



*County of Orange Human Resources Department*  
**Memorandum**

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October, 2007

To: County of Orange Eligibility Worker Retiree

From: Human Resources, Employee Benefits

Subject: **2008 Health Plan Changes for Retirees with One Spouse Under the Age of 65 and One Spouse Over the Age of 65 (Mixed Enrollment)**

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In a recent communication, you received important information on changes to the County of Orange health plans. This correspondence will serve as a follow-up to provide a preview of your 2008 Open Enrollment options and provide additional details regarding:

- New Health Plans and Health Plan Summaries
- Health Plan Rates for 2008
- Open Enrollment Presentations and Information Phone Lines

**New Health Plans and Health Plan Summaries**

In order to minimize the impact of the split pool rates, and maintain affordable, high quality benefits for our retirees, several new health plans will be available to choose from in 2008.

**Retiree or Dependent(s) Under Age 65**

Two new HMO options will be added: Blue Cross Traditional HMO and Blue Cross Select HMO. The HMO options are available to retirees who resided within the covered zip codes in California. The Traditional HMO Plan's provider network is extensive. The Blue Cross Select HMO provides an additional plan with premiums lower than the other HMOs offered by the County. The Select HMO network is built around medical groups and hospitals that demonstrate the most efficient practice patterns.

One new PPO option will be added: Exclusive Care Select Health Plan. Exclusive Care is a Retiree Health Plan operated by the County of Riverside and provides nationwide coverage. The PPO Network is comprised of three tiers. Tier one is comprised of the County of Riverside Medical facilities and four private hospitals in Riverside County. Tier two is comprised of the Blue Shield regional and nationwide network. Tier three is non-network and provides coverage with any licensed provider with higher out-of-pocket costs.

### **Retiree or Dependent(s) Over Age 65**

Two new Medicare Advantage Plans will be added for Retirees Over 65 with Medicare Part A and B: Blue Cross Private Fee-for-Service (PFFS) Custom Plan and Blue Cross Private Fee-for-Service (PFFS) Standard Plan. PFFS plans are a newer type of Medicare Advantage plan. PFFS plans are licensed in 50 states and in Washington, DC which allows retirees access to care across the United States. A retiree with Medicare Part A & B can select any licensed provider who participates in the Medicare program, i.e. accepts Medicare Assignment. There is no Health Plan network restricting the retiree's access to medical care. The custom plan has coverage with copayments that are similar to the current CIGNA HMO retiree health plan. The standard plan has coverage with higher copayments and a lower premium rate.

One new PPO option will be added: Exclusive Care Select Health Plan. Exclusive Care is a Retiree Health Plan operated by the County of Riverside and provides nationwide coverage. The network comprised of two tiers. Tier one is comprised of the County of Riverside Medical facilities and four private hospitals in Riverside County. Tier two allows a retiree to select any licensed provider who participates in the Medicare program, i.e. accepts Medicare Assignment.

Premier Sharewell has been identified as a Health Savings Account (HSA) compliant Plan for all retirees. The plan design complies with an HSA, high deductible plan, but without the health savings account contribution. This will enable you to establish your own HSA, to which you may contribute and be reimbursed for Sharewell premiums, co-payments, deductibles and health care expenses on a non-taxable basis. Please consult with a tax advisor regarding the tax implications of establishing a HSA.

Enclosed are Health Plan Summaries with the benefit coverage for each of the plans available to you including the new health plans.

Please note that the Blue Cross Private Fee for Services (PFFS) Health Plan Summary has benefit areas highlighted in **bold type**. The information in bold will differ from the information contained in the Benefits Enrollment Guide which you will receive in your Open Enrollment packet. Please be advised that the benefits in the enclosed Health Plan Summary in **bold type** reflect the most up to date and current plan benefit information and should be regarded as a corrected Health Plan Summary for this plan.

### **Health Plan Rates for 2008**

Enclosed is the 2008 health plan rate table for each health plan available to you through the County of Orange. Please review the rates carefully, as they include the new health plans available to you in 2008.

### **Open Enrollment Presentations and Information Phone Lines**

The County remains committed to quality, affordable health plans and educating our retirees in making wise health care decisions. During Open Enrollment there will be a variety of resources to support and assist you with your questions and concerns. One form of assistance will be Open Enrollment Presentations beginning October 22<sup>nd</sup> through November 19<sup>th</sup>. These presentations will include an overview of each of the health plans and an opportunity for you to ask questions

of each of the health plan representatives. Enclosed is the 2008 Retiree Open Enrollment Presentation schedule. In addition, information phone lines will be available for you to speak to Customer Service Representatives from each of the health plans about your own personal situation. Please see the enclosed Health Plan Summaries for the toll-free phone numbers for each plan.

With all this information in mind, we encourage you to begin thinking about which health plan may be right for you. At the end of October, you will receive your Open Enrollment packet that will contain your Benefits Enrollment Guide and your personalized Benefits Enrollment Summary. Your personalized summary will show the health plans you are eligible to enroll in through the County of Orange and the 2008 rates for each plan. Should you have any questions regarding eligibility, the Benefits Resource Line is available at 1-866-325-2345 to assist you and answer your questions.

Enclosures

**2008 Retiree Health Plan Rate Table**

RETIREES WITH DEPENDENT(S) - MIXED MEDICARE A&B AND NON-MEDICARE ENROLLMENT									
RETIREE ENROLLMENT STATUS	PPO PLANS			Non-Medicare & Medicare HMO			Non-Medicare HMO & Medicare PFFS		
	Premier Wellwise Plan	Premier Sharewell Plan	Exclusive Care Plan	CIGNA Health Plan	Kaiser HMO & Senior Advantage Plan	Traditional HMO & SmartValue Custom Plan	Blue Cross Select HMO & SmartValue Custom Plan	Blue Cross Select HMO & SmartValue Custom Plan	Blue Cross Select HMO & SmartValue Custom Plan
<b>RETIREE W/1 DEPENDENT</b>									
One W/ Medicare Part A & B	\$1,031.83	\$277.80	\$1,019.91	\$1,095.27	\$805.32	\$831.86		\$703.45	
<b>RETIREE W/2 OR MORE DEPENDENTS</b>									
One W/ Medicare Part A & B	\$1,509.06	\$377.02	\$1,602.52	\$1,567.07	\$1,354.32	\$1,088.15		\$852.85	
Two W/ Medicare Part A & B	\$1,031.83	\$257.96	\$1,179.15	\$1,415.41	\$939.64	\$1,069.86		\$941.45	

NOTE: Eligible Retirees and/or enrolled dependent age 65 or older must enroll in Medicare Part B. Eligible Retiree entitled to Medicare Part A without a premium must enroll in Medicare Part A. Evidence of Medicare coverage is required. For EW eligible retirees, the Retiree Medical Grant for 2008 is \$ 17.50 per month for each year of County Service to a maximum of 25 years. Grant is subject to change based upon retirement date and grant eligibility.

**Retirees & Dependents Over & Under Age 65  
Premier Wellwise PPO Plan**



1-888-235-1767 for additional information  
& 1-800-573-3583 for Prescription Drug Information

	Network Provider (co-insurance)	Non-Network Provider (co-insurance)
Annual Deductible (included in the Major Expense Benefit)	\$300 individual / \$600 family	\$500 individual / \$1,000 family
Primary Care and Specialist Physician Office Visits	10%	30%
Inpatient Hospital Services <i>(requires pre-admission review for Non-Network provider)</i>	10%	30%
Outpatient Facility Services	10%	30%
Hospital Emergency Room or Outpatient Facility	10%	30%
Urgent Care Facility	10%	30%
Rehabilitative Therapy	10%	30%
Durable Medical Equipment <i>(requires prior authorization if the cost is more than \$5,000)</i>	10%	30%
External Prosthetic Appliances	10%	30%
Home Health Services <i>(requires prior authorization)</i>	10%	30%
Hospice Services <i>(requires prior authorization)</i>	10%	30%
Skilled Nursing and Rehabilitation Facilities <i>(60 visits maximum per participant per calendar year)</i>	10%	30%
Laboratory and Radiology Services	10%	30%
Mental Health Inpatient Services <i>(\$30,000 lifetime maximum per participant combined with Substance Abuse. The lifetime maximum does not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act.) - (requires pre-admission review for Non-Network provider)</i>	10%	30%
Mental Health Outpatient Services <i>(\$50 per visit maximum, 50 visits per participant, per calendar year. \$30,000 lifetime maximum per participant combined with Substance Abuse. The visit and lifetime maximum does not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act.)</i>	50%	50%

(Coverage Continued on Back Page)

**Retirees & Dependents Over & Under Age 65  
Premier Wellwise PPO Plan**

1-888-235-1767 for additional information  
& 1-800-573-3583 for Prescription Drug Information



(Coverage Continued)

	Network Provider (co-insurance)	Non-Network Provider (co-insurance)
Substance Abuse Detoxification Inpatient Services <i>(\$30,000 lifetime maximum per participant combined with Mental Health.) - (requires pre-admission review for Non-Network provider)</i>	10%	30%
Substance Abuse Detoxification Outpatient Services <i>(\$50 per visit maximum, 50 visits per participant, per calendar year. \$30,000 lifetime maximum per person combined with Mental Health.)</i>	50%	50%
Vision Care	Not Covered	Not Covered
Pharmacy/Prescription Drug Card program <i>(current Pharmacy Benefit Manager is WHI)- (Certain drugs require Prior Authorization, as determined by Pharmacy Benefit Manager for Medical Necessity).</i>  <ul style="list-style-type: none"> <li>- Generic Drugs on the Formulary Drug List</li> <li>- Preferred Brand-Name Drugs - Medically Necessary Name Brand Drugs designated as preferred on the Formulary Drug List, with no Generic Equivalent</li> <li>- Non-Preferred Brand-Name Drugs- Medically Necessary Name Brand Drugs not listed on the Formulary Drug List</li> </ul>	<b>Must use the Prescription Drug Card program:</b>  Generic Drugs - 20% per prescription  Preferred Brand-Name Drugs - 25% per prescription  Non-Preferred Brand Name Drugs - 30% per prescription	
<u><i>Additional Programs offered:</i></u> <b>Health Advocate program</b> – Registered nurses who provide clinical advice and support. <b>Disease Management programs</b> – Covering a wide range of conditions, each program helps people manage their health through tools, knowledge and support <b>NurseHelp 24/7</b> – Registered nurses on call 24 hours a day when you need health information at a moment's notice.		

\* This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the Plan Document.

**Retirees & Dependents Over & Under Age 65  
Premier Sharewell PPO Plan**

1-888-235-1767 for additional information



	Network Provider (co-insurance)	Non-Network Provider (co-insurance)
Annual Deductible (included in the Major Expense Benefit)	\$5,000 family	
Primary Care and Specialist Physician Office Visits	10%	20%
Inpatient Hospital Services <i>(requires pre-admission review for Non-Network provider)</i>	10%	20%
Outpatient Facility Services	10%	20%
Hospital Emergency Room or Outpatient Facility	10%	20%
Urgent Care Facility	10%	20%
Rehabilitative Therapy	10%	20%
Durable Medical Equipment <i>(requires prior authorization if the cost is more than \$5,000)</i>	10%	20%
External Prosthetic Appliances	10%	20%
Home Health Services <i>(requires prior authorization)</i>	10%	20%
Hospice Services <i>(requires prior authorization)</i>	10%	20%
Skilled Nursing and Rehabilitation Facilities <i>(60 visits maximum per participant per calendar year)</i>	10%	20%
Laboratory and Radiology Services	10%	20%
Mental Health Inpatient Services <i>(\$30,000 lifetime maximum per participant combined with Substance Abuse. The lifetime maximum does not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act.)- (requires pre-admission review for Non-Network provider)</i>	10%	20%
Mental Health Outpatient Services <i>(\$50 per visit maximum, 50 visits per participant, per calendar year. \$30,000 lifetime maximum per person combined with Substance Abuse. The visit and lifetime maximum does not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act.)</i>	50%	50%

**(Coverage Continued on Back Page)**

Retirees & Dependents Over & Under Age 65  
Premier Sharewell PPO Plan

1-888-235-1767 for additional information



(Coverage Continued)

	Network Provider (co-insurance)	Non-Network Provider (co-insurance)
Substance Abuse Detoxification Inpatient Services <i>(\$30,000 lifetime maximum per participant combined with Mental Health)- (requires pre-admission review for Non-Network provider)</i>	10%	20%
Substance Abuse Detoxification Outpatient Services <i>(\$50 per visit maximum, 50 visits per participant, per calendar year. \$30,000 lifetime maximum per person combined with Mental Health.)</i>	50%	50%
Vision Care	Not Covered	Not Covered
Pharmacy – Prescription Drugs	20% per prescription	
<p><u>Additional Programs offered:</u>  <b>Health Advocate program</b> – Registered nurses who provide clinical advice and support.  <b>Disease Management programs</b> – Covering a wide range of conditions, each program helps people manage their health through tools, knowledge and support  <b>NurseHelp 24/7</b> – Registered nurses on call 24 hours a day when you need health information at a moment's notice.</p>		

\* This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the Plan Document.

**Retirees & Dependents Under Age 65  
Exclusive Care Select Non-Medicare**



Call 1-800-962-1133 for additional information

	Tier 1	Tier 2	Tier 3
Annual Out-Pocket Maximum for Certain Services	\$1,500/person \$4,500/family	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family
Deductible	\$250/person \$750/family	\$500/person \$1,500/family	\$1,000/person \$3,000/family
Primary Care and Specialist Physician Office Visits	\$10 co-pay/primary care \$20 co-pay/specialist	\$25 co-pay/primary care \$50 co-pay/specialist	60%
Inpatient Hospital Services <i>(Mandatory Centers of Excellence apply)</i>	90%	80%	60%
Outpatient Facility Services <i>(Mandatory Centers of Excellence apply to some Outpatient Facility)</i>	90%	80%	60%
Hospital Emergency Room	\$50 co-pay, then 90%	\$100 co-pay, then 80%	\$100 co-pay, then 80%
Urgent Care Facility	\$20 co-pay	\$50 co-pay	60%
Rehabilitative Therapy (Some Limits Apply)	90%	80%	60%
Durable Medical Equipment (Maximum \$1,000 per person per year)	90%	80%	60%
External Prosthetic Appliances	90%	80%	60%
Home Health Services <i>(Up to 26 days/year)</i>	90%	80%	60%
Hospice Services	90%	80%	60%
Skilled Nursing and Rehabilitation Facilities <i>(100 visits maximum per year)</i>	90%	80%	60%
Laboratory and Radiology Services	90%	80%	60%

(Coverage Continued on Back Page)

**Retirees & Dependents Under Age 65  
Exclusive Care Select Non-Medicare**



Call 1-800-962-1133 for additional information

(Coverage Continued)

	Tier 1	Tier 2	Tier 3
Mental Health Inpatient Services <i>Mandatory Centers of Excellence apply</i>	90%	80%	Not Covered
Mental Health Outpatient Services (30 days maximum per year, unless Severe Mental Illness; Mandatory Centers of Excellence apply)	\$20 co-pay		Not Covered
Substance Abuse Detoxification Inpatient Services (3-5 day max as medically necessary, one episode/lifetime; Mandatory Centers of Excellence apply)	90%	80%	Not Covered
Substance Abuse Detoxification Outpatient Services (30 days maximum per member per year; Mandatory Centers of Excellence apply)	\$20 co-pay		Not Covered
Vision Care: Eye Exam	\$10 co-pay	\$25 co-pay	Not Covered
Vision Care: One Pair of Approved Glasses	Not Covered		
Participating Retail Pharmacy	Generic: \$15 co-pay Brand-name formulary: \$25 co-pay Non-formulary Brand: \$40 co-pay Significant or new therapeutic class drugs: 50%		
Participating Mail-Order pharmacy (up to a 90 day supply)  <b>Mail-order is MANDATORY for maintenance medications</b>	Generic: \$30 co-pay Brand-name formulary: \$50 co-pay Non-formulary Brand: \$80 co-pay		

- This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the Summary Plan Document (SPD).

**Retirees & Dependents Over Age 65  
Exclusive Care Select Medicare Coordination**

Call 1-800-962-1133 for additional information



	Tier 1	Tier 2
Annual Out-Pocket Maximum for Certain Services	\$1,500/person \$4,500/family	\$2,500/person \$7,500/family
Deductible	\$250/person \$750/family	\$500/person \$1,500/family
Primary Care and Specialist Physician Office Visits	\$10 co-pay/primary care \$20 co-pay/specialist	\$25 co-pay/primary care \$50 co-pay/specialist
Inpatient Hospital Services ( <i>Mandatory Centers of Excellence apply</i> )	90%	80%
Outpatient Facility Services ( <i>Mandatory Centers of Excellence apply to some Outpatient Facility</i> )	90%	80%
Hospital Emergency Room	\$50 co-pay, then 90%	\$100 co-pay, then 80%
Urgent Care Facility	\$20 co-pay	\$50 co-pay
Rehabilitative Therapy (Some Limits Apply)	90%	80%
Durable Medical Equipment (Maximum \$1,000 per participant per year)	90%	80%
External Prosthetic Appliances	90%	80%
Home Health Services ( <i>up to 26 day/year</i> )	90%	80%
Hospice Services	90%	80%
Skilled Nursing and Rehabilitation Facilities ( <i>100 visits maximum per participant per year</i> )	90%	80%
Laboratory and Radiology Services	90%	80%
Mental Health Inpatient Services ( <i>Mandatory Centers of Excellence apply</i> )	90%	80%

(Coverage Continued on Back Page)

**Retirees & Dependents Over Age 65  
Exclusive Care Select Medicare Coordination**



Call 1-800-962-1133 for additional information

	Tier 1	Tier 2
Mental Health Outpatient Services <i>(30 days maximum per participant per year, unless Severe Mental Illness - Mandatory Centers of Excellence apply)</i>	\$20 co-pay	
Substance Abuse Detoxification Inpatient Services <i>(Mandatory Centers of Excellence apply)</i>	90%	80%
Substance Abuse Detoxification Outpatient Services <i>(30 days maximum per participant per year – Mandatory Centers of Excellence apply)</i>	\$20 co-pay	
Vision Care: Eye Exam	\$10 co-pay	\$25 co-pay
Vision Care: One Pair of Approved Glasses	Not Covered	
Participating Retail Pharmacy (up to 30 day supply)	Generic: \$15 co-pay Brand-name formulary: \$25 co-pay Non-formulary Brand: \$40 co-pay Significant or new therapeutic class drugs: 50%	
Participating Mail-Order pharmacy (up to a 90 day supply)  <b>Mail-order is MANDATORY for maintenance medications</b>	Generic: \$30 co-pay Brand-name formulary: \$50 co-pay Non-formulary Brand: \$80 co-pay	

- This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the Summary Plan Document (SPD).

**Retirees & Dependents Over & Under Age 65**

For more information, contact  
CIGNA at 1-800-CIGNA24 or 1-800-244-6224



CIGNA HealthCare

Total Co-payment Maximums	
Retiree Only	\$1,000 per calendar year
Retiree with 1 Dependents	\$2,000 per calendar year
Retiree with 2 or More Dependents	\$2,000 per calendar year
Covered Services & Supplies	
Primary Care and Specialist Physician Office Visits	\$15 Co-payment per visit
Inpatient Hospital Services	100% after \$100 per admission Co-payment
Outpatient Facility Services	No Charge
Hospital Emergency Room or Outpatient Facility	\$50 Co-payment per visit, waived if admitted
Urgent Care Facility	\$25 Co-payment per visit
Rehabilitative Therapy	\$15 Co-payment per visit
Durable Medical Equipment	No Charge
External Prosthetic Appliances	No Charge
Home Health Services	No Charge
Hospice Services	No Charge
Skilled Nursing and Rehabilitation Facilities (100 visits maximum per participant per year)	No Charge
Laboratory and Radiology Services	No Charge
Mental Health Inpatient Services (30 days maximum per participant per year)	100% after \$100 per admission Co-payment
Mental Health Outpatient Services	\$20 Co-payment per visit
Substance Abuse Detoxification Inpatient Services	100% after \$100 per admission Co-payment
Substance Abuse Detoxification Outpatient Services	\$15 Co-payment per visit
Vision Care: Eye Exam (limit one every 12 months)	\$5 Co-payment per visit
Vision Care: One Pair of Approved Glasses (limit one every 12 months)	\$10 Co-payment
Pharmacy	
- Generic Drugs on the Prescription Drug List	\$10 Co-payment per prescription
- Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent	\$20 Co-payment per prescription
- Non-Preferred Brand - Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List	\$40 Co-payment per prescription

(Additional Services & Program information on back page)

**Retirees & Dependents Over & Under Age 65**

For more information, contact  
CIGNA at 1-800-CIGNA24 or 1-800-244-6224



*Additional Services & Programs that can make a difference in your life:*

**Healthy Rewards®** - Discounts on laser vision correction, weight management, smoking cessation, and more.

**CIGNA Well Aware for Better Health®** - Helping you manage certain chronic conditions

Online Tools and Resources on [myCIGNA.com](http://myCIGNA.com)

**CIGNA HealthCare 24-Hour Health Information Line** – Round-the-Clock access to Registered Nurses.

\* This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the Group Service Agreement (GSA).

\* All Co-payments paid for Mental Health & Substance Abuse Services (except for Severe Mental Illness & Serious Emotional Disturbances of a Child), Vision care services and prescription drugs do not apply towards the total co-payment maximums.

**Retirees & Dependents Under the age of 65**

For more information, contact  
Kaiser Permanente at 1-800-464-4000 or [www.kp.org](http://www.kp.org)

(Coverage Continued)

Durable Medical Equipment (DME)	You Pay
Most covered DME for home use in accord with our DME formulary guidelines	No charge

Mental Health Services	You Pay
Inpatient psychiatric care (up to 45 days per calendar year)	\$100 per admission
Outpatient visits: Up to a total of 20 individual and group therapy visits per calendar year	\$15 per individual therapy visit
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the <i>EOC</i> .	

Chemical Dependency Services	You Pay
Inpatient detoxification	\$100 per admission
Outpatient individual therapy visits	\$15 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission

Home Health Services	You Pay
Home health care (up to 100 two-hour visits per calendar year)	No charge

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge
Chiropractic Care	\$15 per visit/30 visits per year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *Evidence of Coverage (EOC)*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

**Retirees & Dependents Under the age of 65**

For more information, contact  
Kaiser Permanente at 1-800-464-4000 or [www.kp.org](http://www.kp.org)

Annual Out-of-Pocket Maximum for Certain Services	
Retiree Only	\$1,500 per calendar year
Retiree with 1 Dependent	\$1,500 per calendar year
Retiree with 2 or More Dependents	\$3,000 per calendar year

Deductible or Lifetime Maximum:	None
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Professional Services (Plan Provider office visits)	You Pay
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$15 per visit
Routine preventive physical exams	\$15 per visit
Routine preventive refraction exams	\$15 per visit
Routine preventive hearing tests	\$15 per visit
Physical, occupational, and speech therapy visits	\$15 per visit

Outpatient Services	You Pay
Outpatient surgery	\$15 per procedure
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health education:	
Individual visits	\$15 per visit

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$100 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	\$50 per visit (does not apply if admitted directly to the hospital as an inpatient)

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program:	
Generic items	\$10 for up to a 100-day supply
Brand-name items	\$20 for up to a 100-day supply

**Retirees & Dependents Over Age 65**  
**(Must Have Medicare Part A & B or B only)**  
 For more information, contact  
*Kaiser Permanente at 1-800-443-0815 or [www.kp.org](http://www.kp.org)*

**\*\*\*Important Enrollment Information\*\*\***

The election for this health plan requires an enrollment form to be submitted to Kaiser for each member of your family that is Medicare eligible. If the form is not received and approved by Kaiser on or before **December 31, 2007**, you and your family will remain in your current plan. Once the enrollment is approved by Kaiser you will be enrolled into Kaiser Senior Advantage effective January 1, 2008. However, the Center for Medicare and Medicaid Services (CMS) must also assign Medicare to Kaiser. If this assignment is not approved by CMS, or if you or one of your dependents lose Medicare in the future you and any dependents will be defaulted into Premier Wellwise on the 1<sup>st</sup> of the following month from receiving denial from CMS.

Annual Out-of-Pocket Maximum for Certain Services	
Retiree Only	\$1,500 per calendar year
Retiree with 1 Dependent	\$1,500 per calendar year
Retiree with 2 or More Dependents	\$3,000 per calendar year

Deductible or Lifetime Maximum	None
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Professional Services (Plan Provider office visits)	You Pay
Primary and specialty care visits (includes routine and Urgent Care appointments)	\$15 per visit
Routine preventive physical exams	\$15 per visit
Routine preventive refraction exams and glaucoma screening	\$15 per visit
Routine preventive hearing tests	\$15 per visit
Physical, occupational, and speech therapy visits	\$15 per visit

Outpatient Services	You Pay
Outpatient surgery	\$15 per procedure
Vaccines (immunizations)	No charge
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	\$15 per visit
Health education: Individual visits	\$15 per visit

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$100 per admission

Emergency Health Coverage	You Pay
Emergency Department and Out-of-Area Urgent Care visits	\$50 per visit (does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition)

<p><b>Retirees &amp; Dependents Over Age 65</b>                  (Must Have Medicare Part A &amp; B or B only)                  For more information, contact                  Kaiser Permanente at 1-800-443-0815 or <a href="http://www.kp.org">www.kp.org</a></p>
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(Coverage Continued)

<b>Ambulance Services</b>	No charge
<b>Prescription Drug Coverage</b>	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Generic items	\$10 for up to a 100 day supply
Brand-name items	\$20 for up to a 100 day supply
<b>Durable Medical Equipment (DME)</b>	You Pay
Most covered DME for home use in accord with our DME formulary guidelines	No charge
<b>Mental Health Services</b>	You Pay
Inpatient psychiatric care: first 190 days per lifetime as covered by Medicare. Thereafter, up to 45 days per calendar year	\$100 per admission
Outpatient individual and group therapy visits	\$15 per individual therapy visit/\$7 Per group
<b>Chemical Dependency Services</b>	You Pay
Inpatient detoxification	\$100 per admission
Outpatient individual therapy visits	\$15 per visit
Outpatient group therapy visits	\$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission
<b>Home Health Services</b>	You Pay
Home health care (part-time, intermittent)	No charge
<b>Other</b>	You Pay
Eyewear purchased from Plan Optical Sales Offices every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Chiropractic Care	\$15 per visit/30 visits per year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *Evidence of Coverage (EOC)*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

**Retirees & Dependents Under Age 65**  
**Blue Cross Traditional HMO**  
 1-877-359-9653 Customer Services 8:00 a.m. to 12:00 p.m.



&  
 1-800-700-2541 Pharmacy Customer Services 7:00 a.m. to 9:00 p.m.

Annual Out-Pocket Maximum for Certain Services	\$1,500 for Retiree only \$3,000 for Retiree with one dependent \$4,500 for Retiree with two or more dependents
Primary Care and Specialist Physician Office Visits	\$15 Co-payment per visit
Inpatient Hospital Services	100% after \$100 per admission Co-payment
Outpatient Facility Services	No Co-payment
Hospital Emergency Room or Outpatient Facility	\$50 Co-payment per visit, waived if admitted
Urgent Care Facility	\$15 Co-payment per visit
Rehabilitative Therapy	\$15 Co-payment per visit
Durable Medical Equipment	No Co-payment
External Prosthetic Appliances	No Co-payment
Home Health Services	No Co-payment, limited to 100 days/cal.
Hospice Services	No Co-payment
Skilled Nursing and Rehabilitation Facilities <i>(100 visits maximum per participant per year)</i>	No Co-payment
Laboratory and Radiology Services	No Co-payment
Mental Health Inpatient Services <i>(30 days maximum per participant per year)</i>	100% after \$100 per admission Co-payment
Mental Health Outpatient Services	\$20 Co-payment per visit

(Coverage Continued on Back Page)

**Retirees & Dependents Under Age 65**  
**Blue Cross Traditional HMO**  
 1-877-359-9653 Customer Services 8:00 a.m. to 12:00 p.m.  
 &  
 1-800-700-2541 Pharmacy Customer Services 7:00 a.m. to 9:00 p.m.



(Coverage Continued)

Substance Abuse Detoxification Inpatient Services	100% after \$100 per admission Co-payment
Substance Abuse Detoxification Outpatient Services	Not Covered
Vision Care: Eye Exam ( <i>limit one every 12 months</i> )	\$15 Co-payment per visit
Vision Care: One Pair of Approved Glasses ( <i>limit one every 12 months</i> )	Not Covered
Pharmacy <ul style="list-style-type: none"> <li>- Generic Drugs on the Prescription Drug List</li> <li>- Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent</li> <li>- Non-Preferred Brand - Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List</li> </ul>	30 Days \$10 Co-payment per prescription  \$20 Co-payment per prescription  \$40 Co-payment per prescription
<p><u><i>Additional Programs offered:</i></u>            90 Days Mail Drug Order            Generic \$20 Co-payment per prescription             Brand Name \$40 Co-payment per prescription             Non-Formulary \$80 Co-payment per prescription</p>	

\* This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the *Evidence of Coverage (EOC)*.

**Retirees & Dependents Under Age 65**  
**Blue Cross Select HMO**  
 1-877-359-9653 Customer Services 8:00 a.m. to 12:00 p.m.  
 &  
 1-800-700-2541 Pharmacy Customer Services 7:00 a.m. to 9:00 p.m.



Annual Out-Pocket Maximum for Certain Services	\$1,500 for Retiree only \$3,000 for Retiree with 1 dependent \$4,500 for Retiree with 2 or more dependents
Primary Care and Specialist Physician Office Visits	\$15 Co-payment per visit Primary Care \$30 Co-payment per visit Specialist
Inpatient Hospital Services	No Co-payment
Outpatient Facility Services	No Co-payment
Hospital Emergency Room or Outpatient Facility	\$100 Co-payment per visit, waived if admitted
Urgent Care Facility	\$15 Co-payment per visit
Rehabilitative Therapy	\$15 Co-payment per visit
Durable Medical Equipment	No Co-payment
External Prosthetic Appliances	No Co-payment
Home Health Services	No Co-payment, limited to 100 days/cal.
Hospice Services	No Co-payment
Skilled Nursing and Rehabilitation Facilities <i>(100 visits maximum per participant per year)</i>	No Co-payment
Laboratory and Radiology Services	No Co-payment
Mental Health Inpatient Services <i>(30 days maximum per participant per year)</i>	100% after \$100 per admission Co-payment
Mental Health Outpatient Services	\$30 Co-payment per visit

(Coverage Continued on Back Page)

**Retirees & Dependents Under Age 65**  
**Blue Cross Select HMO**  
 1-877-359-9653 Customer Services 8:00 a.m. to 12:00 p.m.  
 &  
 1-800-700-2541 Pharmacy Customer Services 7:00 a.m. to 9:00 p.m.



(Coverage Continued)

Substance Abuse Detoxification Inpatient Services	100% after \$100 per admission Co-payment
Substance Abuse Detoxification Outpatient Services	Not Covered
Vision Care: Eye Exam ( <i>limit one every 12 months</i> )	\$15 Co-payment per visit
Vision Care: One Pair of Approved Glasses ( <i>limit one every 12 months</i> )	Not Covered
Pharmacy <ul style="list-style-type: none"> <li>- Generic Drugs on the Prescription Drug List</li> <li>- Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent</li> <li>- Non-Preferred Brand - Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List</li> </ul>	30 Days \$100 Deductible/Member 50% Of drug negotiated rate up to \$10 Co-payment per prescription (Deductible Waived)  45% Of drug negotiated rate up to \$25 Co-payment per prescription  45% Of drug negotiated rate up to \$40 Co-payment per prescription
<p><u>Additional Programs offered:</u>            90 Days Mail Drug Order \$100 Deductible/Member            Generic 50% Of drug negotiated rate up to \$20 Co-payment per prescription (Deductible Waived)             Brand Name 45% Of drug negotiated rate up to \$50 Co-payment per prescription             Non-Formulary 45% Of drug negotiated rate up to \$80 Co-payment per prescription</p>	

\* This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the *Evidence of Coverage (EOC)*.

**SmartValue Private Fee For Service (PFFS) Custom Plan  
For Retirees & Dependents Over Age 65  
And Mixed Family Enrollment**



**For more information, contact:**  
**Blue Cross First Impressions Line at 1-866-657-4970**  
**or**  
**1-877-326-2201 Member Services - 7:00 a.m. to 8:00 p.m. CT**  
**TTY: 1-800-425-5705**

Your election for this health plan requires the approval of the health plan and the Center for Medicare and Medicaid Services (CMS). After January 1, 2008, you will be covered under the new health plan that you have elected, however if you are electing the SmartValue Custom plan and do not receive approval from CMS, or lose Medicare in the future, you will be automatically enrolled into the Blue Cross HMO plan that your dependent has elected. If your dependent is electing the SmartValue Custom plan and does not receive approval from CMS or loses Medicare in the future, they will be automatically enrolled into the Blue Cross HMO plan that you have elected.

Annual Out-Pocket Maximum for Certain Services	\$3,250
Primary Care and Specialist Physician Office Visits	\$15 Co-payment per visit
Inpatient Hospital Services	100% after \$100 per admission Co-payment
Outpatient Facility Services	\$15 Co-payment
Hospital Emergency Room or Outpatient Facility	\$50 Co-payment per visit, waived if admitted within 72 hours
Urgent Care Facility	\$15 Co-payment per visit
Rehabilitative Therapy	\$15 Co-payment per visit
Durable Medical Equipment	\$0 Co-payment for DME charges
External Prosthetic Appliances	\$0 Co-payment
Home Health Services	\$0 Co-payment per visit
Hospice Services	\$0 Co-payment for Medicare approved services, when enrolled in a Medicare-certified Hospice, services are paid by Medicare
Skilled Nursing and Rehabilitation Facilities <i>(100 visits maximum per participant per year)</i>	\$0 Co-payment per day
Laboratory and Radiology Services	\$0 Co-payment for each Medicare approved clinical/diagnostic lab test. \$0 Co-payment for each x-ray

**(Coverage Continued on Back Page)**

Blue Cross of California (BCC) is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. AICI is the risk bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. AICI has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region. Blue Cross of California is an independent licensee of the Blue Cross Association. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

**SmartValue Private Fee For Service (PFFS) Custom Plan  
For Retirees & Dependents Over Age 65  
And Mixed Family Enrollment**



**For more information, contact:**  
**Blue Cross First Impressions Line at 1-866-657-4970**  
**or**  
**1-877-326-2201 Member Services - 7:00 a.m. to 8:00 p.m. CT**  
**TTY: 1-800-425-5705**  
**(Coverage Continued)**

Mental Health Inpatient Services	100% after \$100 per admission Co-payment (190-day life-time maximum) <b>Life-time max. only for inpatient.</b>
Mental Health Outpatient Services	<b>\$15 Co-payment per visit</b> <b>No life-time max. applies</b>
Substance Abuse Detoxification Inpatient Services	100% after \$100 per admission Co-payment <b>No life-time max. applies</b>
Substance Abuse Detoxification Outpatient Services	\$15 Co-payment per visit <b>No life-time max. applies</b>
Vision Care: Eye Exam	\$15 Co-payment per visit
Vision Care: One Pair of Approved Glasses	Frames and lens benefit maximum \$150
Pharmacy – 30 day supply - Retail	
- Generic Drugs on the Prescription Drug List	\$10 Co-payment per prescription
- Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent	\$15 Co-payment per prescription

\* This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the *Evidence of Coverage (EOC)*.

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Blue Cross of California (BCC) is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFFS) noted above or herein. AICI is the risk bearing entity licensed under applicable state law to offer the PFFS plan(s) noted. AICI has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the PFFS plan(s) available in this region. Blue Cross of California is an independent licensee of the Blue Cross Association. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



**SmartValue Private Fee For Service (PFSS) Standard Plan  
For Retirees & Dependents Over Age 65  
And Mixed Family Enrollment**

**For more information, contact:  
Blue Cross First Impressions Line at 1-866-657-4970  
or  
1-877-326-2201 Member Services - 7:00 a.m. to 8:00 p.m. CT  
TTY: 1-800-425-5705**

Your election for this health plan requires the approval of the health plan and the Center for Medicare and Medicaid Services (CMS). After January 1, 2008, you will be covered under the new health plan that you have elected, however if you are electing the SmartValue Standard plan and do not receive approval from CMS, or lose Medicare in the future, you will be automatically enrolled into the Blue Cross HMO plan that your dependent has elected. If your dependent is electing the SmartValue Standard plan and does not receive approval from CMS or loses Medicare in the future, they will be automatically enrolled into the Blue Cross HMO plan that you have elected.

Annual Out-Pocket Maximum for Certain Services	\$3,250
Primary Care and Specialist Physician Office Visits	\$20 co-pay per visit
Inpatient Hospital Services	<b>\$750 co-pay per admission, if pre-notified \$500 co-pay</b>
Outpatient Facility Services	<b>\$100 co-pay per Outpatient Surgery</b>
Hospital Emergency Room or Outpatient Facility	\$50 co-pay per visit, waived if admitted within 72 hours
Urgent Care Facility	\$20 co-pay per visit
Rehabilitative Therapy	\$20 co-pay per visit
Durable Medical Equipment	\$100 co-pay for DME charges over \$750, \$0, if pre-notified 20% co-insurance on all Medicare approved DME
External Prosthetic Appliances	20% co-insurance on all Medicare approved prosthetics
Home Health Services	\$25 co-pay per visit, \$0 co-pay if you pre-notify
Hospice Services	\$0 co-pay for Medicare approved services. When you enroll in a Medicare certified Hospice, services are paid by Medicare
Skilled Nursing and Rehabilitation Facilities ( <i>100 visits maximum per participant per year</i> )	<b>\$150 co-pay per day, \$75 if you pre-notify. Co-pay will be charged for days 1-10</b>
Laboratory and Radiology Services	\$0 co-pay for each Medicare approved clinical/diagnostic lab test. 20% co-insurance for each x-ray.
<b>(Coverage Continued on Back Page)</b>	

Blue Cross of California (BCC) is the legal entity who has contracted with the Centers for Medicare and Medicaid Services (CMS) to offer the Private Fee for Service plan(s) (PFSS) noted above or herein. AICI is the risk bearing entity licensed under applicable state law to offer the PFSS plan(s) noted. AICI has retained the services of its related companies and the authorized agents/brokers/producers to provide administrative services and/or to make the PFSS plan(s) available in this region. Blue Cross of California is an independent licensee of the Blue Cross Association. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



**SmartValue Private Fee For Service (PFFS) Standard Plan  
For Retirees & Dependents Over Age 65  
And Mixed Family Enrollment**

**For more information, contact:  
Blue Cross First Impressions Line at 1-866-657-4970  
or  
1-877-326-2201 Member Services - 7:00 a.m. to 8:00 p.m. CT  
TTY: 1-800-425-5705**

Mental Health Inpatient Services	\$750 co-pay per admission, if pre-notified \$500 co-pay. 190-day life-time maximum <b>(Max. applies to inpatient only)</b>
Mental Health Outpatient Services	50% co-insurance <b>No life-time maximum</b>
Substance Abuse Detoxification Inpatient Services	\$750 co-pay per admission, if pre-notified \$500 co-pay <b>No life-time maximum</b>
Substance Abuse Detoxification Outpatient Services	\$20 co-pay per visit <b>No life-time maximum</b>
Vision Care: Eye Exam	Not Covered
Vision Care: One Pair of Approved Glasses	Not Covered
Pharmacy – 30 day supply - Retail	
- Generic Drugs on the Prescription Drug List	\$10 co-pay per prescription
- Preferred Brand - Medically Necessary Name Brand Drugs designated as preferred on the Prescription Drug List, with no Generic Equivalent	\$30 co-pay per prescription
- Non-Preferred Brand - Non-Medically Necessary Name Brand Drugs on the Prescription Drug List with a Generic Equivalent and drugs designated non-preferred on the Prescription Drug List	\$60 co-pay per prescription Injectable Drugs covered 30% to a \$100 maximum

- This is a summary of the frequently asked about benefits. This chart is not meant to be a comprehensive explanation of benefits, cost sharing, exclusions or limitations. For a complete explanation of benefits, please refer to the *Evidence of Coverage (EOC)*.

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**The 2008 Retiree Open Enrollment  
Meeting Schedule for Retirees with  
Part B Only or Mixed Enrollment**



**Monday, October 22, 2007**  
**CEO Hall of Administration**  
333 W Santa Ana Blvd.  
Santa Ana, CA, 92701  
Board Room

Directions: [www.oc.ca.gov/hr/images/10.gif](http://www.oc.ca.gov/hr/images/10.gif)

**2:00 pm to 3:30 pm**

**Monday, October 29, 2007**  
**CEO Hall of Administration**  
333 W. Santa Ana Blvd.  
Santa Ana, CA, 92701  
Board Room

Directions: [www.oc.ca.gov/hr/images/10.gif](http://www.oc.ca.gov/hr/images/10.gif)

**2:00 pm to 3:30 pm**

**Thursday, November 8, 2007**

**CEO/Info & Technology**  
1400 S. Grand Ave.  
Santa Ana, CA 92705  
Main Conference Room

Directions: <http://www.oc.ca.gov/hr/images/1400.jpg>

**2:00 pm to 3:30 pm**