

Recognized Charges (RC) represent the maximum eligible amount the Plan will recognize when services are rendered by an Out-of-Network provider. RC is based on the usual rates charged by 80% of the providers in your geographic area, for a medical or dental service or supply. The Plan Administrator determines the appropriate RC levels for Out-of-Network claims using nationally recognized data.

Out-of-Network providers are not bound by network contracts and can bill you the balance over RC. You are responsible for paying any charges that exceed Recognized Charges if you are receiving services from an Out-of-Network provider.

Medical/Rx Benefits for Non-Medicare Eligible Retirees

The Court's Medical/RX Plan utilizes Preferred Provider Organizations (PPOs). A PPO is a network of providers working in private practice, clinics, hospitals, or other health care facilities, who have agreed to charge lower network rates, so the cost savings is passed on to you in the form of a higher benefit. The plan gives you the choice of using preferred (PPO) providers or non-preferred (non-PPO) providers. Using the preferred providers keeps your costs down. Contact the PPO networks listed on your Identification Card by phone or via their websites for a current list of PPO providers.

PPO MEDICAL PLAN - BENEFITS-AT-A-GLANCE		
Benefit	In-Network (PPO)	Out-of-Network (Non-PPO)
Prior Authorization	**Some services require prior authorization. Refer to the Plan Document and your ID card.**	
PPO Network	Anthem Blue Cross	Not Applicable (where used below, "RC" refers to the "Reasonable and Customary" allowances as defined in the Plan Document.
Calendar Year Deductible	$0	$250 per individual / $500 per family (2 family members must meet $250)
Calendar Year Out-of-Pocket Maximum (Medical)	$1,500 per individual / $3,000 per family (2 family members must meet $1,500)	$2,500 per individual / $5,000 per family (2 family members must meet $2,500)
Lifetime Maximum	Unlimited	
Office Visit	Primary Care Physician - $20 copay Specialist Physician - $30 copay	70% coverage RC (after deductible)
Chiropractic Care (maximum of 30 visits per calendar year)	$20 maximum benefit per visit	$20 maximum benefit per visit
Diagnostic, X-ray, and Laboratory	90%	70% coverage RC (after deductible)
Durable Medical Equip. (amounts > $500 require pre-authorization)	$0 copay	70% coverage RC (after deductible)
Emergency Room	$100 copay (waived if admitted)	100% coverage RC after a $100 copay (copay waived if admitted)
Hearing Aids (Including exams and fittings) (Up to $3,000 per 3-year period)	90%	70% coverage RC (after deductible)
Hospital Services – Inpatient (Including Mental Health/Chemical Dependency)	$150 copay / day (maximum copays of $750 / calendar year)	70% coverage RC (after deductible)
Hospital Services – Outpatient	90%	70% coverage RC (after deductible)
Maternity Care	$200 copay	70% coverage RC (after deductible)
Outpatient Mental Health and Chemical Dependency	$20 copay	70% coverage RC (after deductible)
Outpatient Surgery	$100 copay	70% coverage RC (after deductible) (maximum of $1,000 per surgery)
Preventive Care (Refer to the SPD for a list of Preventive Care)	$0 copay	Not Covered
Urgent Care	$20 copay	70% coverage RC (after deductible)
Urgent Care - Physician	$0 copay	70% coverage RC (after deductible)
Prescription Drugs (Express Scripts) • Generic • Preferred Brand* • Non-Preferred Brand*	In-Network Pharmacy Calendar Year Out-of-Pocket Maximum: $7,950/individual, 15,900/family Retail: 30-day supply for 1 copay / Mail Order: 90-day supply for 2 copays $10 copay (waived for oral contraceptives) $20 copay $40 copay *If an FDA approved Generic equivalent is available, and you request the Brand, you will be responsible for the difference in cost between the Brand and Generic plus the Brand copay.	

This is a summary of benefits only. Actual Plan provisions and benefits are governed by the formal Plan Document.

Prescription Drug Program

Your pharmacy and mail order Prescription Drug Program is provided through Express Scripts. For short-term medications, fill your prescription at your local retail pharmacy. The amount of your copay for a 30-day supply will vary depending on whether you are requesting generic versus brand name drugs. If a Generic is available and the Brand is requested, you will be responsible for the difference in cost between the Brand and Generic in addition to the Brand copay.

For long-term or maintenance medications, consider using Express Scripts Mail Order. Filling your long-term medications through mail order allows you to get a 90-day supply for only two copays. The medications are delivered to your home, and you may refill either by phone or online.

Save Money with Generic Prescriptions

Save money on prescription medications by requesting generic drugs when filling a prescription. Generic drugs are comparable in strength, concentration, and dosage to their brand name counterparts.

PRESCRIPTION DRUG PLAN - BENEFITS AT-A-GLANCE	
Pharmacy Calendar Year Out-of-Pocket Maximum: $7,950 per individual / $15,900 per family	
PRESCRIPTION DRUGS – RETAIL	**30-day Supply**
Generic	$10 copay per prescription
Brand Name*	$20 copay per prescription
Non-Formulary*	$40 copay per prescription
PRESCRIPTION DRUGS – MAIL ORDER	**90-day Supply**
Generic	$20 copay per prescription
Brand Name*	$40 copay per prescription
Non-Formulary*	$80 copay per prescription
*If an FDA approved Generic equivalent is available, and the Brand is still requested, you will be responsible for the difference in cost between the Brand and Generic in addition to the brand copay.	
This Benefits At-A-Glance is intended to provide highlights of the benefit plan. Actual plan benefits and provisions are governed by the formal Plan Document.	

Court-Approved Med/Rx Plans - Non-Medicare Eligible Retirees (through the County of Kern)		
Benefit	HEALTH Net "Under 65" HMO	Kaiser HMO
Office Visit	$5 copay	$15 copay
Hospital Admissions	100%	100%
Emergency Room	$35 copay (waived if admitted)	$50 copay
Rx (Retail) Generic Brand Non-Formulary	 $5 copay $10 copay $35 copay	 $10 copay $20 copay
Lifetime Maximum	Unlimited	Unlimited
Vision Exams Frames	 $5 copay Frames: $100 / 24 months	 $15 copay Frames: $125 / 24 months

This is a summary of benefits only. Actual Plan provisions and benefits are governed by the formal Plan Documents.

Medical/Rx Benefits for Medicare Eligible Retirees

Medicare-eligible retirees and beneficiaries may participate in a Court-approved plan, through the County of Kern. If you are Medicare-eligible, you must enroll in Medicare Parts A and B. The following seven plans are available to Medicare-eligible retirees and/or beneficiaries. Some of these plans require that you assign your Medicare benefits, while others simply coordinate benefits with Medicare.

BENEFITS-AT-A-GLANCE							
	Kaiser Senior Advantage HMO	Anthem Blue Cross Senior Secure HMO	Blue Shield 65 Plus HMO	Health Net Seniority Plus HMO	Health Net COB Point of Service POS	Anthem Blue Cross Gold	Anthem Blue Cross Silver
Medicare Assignment Req'd	Yes	Yes	Yes	Yes	Medical: No Rx: Yes	Medical: No Rx: Yes	No
Office Visits -PCP	$10 copay	$5 copay	$0 copay	$10 copay	$10 HMO $20 PPO 30% OON	Up to 20% of Allow. Chgs.	Up to 20% of Allow. Chgs.
Office Visits - Specialist	$10 copay	$5 copay	$10 copay	$10 copay	$10 HMO $20 PPO 30% OON	Up to 20% of Allow. Chgs.	Up to 20% of Allow. Chgs.
ER Visits	$50 copay (waived if admitted)	$20 copay	$50 copay (waived if admitted)	$50 copay (waived if admitted)	$35 HMO $50 PPO 30% OON	Up to 20% of Allow. Chgs.	Up to 20% of Allow. Chgs.
Hospital Admission	No Charge	No Charge	$150 /admission	$200 /admission	$0 HMO 10% PPO 30% OON	Covers Medicare Part A Deductible	Covers Medicare Part A Deductible
Rx - Retail Generic Brand Non-Formulary Specialty Quantity Limit	 $10 copay $20 copay 100 days	 $5 copay $10 copay 	 $10 copay $20 copay $20 copay 25% 30 days	 $5-$10 copay $20 copay $40 copay 25% 30 days	 $10 copay $15 copay $35 copay 25% 30 days	 $8 copay $12 copay 30 days	 No Benefit
Rx - Mail Generic Brand Non-Formulary Specialty Quantity Limit	 $10 copay $20 copay 100 days	 $5 copay $10 copay 90 days	 $20 copay $40 copay $40 copay 25% (30 day) 90 days	 $0 copay $40 copay $80 copay 25% 90 days	 $20 copay $30 copay $70 copay 25% 90 days	 $0 copay $6 copay 90 days	 No Benefit
Deductibles	None	Paid by the Plan	None	Paid by the Plan	HMO & PPO: $0 OON: $200 Ind. /$600 Family	Medicare Part B Ded.	Medicare Part B Ded.
Lifetime Max.	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	$1,000,000	$1,000,000
Vision	$150 allowance every 24 months	Lenses: $0 Frames: $100/2yrs	Std Lenses: $0 Frames: $100/2 yrs	Lenses: every 12 months Frames: $100/24 mos.	HMO Only Eye Exam: $10 Frames/Lenses: No Benefit	No Benefit	No Benefit

This is a summary of benefits only. Actual Plan provisions and benefits are governed by the formal Plan Document.

Dental

NEW DENTAL NETWORK AND CHANGE IN CHILD ORTHODONTIA COPAY FOR 2024!

Dental Coverage is an important part of your health care benefits. The Court's Dental Plan gives you the choice of using any dentist you like. However, employees are encouraged to access dental providers through the **Anthem Dental PPO** network to take advantage of the additional discounts and the In-Network level of benefits. Using the Dental plan wisely will lower your out-of-pocket expenses.

PPO DENTAL PLAN - BENEFITS-AT-A-GLANCE		
	In-Network (PPO)	Out-of-Network (Non-PPO)
PPO Network	First Dental Health (FDH) or Connection Dental	Not Applicable (where used below, "RC" refers to the "Recognized Charges" allowances as defined in the Plan Document.
Calendar Year Deductible	$50 per individual / $150 per family (3 family members must meet $50)	
Deductible is Waived For	Class A - Preventive Services, Class D - Orthodontia	Class A - Preventive Services, Class D - Orthodontia
Calendar Year Maximum	$1,750 per covered person	
Class A - Preventive Services		
Routine Oral Exams (maximum of 2 per year)	90% of contract amount	70% of RC amount
Cleaning & Scaling (maximum of 2 per year - once every 6 months)	90% of contract amount	70% of RC amount
Bitewing X-Rays (1 series per year)	90% of contract amount	70% of RC amount
Full Mouth (Panorex) X-Rays (1 every 36 months)	90% of contract amount	70% of RC amount
Fluoride Treatment for Children < 16 (maximum of 2 per year)	90% of contract amount	70% of RC amount
Sealants for Children < 16 (1 per 1st or 2nd permanent molar, every 5 years)	90% of contract amount	70% of RC amount
Class B- Basic Services		
Fillings - (per surface: once every 3 years)	90% of contract amount (Gold paid at 90% of resin composite contract amount)	70% of RC amount
Space Maintainers for Children < 16 (once lifetime to replace primary teeth)	90% of contract amount	70% of RC amount
Endodontics - Root Canal (once per site)	90% of contract amount	70% of RC amount
Oral Surgery	90% of contract amount	70% of RC amount
Extractions	90% of contract amount	70% of RC amount
Emergency Palliative Treatment	90% of contract amount	70% of RC amount
General Anesthesia (if req'd for children < age 6)	90% of contract amount	70% of RC amount
Class C- Major Services		
Inlays & Onlays (once every 5 years)	90% of contract amount	70% of RC amount
Installation of Crowns (once every 5 years)	90% of contract amount	70% of RC amount
Dentures - Full or Partial	90% of contract amount	70% of RC amount
Repair of Crowns, Bridges & Dentures	90% of contract amount	70% of RC amount
Dental Implants ($250 max per CY)	90% of contract amount	70% of RC amount
Class D- Orthodontia		
Initial Exam	$50 copay	$50 copay
Lifetime Maximum	The Plan will pay up to $3,000 per covered person (after any copays)	
Copays • Per Adult • Per Child	 $2,400 **$2,400**	 $2,400 **$2,400**

This is a summary of benefits only. Actual Plan provisions and benefits are governed by the formal Plan Document.

Helpful Benefit Terms

Health Insurance terms can sometimes feel like a foreign language. To help you with these terms, below is a list of commonly used terms and their definitions.

A	
Adjudication	The process used by health plans to determine the amount of payment for a claim.
Allowable Charge	The maximum fee that a health plan will reimburse a provider for a given service.
Appeals	The process used by a member to request that the health plan re-considers a previous authorization or denial decision.
B	
Benefit	Payments provided for covered services under the terms of the policy. The benefits may be paid to the insured, or on his behalf, to the medical provider. Benefit design includes the types of benefits offered and any applicable limits to those benefits, e.g., number of visits, percentage paid, or dollar maximums applied, subscriber responsibility (cost sharing components), or subscriber incentives to use network providers.
Brand Name Drug	A prescription drug that has been patented and is only available through one manufacturer.
C	
Case Management	A program that assists the patient in determining the most appropriate and cost-effective treatment plan. Case management is usually provided to patients who have prolonged expensive or chronic conditions. The program helps determine the treatment location (hospital, other institution, or home) and may authorize payment for such care if it is not covered under the member's benefit agreement.
Chiropractic Care	An alternative medicine therapy administered by a licensed Chiropractor. The Chiropractor adjusts the spine and joints to treat pain and improve general health.
Claim	A request for payment for benefits received or services rendered.
Co-payment (or Co-pay)	A way in which the enrollee shares in the cost of health care. The benefit plan requires the enrollee to pay a flat dollar amount per unit of service. An example of a common co-pay is $10 per physician office visit.
COBRA	Consolidated Omnibus Budget Reconciliation Act: a federal law that requires most employers with 50 or more employees to provide continuation of coverage for members as prescribed by current federal law.
Coinsurance	An arrangement under which the insured person pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, a health plan might pay 80% of the allowable charge, with the enrollee responsible for the remaining 20%; the 20% amount is then referred to as the coinsurance amount.

Coordination of Benefits (COB)	The provision which applies when an enrollee is covered by two health plans at the same time. The provision is designed so that the payments of both plans do not exceed 100% of the covered charges. The provision also designates the order in which the multiple health plans are to pay benefits. Under a COB provision, one plan is determined to be primary, and its benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" between the two health plans.
Covered Services	Hospital, medical, and other health care services incurred by the enrollee that are entitled to a payment of benefits under a health benefit contract. The term defines the type and amount of expense, which will be considered in the calculation of benefits.
Custodial Care	Care that is provided primarily to meet the personal needs of the patient. Such care includes help in walking, bathing, or dressing. It also includes preparing food or special diets, feeding, administering medicine, or any other care, that does not require continuing services of medical-trained personnel.

D

Deductible	An amount the insured person must pay for covered services during a calendar year, January 1 through December 31, before health benefit payments begin.
Dependent	Person (spouse or child) other than the subscribing member who is covered under the subscriber's benefit plan.
Diagnostic Tests	Tests and procedures ordered by a physician to determine if the patient has a certain condition or disease based upon specific signs or symptoms demonstrated by the patient. Such diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory, pathology services or tests.
Durable Medical Equipment (DME)	Mechanical devices, equipment, and supplies, which enable a person to maintain functional ability. Also called Medical Equipment.

E

Effective Date	The date that you become covered or entitled to receive the benefits provided under the Plan.
Emergency Care	An injury or sudden, unexpected illness (including severe pain and active labor) of sufficient severity that if the member does not receive immediate treatment, it could present a serious threat to his or her health, could seriously impair physical functions, or could cause a serious dysfunction of any organ or body part if immediate medical treatment is not received.
Enrollee	An individual who is enrolled and eligible for coverage under a health plan contract. This term encompasses both the subscriber and any of his/her covered dependents, each of whom may also be referred to as a "Member".

Exclusions	Specific conditions or circumstances that are not covered under the health plan benefit agreement. It is very important to consult the health plan benefit agreement (may also be called the Evidence of Coverage, Certificate, or Subscriber Contract) to understand what services are not covered benefits.
Experimental Procedures	Procedures that are mainly limited to laboratory research.
Explanation of Benefits (EOB)	A form sent to the enrollee after a claim for payment has been processed by the health plan. The form explains the action taken on that claim. This explanation usually includes the amount paid, the benefits available, reasons for denying payment, and the claims appeal process.

G

Generic Drug	A drug, which is the pharmaceutical equivalent to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand drug.

H

Health Benefits	The plan described and is defined in the health plan benefit booklet which describes the covered health care services and benefits offered, and the health care provider network available, to the member.
Home Health Care	Health services rendered in the home to an individual who is confined to the home. Such services are provided to aged, disabled, sick or convalescent individuals who do not need institutional care, but who do need nursing services or therapy, medical supplies, and special outpatient services.
Hospice	A facility or service that provides care for the terminally ill patient and who provides support to the family. The care, primarily for pain control and symptom relief, can be provided in the home or in an inpatient setting.
Hospital	An institution whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and non-surgical. In addition, most hospitals provide some outpatient services, particularly emergency care.

I

Identification Card (ID Card)	A card issued to a subscriber and possibly his/her dependents, which allows the subscriber to identify himself or his covered dependents to a provider for health care services. The card is subsequently used by the provider to determine benefit levels and to prepare the billing statement.
Immunizations	Immunizations and injections that are recommended by guidelines published by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service or the American Academy of Pediatrics (AAP).

In-Network	Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage enrollees to use participating (in-network) providers to reduce the enrollee's out-of-pocket expense.
Inpatient	Service provided after the patient is admitted to the hospital. Inpatient stays are those lasting 24 hours or more.
Investigational Procedures	Procedures that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community.

M

Maternity Care	Health care provided during pregnancy, including care rendered during the pre- and post-natal phase of pregnancy, as well as care rendered throughout the entire course of pregnancy, continuing through to infant delivery and circumcision.
Medically Necessary	Services or supplies provided by a licensed health facility or health professional, which are determined by the health plan company and its contracting or employed Physician Group to be: 1. Not Experimental or Investigational, 2. Appropriate and necessary for the symptoms, diagnosis, or treatment of a condition, illness or injury, 3. Provided for the diagnosis or care and treatment of the condition, illness, or injury, 4. Not primarily for the convenience of the Member the Member's Physician, or anyone and the most appropriate supply or level of service that can safely be provided. For example, outpatient rather than inpatient surgery may be authorized when the setting is safe and adequate.
Member	An individual or dependent who is enrolled in and covered by a managed health care plan. Also called Enrollee or Beneficiary.
Mental Health / Behavioral Health	Conditions that affect thinking and the ability to figure things out and that affect perception, mood, and behavior. Such disorders are recognized primarily by symptoms or signs that appear as distortions of normal thinking or distortions of the way things are perceived (seeing or hearing things that are not there.) Disorders can also be recognized by moodiness, sudden or extreme changes in mood, depression, and highly agitated or unusual behavior.

N

Network	The doctors, clinics, hospitals, and other medical providers that a health plan contracts with to provide health care to its members.
Network Provider	Physicians, Hospitals or other providers of health care who have a written agreement with the health plan to participate in the network. Providers are listed in the Preferred Provider Directory given to each Member upon enrollment and periodically updated.
Non-participating Provider	A medical provider who has not contracted with a health plan as a participating provider.

O

Occupational Therapy	Treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, and bathing.
Out-of-Network	The use of health care providers who have not contracted with the health plan to provide services. Members can go out-of-network but will pay some additional costs.
Out-of-Pocket Maximum	Refers to the maximum amount that an enrollee will have to pay for expenses covered under the health plan. The maximum is a sum of all paid deductible and co-payment or coinsurance amounts.
Outpatient	A patient who is receiving care at a hospital, physician office or other health facility without being admitted to the facility for an overnight stay. The term "ambulatory" is often used to describe outpatient care.
Outpatient Surgery	Surgical procedures performed that do not require an overnight stay in the hospital or ambulatory surgery facility. Such surgery can be performed in the hospital, a surgery center, or physician office.

P

Participating Provider	A physician, hospital, pharmacy, laboratory, or other appropriately licensed facility or provider of health care services or supplies, that has entered into an agreement with a managed care entity, or HMO, to provide services or supplies to a patient enrolled in a health benefit plan.
Physical Therapy	Treatment involving physical movement to relieve pain, restore function and prevent disability following disease, injury, or loss of limb.
Pre-Authorization	A procedure used to review and assess the medical necessity and appropriateness of elective hospital admissions and non-emergency outpatient services before the services are provided.
Pre-Existing Condition	A health condition (other than a pregnancy) or medical problem that was diagnosed or treated before enrollment in a new health plan or insurance policy. Some pre-existing conditions may be excluded from coverage.
Preferred Provider Organization (PPO)	A type of health benefit plan designed to give enrollees incentives to use health care providers designated as "preferred providers", but that also give substantial coverage for services received from other health care providers.
Prescription	A written order or refill notice issued by a licensed medical professional for drugs which are only available through a pharmacy.
Preventive Care	Office visits for the evaluation and management of the member's physical development for prevention of future medical problems.
Prior Authorization	The process of obtaining advance approval before receiving certain health care services covered under a Certificate of Insurance or Evidence of Coverage.
Provider	A licensed health care facility, program, agency, physician, or other health professional that delivers health care services.

Provider Network	The set of providers contracted with a health plan to provide services to the enrollees.

R

Radiation Therapy	Treatment of disease by x-ray, radium, cobalt, or high energy particle sources.
Recognized Charges	A charge that falls within the common range of services by a majority of providers for any procedure in a given geographic region, or which is justified based on the complexity or the severity of the treatment for a specific case.

S

Second Opinion	The voluntary option or mandatory requirement to visit another physician or surgeon regarding diagnosis, course of treatment or having specific types of elective surgery performed.
Skilled Nursing Facility (SNF)	A licensed institution (or a distinct part of a hospital) that is primarily engaged in providing continuous skilled nursing care and related services for patients who require medical care, nursing care or rehabilitation services.
Speech Therapy	Treatment of the correction of a speech impairment which resulted from birth, or from disease, injury, or prior medical treatment.
Substance Abuse / Chemical Dependency	Alcoholism, drug addiction, or other chemical dependency problems.

U

Urgent Care	Services received for an unexpected illness or injury that is not life threatening but requires immediate outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever.
Usual, Customary And Reasonable (UCR)	The amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and the reasonable cost of services for a given patient after medical review of the case. Also referred to as the Recognized Charge (RC).
Utilization Management	The entire program of systems designed to ensure that members receive quality, medically necessary health care services at the appropriate level of care in a timely, effective, and cost-efficient manner. It includes precertification, concurrent review, discharge planning, care management and retrospective review.

W

Well Baby / Well Child Care	Routine care, testing, checkups, and immunizations for a generally healthy child.