Benefit Plans Handbook

Flexible Benefits Program
Plan Year 2018

Health Insurance Plan Year
December 31, 2017—December 29, 2018

Flexible Spending Account Plan Year
January 1, 2018—December 31, 2018

This handbook includes important Employee Notices and other miscellaneous benefit information.

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On-Line Resources

- **www.ventura.org/benefits**
- **http://myvcweb/index.php/benefits/**
- **VCHRP**
  - o *Self-Service → Benefits*
- **Health Plan websites**
  - o VCHCP (www.vchealthcareplan.org)
  - o Anthem (www.anthem.com/ca)
  - o MetLife (www.metlife.com/mybenefits)
  - o MES Vision (www.mesvision.com)

Important Sections to Check

✓ Life Events Checklist

If you experience a change in employment or family status, review the *Life Events Checklist.* It will tell you how that event may affect your benefits and what actions you need to take.

✓ Appendix A – Consumer Issues

Terminology, Patients' Rights, Medical Plan Opt-Out information and other general health benefits information.

✓ Appendix B – Employee Notices

- **Family and Medical Leave Act of 1993 (FMLA)**
- **Pregnancy Disability Leave (PDL) – "Notice A"**
  - **Your Rights and Obligations as a Pregnant Employee**
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- **The Newborns' and Mothers' Health Protection Act**
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- **Women's Health and Cancer Rights Act of 1998**
- **Organ and Bone Marrow Donation Protection Act**
- **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
- **California AB 1401–additional extension of medical insurance (Cal-COBRA)**
- **Mental Health Parity Act**
- **Important Notice about Your Prescription Drug Coverage and Medicare (Medicare Part D)**
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **Rights of Victims of Domestic Violence, Sexual Assault, and Stalking**

This Benefit Plans Handbook contains information about the Flexible Benefits Program, the medical, dental and vision coverages available, Flexible Spending Account options, and other general benefits information.

The plan descriptions in this booklet are general in nature and cannot modify or affect the Plan Contracts in any way. For more detail on plan benefits, call the health plan directly at the telephone number listed on the back cover of this handbook, or refer to the plan booklets given to each new enrollee. Exact administrative contract specifications are contained in the plan documents that are available in County Human Resources.

The Flexible Benefits Program is regulated by the Internal Revenue Service and subject to change. If you require more information on the Flexible Benefits Program, contact your department's Human Resources/Benefits Representative or call the Benefits Unit of County Human Resources at (805) 654-2570.

This handbook completely replaces any previous Plan Year's Benefit Plans Handbook. Since plan benefits may change from year to year, review this handbook for changes that may affect you and eligible family members.

KEEP THIS HANDBOOK FOR FUTURE REFERENCE

Online Open Enrollment

The County of Ventura utilizes VCHRP for online enrollment (Ventura County Human Resources & Payroll).

TO FIND VCHRP

You can access the online enrollment system through the County's Intranet or from the Internet from home.

1. Through the County Intranet, go to the Ventura County Human Resources and Payroll system (VCHRP) at http://vchrp
2. From any computer with web/internet access, log on to VCHRP at http://www.ventura.org/benefits.
3. Internet access should also be available at all public libraries or at any of the County's Job & Career Centers.

SIGNING ON TO VCHRP

Use your employee identification number (Empl. ID) and password to log on.

If you do not remember your password, please contact your Department Representative or the Benefits Information Line at 654-2570. Once your password has been reset, your password will be the default password (see box below).

Default Password
(logging in after password reset)

When your password has been reset, your initial password is your two-digit birth month, two-digit birth date, followed by the last four digits of your social security number.

For example, if your birth date is 01/01/1960 and your SSN is 123-45-6789, your default password is 01016789.

ONLINE ENROLLMENT

From the VCHRP Main Menu:

1. Click on "Self Service"
2. Click on "Benefits"
3. Click on "Benefits Enrollment"
4. Your Benefits Enrollment screen will appear (check to make sure that your name appears on the screen).

The system will now guide you through the process. Read each screen for instructions.

Be sure to continue through the screens until you see a screen that states your choices have been sent to Benefits. If you do not see this confirmation screen, you have not finished the process and your changes will NOT be saved. It's a good idea to print a copy of your confirmed changes to compare with the Confirmation Statement that will be sent to your home in early December.

Life Events Checklist

Do you know what to do and who to notify when you:

> Change your name
> Move
> Get married
> Have or adopt a baby
> Need time away from work
> Get legally separated or divorced
> Have a child who reaches the dependent age limit
> Register a domestic partner
> Change jobs, hours or have a salary change
> Leave County employment (including retirement)

You can either go to our Intranet website at http://myvcweb/index.php/benefits, our internet website at http://www.ventura.org/benefits, or contact your Department's Human Resources/Benefits Representative to obtain forms you may need. *A Beneficiary Designation Checklist is available on the websites noted above.* See the Flexible Benefits Program Information and Miscellaneous Benefits chapters for descriptions of the plans and programs that appear below.

Life Events Checklist

Event	Actions
New Regular Employee • New Hire • From Optimum Census Staffing (OCS) • From Extra-Help • From Per-Diem Pool	■ Attend a County Human Resources New Employee Orientation for an overview of County benefits. If your work schedule is 40 hours per pay period or more, you are now eligible for: ✓ Flexible Benefits Program (*enroll within 31 days of eligibility*) ✓ Optional term life insurance (best to apply within 90 days of eligibility) ✓ Short-Term Disability Plan (apply within 90 days of eligibility) ✓ Deferred compensation plans (you may be eligible for County 401(k) match) ✓ Defined Benefit Pension Plans: • If your work schedule is at least 64 hours per pay period, you are in the Ventura County Employees' Retirement Association (VCERA) retirement plan. VCERA will mail you plan information. • All other employees, except rehired annuitants and reserve firefighters, participate in the Safe Harbor Retirement Plan. The Plan will mail you benefit information and a beneficiary designation form.
Changed your Address Changed your Name	■ Enter your new address in VCHRP (Self Service > Personal Information > Home and Mailing Address), or notify your department representative to update your address and your name in VCHRP. Notification will go to your insurance and retirement plans and to the Auditor/Controller for your annual W-2 form. ■ Have a 457 Plan or 401(k) Plan account? If you are not currently making payroll contributions, complete the top section of a new 457 and/or 401(k) Participation Agreement. ■ If you have funds on deposit in the Safe Harbor Retirement Plan but aren't currently contributing, notify the Plan at (805) 654-2921. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Salary Change	■ You may want to change your 457 Plan or 401(k) Plan contribution amount(s). Call Fidelity at (800) 343-0860 or go online at http://netbenefits.com/ventura. ■ You may want to adjust your tax-withholding amount.
Job Change	■ If your new position is represented by a different Bargaining Unit (union), check with your department to see if you have gained or lost eligibility for any benefits. For example: ✓ Your Flexible Benefit Plan Choices may have changed. If so, you may be eligible to add, drop or change plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ✓ Your 401(k) Plan County Match may have changed. Your new job may have a different minimum 401(k) contribution. To change your 457 or 401(k) Plan contribution amount, log on to Fidelity Net Benefits at http://netbenefits.com/ventura.

Life Events Checklist *(continued)*

Event	Actions
Marriage Registration of Domestic Partner New dependent child as a result of birth, legal adoption, or marriage	■ You have *31 days* to turn in an Enrollment & Change Form to add your new dependents to your medical, dental and vision plans. Otherwise, you may have to wait for the next open enrollment period. ■ If you have Dependent Life Insurance coverage on other dependents, you have 31 days to complete a Dependent Life Enrollment Form to add your new dependent children. New spouses must complete a Statement of Health (SOH) form, and coverage is conditional upon approval by MetLife. ■ You may be eligible to add or change Flexible Benefit Program plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions. ■ Is it time to apply for or increase life insurance coverage for yourself or your dependent(s)? For a description, see the Life Insurance section of the Miscellaneous Benefits chapter or the Optional Life Brochure (http://myvcweb/index.php/hr/benefits/home). ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Legal Separation or Divorce Child no longer meets eligibility criteria	■ Complete an Enrollment & Change Form to formally cancel coverage on your dependent and trigger an offer of continued coverage through COBRA. COBRA can only be offered if the dependent is dropped within 60 days of the event. Be sure to include the dependent's current mailing address, if different than employee's. Until you turn in the form, you may be liable for claims paid after eligibility ends. ■ You may want to drop your life insurance or dependent life insurance. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Loss of Other Health Insurance	■ If you are Opting Out of County medical insurance, you must notify County Human Resources (contact your department representative) if you lose your other group health coverage. You are required to enroll in one of the County's health plans or waive participation in the Flexible Benefits Program.
Change in Other Health Insurance	■ In some instances where you gain, lose or have a change in health insurance from another source, you may be eligible to add, drop or change Flex plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions.
Standard Hours Decrease • From 60 hours or more to between 40 & 59 hours per pay period	■ If you are in a union-represented job title, your Flexible Credit Allowance amount probably changed, and you may be eligible to drop a health plan or change to a lower cost plan. See the Flexible Benefits Program Information chapter for eligibility. ■ Covered employees lose County Long-Term Disability Plan (LTD) eligibility at Standard Hours of fewer than 60 hours a pay period (unless covered under the Management Resolution); no form needed.
Standard Hours Decrease • To fewer than 40 hours per pay period	■ You lose eligibility for the Flexible Benefits Program. You'll be sent an application for continuation of group health insurance under COBRA. See the Flexible Benefits Program Information chapter and COBRA appendix for eligibility, deadlines and instructions. ■ You lose eligibility for Optional Life Insurance, 401(k) Plan contributions, Short-Term Disability Plan, and County Long-Term Disability Plan (LTD). Some groups lose 457 Plan eligibility.
Standard Hours Increase • To between 40 & 59 hours per pay period	■ You are now eligible for the Flexible Benefits Program. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ Covered job titles have a County Long-Term Disability plan (LTD) if the Standard Hours is at least 60 hours a pay period, or at least 40 hours per pay period if covered under the Management Resolution. ■ You are eligible to enroll in the 401(k) Plan and Optional Term Life Insurance. If you are in CNA, SPOAVC or IUOE, you are now eligible to enroll in the Section 457 Plan.
Standard Hours Increase • To 60 hours or more per pay period	■ If you are in a union-represented job title, your Flexible Credit Allowance amount may increase, and you may be eligible to add a health plan or change to a higher cost plan. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ If you are in the Safe Harbor Retirement Plan and your hours increase to 64 or more per pay period, check your pay stub to be sure contributions stopped. You'll be in the Ventura County Employees' Retirement Association (VCERA) from now on. VCERA will mail you plan information.

Life Events Checklist *(continued)*

Event	Actions
Leave of Absence Request	■ Ask your department or check online sources for an Absence Management handbook; read it thoroughly. ■ You may be required to immediately begin payment of part or all of your health plan premiums. Check with your department Personnel Representative for an Employee Premium Continuation Notice. ■ If you have a 401(k) loan, you may need to continue making loan payments. Contact the Deferred Compensation Program at (805) 654-2620. ■ If you have a Dependent Care Flexible Spending Account, unless your entire leave will be unpaid, you may complete an Enrollment & Change Form now to drop your account when your leave starts, and complete another form upon your return. You may not file claims for services incurred while you are not working.
Leaving County Employment or Retiring	■ If you experience a qualified federal COBRA event resulting in a loss of health coverage, you'll receive a COBRA Continuation Offer from our COBRA Administrator. Please contact Fidelity regarding 457 and 401(K) Plans at (800) 343-0860. ■ If you are changing jobs, in most circumstances you can continue your basic and optional life insurance for up to two years unless you become covered by another group plan. See the MetLife Certificate of Insurance for more information (http://myvcweb/index.php/benefits). ■ If you're retiring soon: ✓ Ventura County Employees' Retirement Plan (VCERA) members - Call (805) 339-4250 ✓ Safe Harbor Retirement Plan members - Call (805) 654-2921
Death of a Dependent	■ If the dependent is covered under County health insurance, complete an Enrollment & Change Form to notify Benefits and the health plan. ■ If the dependent is covered under County dependent life insurance through MetLife, notify County Benefits. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Death of a Regular County Employee	■ If the employee is enrolled in the County's Flexible Benefits Program, his/her department will pay a $1,000 death benefit to his/her beneficiary (see "Beneficiary Update" on page L-3). ■ If the employee has County health insurance, life insurance or disability insurance (LTD or Short-Term Disability Plan), notify Benefits at (805) 654-2570. The surviving spouse and/or dependent children may be eligible for continued health insurance coverage through COBRA. ■ Notify the Ventura County Employees' Retirement Association (VCERA) at (805) 339-4250. ■ If the employee was ever an extra-help or part-time employee, notify Safe Harbor Retirement Plan at (805) 654-2921. ■ If the employee ever made contributions to 457 or 401(k) with the County, call Fidelity at (800) 343-0860 or ING at (805) 642-6190.
Beneficiary Update	■ You may access beneficiary change forms on the following websites: • Salary/Wages, Leave & Compensatory Banks – http://vcportal.ventura.org/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf • Optional Life Insurance - http://vcportal.ventura.org/CEO/benefits/docs/OLI-Beneficiary_Designation-5-2016.pdf • Basic Life Insurance - http://vcportal.ventura.org/CEO/benefits/docs/BLI_Enrollment_Form.pdf • Deferred Compensation (401k and 457 plans) - http://vcportal.ventura.org/CEO/benefits/def-comp/docs/Online_Beneficiary.pdf • Death Benefit (Flexible Benefits Program) - http://vcportal.ventura.org/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf • Wage Supplement Plan AD&D - http://vcportal.ventura.org/CEO/benefits/docs/WSP-Enrollment_Form-Brochure.pdf • Ventura County Employees' Retirement Association - http://vcportal.ventura.org/VCERA/docs/forms/Beneficiary_Form_0416.pdf • Safe Harbor Retirement Plan - http://vcportal.ventura.org/CEO/benefits/safe-harbor/docs/Beneficiary_Designation_Form.pdf • Accidental Death Benefit per MOA/Management Resolution (a.k.a. Supplemental Life Insurance) - http://vcportal.ventura.org/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf *NOTE: Beneficiaries are tracked separately by Plan or Plan Administrator and are not tracked in VCHRP*

Chapter 1
Flexible Benefits Program Information

This chapter provides general information on the County's Flexible Benefits Program and the various plans offered through the Program:

- Rules that apply to ALL plans in the Flexible Benefits Program
- How to enroll in the Flexible Benefits Program
- When and how to add or cancel coverage for a dependent
- When coverage begins and ends
- How you can change plans
- Your options if you lose coverage

How the Flexible Benefits Program Works

The County of Ventura's Flexible Benefits Program is an Internal Revenue Service (IRS)-approved program (sometimes called a cafeteria plan) that allows you to choose how to spend your benefit dollars. Participation is optional. You decide whether to participate or waive your right to enrollment and the Flexible Credit Allowance.

Here's how it works: When you enroll in the Flexible Benefits Program, the County provides you with a Flexible Credit Allowance to spend on your choice of plans. If your choices cost more than your Flexible Credit Allowance, you pay the rest through pre-tax salary reduction. This means you get a tax break—your share of the cost is deducted from your pay before federal and state income taxes and Social Security taxes are calculated, so you don't pay taxes on the money you spend on benefits.

Depending on the plan(s) you choose, you may get "Cash Back" added to your taxable pay because of Flexible Credits not spent. Your Flexible Credit Allowance is not taxed, except for the portion taken as "Cash Back" in your paycheck. "Cash Back" gives you additional income. If this is the case, you may wish to lower your current tax liability and invest in your own future by channeling those extra dollars into a tax-deferred savings program. The Deferred Compensation Program is one of the topics covered in the chapter on Miscellaneous Benefits in this book.

Am I eligible for the Flexible Benefits Program?

You are eligible to enroll in the Flexible Benefits Program if you are a regular County employee with a regular work schedule (standard hours) of at least 40 hours each biweekly pay period.

Once you have enrolled in the Program, you may continue to participate as long as you remain a regular employee and your regular work schedule (standard hours) does not fall below the minimum hours per pay period required to participate.

If your job classification is represented by a collective bargaining agreement, your Flexible Benefits Program eligibility and Flexible Credit Allowance are subject to periodic negotiations between the County and that union.

▪ Your Flexible Benefits Choices

You choose among:

- Medical Plans (or Medical Plan Opt-Out)
- Dental Plan
- Vision Plan
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Cash Back Option that adds any unspent dollars to your salary

You can generally change your selections only once each year; during the annual open enrollment period described later in this chapter.

▪ How Do I Enroll in the Flexible Benefits Program?

1. Learning About Your Plan Options

Chapters 2 through 5 of this handbook have basic information on the plan options. If you require more detail on a specific health plan, please refer to the Summaries of Benefits and Coverage in Appendix C of this book, or contact the plan's customer service center (contact information is listed on the back cover of this book).

2. Making Flexible Benefits Program Selections

You must enroll in a medical plan to participate in the Program or, if you already have employer group medical insurance or Medicare, you may opt-out of County medical coverage. Information on Medical Plan Opt-Out is in the chapter on Medical Plan Options. If you opt-out now, you must enroll later if you lose your other coverage. See *"Can I Change My Mind?"* later in this chapter.

Important! Complete the Enrollment & Change Form for your initial enrollment in the Flexible Benefits Program:

- **To enroll in any medical, dental or vision plan**: Complete, sign and submit the Enrollment & Change form. Attach proof of eligibility for all dependents.
- **To opt out of medical coverage:** Complete, sign and submit the Enrollment & Change Form, the Proof to Opt-Out form, and include your proof of other employer group medical coverage.
- **To waive all coverage:** Complete and sign the ***Waiver of Benefits*** section of the Enrollment & Change Form, and submit the form to your department's Human Resources/Benefits Representative.

All forms are available at:
http://myvcweb/index.php/benefits or http://www.ventura.org/benefits.

All required forms and documentation must be received by CEO/Human Resources/Benefits by the enrollment deadline(s).

You may choose other benefit plans (dental plan, vision plan and/or flexible spending accounts) with any remaining Flexible Credits. Any unspent Credits will be added to your biweekly paycheck as "Cash Back." If you spend more than your Credits will cover, part of your salary will be taken on a pre-tax basis to cover the cost of the benefits you choose.

You can also choose to waive all coverage. This means forfeiting your participation in the Flexible Benefits Program and your Flexible Credit Allowance.

3. Filling Out Your Forms

Complete the proper enrollment form(s) and return within the deadlines discussed under *"Employee Enrollments"* and/or *"Can I Change My Mind?"* later in this chapter.

Before you decide whether to enroll a dependent, be sure to read *"When and How Can I Enroll Dependents?"* later in this chapter. All forms are available on our websites: http://myvcweb/index.php/benefits (intranet) and http://www.ventura.org/benefits (internet)

The Human Resources/Benefits Representative for your department can also provide you with the form(s) you need, and help you with the enrollment process.

▪ Employee Enrollments

From the date you become eligible for the Flexible Benefits Program, you have ***31 calendar days*** to submit your Enrollment & Change Form.

1. Eligible New Employees

The 31-day period begins on your date of hire that is listed in VCHRP. The sooner you turn in your form(s), the sooner coverage begins for you and your enrolled dependents. If you wait until the end of your 31-day enrollment window, you could delay your coverage and lose your credit allowance for up to 6 weeks from your eligibility date because coverage is not retroactive. See item 6, *"When Coverage Begins."*

For your protection, if you fail to turn in your Enrollment & Change Form or a Waiver of Benefits (blue box on page 2 of the Enrollment & Change Form) within 31 days of becoming eligible, you will be automatically enrolled in the lowest-cost County-sponsored or Association-sponsored medical plan for which you are eligible. Currently, this is the Ventura County Health Care Plan (VCHCP) for most employees.

2. Consequences of Not Submitting Your Forms on Time

If you think automatic enrollment sounds easier than filling out forms, there are serious consequences to consider:

- You will lose up to two months of medical coverage if you miss the 31-day deadline; your coverage will become effective in the pay period that includes your 60th day of eligibility.
- You will forfeit medical coverage for your dependents.
- You will lose your opportunity to opt-out of County medical coverage, which may have given you additional cash back in your pay.
- You will lose the opportunity to enroll in dental and vision plans and Flexible Spending Accounts until the next annual Open Enrollment.

3. Changing from Extra-Help, Optimum Census Staffing (OCS), or Per Diem Pool Status

If your employee class changes from Extra-Help, OCS, or Per Diem Pool Status to regular employment, read *"Am I Eligible for the Flexible Benefits Program?"* earlier in this chapter. If you are now eligible, your 31-day period begins on the date of the change in your employment status. The information under *"Eligible New Employees"* in item 1 above also applies to you.

4. If Your Regularly Scheduled Hours Increase to 40 hours or more a Pay Period

Follow the same steps as item 3 above.

5. If Your Regularly Scheduled Hours Decrease to fewer than 40 Hours a Pay Period

See the *"Work Schedule Reduction"* section under *"When Does Coverage End?"* in this chapter.

6. When Coverage Begins

Health premiums are paid one pay period in advance. Generally, coverage begins on the first day of the pay period after the pay period that the first premium deduction is taken from your paycheck. Example: If the first premium is deducted in Pay Period 04, your coverage begins the first day of Pay Period 05. For most plans, if you are on unpaid leave of absence on the day your coverage would go into effect, your coverage effective date could be delayed until the pay period after you return to work (there may be an exception if there was no lapse in premium contributions during your leave).

▪ Dependent Enrollments

No dependent coverage is automatic, even for newborns *(coverage for newborn children of current plan members ends at 31 days after birth if an Enrollment & Change Form has not been received).* Whether you acquire a new dependent after your coverage has begun, or you wish to enroll an existing dependent, be sure to read this section for instructions and information on coverage effective dates.

1. Whom Can I Enroll as a Dependent?

All plans accept these dependents for coverage under your medical, dental and vision plans:

- Your current legal spouse,
- Domestic partners officially registered with the appropriate entity, such as the State of California or any other California County or Municipality official domestic partner registry,
- Your children under the age of 26,
- Dependent children of an officially-registered domestic partner who meet the same eligibility requirements as other dependent children,
- Certain unmarried dependent children age 26 and over if handicapped, incapable of self-support, continuously covered by a County-sponsored plan since prior to age 26, and whose disability was certified by the health plan and began before age 26. *Please contact the health plans directly no later than 60 days prior to your child turning 26 years of age to initiate certification of disability.*

The basic definition of Child(ren) is the same for all plans: Any natural child, stepchild, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, of either you or your current spouse or registered domestic partner, or both. Some plans are more restrictive, and some recognize additional categories. The chapters that describe specific health plans list any variations in dependent eligibility requirements.

For most plans, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews and non-relatives.

2. When and How Can I Enroll Dependents? When Does Coverage Begin?

• ***New Employee***: When you first enroll, your Enrollment & Change Form must list all eligible dependents you wish to cover for the current Plan Year. Employee and dependent coverage begins on the same coverage effective date (see *"When Coverage Begins"* under *"Employee Enrollments"*).

• ***New Dependent***: If you want new dependents covered under your health plan(s) for the remainder of the Plan Year, you must enroll them within 31 days of eligibility; for example, marriage, registration of domestic partnership, birth of a child, adoption placement, or loss of the dependent's other coverage.

• ***Existing Dependent***: For all plans, dependents not added within 31 days cannot be enrolled until the next Open Enrollment period unless there are special circumstances. See *"Open Enrollment"* and *"Mid-Year Changes"* under *"Can I Change My Mind?"*

Submit a new Enrollment & Change Form whenever you acquire a new dependent. Except for 31 days of coverage from the date of birth for a newborn child, coverage for dependents is never automatic. Coverage is also not retroactive. Restrictions may apply in some cases for some plans. See the medical, dental, and vision chapters for further information.

If an enrollment form is submitted timely, coverage for new dependent children begins on the date of birth or placement for adoption. The effective date for coverage of dependents resulting from a marriage or registration of domestic partnership varies by plan.

Important! A person may only be enrolled in a County–sponsored medical plan under one person's employee identification number.

- Two employees cannot list the same dependent under their County–sponsored medical plan, even if the two employees have different plans.
- An employee cannot be covered as an employee and as a dependent under County-sponsored medical plans. In a two-County-employee family, one of the employees in the Flexible Benefits Program may wish to opt-out of medical coverage and use the extra Flexible Credits for other benefits, or "Cash Back" in their salary.

3. When Must I Cancel a Dependent's Coverage?

Submit a revised Enrollment & Change Form whenever a dependent becomes ineligible.

Examples:

- Divorce or legal separation
- Termination of a Domestic Partnership
- Dependent child turns age 26
- Death of a dependent

Turn in forms ***within 31 calendar days of the event*** (date eligibility ends). If you do not cancel coverage for ineligible dependents, you may be liable for claims incurred after the date dependent eligibility ended and you jeopardize their eligibility for continuation of coverage.

Loss of dependent eligibility does not necessarily mean the loss of County health coverage. The section later in this chapter titled *"When Does Coverage End?"* contains information on extension of coverage options that may be available if you notify the County in a timely manner of a loss of eligibility.

Federal COBRA laws and regulations do not apply to domestic partners or their dependent children.

▪ Can I Change My Mind about the Plans I've Chosen?

1. Open Enrollment

There is an annual Flexible Benefits Program Open Enrollment period, which generally takes place in November. New choices can be made at that time, including changes in plans, re-enrollment and enrollment in Flexible Spending Account(s), and the addition of existing dependents who are not eligible to be added as late dependents mid-year. During each Open Enrollment, you'll want to review your options and decide whether your current selections still fit your needs.

Health plan coverage for the new Plan Year begins with the first day of the County's biweekly payroll period that includes January 1, and ends with the last day of the payroll period that precedes January 1 of the following year. Flexible Spending Account Plan Years begin on January 1 and end on December 31.

If you are on an approved leave of absence, and you or your department has continued to pay your premiums while you are on leave, any plan changes will be effective at the beginning of the new Plan Year. If you are on an approved leave of absence and your coverage has lapsed, your coverage effective date will be delayed until the pay period following your first paycheck with premium deductions after you return to work.

2. Mid-Year Changes

Due to IRS restrictions on Flexible Benefits Programs, the choices you make generally **cannot** be changed until the next annual Open Enrollment period. However, the IRS does permit you to file revised elections, or adjust Flexible Spending Account contributions, **within 31 days** of certain qualified mid-year events, such as changes in your family/employment status.

Read your Open Enrollment materials very carefully!
Open Enrollment procedures vary from year to year.

- ❖ Some years, if you do not designate your choices during Open Enrollment, your current selections or waiver may be canceled, and you may be enrolled in a medical plan by default.
- ❖ In other years, your current health plan selections continue if you take no action.

The change in your plan selections must be because of, and consistent with, the reason for the change. Consistency is met if the election change affects eligibility for coverage under the plan. The election change has to be on account of and correspond with the event. In some cases, the IRS requires that the change be retroactive to the pay period in which you became eligible to make the change.

The following are considered qualified mid-year events by the IRS:

- Change in legal marital status, including marriage, registration of domestic partnership, death of spouse, divorce, legal separation, termination of a domestic partnership, and annulment; **with the consequence that there is a gain or loss of coverage due to the change in marital status;**

- Change in number of tax dependents, including birth, adoption, placement for adoption or death of a dependent; **with the consequence that there is a gain or loss of coverage due to the change in tax dependents;**

- Change in employment status or work schedule, including the start or termination of employment by you, your spouse, or your dependent child; this could also include a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite; any other changes in employment status that change eligibility of the employee, spouse or tax dependent under the benefit

plan, such as a change from part-time to full-time or full-time to part-time status, a change from salaried to hourly-paid, or hourly-paid to salaried employment, ***with the consequence that an individual becomes (or ceases to be) eligible under the plan,*** constitutes a change in employment status under this section;

Individuals who terminate employment but are rehired within 30 days from the date of separation must continue with their prior benefit elections for the remainder of the plan year; individuals who separate from service and are rehired more than 30 days from the date of separation may make new prospective benefit elections in the same plan year, except that employees with negative Health Care Flexible Spending Account balances must elect a Health Care Flexible Spending Account for the same annual pledge amount previously elected.

- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them. Events that cause an employee's tax dependent to satisfy or cease to satisfy eligibility requirements for coverage are: attainment of age, or any similar circumstance as provided in the health plan under which the employee receives coverage; the change allowed is restricted to adding or dropping coverage for the dependent affected;

- Change in the place of residence of the employee, spouse or tax dependent that affects the employee's eligibility for coverage (e.g., moving out of the HMO service area of the employee's current plan, or change that affects the accessibility of network providers of the employee);

- Change in an individual's eligibility for Medicaid or Medicare, such as an employee, spouse or tax dependent becoming entitled to or losing coverage under Medicaid or Part A or Part B of Medicare;

- A judgment, decree, or court order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for an employee's child, or for a foster child, or any other change in status that entitles an employee, spouse or tax dependent to change benefit elections pursuant to COBRA (Consolidated Omnibus Reconciliation Act), HIPAA (Health Insurance Portability and Accountability Act) or any other law;

- An event that is a special enrollment event under HIPAA, including acquisition of a new dependent (when an employee, spouse or new tax dependent is entitled to enroll in a health plan under HIPAA's special enrollment rules, the employee may also elect to enroll other pre-existing dependents or spouse), or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:

  - Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation;
  - Termination of employer contributions toward the other coverage, OR
  - If the other coverage was COBRA Continuation Coverage, exhaustion of the coverage;

- A significant increase or decrease in premium cost or coverage, the elimination of an existing plan, or the availability of a new group plan (applies to health plans and Dependent Care Flexible Spending Accounts; *does <u>not</u> permit a change to a Health Care Flexible Spending Account contribution/election);*

- A change of spouse's or tax dependent's coverage, such as an election change made by an employee's spouse or tax dependent under his or her employer's cafeteria plan; when an employee makes a change that is consistent with the spouse's or tax dependent's election change, for example, if spouses have each elected single coverage under their respective employer's health plans, and subsequently adopt a

child, one spouse could elect to drop coverage, if the other spouse changes his/her election to add family coverage. An election change that is made to conform to a change made by a spouse or tax dependent under his or her employer's open enrollment period may also be permitted;

- For Dependent Care Flexible Spending Accounts, a status change that affects the employee's eligibility for tax-favored treatment for Dependent Care Flexible Spending Accounts, including a change in dependent care provider, a raise for the provider (except in the instance where the provider is related to the employee), a reduction in care-giver hours due to tax dependent's enrollment in school, or a change in the number of tax dependents, including a dependent's loss of eligibility under IRC Section 21 (b).

Eligible to cancel a Flexible Spending Account mid-year?

When Flexible Spending Account contributions end, your Plan Year for that account also ends. Claims cannot be filed for services received after contributions end, or the end of *your* Plan Year.

- Any changes you make must be because of and consistent with the change in status, AND
- You must make the changes within 31 days of the date the event (marriage, birth, etc.).

Revised forms *must be received by CEO/Human Resources/Benefits* ***within 31 days*** *of the qualified change in status, or you may not be able to make the requested change until the next Open Enrollment period.* Depending on the nature of the change, documentation may be required (such as a copy of a marriage or birth certificate, court documents, or a letter from a current or former employer). If there will be a delay in obtaining the documentation, submit the form within the 31 days and *attach a note of explanation*. Follow-up as soon as possible with the documentation.

Qualified Medical Child Support Order (QMCSO)

In addition to events that qualify participants to change plans or add dependents mid-year under Internal Revenue Code, children may be added to the employee's existing health plan as a result of a Qualified Medical Child Support Order (QMCSO). Upon receipt of a court order, the Benefits Unit of Human Resources will notify the participant and make available the County's written procedures for determining if an order is a QMCSO. Within a reasonable period of time, the plan administrator will determine if the order is a QMSCO and notify all parties of the decision.

▪ When Does Coverage End?

1. New Plan Year

If you make changes to your plan selections during Open Enrollment, the health plan changes become effective at the beginning of the pay period that includes January 1st of the next year. If you are on an approved Leave of Absence, see the "Open Enrollment" section earlier in this chapter.

Example: If the new Plan Year begins on January 1, coverage under the new plan begins on January 1, and your last day of coverage under the old plan would be December 31.

2. Dependent Coverage

Dependent coverage ends when your coverage ends, or on the date the dependent becomes ineligible (divorce, loss of eligibility as a dependent child, etc.), whichever occurs first.

If your dependent becomes ineligible, you must complete a County of Ventura Enrollment & Change Form and cancel coverage for the dependent ***within 31 days*** of the date your dependent becomes ineligible. The completed form must be submitted to CEO/Human Resources/Benefits within 31 days of the event.

CEO/Human Resources/Benefits will send a copy of the form to notify the plan(s) of the date and the reason that coverage should be canceled. Provide the dependent's new address, if it is different from yours, so that CEO/Human Resources/Benefits can notify the COBRA Administrator to send COBRA information to the dropped dependent.

Direct notification to the Plan is not sufficient.

Once your County forms have been processed by CEO/Human Resources/Benefits:

- The County's COBRA Administrator will send your dependent information on continuation of coverage (COBRA) options, if the County form is received within 60 days of the loss of eligibility.[1]
- Federal COBRA laws and regulations do not apply to domestic partners or their dependent children.

3. Termination of Employment

If you are terminating or retiring or if you lose coverage due to a reduction of standard hours, you and any enrolled dependents are covered for a full pay period after the end of the pay period in which your paycheck includes a premium deduction. Once your termination has been processed:

- The County's COBRA Administrator will send you information on continuation of coverage options.[1]

4. Eligible for Retirement with a Pension?

If you are retiring and want information on County retiree health plan options, you may call (805) 662-6791 to request a Retiree Health Benefits Program handbook and rate sheet. The Retiree Health Benefits Program handbook and rate sheet are also available on the following websites:

- http://myvcweb/index.php/benefits (under "Flexible Benefits Program")
- http://www.ventura.org/benefits (under "Medical, Dental, and Vision insurance")

5. Leave of Absence

If you are on an approved leave of absence, you may continue your health plan(s) and Health Care Flexible Spending Account coverage for up to one year while on an approved leave, by paying the biweekly premium and/or contribution amounts directly to the County.

While you are on an approved paid or unpaid medical or Pregnancy Disability Leave, or on certain Family and Medical Leave Act (FMLA) leaves to care for sick family members, including California Family Rights Act (CFRA) leaves to bond with your newborn child, your department will continue to contribute the amount it normally pays toward some or all of your health plan premium(s) for a number of pay periods, providing that you make timely premium copayments as required.

To continue coverage once your County contributions end, or if the County contribution is less than the cost of your premiums, you must make biweekly premium payments directly to the County. After one year on leave, if you have continued your health plan premiums payments, you may qualify for extended health coverage under COBRA continuation of coverage provisions.[1]

If you are considering a Leave of Absence, be sure to read the *Leave of Absence* section of the chapter on Miscellaneous Benefits and Employee Notices in Appendix B. You should also review a copy of the County's Absence Management Program Handbook (http://www.ventura.org/benefits/leave-of-absence).

[1] You will be sent information on continuation of coverage options through the County's COBRA and Cal-COBRA programs, as described in the Employee Notices section. In addition, you may be eligible for one of several options that could extend health coverage, including Extension of Benefits, if you are completely disabled, conversion to an individual policy, or coverage under plans offered to eligible County retirees. Availability and eligibility requirements vary by plan and by option. Check your health plan booklet for details.

On-Line Resources

- **www.ventura.org/benefits**
- **http://myvcweb/index.php/benefits**
- **VCHRP**
  - *Self-Service → Benefits*
- **Health Plan websites**
  - VCHCP (www.vchealthcareplan.org)
  - Anthem (www.anthem.com/ca)
  - MetLife (www.metlife.com/mybenefits)
  - MES Vision (www.mesvision.com)

Chapter 2
Medical Plan Options

The medical plans offered through the County of Ventura's Flexible Benefits Program vary in the coverage and providers available to you. In selecting a plan, be sure to compare benefits, copayments, out-of-pocket expenses, and networks, as well as premiums. Depending on your family's needs, the "best" plan for you may not be the most expensive, or the least expensive plan. By studying the plan descriptions in the Comparison of Medical Plan Benefits Chart included in this chapter, and comparing the networks and premiums, you can determine which plan is best for you and your family. This chapter also reviews your options if you do not wish to enroll in medical coverage through the County.

Included at the end of the Comparison Chart in this chapter are each medical plans' dependent eligibility rules. Basic rules regarding your employee and dependent eligibility, enrollment procedures, the effective date of coverage, and changing plans are the same for all health plans and can be found in Chapter 1, *Flexible Benefits Program Information.*

▪ Types of Plans

Health Maintenance Organization (HMO) - A HMO is a plan in which you choose a physician to act as your Primary Care Physician (PCP). This physician acts as the "coordinator" for all your health care.

Typically, when you need medical care, your first call is to your PCP. If you need a specialist, your PCP will refer you to one within the plan. For some plans, you will be referred to a specialist within the PCP's medical group or Independent Practice Association (IPA). Should you choose to receive services without a referral or outside the plan's network of providers, you will not be entitled to coverage by the plan.

At the time you enroll, you must choose a PCP for yourself and each eligible dependent from the plan's panel. The panel includes general and family practitioners, internists and pediatricians. If you do not choose a PCP, one will be assigned to you. You may choose a different PCP for each member of your family, and you can change providers during the year. If your PCP leaves the plan during the Plan Year, you must select a new PCP within the plan.

Exclusive Provider Organization (EPO) - An EPO is similar to a HMO, in that you MUST use network providers (except in an emergency); however, with an EPO, you do **NOT** need to select a PCP, nor do you need a referral to see a specialist. If care is received from a non-participating provider, there is no benefit coverage. It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.

Preferred Provider Organization (PPO)

With a PPO plan, you do not need to select a PCP, or obtain a referral to see a specialist. Each time you need medical services, you choose whether to self-refer to a PPO provider and receive in-network benefits or a non-participating provider and receive out-of-network benefits.

Some people prefer this type of plan because they have a doctor they have been seeing for years who is not in an HMO, they want access to specialists who do not participate in a HMO, or they do not like the provider and referral restrictions of a HMO.

When you self-refer to a non-network provider, you pay a co-insurance amount, plus any provider charges above the amount the plan pays for the services provided. Out-of-network reimbursements are based on 110% of the Medicare published rates. Depending on the billing practices of the non-network providers you select, you may have to pay for the services first, and then file a claim with the insurance company for reimbursement.

▪ What Plans are Available?

The County offers three medical plans to choose from:

- Ventura County Health Care Plan (HMO)
- Anthem EPO
- Anthem High-Deductible PPO (High Deductible Health Plan; HSA-compatible)

Regardless of which plan you select, once you enroll, the plan will mail ID cards and plan information directly to your home.

❖ Ventura County Health Care Plan (HMO)

The Ventura County Health Care Plan (VCHCP) is a licensed HMO that arranges for the provision of cost-effective health care services for its members. As a member of VCHCP, you will select a Primary Care Physician (PCP) who will oversee your health care needs. Members may select different PCPs for themselves and each of their dependents. If specialty services are required, your PCP may need to submit a request for authorization to VCHCP for the required service.

There is no annual deductible to meet, and services are generally covered in full after any required copayment when accessing the Plan's primary facility, Ventura County Medical Center (VCMC)/Santa Paula Hospital, or an associated VCMC ambulatory care clinic. Services are also available, after any required copayment, from a variety of contracted community primary care and specialty care physicians, hospitals, and facilities.

Additional Plan benefits include, but are not limited to:

- Members have access to several contracted urgent care facilities located throughout the County of Ventura.

- Female members may self-refer for OB/GYN services by selecting a listed Direct Access OB/GYN in the Provider Directory

- Members may self-refer for an annual vision refraction exam, and for chiropractic and acupuncture services. (Reimbursement varies; for benefit details, see Comparison Chart in this chapter).

VCHCP's geographic service area is the County of Ventura. You must live or work in the service area at the time of enrollment to be eligible for coverage under VCHCP. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a region outside the County of Ventura, unless you are a subscriber who works in the County of Ventura, or you are a dependent child under the age of 26.

If you have an eligible dependent attending school or living in an area outside Ventura County, you must select a VCHCP PCP for that dependent, and the dependent must come to Ventura County for coverage of routine physical exams and medical services. Only emergency care services, urgent care services, and prescriptions are covered out of the Plan's service area.

❖ Anthem EPO

Anthem's EPO offers a broad range of benefits and low out-of-pocket expenses. Members do not pay an annual deductible.

Unlike a HMO, you do not need to select a Primary Care Physician (PCP) to direct your care, nor do you need to obtain a referral to see a specialist. You do however need to seek services from providers who participate in the Prudent Buyer PPO network (except in an emergency). If care is received from a non-participating provider, there is no benefit coverage. It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.

To see a list of the providers who participate in the Prudent Buyer PPO network:

1) Go to the Anthem website (www.anthem.com/ca).
2) Click on "Find a Doctor".
3) Click the "Continue" button in the "Search as a Guest" section.
4) Select the "Blue Cross PPO (Prudent Buyer) – Large Group" plan when prompted to do so.

If you are looking for a provider outside the State of California:

1) Go to www.bluecares.com.
2) Click on "Find a Doctor".
3) Click on "In the United States, Puerto Rico, and U.S. Virgin Islands".
4) Enter the first three letters of your Member ID (MTY), if you are already a member, or choose "BlueCard PPO/EPO" network.

If you are enrolled in this plan, you also have access to the following programs:

- TelaDoc - a national network of board-certified doctors that are available via telephone (800-835-2362), web (www.teladoc.com), or mobile app 24 hours per day, 7 days per week. There is no cost for Anthem members to use this service.
- Healthy Reward$ - a wellness program where employees enrolled in an Anthem plan have an opportunity to earn up to $500 per year for completing different health actions during a set time frame. To access this program, go to www.mcsig.com, click on "Discover MCSIG," and then click on "Wellness Programs."
- CastLight Health – a personalized healthcare assistant that will guide you, based on your unique profile, to the best healthcare resources, whether you are healthy, chronically ill, or actively seeking medical care. It makes researching care options, tracking expenses, and understanding benefits easy. www.castlighthealth.com
- BridgeHealth – helps members control surgical costs; www.bridgehealth.com

❖ Anthem High-Deductible PPO (High Deductible Health Plan; HSA-compatible)

Anthem's PPO offers greater flexibility in obtaining care. Each time care is needed, you decide where to receive treatment and who will provide it. You have the option of obtaining care from any Anthem Prudent Buyer PPO network provider or any non-network provider, with your out-of-pocket expenses being less with a network provider.

This plan is a High Deductible Health Plan, and the deductibles are $3,000 for employee-only coverage and $6,000 for family coverage. If you have family coverage, the $6,000 deductible will apply regardless of the number of family members who are receiving treatment. Please note that the deductible, which must be met before the plan benefits are payable, applies to **all** expenses (except preventative care).

Self-Referral to Network Provider:
You may seek care from any Anthem Prudent Buyer PPO provider. For basic physician services, you pay 20% after deductible. For most other services, you pay 20% of the negotiated rate, plus the annual deductible amount. Your PPO provider may file claims on your behalf.

Self-Referral to Any Non-Network Provider:
For most covered services received from a non-network provider, the plan pays 60% of an amount based on 110% of the Medicare published rates, and you pay the remainder, plus the annual deductible amount. You may be responsible for filing your own claims.

Most hospitals contract with Anthem. In order to be covered, hospital admissions and surgeries require prior authorization.

If you are enrolled in this plan, you are also eligible to participate in a Health Savings Account (HSA). While you are free to open an HSA anywhere you choose, the County has contracted with HealthEquity, a third party administrator, to administrate a pre-tax HSA for those who wish to have pre-tax contributions taken from their County paycheck. You can either enroll during Open Enrollment using VCHRP Self-Service or on the enrollment form that you receive in your Open Enrollment packet in the mail, or you may complete the HealthEquity HSA packet on our websites (see back cover for links).

HSAs are individually-owned savings accounts, similar to an IRA or 401(k) retirement plan, except that funds are used to pay for health care costs. HSAs provide consumers with a tax-efficient method of saving and paying for qualified medical expenses. However, an account owner must not be enrolled in Medicare, claimed as a dependent on another's tax return, or enrolled in another health plan that is not a high deductible health plan.

If you are enrolled in this plan, you also have access to the following programs:

- TelaDoc - a national network of board-certified doctors that are available via telephone (800-835-2362), web (www.teladoc.com), or mobile app 24 hours per day, 7 days per week. There is no cost for Anthem members to use this service.
- Healthy Reward$ - a wellness program where employees enrolled in an Anthem plan have an opportunity to earn up to $500 per year for completing different health actions during a set time frame. To access this program, go to www.mcsig.com, click on "Discover MCSIG," and then click on "Wellness Programs."
- CastLight Health – a personalized healthcare assistant that will guide you, based on your unique profile, to the best healthcare resources, whether you are healthy, chronically ill, or actively seeking medical care. It makes researching care options, tracking expenses, and understanding benefits easy. www.castlighthealth.com
- BridgeHealth – helps members control surgical costs; www.bridgehealth.com

❖ Medical Plan Opt-Out

If you are a covered dependent under another comprehensive employer group medical plan, you can decide whether or not to enroll for medical coverage under a County-sponsored plan. Examples of medical plan coverages which qualify you for Opt-Out include TRICARE, Medicare Parts A and B, Medi-Cal, and other employer group health plans. For more information, be sure to read the section titled *"If You and Your Family Are Covered by More Than One Plan"* later in this chapter.

To opt-out, select "Opt-Out" on the *Enrollment & Change Form* or in your Open Enrollment event in Self Service on VCHRP during Open Enrollment, complete the County's *Opt Out Certification Form*, attach proof that you have other employer-group medical coverage (for example, a copy of the front and back of your medical plan identification card or a letter from the insurer with information on your coverage), and submit the documents to CEO-Human Resources/Benefits.

If you opt-out of medical plan coverage, a portion of your County Flexible Credit Allowance is allocated to the Medical Internal Service Fund (ISF) as your portion of administrative costs of the program and the general risk pool. For more information on the risk pool, see *Appendix A*. You can use the remaining Flexible Credits to pay for other Flexible Benefit Plans, or you may elect to receive them as cash back in your paycheck.

If you opt-out of County-sponsored medical coverage, you are still eligible to participate in the County Employee Assistance Program, the Wellness Program, the Work/Family Program and Employee Health Services.

If you opt-out of County-sponsored medical coverage due to Medicare coverage, Medicare will be the primary payer for Medicare-covered health services. Keep in mind that Medicare Parts A and B do not cover all medical services. For added protection, you may wish to enroll in a Medicare supplement plan. Since the law does not allow employers to offer Medicare-supplement plans to active employees, you will need to explore plans available through other sources.

❖ No Medical Coverage

There may be a reason, such as a religious principle, that you wish to decline medical coverage altogether. Unlike the Medical Plan Opt-Out option, you will not have to show proof that you have medical coverage elsewhere, but you forfeit Flexible Benefits Program participation and you will not receive any Flexible Credits. If you choose no medical coverage, you must sign a waiver agreement when you first become eligible for a medical plan or during an Open Enrollment. If you do not turn in a waiver, you will be automatically assigned coverage in the medical plan available to you with the lowest biweekly premium, as described in the *Flexible Benefits Program Information* chapter.

❖ If You and Your Family Are Covered by More Than One Plan

If you are married and your spouse works, it is possible that your family is covered by more than one group health care plan. If there are two plans, your benefits from both plans will be coordinated. Note: A person cannot be covered under more than one County-sponsored medical plan. See *"Who Can I Enroll as a Dependent?"* in Chapter 1.

This is how the coordination process generally works:

- First, file your claim with the primary plan. After your claim is processed, you will receive an Explanation of Benefits (EOB) from the primary plan.

- Then, file a claim with your secondary plan. Be sure to attach a copy of the EOB from your primary plan to your claim form. The secondary plan may reimburse you for a part of your claim that the primary plan did not cover.

- Be sure to keep a copy of each EOB in a safe place in case a question arises. You may find your EOBs are valuable to you when you complete your income tax returns or file claims under your Health Care Flexible Spending Account or your Health Savings Account.

The standard coordination of benefits rules do not always apply. For example:

- Most HMOs do not provide EOBs. If your primary plan is an HMO, check with your secondary plan to see if they'll accept a provider's itemized receipt for the copayment amount in lieu of an EOB. In some circumstances, VCHCP and Anthem can provide an EOB upon request.

- If your secondary plan is a HMO-type plan, and you received services from a provider who is not a provider for the secondary plan, your secondary plan probably will not cover those services, unless they were out-of the-area emergency services.

- If the services you received will not be covered by your primary plan, you may still need to submit a claim to them in order to obtain an EOB or letter of denial to send to your secondary plan.

- If you or a covered dependent is age 65 or over, and you are still working, Medicare is always the secondary payer to any employer group health plan coverage you have, such as any of the plans offered through the County. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services.

Review the *Evidence of Coverage* Booklet provided by your medical plan for specific information on the plan's coordination of benefits rules, or call the plan's Member Services Office.

How to determine which plan is primary (pays first) for each family member and which is secondary:

CLAIMS FOR	PRIMARY PLAN	SECONDARY PLAN
Yourself	Yours	Spouse's/Domestic Partner's
Spouse/Domestic Partner	Spouse's/Domestic Partner's	Yours
Children living with and covered by both parents	Plan of the parent whose birth date is earlier in the year, regardless of parent's year of birth	Other parent's plan

Comparison of Medical Plan Benefits

These plan descriptions are general in nature and cannot modify or affect the Plans in any way. Consult the Plan's Evidence of Coverage booklet for governing provisions.

	Ventura County Health Care Plan (HMO)	**Anthem EPO** (Prudent Buyer PPO Network)	**Anthem High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	**Non-Participating Provider**
Deductible *(Per Member/Per Family; per Calendar Year)*	None	None	Applies to all expenses except preventative care: $3,000/$6,000 [5]	
Maximum Out-of-Pocket Expense *(Per Member/Per Family; per Calendar Year)*	Includes copayments made to providers for covered medical, pharmacy, and behavioral health services	Excludes premiums and health care expenses that this plan doesn't cover	Excludes premiums and non-covered expenses. In-network/out-of-network out-of-pocket maximums are exclusive of each other, and include calendar-year deductible and prescription drug maximum allowed amounts.	
	$3,000/$6,000	$1,500/$3,000	$5,000/$10,000	$10,000/$20,000
PHYSICIAN SERVICES				
Office visits *(consultations and in-office procedures)*	$10 copay/visit with a VCMC provider; $20 copay/visit at other contracted providers	$15 copay per visit; no copay if you use TelaDoc	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Preventative Care	100% coverage (no copay)	100% coverage (no copay)	100% coverage (no copay)	60% coverage [3]
Maternity Care	100% coverage (no copay)	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Specialist	$20 copay/visit with VCMC specialist; $40 copay/visit at other contracted providers	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Well Woman Annual Exam *(exam, pap smear & associated tests)*	100% coverage (no copay) (may self-refer to any OB/GYN who participates in the Plan's Self-Referral Program for most OB/GYN services)	100% coverage (no copay)	100% coverage (no copay)	60% coverage [3]
Well child, including immunizations *(birth through age 18)*	100% coverage (no copay)	100% coverage (no copay)	100% coverage (no copay)	60% coverage [3]
Adult Immunizations	100% coverage (no copay) *(excluding occupational; ACIP-approved travel immunizations are covered)*	100% coverage *(excluding travel & occupational)*	100% coverage *(excluding travel & occupational)*	60% coverage [3]
Allergy Testing & Treatment *(includes injections/serum)*	100% coverage	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]

Footnote descriptions are on page 2-11

	Ventura County Health Care Plan (HMO)	**Anthem EPO** (Prudent Buyer PPO Network)	**Anthem High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	**Non-Participating Provider**
HOSPITAL/FACILITY				
Inpatient Services and Supplies [6]	No copay at VCMC/SPH; $150 per day copay at contracted non-VCMC facilities (up to $600 maximum)	$100/admit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3] ($1,000/day limit)
Skilled Nursing Facility	$50 per day copay, $500 maximum (up to 100 combined days for all stays)	100% coverage (limited to 100 days per calendar year)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Outpatient Surgery [6]	No copay at VCMC/SPH; $250 copay at non-VCMC[9] contracted facilities, when preauthorized	$50 copay	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3] ($350/admit limit)
Emergency Room *(covers emergency services only)*	$150 copay (copay waived if directly admitted)	$100 copay (copay waived if directly admitted)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3] (deductible waived if directly admitted)
OTHER SERVICES				
Ambulance *(when medically necessary)*	$150 copay (air and ground)	$100 copay (air and ground)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage; 40% w/o referral [3] (air and ground)
Urgent Care	$50 copay (no PCP or Plan referral required)	$15/visit (copay waived if directly admitted)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Rehabilitation Therapy *(includes physical, speech, occupational, and respiratory therapy)*	$10 copay/visit at VCMC/SPH; $20 copay/visit at other contracted facilities	$15/visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Chiropractic/Acupuncture	Plan reimburses $20/visit to any chiropractor/acupuncturist (limited to 15 combined chiropractor/ acupuncturist visits per Plan Year) [7]	$15/visit (chiropractic services limited to 30 visits per year; acupuncture limited to 20 visits per year)	80% of Negotiated Allowance [2] (20% coinsurance) *Limits: Chiropractic Services – 30 visits/year Acupuncture – 20 visits/year*	60% of Negotiated Allowance [3] (40% coinsurance) *Limits: Chiropractic Services – 30 visits/year Acupuncture – 20 visits/year*
Imaging (MRI, CT, PET)	No copay at VCMC/SPH; $125 copay at other contracted facilities	$100/test	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Diagnostic/screening X-Ray, Ultrasound *(Outpatient)*	No copay at VCMC/SPH; $20 copay at other contracted facilities	100% coverage (no copay)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]

Footnote descriptions are on page 2-11

	Ventura County Health Care Plan (HMO)	**Anthem EPO** (Prudent Buyer PPO Network)	**Anthem High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	**Non-Participating Provider**
Hospice	**Inpatient:** 100% coverage **Outpatient:** 100% coverage; prognosis of life expectancy of six months or less	100% coverage (no copay)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Home Health Services	$20 copay/visit; 100 visits/calendar year (max does not apply to Behavioral Health treatment)	$15/visit (limited to 100 visits per calendar year)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Durable Medical Equipment	10% copay; 50% copay for replacement, when medically necessary	20% copay (rental or purchase; breast pump and supplies are covered under preventative care at no charge)	50% of Negotiated Allowance [2]	50% coverage [3]
Annual Eye Refraction Exam	Plan reimburses cost of refraction exam, up to $50 per person per calendar year [7] (no PCP referral needed)	Not Covered	Not Covered	Not Covered
BEHAVIORAL HEALTH				
Mental Health & Substance Abuse Services	Self-referral to any "Life Strategies" provider; PCP referral not required			
Inpatient [1, 6, 8]	**Through VCHCP's "Life Strategies" Program only** 100% coverage (no copay)	$100/admit (subject to utilization review)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Residential/Alternative Treatment [1, 6, 8]	**Through VCHCP's "Life Strategies" Program only** 100% coverage (no copay)	100% coverage (no copay)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Outpatient [1, 8]	**Through VCHCP's "Life Strategies" Program only** $10/visit	$15/visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]

Footnote descriptions are on page 2-11

	Ventura County Health Care Plan (HMO)	**Anthem EPO** (Prudent Buyer PPO Network)	**Anthem High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	**Non-Participating Provider**
PRESCRIPTION BENEFITS				
Outpatient Prescriptions	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.
Plan's Local Pharmacy Network *(Retail Pharmacy)*	100% for up to a 30-day supply after copay of: Tier 1 - $9 Tier 2 - $30 Tier 3 - $45 Tier 4* - 10% up to $250/script/month * Specialty Drugs 50% for covered infertility drugs	100% for 30-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $25 Approved Non-Formulary - $45 Specialty Drugs - 20% coinsurance, up to $150 per fill	**Contracting Pharmacies:** 100% for 30-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $30 Approved Non-Formulary - $50 Specialty Drugs - 30% coinsurance, up to $150 per fill	**Non-Contracting Pharmacies:** All Tiers - 40% coinsurance, plus costs in excess of maximum allowed amount (compound drugs & specialty pharmacy drugs are not covered; classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program)
Plan's Mail-Service	100% for up to a 90-day supply after copay of: Tier 1- $18 Tier 2- $60 Tier 3- $90 50% for covered infertility drugs	100% for 90-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $50 Approved Non-Formulary - $90 Specialty Drugs – 20% coinsurance, up to $300 per fill	100% for 90-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $60 Approved Non-Formulary - $100 Specialty Drugs – 30% coinsurance, up to $300 per fill	Not covered

Footnote descriptions are on page 2-11

In the event of a discrepancy between what is stated in this comparison chart and what is stated in the Plan's Evidence of Coverage (EOC), the information stated in the EOC shall be the deciding authority.

ELIGIBLE DEPENDENTS

Periodic documentation of eligibility may be required by your plan. No person can be covered as an employee and as a dependent, or as a dependent of more than one employee.

* Your current legal husband or wife.

* Your domestic partner, **if** you provide documentation that you and your partner have registered a Declaration of Domestic Partnership with the Secretary of State or a California county or municipality.

* Any natural child, stepchild, adopted children, children of domestic partners, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted up to age 26. Unless stated otherwise for that plan, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews and non-relatives. Certain unmarried dependent children age 26 and over if handicapped, incapable of self-support, continuously covered by a County-sponsored plan since prior to age 26, and whose disability was certified by the health plan and began before age 26.

A domestic partner is subject to the same terms and conditions as any other dependent, except for continuation of coverage (COBRA). Domestic partners and their dependents are not eligible for COBRA.

These plan descriptions are general in nature and cannot modify or affect the Plan in any way.

Consult the Plan's Evidence of Coverage booklet for governing provisions.

Medical Plan Options Footnotes

1 If a member requests a brand name drug when a generic drug exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of Anthem's average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of this program.

2 These PPO Benefits are payable only after satisfaction of the annual deductible. Provider payments are based on negotiated fees.

3 These Out-of-Network Benefits are payable only after satisfaction of the annual deductible. Provider payments are based on **110% of the Medicare published rates**. Member pays the applicable co-insurance and is also responsible for amounts charged by the provider in excess of this co-insurance.

4 Coverage for diagnosis and treatment of infertility does not include laboratory medical procedures involving the actual in vitro fertilization process.

5 There is no per member deductible accumulation/accrual. It is a single comprehensive family deductible. If a member changes plan status from family to individual, any family deductible amount will be applied to the new individual deductible. In addition, if a member changes plan status from individual to family, any individual deductible amount will be applied to the new family deductible. No one in the family is eligible for benefits until the family coverage deductible is met.

6 Prior authorization may be required, except under emergency conditions. Prior authorization arrangements will be made by your plan provider or plan-authorized specialist. If prior authorization is not obtained for scheduled hospital admissions and surgeries, services will not be covered.

7 VCHCP: Chiropractic, Acupuncture, and Eye Refraction claims must be submitted within 180 days from the date of service.

8 Serious Emotional Disturbances (SED) of children and Severe Mental Illnesses (SMI) diagnoses, as defined in California Assembly Bill 88, are covered at regular medical plan benefit levels subject to deductibles and copayments.

9 There is no copayment to the member for services if the service is available and obtained at VCMC/SPH. If the service is not available at VCMC/SPH, for whatever reason, the member will need to obtain the service at another contracted facility and a copay will apply.

This is a summary only. The Plan's Employer Group Agreement and/or Evidence of Coverage booklet should be consulted to determine the exact nature of governing contractual provisions. The plan descriptions in this Handbook are general in nature and cannot modify or affect the Plan in any way.

Chapter 3
Dental Plan Option

In considering whether you and your family should participate in a dental plan, you should keep in mind that:

- Regular dental checkups have been proven to reduce the need for later extensive dental procedures. Not going to the dentist regularly could result not only in more cost, but also in more pain and discomfort in the future.

- Studies have also shown that there is a link between your oral health and your overall general health. Specifically, good oral health has been associated with decreased risk of coronary heart disease and lower incidence of premature delivery of low birth weight babies.

With this in mind, you may want to consider the dental plan offered through the County. If you decide not to participate in the dental plan, you may wish to consider a Health Care Flexible Spending Account to fund any expected dental expenses.

▪ What Plan is Available?

❖ MetLife Dental PPO

The MetLife Dental PPO Plan (PDP Plus) is a comprehensive dental plan. Each time care is needed, you decide where to receive treatment and who will provide it. You can go to any dentist you wish, change dentists at any time without pre-approval, and you do not need pre-approval to see a specialist.

Please note: If you choose a licensed dentist who does not participate in the PPO Dental network, your out-of-pocket expenses will be greater. You will be responsible for your annual deductible and for your portion of the Covered Expenses plus charges in excess of Covered Expenses. Covered Expense is either the customary and reasonable charge or the Maximum Allowable Fee Schedule for professional services, depending on your plan. Please see your Certificate of Insurance (Certificate) for details. You may also be asked to pay your portion of the bill at the time of service and submit claim forms for reimbursement.

Eligibility and benefit information are available on-line, including the ability to print an ID card: www.metlife.com/mybenefits. You may also call their customer service department at (800) 438-6388.

Providers

Any Dentist – With the MetLife Dental PPO plan, you do not need to sign up for a specific dentist. The services listed in the dental plan benefit chart are covered by MetLife when they are provided by a licensed dentist, if the services meet generally accepted dental practice standards for necessary and customary services.

MetLife Dentist – When you use one of the MetLife dentists in California, the dentist's fees have been pre-approved. The MetLife dentist bills MetLife directly, so you have no claim forms to complete, and are responsible only for your portion of the bill. For a MetLife dentist provider directory, you can call MetLife

at (800) 438-6388, or find a dentist online at: www.metlife.com/mybenefits. When asked to select Network Type, select the "*PDP Plus*" option.

Covered Fees

After an annual deductible, the MetLife Dental PPO plan pays a percentage of the negotiated fee, up to the plan maximum benefit per person per year. If you select a non-contracting dentist, payment is made based on the fee actually charged or the customary and reasonable fee, which satisfies the majority of participating dentists, whichever is less. If the dentist charges a higher amount than the customary and reasonable amount, MetLife payment may cover a lower percentage of the dentist's actual fees. This may mean additional out-of-pocket expense for you. In addition, you are responsible for paying the entire bill, and MetLife will reimburse you directly.

Predetermination of Costs

MetLife strongly recommends, whenever you are considering extensive or complex dental services in excess of $350.00, that you have your dentist submit a predetermination in advance so that the costs and coverage are predetermined and explained to you before you begin the proposed treatment.

Coordination of Benefits (Dual Coverage)

If you or your dependent(s) are entitled to dental benefits under more than one group plan, MetLife will coordinate its payment in accordance with the rules specified in the County's Group Dental Agreement with MetLife so that the total payments made by all plans will not be greater than the actual cost of covered services.

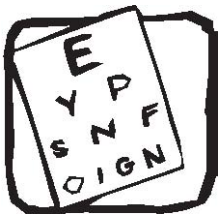
Limitations and Exclusions

MetLife Dental PPO Plan Limitations and Exclusions are listed in the Summary of Benefits/Evidence of Coverage Booklet.

	MetLife Dental PPO Group Number 0154209	
	In DPO Network	**Out of DPO Network**
CALENDAR YEAR DEDUCTIBLE Per Member/Per Family	$15/$45	$25/$75
MAXIMUM BENEFIT Each Calendar year (excluding MPD-TMJ and Orthodontics)	$2,000 per person	$1,000 per person
SEPARATE LIFETIME MAXIMUM: Orthodontic Benefits	$1,000 per person	
Benefits Coverage	**In DPO Network**	**Out of DPO Network**
DIAGNOSTIC/PREVENTIVE SERVICES		
Oral exam, x-rays	Plan pays 100% Deductible does not apply	Plan pays 100% Deductible does not apply
Biopsy/Tissue Exam, Study Models		
Prophylaxis (cleaning)		
Topical fluoride treatment (up to age 14)		
Emergency Palliative Treatment		
Space maintainers		
BASIC BENEFITS		
Oral Surgery: Simple Extraction; Local Anesthesia; Frenulectomy; Pre/Post-Operative visits	Plan pays 80% (after you have met your deductible)	Plan pays 70% (after you have met your deductible)
Impactions		
Restorative (treatment of carious lesions resulting from dental decay)		
Fillings (amalgam and resin/composite)		
Endodontic – Tooth Pulp:		
Pulp capping; Pulpotomy		
Recalcification/Apexification		
Root Canal (per canal)		
Apicoectomy Anterior & Bicuspid, first root Molar, first root Each additional root		
Retrograde filling, per root		
Periodontic (treatment of gums, bones, and supporting teeth)		
ORTHODONTIC BENEFITS – ADULT OR CHILD **(Malalignment of teeth or jaws)**		
Full or partial banded case	Plan pays 50%; up to $1,000 lifetime maximum	Plan pays 40%; up to $1,000 lifetime maximum

Benefits Coverage	MetLife Dental PPO Group Number 0154209 In or Out of DPO Network	
CROWNS, JACKETS, AND CAST RESTORATIONS Treatment of carious lesions (resulting from dental decay) which cannot be filled		
Crowns/bridges, per unit	Plan pays 50% (See MetLife Dental PPO Plan Exclusions and Limitations)	Plan pays 40% (See MetLife Dental PPO Plan Exclusions and Limitations)
Porcelain		
Porcelain with metal		
Full cast metal		
Stainless steel (temporary)		
Cast post and core in addition to crown; prefabricated post and core in addition to crown		
Pin retention in addition to restoration, per tooth		
Recementation: Inlay, Crown, Bridge		
PROSTHETIC (DENTURE) BENEFITS		
Complete or partial upper or lower denture	Plan pays 50%	Plan pays 40%
Interim partial denture, upper or lower		
Teeth and clasps (per tooth/unit)		
Simple stress breaker (each)		
Stayplate		
Adjust denture or partial; reline in office		
Adjust denture or partial; reline in lab		
Repairs to denture/partial (no teeth)		
Add teeth or clasps to partial (per unit/tooth)		
Replace/add denture clasp		
Extra denture		
LIMITATIONS AND EXCLUSIONS (listed in the plan's Summary of Benefits/Evidence of Coverage booklet)	Excludes most procedures started prior to joining the plan	

This is a summary only. The Plan's Evidence of Coverage booklet should be consulted to determine the exact nature of governing contractual provisions. The plan descriptions in this Handbook are general in nature and cannot modify or affect the Plan in any way.



Chapter 4
Vision Coverage Options

Annual eye exams can do more than just test your vision. They can save your life! Even before obvious symptoms would cause you to seek care from your primary care physician, annual eye exams may provide early detection for potentially serious conditions such as glaucoma, diabetes and hypertension.

▪ What Options are Available?

There are several vision options available to you and your family members through the County. You decide which, if any, are appropriate for you and your dependents.

❖ **Medical Eye Services (MES) – Vision Plan**

MES offers the largest and most comprehensive network in California and nationally through its provider network, The Eye Care Network (ECN). In California alone, there are over 7,000 participating providers, with 29,000 providers nationally to choose from.

MES members have full access to the entire ECN network, with their choice of Ophthalmologists (MDs), Optometrists (ODs), or Opticians. The ECN network also includes many retail outlets, which offer the flexibility of later weekday and weekend hours, often without an appointment.

Members have the freedom to choose from a variety of eye care providers, and also have the choice to receive an exam from one provider and eye wear from another provider. Many feel they can extend their benefit dollar by going to an optical store for materials after they visit an MD or OD for their exam.

▪ How to Use the Plan

Covered employees follow these steps to receive their vision benefits:

1. The employee can make an appointment with the eye care specialist of his/her choice. Members will have less out of pocket if they utilize an MES Participating Provider and the provider will file the claim on behalf of the member so the member does not need to take a claim form with them to their appointment. To find a Participating Provider, please go to the MES website at www.mesvision.com, or contact MES directly at (800) 877-6372 or (714) 619-4660.

2. At the time of the vision appointment, please make sure you notify the provider you are an MES member. The Participating Provider will contact MES for benefit determination and eligibility verification and then submit the Claim Form for payment for Covered Services.

3. If Covered Services are received from a Non-Participating Provider, the eligible employee is responsible for paying the provider in full at the time services are rendered. The eligible employee or the provider must submit an itemized billing and a copy of his/her prescription with the Claim Form to MES. Please go to www.mesvision.com and download a claim form for reimbursement

should you chose to go to an out of network provider. Reimbursement will be made to the eligible employee, up to the Schedule of Allowances shown for Non-Participating Providers.

Contact lenses can be provided in lieu of spectacles (lenses and frame).

There is a $20 copayment required for an exam and a $20 copayment for materials, due at the time of service.

Members are responsible for the difference between the allowable amount and the charges for more expensive frame styles or lens upgrades above lens allowance. This applies regardless of whether the frame or lens is dispensed by a participating or non-participating provider.

Medical Eye Services (MES) Summary of Benefits

Vision Service	Participating Provider Benefit *Amount Covered by the Plan*	Non-Participating Provider Benefit Amount *Reimbursed by the Plan*	Benefit Frequency (months)
Vision Examination	Covered in Full after $20 copay	$40 after $20 copay	12
Standard Lenses (less than 61mm)	Covered in Full	$30 Single $50 Bifocal $65 Trifocal $125 Lenticular	12
Frame	Up to $100 Retail	Up to $40 Retail	24
Contact Lenses – Non-Elective/ Medically Necessary[1]	Covered in Full with Authorization	Up to $250	12
Contact Lenses – Elective/Cosmetic[1]	Up to $105	$100	12

Note: The $20 copayment for exam and $20 copayment for materials are required at the time of service.

1 The contact lens allowance is in lieu of other eyewear. The allowance includes the contact lens evaluation, fitting costs, and materials. Any different between the allowance and the provider's charge is the patient's responsibility.

Medical Eye Services Limitations & Exclusions

MEDICAL EYE SERVICES – LIMITATIONS

- Contact lenses, except as specifically provided;
- Contact lens fitting, except as specifically provided;
- Eyewear when there is no prescription change, except when benefits are otherwise available;
- Lenses or frames which are lost, stolen or broken will not be replaced, except when benefits are otherwise available;
- Lenses such as no-line (blended type), progressive, beveled, faceted, coated or oversize exceeding the allowance for covered lenses;
- Tints, other than pink or rose #1 or #2, except as specifically provided;
- Two pair of glasses in lieu of bifocals, unless prescribed.

MEDICAL EYE SERVICES – EXCLUSIONS

- Any eye examinations required by an employer as a condition of employment;
- Any covered services provided by another vision plan;
- Conditions covered by Workers' Compensation;
- Contact lens insurance or care kits;
- Covered services which began prior to the insured's effective date, or after the benefit has terminated;
- Covered services for which the insured is not legally obligated to pay;
- Covered services required by any government agency or program, federal, state or subdivision thereof;
- Covered services performed by a close relative or by an individual who ordinarily resides in the insured's home;
- Medical or surgical treatment of the eyes;
- Non-prescription (plano) eyewear;
- Orthoptics, subnormal vision aids or vision training;
- Services that are experimental or investigational in nature;
- Services for treatment directly related to any totally disabling condition, illness or injury.

Coverage Through Your Medical Plan

Ventura County Health Care Plan (VCHCP)

VCHCP will reimburse you for the cost of your annual eye refraction exam, up to $50 for you and each covered dependent. You can go to any eye doctor you choose. To file a claim for reimbursement, you may obtain a claim form from VCHCP's website (http://www.vchealthcareplan.org). *Claims must be presented to VCHCP within 180 days from the date of the exam.*

VCHCP does not cover materials such as frames and lenses.

Vision-Related Discounts

County employees, retirees and their dependents can get special discounts on frames and lenses through a variety of local Ventura County providers. Some of these providers also offer you discounts on vision exams, contact lenses, refractive eye surgery and other services.

Health Care Flexible Spending Account

Flexible Benefits Program participants can set aside Flex Credits, and/or part of their salary, in a nontaxable account to fund health care expenses that are not covered by a plan.

For single people, small families, and those who do not anticipate large vision expenses, a Flexible Spending Account can be a practical alternative to a full vision plan. For more information, review the chapter in this handbook on Flexible Spending Account options.

Chapter 5
Flexible Spending Account Options

As part of the Flexible Benefits Program, the County offers both a Dependent Care Flexible Spending Account, which pays for your expenses for caring for certain tax dependents while you work, and a Health Care Flexible Spending Account, which pays for health care expenses for you and your tax dependents.

These accounts enable you to set aside money in special nontaxable accounts from which your funds are released for *eligible* health care or dependent care expenses. These are voluntary accounts; you decide if you want one or both accounts and you specify the annual pledge to be set aside. There are minimum and maximum amounts for each account. You can use part of your Flexible Credit Allowance to fund your account, and if you want to set aside additional money, you can convert part of your pay to additional pre-tax contributions. The amounts deposited into your accounts do not accrue interest. Once you enroll, *you cannot cancel* your account or change the amount of your biweekly contribution during the Plan Year except under very limited circumstances as described in Chapter 1, Flexible Benefits Program Information under *"Can I Change My Mind?"*

"Can I Change My Mind?" also describes your Flexible Spending Account options if you terminate employment and return during the same Plan Year.

What Does Non-Taxable Mean?

The amount you deposit into a Flexible Spending Account is not included as part of your taxable wages; therefore, no income taxes are withheld and you are taxed only for that part of your salary remaining after your contributions are made. In other words, your taxable income is reduced by the amount contributed to the account. Withholdings for Federal and State income taxes are reduced and wages reported to Social Security are also reduced. **Talk to your tax advisor to clarify the impact these benefits would have on your personal tax return.**

IMPORTANT!

Before enrolling in a Flexible Spending Account, be sure you have read this chapter and have estimated the amount of expenses you will have in the Plan Year.

- Your elections will terminate at the end of the Plan Year. You must make a new election during the annual Open Enrollment period (November 1 – 30) to enroll in a Flexible Spending Account in the new Plan Year.

- There are 24 contribution periods during each Plan Year. Account contributions are only taken on your 1st and 2nd paychecks in a month, so you will not have a deduction on any 3rd paycheck in a month (*Your chosen Annual Pledge divided by 24 = your semi-monthly contribution amount*). If you are enrolling mid-year, divide your annual contribution amount by the number of contribution periods remaining in the year. Your contributions will appear on your paychecks under "Before-Tax Deductions".

- As required by the IRS, you forfeit to the County all funds remaining in your Flexible Spending Account after all claims for expenses incurred during the Plan Year have been processed. Therefore, set aside only as much as you expect to incur during the Plan Year. Claims must be received by County

Benefits by April 15 of the following year (or the next business day if April 15 falls on a weekend or County holiday). For example, all claims for Plan Year 2018, must be submitted by April 15, 2019.

- Be sure to make allowances for coverage and reimbursements provided by all medical, dental, and vision plans.

- Be sure to make allowances for vacations, sick days, leaves of absence, or other times dependent care services will not be eligible for reimbursement.

- You can only file claims for expenses incurred (services received) in the same Plan Year that you made your contributions and only for periods for which contributions were made. For Dependent Care FSA participants, please keep in mind that expenses cannot be reimbursed to you during periods where you and/or your spouse are not working (i.e. leave of absence, vacation), regardless of whether you made a contribution for that period.

Flexible Spending Accounts

Payroll Calendar	PP #	Pay Period	Pay Day	FSA Plan Year 2018 (01/01/18-12/31/18)	Coverage Period
	18-01	12/17/17-12/30/17	01/05/18		01/01/18-01/15/18
	18-02	12/31/17-01/13/18	01/19/18		01/16/18-01/31/18
	18-03	01/14/18-01/27/18	02/02/18		02/01/18-02/15/18
	18-04	01/28/18-02/10/18	02/16/18		02/16/18-02/28/18
	18-05	02/11/18-02/24/18	03/02/18		03/01/18-03/15/18
	18-06	02/25/18-03/10/18	03/16/18		03/16/18-03/31/18
	18-07	03/11/18-03/24/18	03/30/18		NO DEDUCTION
	18-08	03/25/18-04/07/18	04/13/18		04/01/18-04/15/18
	18-09	04/08/18-04/21/18	04/27/18		04/16/18-04/30/18
	18-10	04/22/18-05/05/18	05/11/18		05/01/18-05/15/18
	18-11	05/06/18-05/19/18	05/25/18		05/16/18-05/31/18
	18-12	05/20/18-06/02/18	06/08/18		06/01/18-06/15/18
	18-13	06/03/18-06/16/18	06/22/18		06/16/18-06/30/18
	18-14	06/17/18-06/30/18	07/06/18		07/01/18-07/15/18
	18-15	07/01/18-07/14/18	07/20/18		07/16/18-07/31/18
	18-16	07/15/18-07/28/18	08/03/18		08/01/18-08/15/18
	18-17	07/29/18-08/11/18	08/17/18		08/16/18-08/31/18
	18-18	08/12/18-08/25/18	08/31/18		NO DEDUCTION
	18-19	08/26/18-09/08/18	09/14/18		09/01/18-09/15/18
	18-20	09/09/18-09/22/18	09/28/18		09/16/18-09/30/18
	18-21	09/23/18-10/06/18	10/12/18		10/01/18-10/15/18
	18-22	10/07/18-10/20/18	10/26/18		10/16/18-10/31/18
	18-23	10/21/18-11/03/18	11/09/18		11/01/18-11/15/18
	18-24	11/04/18-11/17/18	11/23/18		11/16/18-11/30/18
	18-25	11/18/18-12/01/18	12/07/18		12/01/18-12/15/18
	18-26	12/02/18-12/15/18	12/21/18		12/16/18-12/31/18

The contribution deducted from the:

- First paycheck of the month covers qualified expenses for dates of service incurred on the 1st-15th of the month.
- Second paycheck of the month covers qualified expenses for dates of service incurred on the 16th-last day of the month.

You can keep track of your Flexible Spending Account activity and balance by reviewing your account information through Self Service in VCHRP, using the following navigation path:

Self Service > Benefits > Benefits Information > Flexible Spending Accounts

- If your Health Care Account has a negative balance when you terminate or retire, you will not be eligible to elect COBRA benefits for this account.

- **The Dependent Care and Health Care Flexible Spending Accounts are separate.** ***Under no circumstance can dollars be transferred between your Dependent Care and your Health Care Flexible Spending Accounts.***

- The Flexible Spending Account Plan Year is the calendar and tax year (January 1 through December 31). For Health Care Flexible Spending Accounts only, the County offers an IRS-approved 2½-month grace period that begins on January 1 and ends on March 15, during which you may incur additional expenses to claim against your remaining Flexible Spending Account balance after the close of the Plan Year. However, this grace period is only available to employees who make a contribution into their account in the final contribution period of the Plan Year (for 2018, this will be pay period 18-26).

Preparing Your Claim

Claim forms, lists of common eligible expenses (for both Health Care and Dependent Care Accounts), and the Letter of Medical Necessity form can be found on our intranet and internet sites:

Intranet - http://myvcweb/index.php/hr/benefits/flexible-benefits-program - under "*Flexible Spending Accounts*"
Internet - http://www.ventura.org/benefits/flexible-spending-accounts

To contain administrative costs, participants are encouraged to *hold claims until the total is at least $50*. Please summarize expenses and submit only *one claim form per pay period*.

When preparing your claim, be sure to keep photocopies of all supporting documentation. *The copies you send with your claim will not be returned.*

Filing Your Claim

Submit completed claim forms with all supporting documentation to County HR/Benefits using ***one*** of the following options (please do not send duplicate copies):

- Scan as a PDF and e-mail the PDF to FSA.Account@ventura.org
- Fax to (805) 654-2665
- Brown Mail to #1970 FSA
- Drop off at HR Reception or mail to 800 S Victoria Ave, #1970, Ventura, CA 93009-1970

Information about claims you submit:

- ✓ Claims will be processed in the order that they are received.
- ✓ Claims are generally processed within 2 weeks of claim receipt.
- ✓ **Heavy claim volume around, Open Enrollment, the end of the year, and the April 15 claim deadline may delay payment of your claim. Please file your claim early, if possible.**
- ✓ Claims that are incomplete or submitted without proper documentation may be returned unprocessed with an explanation.
- ✓ Checks are mailed directly to you by the Auditor-Controller's office to the address listed as "mail" in VCHRP; if no "mail" address is listed, the check will be mailed to your "home" address.
- ✓ You may contact the Flexible Spending Account administrator by emailing fsa.account@ventura.org or calling (805) 677-8785.

▪ Dependent Care Flexible Spending Account

You can use this account to pay for the care of an eligible dependent while you work. If you are married, your spouse must be at least one of the following:

- gainfully employed
- seeking gainful employment
- enrolled as a full-time student
- disabled

You can set up your account for any amount from $240 per year ($10 semi-monthly) *up to the annual maximum*. The maximums are restricted to:

- Married couples filing a joint return, OR a single individual: $5,000 per year ($208.33 semi-monthly)
- Married couples filing separate returns $2,599.92 per year ($108.33 semi-monthly)

All unused account balances will be forfeited after the end of the Plan Year, so estimate your needs carefully.

You can claim any employment-related dependent care expenses that meet the requirements adopted by IRS Code Section 129 and the County. Visit our Flexible Spending Account websites for the Common Dependent Care FSA Expenses List.

Please keep in mind that expenses cannot be reimbursed to you during periods where you and/or your spouse are not working (i.e. leave of absence, vacation), regardless of whether or not you made a contribution for that period.

Eligible Dependents

Eligible dependents include:

1. A dependent under the age of 13 for whom the participant is entitled to a deduction under Internal Revenue Service (IRS) Code Section 21, subsections (b)(1)(A) and (e)(5)(B); or

2. A spouse or dependent over age 13 who is physically or mentally unable to care for himself or herself; or

3. In the case of expenditures outside the home to enable the member or spouse to work:
   a. A child described in number 1 above, or
   b. A person described in number 2 above who spends at least eight hours each day in the member's household.

For purposes of these accounts, a "dependent" includes any person for whom you provide over half of his or her financial support, AND you claim as a dependent on your federal tax return. It does not have to be a relative. **Special Rule for Children of Separated or Divorced Parents:** Only the custodial parent may claim the credit, regardless of whether the non-custodial parent may claim the dependency exemption.

Eligible Expenses

Eligible expenses are the same expenses that qualify for a credit on your federal tax return. The County uses Internal Revenue Service (IRS) Publication 503 as a guide for determining eligible dependent care expenses under its cafeteria plan.

Example: Care of an eligible dependent(s), including services provided outside your household (such as before- and after-school care and summer day camp). Services may be provided by an individual or by a dependent care center.

If services are provided by a dependent care center, expenses are eligible only if the center complies with all applicable laws and regulations of a state or unit of local government; and the expenses are incurred for an eligible dependent as defined above.

A "dependent care center" is defined by IRS Code Section 21(b)(2)(D) as any facility which (a) provides care for more than six individuals (other than individuals who reside there); and (b) receives a fee, payment or grant for providing services for any of the individuals' care (regardless of whether the facility is operated for profit).

Eligible Expenses do **NOT** include:

1. Any expenses incurred for payments to any individual who is a dependent of you or your spouse as described in Code Section 151(e), or who is your son, stepson, daughter, or stepdaughter under the age of 19 at the end of the calendar year in which the expense is paid or incurred; or

2. Tuition expenses at any age, if tuition can be separated from after-school care; once a dependent enters kindergarten, tuition expenses *must* be separated from childcare and after-school care.

3. Overnight camp expenses and any camp expenses arising from services or activities other than normal day care services.

4. Food expenses (unless inseparable from care expenses).

5. Incidental expenses (such as extra charges for supplies, special events, or activities, unless these expenses are inseparable from care expenses).

6. Dependent Care while you and/or your spouse are on leave of absence.

IRS Tax Credit: The use of the Dependent Care Flexible Spending Account may eliminate the availability of an income tax credit for dependent care. The maximum amount you may claim for a tax credit for dependent care on your tax return must be reduced by the amount paid under the Dependent Care Flexible Spending Account.

For example, for more than one dependent, you would be eligible to claim a tax credit on expenses up to $4,800. If you utilize the full Dependent Care Flexible Spending Account deduction of $5,000, that must be subtracted from the $4,800 leaving you with no other available tax credit. Consequently, if your dependent care expenses exceed $5,000, you would not get a tax credit for the balance of your expenses.

Preparing and Filing Your Claim

You must submit a completed, signed and dated claim form along with proof (provider's Taxpayer I.D. number or Social Security Number, an itemized statement of services, the name of the person receiving care and their date of birth, amount(s) billed and amounts(s) paid by you). Acceptable proof of payment includes:

- a copy of the front and back of your canceled check
- a receipt from the provider, or
- your provider's signature on the space provided on the claim form

✓ Dependent Care Flexible Spending Account, claims will be processed and funds will be released up to your current account balance.

Prior to enrolling you should consult your tax advisor to determine whether it is more advantageous for you to utilize the Dependent Care Flexible Spending Account or the tax credit.

Prior to enrolling in a Dependent Care Flexible Spending Account, you may wish to complete the following worksheet to estimate your tax savings. Then, compare your Flexible Spending Account tax savings with the amount you would save by taking a federal tax credit instead.

PART 1 - Determine your estimated annual earned income and your federal tax bracket

Use last year's federal tax return as your guide.

Your Annual Income

Between $ _____

And $ _____

Your Filing Status

- ❑ Married and filing jointly or a qualifying widower
- ❑ Married and filing separately
- ❑ Single head of household

Your Tax Bracket

_____ %

PART 2 - Estimating Your Eligible Dependent Care Expenses

A. Estimate what you plan to spend on eligible dependent care for this Plan Year [1, 2]: $ _____

B. If you are married and filing a joint return, enter your estimated earned income OR your spouse's estimated earned income for the Plan Year [1, 2], whichever is *less:* $ _____

C. If you are married and filing separately, enter your estimated earned income for the Plan Year [1, 2] or $2,500, whichever is *less:* $ _____

D. If you are a single head of household, enter your estimated earned income for the Plan Year [1, 2] or $4,800, whichever is *less:* $ _____

E. Enter the smaller of the amounts in A, B, C, or D: $ _____ (annual pledge)

F. Divide the amount in E by 24 contribution periods for the full year. The amount you put into the account must be between $10 and $208.33 per semi-monthly contribution period (if you are enrolling mid-year, divide by the number of contribution periods remaining in the year). $_____

If you are enrolling in a Dependent Care Flexible Spending Account, this is the amount you would enter as your semi-monthly contribution.

PART 3 - Estimating Your Dependent Care Spending Account Tax Savings

A. Enter the estimated amount you will spend on dependent care from Line E above: $ _____ (X)

B. Enter your estimated federal income tax bracket from the table above: _____ % (Y)

C. Multiply (X) times (Y).

This is your estimated tax savings from a Dependent Care Flexible Spending Account: $ _____

[1] If you are a new employee beginning an account mid-year, project only those expenses for the remainder of this Plan Year [2] in step A. In step F, divide the total of step E by the number of months remaining in the current year, then multiply by 2.

[2] The Flexible Spending Plan Year is the same as the calendar year. There are 24 contribution periods in each Plan Year.

Contribution Periods for Plan Year 2018:

24 contribution periods, which include County pay periods 18/01 through 18/26 (excluding pay dates 3/30/18 and 8/31/18)

IMPORTANT

Dependent Care FSA annual contribution maximum per IRS is the lesser of:

- **$5,000 for single individuals or married couples filing joint returns;**
- **$2,500 for married couples filing separate returns**

▪ Health Care Flexible Spending Account

The main advantage of the Health Care Flexible Spending Account is that expenses reimbursed through this account are paid with nontaxable income. Employees enrolled in an HSA-compatible High Deductible Health Plan are not eligible to enroll in a County-sponsored Health Care Flexible Spending Account.

You can file claims for health care expenses incurred (services received) in the same plan year that you made contributions, plus a grace period of two and a half months following the end of the plan year, if you made contributions through the final pay period of the Plan Year. This means if you make a contribution in the final pay period of the Plan Year, you will have a grace period to incur expenses through March 15th.

Claims for health care expenses incurred during the grace period shall be applied to any flexible credits or funds remaining in your account from the prior year Period of Coverage. If no flexible credits or funds remain in your account from the prior Period of Coverage, the claims for health care expenses incurred during the grace period shall apply to the current Period of Coverage.

The minimum amount that can be set aside in your Health Care Flexible Spending Account is $240 per year ($10 semi-monthly), and the maximum is $2,599.92 per year ($108.33 semi-monthly). *All unclaimed account balances are forfeited after the end of the Plan Year, so estimate your needs carefully.*

Eligible Dependents

Any member of your household, as long as you provide over half of his or her financial support AND you claim him or her on your federal tax return. It does not have to be a relative.

Eligible Expenses

You may claim any eligible health care expenses incurred during the Plan Year, as long as the expenses are not reimbursed through another source and are not reimbursable by any medical, dental, or vision plans that cover the eligible person. ***Please keep in mind that medical expenses are incurred when the employee (or the employee's dependent) is provided with the medical care that gives rise to the medical expense, and not when the employee is formally billed, charged for, or pays for the medical care.***

The term "health care" as used in this section means amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease, or the purpose of affecting any structure or function of the body" and amounts paid for transportation essential to such care. Health care must be provided by a licensed medical practitioner.

Examples of Eligible Expenses:

- Acupuncture or Chiropractic care
- Dental care, including orthodontia and dentures *(please note that a copy of the orthodontia contract must be submitted once per Plan Year)*
- Health insurance deductibles and copayments
- Hearing exam, hearing aids and batteries, and special equipment for the deaf
- Infertility treatments
- Learning disability counseling
- Medical equipment (rental or purchase) such as wheelchairs and crutches

- Mileage to health care providers or to fill a prescription (please note that mileage must be well-documented on an itemized log)
- Orthopedic shoes
- Prescribed drug that requires a prescription by a doctor for its use
- Smoking cessation programs
- Vision care, including prescription eyeglasses, prescription contact lenses, contact lens solutions, refractive eye surgery

Examples of Ineligible Expenses:

- Cotton balls, band aids, toothpaste, mouthwash
- Diaper service
- Funeral expenses
- Health club dues
- Insurance or Medicare premiums
- Marriage or family counseling
- Massage therapy, unless it is performed under the State license of a chiropractor
- Maternity clothes
- Non-prescription dietary supplements, vitamins, and weight-loss medications
- Non-prescription reading glasses
- Over-the-Counter drugs and medicines purchased without a prescription
- Services or products that are considered cosmetic (cosmetic surgery, hair transplants, teeth bleaching)

Certain expenses are prohibited by IRS Code section 105(b), which governs Health Care Flexible Spending Accounts. Be sure to review the examples of ineligible expenses above for expenses that are ineligible under Section 105(b). When in doubt, ask the account coordinator.

Preparing and Filing Your Claim

You must submit proof that expenses for eligible services or supplies have been incurred. ***If you have medical, dental, or vision insurance coverage, the required proof is the Explanation of Benefits (EOB) or Notice of Action (NOA) form issued by your insurer either following services or upon request.*** The EOB or NOA usually provides all the required information necessary for your complete claim filing. If you have dual coverage, the expenses must first be submitted to all plans and the EOB or NOA from each must be provided with the claim form for the expenses that you are submitting for reimbursement.

If you do not have insurance coverage for the expense, you must provide a statement that includes all items listed below as required proof.

- Date(s) of service (must be incurred within the Plan Year)
- Patient name
- Provider name
- Description of services provided
- Itemized expenses
- Amount of unreimbursed/unreimburseable expenses

You may attach to your completed claim a copy of a written statement from an independent third party (doctor, dentist, pharmacist, etc. as appropriate) as an alternative form of documentation for the required items of proof, as long as the written statement contains sufficient proof to verify each item listed above.

If you are claiming an expense for an item normally considered personal rather than medical, such as a wig, you must submit a Letter of Medical Necessity from your doctor or other independent third party (physician, dentist, pharmacist, etc. as appropriate) verifying such expense was medically necessary and a statement from you that you would not have incurred the expense but for the medical necessity. This form can be accessed on our CEO-HR/Benefits Intranet and Internet websites: County of Ventura Health Care Flexible Spending Account Letter of Medical Necessity.

- ✓ Health Care Flexible Spending Account, claims will be processed and funds will be released up to your annual pledge.

Is This Medical Expense Eligible for Reimbursement Under Your HCFSA?

Often, participants have a medical expense that they want to submit for reimbursement, but are not sure if it is eligible. You may refer to our Common Expenses list posted on our intranet site (http://myvcweb/index.php/hr/benefits/home) under "*Flexible Benefits Program*," or on our internet site (http://www.ventura.org/benefits) under *"Flexible Spending Accounts*." We also have formulated the questions listed below that you can ask yourself to help you determine if your expense is in fact eligible for reimbursement under your account.

1. Is the expense primarily for a medical purpose? Is it directly or proximately related to the diagnosis, cure, mitigation, or prevention of disease or illness? This is the primary way of determining if your expense is eligible for reimbursement.
2. *Diagnose* means using any procedure to find out whether someone has a disease or dysfunction. *Cure* means a medical treatment or drug used to restore health. For care to *mitigate*, it must make a medical condition less harsh or severe. *Prevent* requires that the care involve the immediate and proximate prevention of a disease, defect, or illness and that the disease, etc. be imminent. Examples of expenses for the purpose of "affecting any structure of the body" include operations or treatments affecting any portion of the body.
3. Why was the expense incurred? For dual purpose items (personal as well as medical reasons) we need adequate substantiation generally requiring a medical practitioner's diagnosis of a medical condition.
4. You must be sick before you can get well- was there the present existence or imminent probability of a defect or ailment that caused you to incur these medical expenses?
5. Is the type of expense permitted (not excluded) under the plan document?
6. Apply the *"But-For"* Test to these expenses. This test basically asks whether an expense that would normally be thought of as a personal expense would have been incurred in the absence of the medical condition. If the answer is yes, then the expense is not reimbursable.
7. Does the expense have any cosmetic uses? Cosmetic expenses are not reimbursable expenses.
8. Finally, if you can still not ascertain whether an expense is eligible for reimbursement, please contact our Flexible Spending Account Administrator at FSA.Account@ventura.org or (805) 677-8785 and we will be glad to help you.

Chapter 6
Miscellaneous Benefits

The County of Ventura offers its employees a variety of benefits designed to assist you in meeting your work and family obligations. The Flexible Benefits Program is described in Chapters 1 through 5. This chapter gives an overview of various other plans and programs offered through the County.

Programs described in this chapter:

- Employee Health Services
- Employee Assistance Program
- Wellness Program
- Work/Life Program
- Deferred Compensation Program
- Retirement Pension Plans
- Absence Management Program (Leaves of Absence)
- Life & Disability Insurance Programs
- $1,000 Employee Death Benefit
- Employee Emergency Assistance Fund
- Long-Term Care Plan
- Transportation Benefit Reimbursement Program

Forms and information can be found on the Benefits websites:

- http://myvcweb/index.php/hr/benefits/home (intranet)
- http://www.ventura.org/benefits (internet)

▪ Employee Health Services

At Employee Health Services (EHS), medical professionals are available to all regular employees for any health problem, whether work-related or not. Their objective is to identify and treat health problems early and help you avoid lost work time. You can go to EHS for many of the first aid and one-time services your own doctor would provide. Services provided by EHS are included in the premium you pay for a County medical plan or medical plan Opt-Out. There is no per-visit charge when you use the services provided by EHS.

You cannot select the EHS or an EHS provider as your medical plan primary care provider (PCP). If EHS finds that your illness or injury requires laboratory, x-rays, or further treatment, you will be directed to contact your personal physician.

EHS is located in the Lower Plaza, Hall of Administration at the Government Center.

For more information about EHS, please call them at (805) 654-3813 or visit their website:
http://www.ventura.org/government/employee-health-services-ehs

▪ Employee Assistance Program

The Employee Assistance Program (EAP) provides confidential and professional mental health assessment, brief treatment, and/or referral recommendations to employees and eligible family members. The EAP has licensed counselors on staff who are available to work with you for up to 5 visits at no cost. They have extensive clinical experience in assessing, developing solution options, and offering resources for a wide range of issues. This includes, but is not limited to, having difficulty with a personal crisis or stressful experience, a marriage/family related problem, a substance abuse related issue, or a troubling challenge at work. The EAP is also a confidential referral source to help you find providers that fit your needs if additional counseling or treatment is recommended or requested.

EAP services are included in the premium you pay when you enroll in a County medical plan or medical plan Opt-Out. There is no additional charge for EAP counseling.

The EAP is located away from most County work locations to protect employee privacy. If you have questions about EAP, you can contact them directly at (805) 654-4EAP (654-4327). Brochures are also available through your department's Personnel Representative or by going to the EAP website (http://www.ventura.org/eap).

For information on medical plan mental health and substance abuse treatment benefits, refer to Chapter 2 of this handbook or the booklet provided by your medical plan.

▪ Wellness Program

The Wellness Program can help you lead a healthier and higher quality of life. The Program also helps control increases in medical costs by helping participants identify and reduce their personal health risks before serious health problems occur. All Regular County employees and their spouses are eligible and encouraged to participate.

The Wellness Program invites you and your spouse to participate in an annual Wellness Profile to evaluate your cholesterol, glucose, blood pressure, and other important risk factors. You'll get an extensive results report to help you improve your health. If high risks are identified, you can choose to meet with a personal Health Track Coach. Be sure to take advantage of the wide variety of Wellness Program classes on topics such as nutrition, fitness, diabetes, weight loss, stress management, parenting and more. The Wellness Program also strives to create an environment supportive of healthy lifestyles and provides resources to help employees eat well and move more.

To view the Wellness Program resources, current schedule, or to register, visit the Wellness Program website at http://www.ventura.org/vcwell. For more information, contact your department's HR Representative or the Wellness Program at (805) 654-2628.

▪ Work/Life Program

The Work/Life Program provides resources and information to assist employees with family caregiving issues and situations. Areas of resources and information include elder care, child care, and lactation accommodation.

Caring for an elderly family member can be overwhelming and stressful. Resources are available to help and a monthly support group is offered.

The Work/Life Program also arranges for County employee discounts at over 70 child care/preschool programs throughout Ventura County. A complete listing of discounts is available on the Work/Life web page (see contact information section below).

The County of Ventura understands the importance of supporting employed mothers to continue breastfeeding after they return to work. The Work/Life Program can help with the transition back to work and finding an appropriate place at the worksite to pump.

For more information on the resources available through the Work/Life Program:

- Email worklife@ventura.org
- Call (805) 477-7234
- Go to the Work/Life web page: http://www.ventura.org/benefits/work/life-program

▪ Deferred Compensation Program

The County sponsors two tax-deferred plans to help you save for retirement - the 401(k) Shared Savings Plan and the Section 457 Plan. With these Plans, you can provide yourself with extra retirement income and, at the same time, you'll save on current taxes. When you put aside money in one of these Plans, you aren't taxed on the dollars you invest, or the increase in your account value, until you take the money out.

In addition, employees have a Roth contribution option available within the County Section 457 Plan. Unlike regular 457 contributions, which are deducted on a pre-tax basis, Roth contributions are made on an after-tax basis. The contributions you make to the Roth 457 are subject to taxes before they are invested in your 457 account. The Roth 457 is not an additional Plan, but a contribution option within the 457 Plan. This option does not change the amount you can contribute; the IRS maximum applies to your total 457 Plan contributions (traditional before-tax and Roth contributions). This option also does not change the way you can invest. The same investment options are available for your Roth contributions as your before-tax contribution.

When deciding whether to enroll, keep in mind these are retirement plans. Except under special, limited circumstances, your access to the money in these accounts is restricted until you retire or terminate employment.

Investment Options: You can choose from a variety of investment options offered through Fidelity Investments including Fidelity and non-Fidelity mutual funds, individual securities, corporate and government bonds, and even certificates of deposit (CDs).

Eligibility: You are eligible to participate in the 401(k) Shared Savings Plan if you are a regular employee with a work schedule of 40 hours or more per biweek. You are eligible to participate in the Section 457 Plans if you are a regular employee with a job title represented by CNA, SPOAVC, or IUOE and have a regular work schedule of 40 hours or more per biweek. All other regular employees, and employees in the CNA Per Diem Unit, are eligible to participate in the Section 457 Plan regardless of work schedule.

401(k) County Match: The County provides a 401(k) Shared Savings Plan matching contribution for most employee groups. Except under limited circumstances, the County provides the matching contribution only for those pay periods you make a contribution. When deciding how much to contribute, you'll maximize your 401(k) Shared Savings Plan match if you make a contribution each pay period of the year.

Plan Information: Although the Plans have many similarities, there are also several key differences. The chart on the following page provides a general comparison of the Plans.

Deferred Compensation Contact Information

Fidelity Investments:

Telephone: (800) 343-0860
Website: http://netbenefits.com/ventura

Deferred Compensation Program:

Telephone: **(805) 654-2620**
E-mail: deferred.compensation@ventura.org
Intranet: http://myvcweb/index.php/hr/benefits/deferred-compensation
Internet: http://www.ventura.org/benefits/deferred-compensation

Comparison of Deferred Compensation Plans

	Section 457 Plan	401(k) Shared Savings Plan
Matching Contribution[1]	No matching County contribution	For most employees, the County provides a matching contribution when you participate in the Plan. The amount varies by group.
Annual Contributions[1]	In addition to the regular IRS annual contribution limit, you may be able to make Special and Baby Boomer Catch-up contributions.	In addition to the regular IRS annual contribution limit, you may be able to make Baby Boomer Catch-up contributions.
Loans Against Your Account Balance	Not available	Loans of up to $50,000 or 50% of your vested account balance are available after 12 months of participation.
Fund Withdrawals While Employed *(In most circumstances, you cannot withdraw funds while you are still employed by the County)*	You may withdraw your balance in a small, inactive account if you have not contributed for at least two years. An emergency withdrawal may be allowed for severe financial need if it is determined that your request meets Internal Revenue Code 457 guidelines.	A hardship withdrawal may be allowed for an immediate and heavy financial need if it is determined that your request meets Internal Revenue Code 401(k) guidelines.
Taxes and Penalties on Distributions	Pre-Tax Option - Distributions are taxed as regular income when they are withdrawn from your account. After-Tax Roth Option – Distributions are tax free if you meet the requirements of a Qualified Distribution.[2] No penalties for distribution prior to age 59½.	Distributions are taxed as regular income. A 10% penalty will also apply before age 59½, unless you leave service on or after age 55 and in other limited circumstances.
Distribution Options at Termination or Retirement	You can remain in the Plan, set up systematic withdrawals, purchase an annuity, transfer to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, or take a lump sum distribution. You do not have a deadline to choose your payout date and option until you are subject to IRS minimum required distribution rules.	You can remain in the Plan, set up systematic withdrawals, transfer to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, or take a lump sum distribution. You do not have a deadline to choose your payout date and option until you are subject to IRS minimum required distribution rules.

[1] See the current year's *Deferred Compensation Program Plan Year Information* for the County match schedules and the IRS contribution limits.

[2] A Qualified Distribution is one that is taken at least five years after the first Roth 457 contribution and you have attained age59 ½.

▪ Retirement Pension Plans

Almost all County employees participate in one of the County's Defined Benefit retirement plans. "Defined Benefit" means that your pension amount is based on a formula, not on the earnings generated by your contributions.

If you are a regular, Per Diem Pool (PDP) or Optimum Census Staffing (OCS) employee with a Work Schedule of 64 hours a pay period or more, you automatically participate in the Ventura County Employees' Retirement Association (VCERA) retirement plan. If you later reduce your hours below 64, you will continue to participate in the plan. The Retirement Department sends a plan description to all new participants. For more information on the VCERA retirement plan, visit their website (http://www.ventura.org/vcera) or call (805) 339-4250.

All other part-time, extra-help, and intermittent employees (except rehired annuitants and Reserve Firefighters) participate in the Safe Harbor Retirement Plan. Your automatic participation begins upon employment. You'll be mailed a Summary Plan Description within 30 days of eligibility for the plan. For further information, visit their website (http://www.ventura.org/benefits/safe-harbor), call (805) 654-2921, or e-mail safe.harbor@ventura.org.

▪ Leaves of Absence *(Absence Management Program)*

The County provides a Leave of Absence Program for regular employees who need a leave of absence. Many program provisions such as length of leave, paid time off, and County contributions toward health benefits are governed by collective bargaining agreements between the County and the group that represents your job title as well as by legislation such as the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), and Pregnancy Disability Leave (PDL). For more information on these legal entitlements, see Appendix B of this handbook.

Events that may qualify for a Leave of Absence include (but are not limited to):

- Employee Medical Leave
- Family Medical Leave
- Pregnancy/Maternity
- Military Service/Military Family Care
- Industrial Leave
- Bonding/Adoption/Foster Care Placement
- Intermittent Leave
- Personal/Educational/Academic
- Organ and Bone Marrow Donation
- Organizational Leave (SEIU Union)
- Emergency Rescue Personnel Leave
- Victims of Domestic Violence Leave

Your department will provide you with a copy of the *County of Ventura Absence Management Program Handbook* when you request a leave, or you may obtain a copy from the Benefits internet and intranet websites (website addresses are listed on the back cover of this book).

If you are thinking about taking a leave of absence, review the handbook thoroughly for important information on these topics and more:

- Family and Medical Protected Leaves
- Employee rights and benefits
- Employee responsibilities
- Leave of Absence approval process

Important!

You must apply for a leave of absence by completing a *Leave of Absence Request Form* for any absence of more than three (3) work days, unless the absence is due to a pre-approved vacation.

Leave of absence information and forms can be found on the Benefits intranet and internet websites (website addresses are listed on the back cover of this book).

Life & Disability Insurance Programs

Optional Life Insurance

The Optional Life Insurance plans offer you a combination of term life insurance, an accidental death and dismemberment benefit, a waiver of premium benefit, and an accelerated benefit that pays all or part of the benefit in advance if you become terminally ill. Premiums are based on your age and the amount of your insurance. If you are a regular employee and your regular work schedule is 20 hours a week or more, you can apply at any time.

If you enroll within your first 90 days of eligibility, you may elect guaranteed optional life coverage of $10,000, one times your base annual earnings, two times your base annual earnings, or three times your base annual earnings, with no Statement of Health required. Complete the Group Life Insurance Enrollment Form (found on the Benefits' intranet and internet websites; see back cover of this book) and turn the form in to your department's Benefits Representative.

If you wait until after the first 90 days of eligibility, you must complete the enrollment form and the Supplemental Enrollment/Statement of Health form for any level of coverage. Your application is subject to underwriting approval by MetLife.

If you need to change your beneficiary, you may complete the Basic/Optional Life Insurance Beneficiary Designation Form found on the Benefits intranet and internet websites (links listed on the back cover of this book).

These are term life policies, which means when you stop paying premiums, there is no cash value built up and your coverage ends the last day of the pay period including the last pay period during which a premium contribution was taken from your pay. In many cases, you can continue your insurance under the Portability Option for up to two years after you leave County employment. Please contact MetLife to inquire about the Portability Option (contact information is listed on the back cover of this handbook).

Dependent Life Insurance

When you enroll yourself in an optional life insurance plan, you can also add life insurance for your dependents. Eligible dependents are your current spouse, registered domestic partner, and eligible children up to their 26th birthday, including step-children who are living with you. A small biweekly premium covers all your eligible dependents regardless of the number you enroll.

Important! You cannot have dual coverage. This means you cannot be insured as an employee and as another employee's dependent. **A child cannot be insured under two parents' plans.**

If you enroll them with your initial enrollment, no dependent Supplemental Enrollment/Statement of Health forms are needed. Once you have dependent life insurance, any newly eligible spouse and children are automatically covered *if added within 31 days of eligibility*. Be sure to complete a new Dependents Life Insurance Change Request form so their name is on file. Coverage for a new spouse is not automatic. You must complete an application. There are two levels of dependent coverage available:

Low Option: $5,000 spouse; $2,000 on each dependent
High Option: $10,000 spouse; $5,000 on each dependent

- **Basic Life Insurance**

Managers, Confidential Clerical and Unrepresented Others covered under the Management Resolution, CJAAVC-represented employees, SEIU-represented employees, IUOE-represented employees, VCPPOA-represented Patrol Unit employees, and VEA-represented employees are automatically covered by a $50,000 group term life insurance/AD&D policy. If you need to change your beneficiary, you may complete the Basic/Optional Life Insurance Beneficiary Designation Form found on the Benefits intranet and internet websites.

- **Long-Term Disability (LTD)**

You are automatically enrolled in LTD if you are a Manager, Confidential Clerical, Unrepresented Other, CJAAVC-represented employee, CNA-represented employee, IUOE-represented employee, VEA-represented employee, or Sheriff's Service Technician. Nurses, Nursing Care Coordinators I-II, Clinical Coordinators, and Clinical Coordinators-Surgical Services who are covered by the Annual Leave program also participate. To be eligible for LTD benefits, you must be scheduled for and working at least 60 hours a biweek, and for all eligible employees covered by the County of Ventura's Management Resolution, you must be scheduled for and working at least 40 hours a biweek.

Your LTD benefit protects you in the event of a disabling illness or injury that lasts more than 30 days. Benefits are integrated with other benefits, for which you may be eligible, to provide you with a benefit which is equivalent to 60% or 66% of your base salary, subject to plan maximums.

A certificate for this policy is available on our internet and intranet websites. Some unions offer similar plans to the employees they represent. For information on these plans, contact the union directly.

- **Short-Term Disability (STD)**

All regular employees are eligible to participate in the Wage Supplement Plan (WSP), as long as you are regularly scheduled to work 40 hours or more per pay period and enroll during the first 90 days of eligibility. You can cancel your enrollment at any time, but once you drop coverage you cannot re-enroll. Evidence of insurability is not required, there are no regular open enrollment periods and premiums are subject to change.

If you become totally disabled while enrolled in this plan and submit completed Claim Statement(s), the dollar amount of weekly benefits and the maximum benefit period are determined by the premium and level of coverage you select. Benefits may be integrated with other benefits, for which you may be eligible, to provide you with a low option of $45.00 per week for a maximum of 13 weeks or a high option of $80.00 per week for a maximum of 26 weeks, benefits are paid bi-weekly. Refer to the County of Ventura's Wage Supplement Plan Document for exceptions, limitations and provisions of this optional program.

- **State Disability Insurance (SDI)**

Many County employees are covered by the State Disability Insurance Program. If your job is covered by a union contract that includes SDI benefits, you are automatically enrolled and premiums will be deducted from your pay.

While you are disabled and unable to work, SDI pays you a benefit based on your earnings history. You are eligible to file an SDI claim once you have made SDI contributions for at least six months. If you were covered under SDI on your last job, your contributions carry over to the County.

SDI is not a County-provided benefit. If you have an SDI question, you may call the State Disability Insurance Program at (800) 480-3287 or visit their website at www.edd.ca.gov.

- **Paid Family Leave Benefits (PFL)**

California Senate Bill 1661 was enacted to extend disability compensation to cover individuals who take time off of work to care for a seriously ill child, spouse, parent, parent-in-law, grandparent, sibling, or domestic partner, or to bond with a new child. This legislation established the Paid Family Leave insurance program administered by the State Disability Insurance (SDI) program. See Appendix for Employee Notices.

For Information on the Paid Family Leave Program call:

(877) 238-4373

Detailed information, including forms and publications and "Frequently Asked Questions" may also be obtained from the EDD website at:

www.edd.ca.gov

Employees covered by the SDI program are also covered for Paid Family Leave insurance benefits. Mandatory employee contributions pay for the program.

▪ $1,000 Employee Death Benefit

In the event of your death prior to termination or retirement, your department will provide your beneficiary(ies) with a $1,000 death benefit, if you are enrolled in the Flexible Benefits Program. If you wish the benefit to go to a person other than the beneficiary you designated for your Retirement Plan, ask your department's Human Resources Representative for a copy of the Death Benefit beneficiary form. Complete the form and return it to your department's Human Resources Representative.

▪ Employee Emergency Assistance Fund

The Employee Emergency Assistance Fund was created to financially assist fellow County employees, retired employees, and their qualifying survivors who are having severe financial hardships resulting from death, illness, accident, or loss of property due to casualty.

A committee comprised of representatives from all employee unions and County Management reviews and approves the applications for assistance from both designated and undesignated recipient accounts.

Designated Recipient Account: County employees may donate up to 40 hours of vacation or annual leave in a calendar year to each designated recipient. The cash value (net proceeds after taxes) of the vacation/annual leave hours goes to the specific recipient you designate.

Undesignated Recipient Account: County employees may also contribute to an account that is used to assist others as their needs are identified. You can make biweekly payroll contributions and/or vacation or annual leave lump sum contributions (net proceeds after taxes).

If you would like to contribute or apply for assistance, please visit our website for the appropriate forms.

▪ Long-Term Care Plan

Long-term care insurance plans help you pay for assistance with basic essential activities like dressing, bathing or eating for persons who are disabled due to chronic illness, injury or the frailty of old age. Most medical plans don't cover these expenses on a long-term basis.

The County participates in the CalPERS Long-Term Care Plan program. All California public employees and their spouses, parents and parents-in-law are eligible to apply. Employee premiums may be paid through payroll deduction.

To request a CalPERS Long-Term Care application, call (800) 266-1050. For general information and claims for policy holders, call (800) 982-1775. Please reference account #5917734.

Website: http://www.calpers.ca.gov/index.jsp?bc=/about/benefits-overview/long-term-care-benefits.xml

▪ Transportation Benefit Reimbursement Program

The Transportation Benefit Reimbursement Program is available to all regular full-time and part-time employees of the County of Ventura who perform services and receive wages.

The transportation program covers:

- employees only
- all public transit systems (i.e. train, subway, bus fares, etc.)

The transportation program does not cover:

- dependents
- independent contractors
- volunteers
- vendors
- commuter highway vehicles
- private vehicles
- parking

The transportation benefit is similar to the pre-tax flexible spending accounts available for medical expenses and dependent care. One important difference, however, is that there is no "use it or lose it" penalty. Unused balances can be rolled over from month to month or year to year within the same account, subject to plan maximums. Maximum reimbursement cannot exceed the IRS limit in any single month (please refer to the Internal Revenue Code §132(f)(1) for the monthly IRS limit).

For more information and forms, please visit one of the following websites or call (805) 677-8785.

- http://www.ventura.org/benefits/transportation-benefit-reimbursement-program
- http://myvcweb/index.php/hr/benefits/optional-benefits

Appendix A
Consumer Issues

Most of the issues covered in this appendix are of concern to you, whether you are enrolled in County-sponsored health plans or not. This is general information that has been collected from a variety of sources, and is intended to help you understand basic benefits concepts. For information specific to your benefit plan, consult the Evidence of Coverage Booklet provided by your plan.

▪ Frequently Used Terms

Coordination of Benefits

When a family is covered under more than one health care plan, coordination of benefits (COB) determines the order in which multiple insurance carriers pay your health plan bills and how much each will pay. One plan is designated as the primary plan and the other as secondary. These standard rules apply to most plans (including the County's plans) in determining which plan pays first:

- The plan that covers an employee in his/her capacity as an employee is the primary plan.
- For dependent children living with both parents, the primary plan is usually determined by the birthday rule: the plan of the parent whose birthday (month and date) falls earlier in the year is primary. The plan of the parent whose birthday falls later in the year is secondary.
- The primary plan for dependent children of separated or divorced parents is the plan of the parent with custody of the child, followed by the plan of the spouse of the parent with custody, then the plan of the parent without custody of the child.
- If none of the above rules determines the order of` benefits, the primary plan is the plan that has covered an employee or member longer. The secondary plan is the plan that has covered the person for the shorter period.
- Medicare is always the secondary payer to an employer provided active employee group health plan.

Some plans do not follow the standard coordination of benefits provisions. For instance:

- Some plans contain a "non-duplication of benefits" provision. Under this provision, the secondary plan will not duplicate benefits paid by the primary plan, so if they both have the same benefit provisions, the secondary plan would pay nothing.
- Some plans use a gender rule instead of the birthday rule to determine which plan is primary for children. In most cases the gender rule states that the father's plan is always primary.
- Some plans contain a "phantom COB" clause. These plans coordinate benefits based on what benefits you could have had if you had not turned down coverage that was available through another employer.

What do all these variations in COB provisions mean to you? Making assumptions can cost you a lot of unnecessary money either in health care premium costs or out-of-pocket medical costs. Before making any decisions on whether or not to enroll in more than one health plan, take the time to review the COB provisions in each plan. In most cases, it is not cost-effective to pay for more than one plan. However, make sure there are no special circumstances that might make it inadvisable to opt-out of a plan.

(Based on an article by Northwestern National Life, and Mary Rowland, Syndicated Columnist)

Capitation

A fixed, predetermined amount paid to a provider per person (like a salary) without regard to the actual number or nature of services provided to each person in a set period of time. For instance, if 700 patients in the same plan have chosen that provider as their primary care physician and if the capitation rate is $10 per month, that provider receives a flat amount of $7,000 a month ($84,000 per year), regardless of how many of those members actually use his/her services. Capitation is the characteristic payment method in health maintenance organizations.

Fee-For-Service

Method of billing for health services, under which a health provider charges separately for each service rendered.

Formulary Drugs

See *Prescription Drug Coverage*.

Generic Drugs

See *Prescription Drug Coverage*.

Group (Clinic) Practice

A group of persons licensed to practice medicine in a state. As a professional agency, it engages in the coordinated practice of medicine in one or more group practice facilities. In this connection, members of the group share common overhead expenses, medical and other records, substantial portions of equipment, and professional, technical, and administrative staffs. Patients will generally be referred to a specialist within the group.

Individual Practice Association (IPA)

A loosely-constructed panel of physicians or other professionals practicing individually or in small groups in the community who have banded together for contracting and billing purposes. They share a central administrative authority, which negotiates health plan contracts for them as a group and are usually reimbursed individually by the IPA on a fee-for-service or capitation basis. In a managed care environment, the IPA, not the health plan, is the decision-maker on specialist referral requests; patients will generally be referred to a specialist within the same IPA or an affiliated IPA.

Preferred Provider Organization (PPO)

A group of hospitals and physicians who contract on a discounted fee-for-service basis with employers, insurance plans, or other third party administrators to provide comprehensive medical service.

Primary Care Provider/Physician (PCP)

A primary care physician oversees the total health services of enrollees, arranges referrals, and supervises other care such as specialist services and hospitalization. The PCP's services are usually covered by a monthly capitation eliminating claims processing and collection.
Medical plan PCP's are usually family practice specialists, general practitioners, internists or pediatricians.

The advantages of seeking medical care from a primary care physician include:

- PCP's consider your overall health. They can advise you about disease prevention and how to stay healthy.
- The PCP becomes familiar with your personal health history and needs and has your medical records on file.
- A PCP can treat all of your family members and become familiar with your individual and family needs.
- In an emergency, you and your family members know who to call for advice and treatment.
- Costs are lower for PCP's than specialists.
- PCP's have broad training to cover a wide range of medical care. In many cases, they can perform medical procedures such as delivering babies, removing small lesions, or providing acne treatment, thus eliminating the need to see a specialist.

(Courtesy of Northwestern National Life)

Customary and Reasonable Charges (C&R)
(also called UCR, R&C, U&C)

These are costs that fall within the usual range of charges for the same health care service or supplies, as determined by the health plan.

When a plan states that they pay a percentage of C&R, the plan will only pay for health care costs that meet the plan's C&R guidelines. In most cases, you are responsible for paying the amount that exceeds C&R expenses. Before you receive treatment, discuss fees for specific procedures or surgery with your provider. Providers are sometimes willing to adjust their charges if they exceed C&R figures.

▪ Patients' Rights

As a health plan member, you have important rights such as the right to privacy, access to quality health care, and the right to participate fully in medical decisions affecting you and your family. You owe it to yourself to do at least as much homework and ask as many questions about your health care as you do before you purchase an automobile or have work done on your house. If any aspect of a medical procedure is confusing to you, ask your doctor for a simple, clear, complete explanation.

As a patient and a plan member, you have the right to:

- Be treated with courtesy and respect.
- Receive health care without discrimination.
- Have confidential communication about your health.
- Have no restrictions placed on your doctor's ability to inform you about your health status and all treatment options.
- Be given sufficient information to make an informed decision about any medical treatment or procedure, including its risks.
- Refuse any treatment.
- Designate a surrogate to make your health care decisions if you are incapacitated.
- Access quality medical care, including specialist and urgent care services, when medically necessary and covered by your health plan.
- Access emergency services when you, as a "prudent layperson," could expect the absence of immediate medical attention that would result in serious jeopardy to you or your covered dependents.
- Participate in a medical review when covered health care services are denied, delayed, or limited on the basis that the service was not medically necessary or appropriate.
- Discuss the costs of your care in advance with your provider.
- Get detailed, written explanation if payment or services are denied or reduced.
- Have your complaints resolved in a fair and timely manner and have them expedited when a medical condition requires speed.

You can help protect your rights by doing the following:

- Express your health care needs clearly.
- Build mutual trust and cooperation with your providers.
- Treat providers and plans with the same consideration and respect you expect to receive.
- Give relevant information to your health care provider about your health history and condition.
- Contact your providers promptly when health problems occur.
- Ask questions if you don't understand a medical condition or treatment.
- Be on time for appointments.
- Notify providers in advance if you can't keep your health care appointment.
- Adopt a healthy lifestyle and use preventive medicine, including appropriate screenings and immunizations.
- Familiarize yourself with your health benefits and any exclusions, deductibles, copayments, and treatment costs.
- Understand that cost controls, when reasonable, help keep good health care affordable.

How and where to get help:

If you have a concern about your patient rights or your health care services, first discuss it with your physician, hospital, dentist, eye doctor, or other provider, as appropriate. Many concerns or complaints can be resolved there. If you still have concerns, you have the right to appeal directly to the health plan. Your health plan wants satisfied customers. Consult your health plan's Evidence of Coverage booklet for information about the covered benefits or information on your appeal rights. Call the plan's Member Services for further information. Plan telephone numbers are on the back of this handbook.

Health plans are licensed under a California law known as the Knox-Keene Health Care Service Plan Act of 1975. The Act is administered by the California Department of Managed Health Care (DMHC). The

DMHC has established a toll-free telephone number to receive and address complaints against health care services. The toll-free number is (888) HMO-2219, or (888) 466-2219. If you wish to file a complaint against your health plan with the DMHC, please do so only after you have contacted your health plan and used the plan's grievance process. However, you may immediately file a complaint with the DMHC in an emergency medical situation. You may also file a complaint with the DMHC if the health plan has not satisfactorily resolved your grievance within 60 days of filing.

Your Role in the Fight Against Health Care Cost Increases

You and your family pay, directly or indirectly, for increases in health care costs. As the costs of healthcare go up, your premium, copay and out-of-pocket costs go up too. Not all of the increase in costs is justified or unavoidable; some is due to unnecessary use of services and provider overcharges. You can help control these costs by doing the following:

Be an Informed Consumer

Read and watch health care related articles and news stories in your local paper, magazines and on television. Be aware that ads and promotions for fast cures probably are "too good to be true." Avoid wasting money on ineffective "cures."

- Take care of yourself
- Practice good health habits
- Eat right
- Get adequate exercise

Use your Medical Plan Wisely

Learn common treatments for colds or flu so you can avoid unnecessary doctor visits.

Be familiar with what services cost and what your plan covers. Keep track of your deductibles and out-of-pocket amounts.

Use the emergency room only for urgent or life-threatening situations. The cost of medical care in a hospital setting is more expensive because of the availability of costly medical equipment and health care professionals trained to treat life-threatening injuries or illnesses. If you're unsure about the severity of your symptoms, call your medical doctor or clinic, where there are doctors on call 24 hours a day who can answer questions or recommend the appropriate level of care.

Ask your doctor and/or pharmacist for the least expensive form of medication available.
Discuss services you are to receive in advance with your doctor, whenever possible. Ask if all the services, including diagnostic tests, are medically necessary.

Keep in mind that you and your coworkers ultimately pay all plan costs through your biweekly premiums. When you protect your medical plan from unnecessary costs, you protect yourself too.

Check Your Medical Bills Carefully

Reviewing your health care bills can help you identify and prevent unnecessary health care costs. Many physicians and hospitals today send their bill directly to your health benefit provider or insurer, so you may not have a chance to review it before it goes through claim processing. But that doesn't mean it's too late.

Physicians and their staff members are human, and billing errors do happen. Here's what to look for to determine if a bill is correct:

- Does the date of service on the bill match the date you went to the doctor or hospital?
- Check all your itemized bills to verify you received all of the services or procedures listed on the bill.
- Are you charged for more X-rays or procedures than you received?

If you receive an Explanation of Benefits (EOB) form from your health plan, review it for accuracy. Compare it with your provider's itemized bill. Notify the provider and your medical plan immediately if there is a discrepancy or error.

Remember, money you save your plan in unnecessary charges will help hold the line on health care costs including costs you pay in the form of premiums, copayments and deductibles.

(Based on an article by Northwestern National Life)

▪ Prescription Drug Coverage

Most managed care plans offer coverage for medically necessary prescription drugs that have been approved by the Federal government's Food and Drug Administration (FDA). Many plans have prescription policies that encourage or require members to choose generic drugs or drugs from the plan's "formulary" to control plan costs.

Generic Drugs/Brand Name Drugs

Generic drugs must contain the same active ingredients as brand name drugs. They are tested and approved by the FDA just as brand name drugs are. They are less expensive (sometimes half the cost of brand name drugs) because the research costs involved in producing them are usually lower.

In some medical plans, the pharmacy is required to substitute generic drugs whenever available, unless a brand name drug has been pre-authorized. In other plans, the member may be required to pay the cost difference between a generic and brand name drug, unless there is no generic equivalent.

For more on prescription coverage, see the prescription coverage portion of the Medical Plan Comparison Chart in Chapter 2.

Drug Formulary

Many medical plans now include a prescription drug formulary, which is a listing of preferred or recommended medications your doctor is authorized to prescribe under the plan.
There are various types of formularies, such as the "open formulary," whereby patients are encouraged to use formulary drugs but pay the same copay for preferred and non-preferred drugs. There is also the "incentive formulary," which provides incentives to use preferred drugs through lower copays. A "closed formulary" generally provides coverage of nonpreferred drugs only if there is no viable preferred drug alternative, or the non-formulary drug is preauthorized by the medical plan.

Your doctor normally checks to make certain that a drug is included on the plan's formulary before prescribing it for you. If the drug isn't on the formulary and a formulary drug is not a viable alternative, the physician should follow the plan's procedure for obtaining prior authorization to give you the drug. If the doctor's request is denied, you may appeal the decision through the plan's normal appeal process.

You can find out in advance if the drugs you want are on your plan's formulary by asking the member services department of your plan. Most managed care organizations make the complete listing of drugs on their formularies available for patients in booklet form or on the internet.

Mail Order Pharmacy Services

Many health plans have special programs that allow you to obtain a two or three-month supply of medication by mail. Some plans may even require you to use this service to buy drugs that you must take for a long time. Even if the plan doesn't require you to use the service, you may find that it is cheaper for you to buy your medication through the mail-order option offered by the plan. Usually your total copayment cost is less than copays for three 30-day supplies from the pharmacy.

Copayment Structures

Prescription costs are consuming an ever-larger portion of health plan dollars. As a result, tiered or "split" copayment options have increased over the last few years providing economic incentives for members to choose more cost-effective treatment while not restricting their choice of drugs. In a two-tiered (generics and brand name drugs) copay structure, the copay for a brand name drug is higher.

Copay options with additional tiers can offer a balance between affordability and member choice. For example: three-tiered (generics, formulary brands and non-formulary brands) and four-tiered options (generics, preferred formulary brands, non-preferred formulary brands and non-formulary brands) are becoming more widespread.

(Excerpts courtesy of AARP "9 Ways to get the most from your Managed Health Care Plan," the Mercer/ Foster-Higgins "National Survey of Employer-sponsored Health Plans," and "Managing Pharmacy Benefits Cost," Merck-Medco Managed Care Report.)

For Further Information

Be sure to check the prescription drug coverage descriptions in the Medical Plan Charts in Chapter 2 of this handbook for details about the various plans' prescription drug coverage.

▪ Why a Medical Plan Opt-Out Charge?

Prior to 1992, all employees were required to participate in a County-sponsored medical plan or forfeit their Flexible Benefits Program Credit Allowance. In the spring of 1992, the Board of Supervisors authorized the addition of an option to decline medical coverage through the County ("Opting Out") without waiving Flexible Benefits Program participation (and Flexible Credits). When they did so, they determined that there should be a charge to the employee's Flexible Credit Allowance when the employee elects to opt-out. In this way, the Opt-Out option does not result in higher rates for those enrolled in the medical plans.

Employees opting out of medical coverage also share in the benefits and costs of the Flexible Benefits Program, including Employee Assistance Program, Wellness, Work/Life, Employee Health Services, and

administrative fees. The remainder of the Opt-Out fee is based on some basic assumptions about the County medical plan, County employees, and our responsibilities to one another.

The purpose of offering a County medical plan to employees is to maintain a healthy work force and to protect employees from financial hardship in the event of illness or injury to themselves or a dependent.

Employees in the Flexible Benefits Program should have the option to decline medical coverage and use Flexible Credits to purchase other benefits as long as they have adequate medical coverage through another group plan, and as long as their decision does not impact the medical rates of those remaining in the plan.

All County employees potentially benefit from the County medical program, whether they are currently in a plan or not. Employees can enroll in the plan during any open enrollment period or midyear if they lose their other coverage, so all employees are a part of our "risk-pool."

At the time the Medical Plan Opt-Out option was developed, an outside actuarial firm was contracted to determine if a fee should be charged to employees opting out. It was determined that:

- Nationally, about 20% of a plan's participants generate 80% of the claims costs in any given year.

- In most cases, those who opt out of a medical plan are the healthier population; employees expecting high expenses prefer the extra coverage.

- Since sicker employees tend to stay in the plan, when employees opt-out there are fewer premium dollars coming into the plan, but claim and administrative costs do not go down in the same proportion. This results in higher premiums for those remaining in the plan, unless a charge is applied for the right to opt out.

In the summer of 1999, the Medical Plan Opt-Out option was re-evaluated by the Segal Company, a national benefits consulting firm. The Segal study confirmed the factors identified by the actuarial firm still applied to the County plans, and the current method of determining the amount of the Opt-Out fee is actuarially valid.

Appendix B
Employee Notices

State and federal laws regulate and protect various aspects of employee benefit coverage. To ensure that employees have the necessary information to make informed benefit selection decisions, and in compliance with regulations, the County provides its eligible new employees with the Notices listed below. In addition, this Benefit Plans Handbook, containing a complete set of the Notices, is distributed annually to all currently eligible employees at Open Enrollment.

Whenever there is a new law establishing new regulations or benefits, or if there are changes to any existing regulations or benefits, information is provided to all eligible employees. Updated replacement copies of the Handbook are distributed, if necessary.

NOTICES TO COUNTY OF VENTURA EMPLOYEES

- **Family and Medical Leave Act of 1993 (FMLA)**
- **Pregnancy Disability Leave (PDL) – "Notice A"**
  Your Rights and Obligations as a Pregnant Employee
- **California Family Rights Act of 1993 (CFRA/PDL) – "Notice B"**
  Family Care and Medical Leave and Pregnancy Disability Leave
- **The Newborns' and Mothers' Health Protection Act**
- **Paid Family Leave Benefits Program**
- **Women's Health and Cancer Rights Act of 1998**
- **Organ and Bone Marrow Donation Protection Act**
- **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
- **California AB 1401–additional extension of medical insurance (Cal-COBRA)**
- **Mental Health Parity Act**
- **Important Notice about Your Prescription Drug Coverage and Medicare (Medicare Part D)**
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **Rights of Victims of Domestic Violence, Sexual Assault, and Stalking**

These notices are informational only. Nothing in these notices supersedes or modifies your actual plan benefits or applicable law, or constitutes a promise, representation or inducement.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Pregnancy Disability Leave

"Notice A"

Your Rights and Obligations as a Pregnant Employee

If you are pregnant, have a related medical condition, or are recovering from childbirth, **PLEASE READ THIS NOTICE**.

- California law protects employees against discrimination or harassment because of an employee's pregnancy, childbirth or any related medical condition (referred to below as "because of pregnancy"). California also law prohibits employers from denying or interfering with an employee's pregnancy-related employment rights.

- Your employer has an obligation to:

    - reasonably accommodate your medical needs related to pregnancy, childbirth or related conditions (such as temporarily modifying your work duties, providing you with a stool or chair, or allowing more frequent breaks);
    - transfer you to a less strenuous or hazardous position (where one is available) or duties if medically needed because of your pregnancy;
    - provide you with pregnancy disability leave (PDL) of up to four months (the working days you normally would work in one-third of a year or 17 ⅓ weeks) and return you to your same job when you are no longer disabled by your pregnancy or, in certain instances, to a comparable job. Taking PDL, however, does not protect you from non-leave related employment actions, such as a layoff; and
    - provide a reasonable amount of break time and use of a room or other location in close proximity to the employee's work area to express breast milk in private as set forth in Labor Code section 1030, et seq.

- For pregnancy disability leave:

    - PDL is not for an automatic period of time, but for the period of time that you are disabled by pregnancy. Your health care provider determines how much time you will need.
    - Once your employer has been informed that you need to take PDL, your employer must guarantee in writing that you can return to work in your same position if you request a written guarantee. Your employer may require you to submit written medical certification from your health care provider substantiating the need for your leave.
    - PDL may include, but is not limited to, additional or more frequent breaks, time for prenatal or postnatal medical appointments, doctor-ordered bed rest, "severe morning sickness," gestational diabetes, pregnancy-induced hypertension, preeclampsia, recovery from childbirth or loss or end of pregnancy, and/or post-partum depression.
    - PDL does not need to be taken all at once but can be taken on an as-needed basis as required by your health care provider, including intermittent leave or a reduced work schedule, all of which counts against your four month entitlement to leave.
    - Your leave will be paid or unpaid depending on your employer's policy for other medical leaves. You may also be eligible for state disability insurance or Paid Family Leave (PFL), administered by the California Employment Development Department.
    - At your discretion, you can use any vacation or other paid time off during your PDL.
    - Your employer may require or you may choose to use any available sick leave during your PDL.
    - Your employer is required to continue your group health coverage during your PDL at the level and under the conditions that coverage would have been provided if you had continued in employment continuously for the duration of your leave.
    - Taking PDL may impact certain of your benefits and your seniority date; please contact your employer for details.

Notice obligations as an Employee:

- Give your employer reasonable notice: To receive reasonable accommodation, obtain a transfer, or take PDL, you must give your employer sufficient notice for your employer to make appropriate plans – 30 days advance notice if the need for the reasonable accommodation, transfer or PDL is foreseeable, otherwise as soon as practicable if the need is an emergency or unforeseeable.

- Provide a Written Medical Certification from Your Health Care Provider. Except in a medical emergency where there is no time to obtain it, your employer may require you to supply a written medical certification from your health care provider of the medical need for your reasonable accommodation, transfer or PDL. If the need is an emergency or unforeseeable, you must provide this certification within the time frame your employer requests, unless it is not practicable for you to do so under the circumstances despite your diligent, good faith efforts. Your employer must provide at least 15 calendar days for you to submit the certification. See your employer for a copy of a medical certification form to give to your health care provider to complete.

- PLEASE NOTE that if you fail to give your employer reasonable advance notice, or if your employer requires it, written medical certification of your medical need, your employer may be justified in delaying your reasonable accommodation transfer, or PDL.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). For more information about your rights and obligations as a pregnant employee, contract your employer, visit the Department of Fair Employment and Housing's web site at www.dfeh.ca.gov, or contact the Department at (800) 884-4684. The text of the FEHA and the regulations interpreting it are available on the Department's web site.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

California Family Rights Act of 1993

"Notice B"

Family Care and Medical Leave and Pregnancy Disability Leave

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.

- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (PDL) of up to four months, or the working days in one-third of a year or 17⅓ weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your PDL.

- Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.

- If you are CFRA-eligible, you have certain rights to take BOTH PDL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must to notify your employer, at least verbally, as soon as you learn of the need for the leave.

- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.

- Your employer may require medical certification from your health care provider before allowing you a leave for:

    - your pregnancy;
    - your own serious health condition; or
    - to care for your child, parent, or spouse who has a serious health condition.

- See your employer for a copy of a medical certification form to give to your health care provider to complete.

- When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.

- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

This notice is a summary of your rights and obligations under the Fair Employment and Housing Act (FEHA). The FEHA prohibits employers from denying, interfering with, or restraining your exercise of these rights. For more information about your rights and obligations, contact your employer, visit the Department of Fair Employment and Housing's Web site at www.dfeh.ca.gov, or contact the Department at (800) 884-1684. The text of the FEHA and the regulations interpreting it are available on the Department's web site.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

The Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act) was signed into law on September 26, 1996, and requires plans that offer maternity hospital benefits for mothers and newborns to pay for at least a 48-hour hospital stay for the mother and newborn following childbirth (or in the case of a cesarean section, a 96-hour hospital stay) unless the attending provider, in consultation with the mother, decides to discharge earlier.

This law became effective for group health plans for plan years beginning on or after January 1, 1998.

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE TO COUNTY OF VENTURA EMPLOYEES

About California Paid Family Leave

There may be times in the life of a working person when there is a need to care for a loved one. Whether you are a working parent bonding with a new child or you are caring for a seriously ill family member, California's Paid Family Leave was created for these times.

Fast Facts About California Paid Family Leave

Provides up to six weeks of partially paid leave to bond with a new child (either by birth, adoption, or foster care placement) or to care for a seriously ill family member (child, spouse, parent, parent-in-law, grandparent, grandchild, sibling, or registered domestic partner).

Provides approximately 55 percent of your salary during your leave. (The wage replacement rate will increase in January 2018.)

Funded through your State Disability Insurance tax withholding so you are most likely eligible for leave if you've paid into State Disability Insurance ("CASDI" on paystubs) or a qualifying voluntary plan.

Must be used within 12 months of a child entering your family.

Does not provide job protection. You may have your job protected under other laws, such as the federal Family and Medical Leave Act (FMLA) or the California Family Rights Act (CFRA).

CALIFORNIA PAID FAMILY LEAVE

moments matter.

In California, it's the law.

Paid Family Leave benefits:
Giving Californians the time they need to be there for the moments that matter.

English	1-877-238-4373
Spanish	1-877-379-3819
Cantonese	1-866-692-5595
Vietnamese	1-866-692-5596
Armenian	1-866-627-1567
Punjabi	1-866-627-1568
Tagalog	1-866-627-1569

TTY: 1-800-445-1312
(This number does not accept voice calls.)

PFL Claim Forms should be mailed to:
PO Box 989315
West Sacramento, CA 95798-9315

EDD Employment Development Department State of California

For more information, visit
CaliforniaPaidFamilyLeave.com

CALIFORNIA PAID FAMILY LEAVE

Helping Californians be present for the moments that matter.

Do I Qualify For California Paid Family Leave?

To qualify for Paid Family Leave benefits, you must meet the following requirements:

- Be covered by State Disability Insurance (or a voluntary plan in lieu of State Disability Insurance) and have earned at least $300 in your base period from which deductions were withheld. The length of time worked at your current job does not affect eligibility.
- Submit your claim *no sooner* than 9 days, but *no later* than 49 days after your family leave begins.
- If required by your employer, use up to two weeks of any earned but unused vacation leave or paid time off prior to receiving benefits.
- Serve a 7-day, unpaid waiting period before benefits begin for each claim within the 12-month period. (The waiting period is being eliminated in January 2018.)
- For caregiving claims only: Supply medical certification showing that the care recipient has a serious health condition and requires your care.
- For bonding claims only: Provide documents to support a claim for bonding with a new biological, adopted, or foster child.

You may not be eligible for benefits if:

- You are receiving Disability Insurance, Unemployment Insurance, or workers' compensation benefits.
- You are not working or looking for work at the time you begin your family care leave.
- You are not losing wages.
- You are in custody due to conviction of a crime.

You are entitled to:

- Know the reason and basis for decisions affecting your benefits.
- Appeal decisions about your eligibility for benefits. Visit *edd.ca.gov/Disability/Appeals.htm* for information about appeals.
- Confidentiality and privacy of your claim information, except for the purposes allowed by law.

How Are Benefit Amounts Calculated?

California Paid Family Leave provides approximately 55 percent of your salary (from $50 up to $1,173 weekly). Your employer may allow you to use vacation, sick, paid time off, or other leave to suplement your PFL benefits to receive up to 100 percent pay. In January 2018, the wage replacement rate increases to approximately 60 to 70 percent of your salary.

The benefit amount is calculated from your highest quarterly earnings over the past 5 to 18 months. The Employment Development Department has an online calculator at *edd.ca.gov/PFL_Calculator* that can help you estimate your weekly benefit amount.

Job Protection

California Paid Family Leave does not provide job protection or return to work rights. However, job protection may be provided if your employer has to follow the federal FMLA or the CFRA. Also, notify your employer of the reason for taking leave according to company's leave policy.

Apply For Benefits

Apply for Paid Family Leave benefits online using SDI Online. Employers and physicians/practitioners can also submit claim information through SDI Online. Visit *edd.ca.gov/Disability* for more information. You may also file using a paper form. Visit *edd.ca.gov/Forms* to request a paper *Claim for Paid Family Leave (PFL) Benefits*, DE 2501F form.

For bonding claims, be sure to provide a proof of relationship document with your claim. For caregiving claims, be sure to provide a physician/practitioner's certification.

If you are currently receiving Disability Insurance pregnancy-related benefits, it is not necessary to request a Paid Family Leave claim form. Claim filing information will be sent through your SDI Online account or via mail when your pregnancy-related disability claim ends.

If you are covered by a voluntary plan, contact your employer to obtain information about your coverage and instructions on how to apply for benefits.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Women's Health and Cancer Rights Act of 1998 (WHCRA)

WHCRA Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WCHRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymph edemas.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under your plan.

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymph edemas? Call your Plan Administrator for more information.

Please see the Medical Plan Comparison Charts in Chapter 2 of this handbook for deductibles and coinsurance, or, if you would like more information on WHCRA benefits, contact your medical plan's Member Services Department (see back cover of this handbook for medical plan contact information).

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Organ and Bone Marrow Donation Protection Act

Organ and Bone Marrow Donation shall be administered in accordance with Government Code Section 19991.11:

A. Subject to subdivision (b), an appointing power shall grant to an employee, who has exhausted all available sick leave, the following leaves of absence with pay:

1. A leave of absence not exceeding 30 days to any employee who is an organ donor in any one-year period, for the purpose of donating his or her organ to another person.

2. A leave of absence not exceeding five days to any employee who is a bone marrow donor in any one-year period, for the purpose of donating his or her bone marrow to another person.

B. In order to receive a leave of absence pursuant to subdivision (a), an employee shall provide written verification to the appointing power that he or she is an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow.

C. Any period of time during which an employee is required to be absent from his or her position by reason of being an organ or bone marrow donor is not a break in his or her continuous service for the purpose of his or her right to salary adjustments, sick leave, vacation, annual leave, or seniority.

D. If an employee is unable to return to work beyond the time or period that he or she is granted leave pursuant to this section, he or she shall be paid any vacation balance, annual leave balance, or accumulated compensable overtime. The payment shall be computed by projecting the accumulated time on a calendar basis as though the employee was taking time off. If, during the period of projection, the employee is able to return to work, he or she shall be returned to his or her former position as defined in Section 18522.

E. If the provisions of this section are in conflict with the provisions of a memorandum of understanding reached pursuant to Section 3517.5, the memorandum of understanding shall be controlling without further legislative action, except that, if those provisions of a memorandum of understanding require the expenditure of funds, the provisions shall not become effective unless approved by the Legislature in the annual Budget Act.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

This notice is in compliance with Title X of the *Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)* and *Health Insurance Portability and Accountability Act of 1996 (HIPAA).*

You and/or your eligible dependents are entitled to continue coverage under the County's group health plans in a number of situations that would otherwise mean the end of coverage. A monthly premium equal to the full cost for active employees, plus a 2% administrative charge will be charged for this coverage. (For those who are eligible for 29 months of continuation coverage due to disability, premiums after the initial 18 months will equal 150% of the full active employee premium.)

These events qualify for coverage:

1. If your employment with the County of Ventura ends or if your hours are reduced below the number required to continue your medical, dental or vision coverage (including expiration of eligibility for coverage while on leave of absence), you and/or your spouse and/or other currently covered dependents (i.e., dependent children of you or your spouse) may continue coverage for up to 18 months. However, termination due to gross misconduct cancels eligibility for this benefit. Federal COBRA laws and regulations do not apply to domestic partners or their dependent children.

   If you or a covered dependent are determined to be disabled under the Social Security Act (SSA) at any time during the first 60 days of COBRA continuation coverage, you and your eligible dependents may be eligible to continue coverage for up to 29 months from the date active employee coverage ended if you notify your employer of the disability within 60 days of the SSA determination, *and* before the end of the original 18-month COBRA coverage period.

   If a child is born to you, or placed with you for adoption during your COBRA coverage, that child will be eligible for coverage as a qualified beneficiary.

2. If one of the following events occurs, your spouse's and other dependents' coverage may be continued for up to 36 months:

   - Your death,
   - Your divorce or legal separation,
   - A dependent child exceeds the maximum age for coverage,
   - You become entitled to Medicare benefits and lose your eligibility for continuation of benefits

Notify County of Ventura Human Resources Benefits, in writing, as soon as any of these events occur.

You and/or your dependents may lose the right to continuation benefits if notification to the County is not made within 60 days of the event.

To qualify for coverage under COBRA, you must respond to the COBRA Administrator's COBRA Notice by submitting the required forms and making the payments by the payment due dates specified. The COBRA election form must be mailed (postmarked) within 60 days of either the qualifying event or the notification of your rights (whichever is later).

Upon enrollment and payment for the COBRA coverage, your extended benefits will be effective as of the date following the qualifying event (date coverage ended), so there is no break in coverage. Extended coverage would end automatically if any of these situations occur:

1. The County stops providing group health benefits to its employees.
2. Required premiums are not paid when due.
3. A person eligible for continued benefits becomes covered, as an employee or otherwise, under another group health plan which does not have an applicable preexisting condition clause (or the clause does not apply because of *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* restrictions on preexisting condition clauses).
4. A person eligible for continued benefits first becomes entitled to benefits under Medicare.
5. The maximum period of COBRA eligibility expires.
6. Disability ends for a person who has exhausted their 18 months of COBRA coverage but is within the 11-month disability extension.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

CalCOBRA Extension

AB1401 was passed by the California Legislature in September 2002. This legislation expanded the COBRA eligible period to 36 months for all events for all employees who elect COBRA coverage on or after January 1, 2003. The additional continuation will apply to medical coverage only, and only to residents of California.

Employees who terminate employment and elect federal COBRA are eligible for continuation coverage of their medical, dental and/or vision coverage for up to 18 months at a rate that is 102% of the applicable rate. Once they exhaust their federal COBRA and if they are a resident of California, they may elect the additional continuation coverage mandated by AB1401 and remain covered under their medical plan only for an additional 18 months at a rate that is 110% of the applicable rate.

Disability extensions and qualifying events are still factors. If someone is disabled, is so certified by Social Security, and reports it within the required time frames, their federal COBRA will extend up to 11 months after the first 18 months at a rate that is 150% of the applicable rate. After this 29-month period is over, the 150% rate would still apply for the remaining seven months of continuation available under AB1401.

Another provision in AB1401 stipulates that any conversion plans offered to employees who terminate after September 1, 2003, must be one of the carrier's HIPAA Guaranteed Issue individual plans. Qualified applicants must make written application and initial premium payment within 63 days of termination of their group coverage, rather than 31 days.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Mental Health Parity Act (MHPA)

Overview

The Mental Health Parity Act of 1996 (MHPA) is a federal law that may prevent your group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower – less favorable – than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. For example, if your health plan has a $1 million lifetime limit on medical and surgical benefits, it cannot put a $100,000 lifetime limit on mental health benefits. The term “mental health benefits” means benefits for mental health services defined by the health plan or coverage.

Although the law requires “parity,” or equivalence with regard to dollar limits, MHPA does NOT require group health plans and their health insurance issuers to include mental health coverage in their benefits package. The law’s requirements apply only to group health plans and their health insurance issuers that include mental health benefits in their benefits packages.

If your group health plan has separate dollar limits for mental health benefits, the dollar amounts that your plan has for treatment of substance abuse or chemical dependency are NOT counted when adding up the limits for mental health benefits and medical and surgical benefits to determine if there is parity.

Coverage under MHPA

MHPA applies to most group health plans with more than 50 workers. MHPA does NOT apply to group health plans sponsored by employers with fewer than 51 workers. MHPA also does NOT apply to health insurance coverage in the individual market. But you should check to see if your State law requires mental health parity in other cases.

For further information, you may go to the Centers for Medicare and Medicaid Services (CMS) website at: http://www.cms.hhs.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

The County of Ventura has determined that your prescription drug coverage with the County of Ventura-sponsored medical plans, (i.e., Ventura County Health Care Plan and Anthem Blue Cross EPO and HDHP PPO Plans) are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

This notice has information about your current prescription drug coverage with the County of Ventura sponsored medical plans and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Effective January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare.

2. The County of Ventura has determined that the prescription drug coverage offered by the Ventura County Health Care Plan, and the Anthem Blue Cross EPO and High-Deductible PPO Plans are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

3. Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Because the County's sponsored medical plans and prescription coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

People with Medicare may enroll in a Medicare prescription drug plan from October 15 through December 7 each year, for the following plan year. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

If you do decide to enroll in a Medicare prescription drug plan and drop your County-sponsored medical plan and its respective prescription drug coverage, be aware that you may not be able to get this coverage back. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

It is important to remember that your current coverage pays for other health expenses in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the County-sponsored medical plans, and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example:

If you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage, please contact our office at (805) 662-6791.

NOTE: You may receive this notice at other times in the future, such as before the next period during which you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy at any time.

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail from Medicare. Upon reaching Medicare eligibility, you may also be contacted directly by Medicare prescription drug plans. You can obtain more information about Medicare prescription drug plans from the following:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at (800) 772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a new plan approved by Medicare, which offers prescription drug coverage, you may need to give a copy of this notice when you join to illustrate that you are not required to pay a higher premium amount.

Retiree Health Benefits Coordinator: Patty Vandewater, Human Resources-Benefits Division, 800 South Victoria Avenue, Ventura, CA 93009-1970, Tel.: 805-662-6791 Fax: 805-654-2665

Distributed in October 2016

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

This Notice is to inform you of certain provisions contained in group health plans and related procedures that may be utilized by the employee and/or member in accordance with federal law. If you have any questions about your rights under HIPAA, you should contact:

Centers for Medicare & Medicaid Services (CMS) - Telephone: (877) 267-2323, TTY: (866) 226-1819

You may reach CMS by mail at: **Centers for Medicare & Medicaid Services,** 7500 Security Boulevard, Baltimore, MD 21244-1850

For general questions about Medicare:

Telephone: **1 (800) 633-4227**
TTY/TDD: **1 (877) 486-2048**

Please note that if you contact the California Department of Managed Health Care with a question about HIPAA, you may be asked to contact the office of CMS directly. Complaints about individual portability will also be forwarded to CMS for resolution.

Information about HIPAA rights is also available from the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, which is listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Further information about portability of health coverage (HIPAA), including consumer information on health plans and frequently asked questions are found at:

US Department of Labor website:

http://www.dol.gov/dol/topic/health-plans/portability.htm

Portability Provision

Any individual who loses coverage under this or any other group plan must elect COBRA continuation coverage or other continuation coverage available under a similar state program – and pay premiums during the continuation period – in order to qualify for the individual health plan protection afforded by HIPAA. Future individual plan HIPAA protection may be jeopardized if a person who loses coverage does not elect to continue coverage, or does not exhaust the continuation period available, or does not purchase an individual conversion policy. Election of continuation coverage is not a requirement for application of creditable coverage under a new group plan.

Pre-existing Conditions Exclusion Provision

This is to advise you that a pre-existing condition exclusion period may apply to you if a pre-existing condition exclusion provision is included in the group health plan that you are or become covered under.

Under HIPAA, a plan cannot treat a medical condition as "pre-existing" unless medical advice, diagnosis, care or treatment for the condition was received or recommended within the six-month period ending on the "enrollment date." A pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior creditable health coverage.

For employer group health plans, these HIPAA provisions generally took effect at the beginning of the first plan year started after June 30, 1997.

Pregnancy cannot be treated as a pre-existing condition. Pre-existing condition clauses do not apply to a newborn or newly adopted child as long as the child had health coverage on the last day of the 30-day period beginning with the child's date of birth or placement for adoption.

Creditable Coverage

Creditable coverage includes coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a state health benefit risk pool, the Federal Employee Health Benefits Program (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under section 5(c) of the Peace Corps Act. Not included as creditable coverage is any coverage that is exempt from the law (e.g., dental only coverage or dental coverage that is provided in a separate policy or even in the same policy as medical, is separately elected and results in additional premium).

If you had prior creditable coverage within the 63 days immediately before your enrollment date, then the preexisting conditions exclusion in your plan, if any, will be reduced or eliminated. Waiting periods imposed before you are eligible for coverage under the plan do not count toward determining the length of a break in coverage. However, any coverage occurring before any 63-day break in coverage will not count as creditable coverage. The duration of the preexisting conditions exclusion will be reduced one day for each day of creditable coverage. If you had no creditable coverage within the 63 days prior to your enrollment date (either because you had no prior coverage or because there

was more than a 63-day gap from the date your prior coverage terminated to your enrollment date), the plan's full preexisting conditions exclusion will apply.

Because of California state law regulating insured plans, if you had prior creditable coverage under an insured plan within the 180 days immediately before your enrollment date, then the preexisting conditions exclusion in your plan, if any, will be waived. If you had no creditable coverage within the 180 days prior to your enrollment date, the plan's preexisting conditions exclusion will apply.

If you have any questions regarding the determination of whether or not a preexisting conditions exclusion applies to you, please call the group health plan's Member Services telephone number. Telephone numbers for County-sponsored plans are listed on the back cover of this handbook.

Special Enrollment Periods Under HIPAA

Note: Under Internal Revenue Code, other events may also qualify you for a mid-year enrollment change. See "Mid-Year Changes" in Chapter 1, Flexible Benefits Program Information, for a description.

Due to Loss of Coverage

If you are eligible for coverage under your employer's medical plan but decline that medical coverage for yourself or your dependents (including your spouse) stating, in writing, that the reason for declining is because you have other medical insurance coverage, you will be allowed to enroll yourself and/or your dependents in an employer's medical plan outside any normal Open Enrollment period, provided that you request enrollment within 30 days after the other coverage ends. Under HIPAA regulations, the following events qualify as loss of other coverage for employees and dependents:

- They exhaust COBRA coverage (coverage ends for other than failure of the individual to pay premiums on time or for cause such as making a fraudulent claim or intentional misrepresentation of a material fact)
- They cease to be eligible for other coverage (includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment)
- Employer contributions for the other coverage cease

For Certain Dependent Beneficiaries

If you have an eligible new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependent under your plan prior to the next annual Open Enrollment period, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you previously declined coverage, you are also eligible to enroll yourself during this special enrollment period even if only the dependent lost other coverage. In the case of the birth or adoption of a child, your spouse may also be enrolled as your dependent if the spouse is otherwise eligible for coverage but not already enrolled.

Special Enrollment Rules

To qualify for the special enrollment, individuals who meet the above requirements must request enrollment no later than 30 days after one of the events described above.

The effective date for individuals who lost coverage will be the date coverage is elected or an earlier date, depending on plan rules. If you seek to enroll a dependent during the special enrollment period, coverage for your dependent (and for you, if also enrolling) will become effective as of the date that the qualifying event occurred (for marriage, as of the enrollment date) once the completed request for enrollment is received.

Standards for Privacy of Identifiable Health Information

As part of the new administrative simplification requirements under HIPAA, full federal privacy rights and protections for patients were enacted. The Standards for Privacy of individually identifiable health information (the Privacy Rule) took effect on April 14, 2001. Compliance was required on April 14, 2003 for most covered entities. The Privacy Rule creates national standards to protect individuals' protected health information (PHI) such as the past, present or future physical health, mental health or condition of an individual that either identifies or could be used to identify the individual. The Privacy Rule also gives patients increased access to their medical records. The Privacy Rule covers health plans, health care clearinghouses and health care providers as covered entities who conduct certain financial and administrative transactions electronically, and departments that use, transmit, collect or report any of the information that HIPAA covers under the act.

The County of Ventura is a legal covered entity and the plan sponsor. The Human Resources/Benefits staff will continue to collect information about plan enrollments and premium payments on all employees in order to continue to provide and administer benefits. As the plan sponsor, the County will comply with the mandated legal requirements.

The plan sponsor has modified the Flexible Benefits Program Plan Document to reflect HIPAA required changes.

The Labor Commissioner's Office

EMPLOYERS MUST PROVIDE THIS INFORMATION TO NEW WORKERS
WHEN HIRED AND TO OTHER WORKERS WHO ASK FOR IT

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING

Your Right to Take Time Off:

- You have the right to take time off from work to get help to protect you and your children's health, safety or welfare. You can take time off to get a restraining order or other court order.
- If your company has 25 or more workers, you can take time off from work to get medical attention or services from a domestic violence shelter, program or rape crisis center, psychological counseling, or receive safety planning related to domestic violence, sexual assault, or stalking.
- You may use available vacation, personal leave, accrued paid sick leave or compensatory time off for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer before, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, court order or doctor's or counselor's note or similar document.

Your Right to Reasonable Accommodation:

- You have the right to ask your employer for help or changes in your workplace to make sure you are safe at work. Your employer must work with you to see what changes can be made. Changes in the workplace may include putting in locks, changing your shift or phone number, transferring or reassigning you, or help with keeping a record of what happened to you. Your employer can ask you for a signed statement certifying that your request is for a proper purpose, and may also request proof showing your need for an accommodation. Your employer cannot tell your coworkers or anyone else about your request.

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, or stalking.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

You can file a complaint with the Labor Commissioner's Office against your employer if he/she retaliates or discriminates against you.

For more information, contact the California Labor Commissioner's Office. We can help you by phone at 213-897-6595, or you can find a local office on our website: www.dir.ca.gov/dlse/DistrictOffices.htm. If you do not speak English, we will provide an interpreter in your language at no cost to you. This Notice explains rights contained in California Labor Code sections 230 and 230.1. Employers may use this Notice or one substantially similar in content and clarity.

Labor Commissioner's Office Victims of Domestic Violence, Sexual Assault and Stalking Notice 5/2017

Appendix C
Summaries of Benefits and Coverage

Health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan's benefits and coverage. The following summaries are designed to help you better understand and evaluate your health insurance choices.

Ventura County Health Care Plan (HMO)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 12/31/2017 – 12/29/2018**
Ventura County Health Care Plan (VCHCP): Large Group Commercial HMO
Coverage for: Small Group Employees and Dependents | Plan Type: Large Group Commercial HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact the Ventura County Health Care Plan (VCHCP) at 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036. (805) 981-5050 or toll free at (800) 600-8247 or by fax at (805) 981-5051 or http://www.vchealthcareplan.org/members/programs.aspx For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossaryto request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	N.A.	This plan does not have a deductible. . See list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,000/person and $6,000/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges on not covered expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.vchealthcareplan.org member section, or call (805) 981-5050 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see a specialist.

* For more information about limitations and exceptions, see the plan or policy document at http://www.vchealthcareplan.org/members/programs.aspx **1 of 7**

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider VCMC (You will pay the least)	Network Provider Non-VCMC (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay	$20 co-pay	Not Covered	None
	Specialist visit	$20 co-pay	$40 co-pay	Not Covered	None
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	$0 $0 $0	$20 co-pay diagnostic/ x-rays No Charge for laboratory tests $125 co-pay	Not Covered Not Covered	None None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.vchealthcareplan.org/members/programs/docs/ProviderDrugList.pdf	Tier 1 - Generic drugs	Not Available	$9 co-pay $18 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 2 - Preferred brand drugs	Not Available	$30 co-pay $60 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 3 - Non-preferred brand drugs	Not Available	$45 co-pay $90 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 4 - Specialty drugs	Not Available	10% of cost up to $250 per script per month	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0	$250 co-pay	Not Covered	None
	Physician/surgeon fees	No Charge	No Charge	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at http://www.vchealthcareplan.org/members/programs.aspx

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider VCMC (You will pay the least)	Network Provider Non-VCMC (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 co-pay per visit	$150 co-pay per visit	$150 co-pay per visit	None
	Professional Fee	No Charge	No Charge	Not Covered	None
	Emergency medical transportation	$150 co-pay	$150 co-pay	$150 co-pay	None
	Urgent care	$50 co-pay	$50 co-pay	$50 co-pay	*Urgently Needed Care is covered while outside the service area. When inside the service area, must use an In-Network facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	$150 per day/ $600 maximum per stay	Not Covered	
	Physician/surgeon fees	No Charge	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Available	Outpatient Office Visit: $10 co-pay per visit Other Outpatient Visits. $10 co-pay per visit	Not Covered	None
	Inpatient services	Not Available	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	No Charge	Not Covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	No Charge	Not Covered	None
	Childbirth/delivery facility	$0	$150 co-pay per	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at http://www.vchealthcareplan.org/members/programs.aspx

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider VCMC (You will pay the least)	Network Provider Non-VCMC (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services		day/ $600 maximum		
If you need help recovering or have other special health needs	Home health care	$20 co-pay per visit		Not Covered	None
	Rehabilitation services	$20 co-pay per day		Not Covered	None
	Habilitation services	$20 co-pay		Not Covered	None
	Skilled nursing care	$50 per day/ $500 maximum		Not Covered	None
	Durable medical equipment	10% coinsurance; 50% coinsurance for replacement		Not Covered	None
	Hospice services	No charge		Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge when part of routine physical (through age 17)		Not Covered	None
	Children's glasses	Not Covered		Not Covered	None
	Children's dental check-up	Not Covered		Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at http://www.vchealthcareplan.org/members/programs.aspx

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adults)
- Dental Care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services). This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric Surgery

* For more information about limitations and exceptions, see the plan or policy document at http://www.vchealthcareplan.org/members/programs.aspx

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Managed Health Care (DMHC) 980 9th Street, Suite 500, Sacramento, CA 95814; Phone: (888) HMO-2219; TDD: (877) 688-9891; FAX: (916) 229-4328 www.hmohelp.ca.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: California Department of Managed Health Care (DMHC) 980 9th Street, Suite 500, Sacramento, CA 95814; Phone: (888) HMO-2219; TDD: (877) 688-9891; FAX: (916) 229-4328 www.hmohelp.ca.gov

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (800) 600-8247.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 600-8247
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 600-8247
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 600-8247

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at http://www.vchealthcareplan.org/members/programs.aspx

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2500
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2500
Copayments	$390
Coinsurance	$1791
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4681**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2500
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1728
Copayments	$1275
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3058**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2500
Specialist *[cost sharing]*	$75
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1187
Copayments	$260
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1487**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Anthem EPO

Anthem Blue Cross Life and Health Insurance Company
VENTURA COUNTY
EPO 15 (0/15/0)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 12/31/17 – 12/29/18
Coverage for: Individual + Family | **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/ca/aso or by calling (800) 727-2762.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 3 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes; **$100** per visit for Emergency room services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes; **$1,500** per member/**$3,000** family for PPO Providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, EPO. For a list of PPO providers, see www.anthem.com/ca or call **(800) 727-2762**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network,

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (800) 727-2762 to request a copy.

CA/L/A/PACE:CUSTOM15(0/15/0)-EPO/NA/NA/10-17

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Important Questions	Answers	Why this Matters:
		preferred, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**)
- This plan may encourage you to use **PPO providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not covered	--------none--------
	Specialist visit	$15 copay per visit	Not covered	--------none--------
	Other practitioner office visit	Chiropractor $15 copay per visit Acupuncture $15 copay per visit	Chiropractor Not covered Acupuncture Not covered	Chiropractor Coverage is limited to 30 visits per benefit period. Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services. Acupuncture Coverage is limited to 20 visits per benefit period.
	Preventive care/ screening/immunization	No cost share	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No cost share X-Ray – Office No cost share	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	$100 copay per test	Not covered	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/ca/pharmacyinformation/	Tier 1 - Typically Generic	$10 copay per prescription (retail only) and $10 copay per prescription (home delivery only)	$10 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug	30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
			maximum allowed amount	only at retail pharmacies). Covers up to a 90 day supply (home delivery program) (includes diabetic supplies).
	Tier 2 - Typically Preferred / Brand	$25 copay per prescription (retail only) and $50 copay per prescription (home delivery only)	$25 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies). Covers up to a 90 day supply (home delivery program) If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
				name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$45 copay per prescription (retail only) and $90 copay per prescription (home delivery only)	$45 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies). Covers up to a 90 day supply (home delivery program) If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
				determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply. Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies (includes compound drugs).
	Tier 4 - Typically Specialty Drugs	20% coinsurance up to $150 per prescription (retail only) and 20% coinsurance up to $300 per prescription (home delivery only)	50% coinsurance	30-day supply for specialty pharmacy. Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30 day supply. Member pays retail pharmacy copay plus 50% for Out-of Network Providers.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay per admission	Not covered	--------none--------
	Physician/surgeon fees	No cost share	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	$100 copay per visit	Covered as In-Network	If admitted inpatient, ER copay is waived.
	Emergency medical transportation	$100 copay per trip	Covered as In-Network	--------none--------
	Urgent care	$15 copay per visit	Covered as In-Network	Copay waived if admitted inpatient and outpatient ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per admission	Not covered	--------none--------
	Physician/surgeon fee	No cost share	Not covered	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit $15 copay per visit Facility Charges No cost share	Office Visit Not covered Facility Charges Not covered	Office Visit --------none-------- Facility Charges --------none--------
	Mental/Behavioral health inpatient services	No cost share	Not covered	This is for facility professional services only. Refer to hospital stay for facility fees.
	Substance use disorder outpatient services	Office Visit $15 copay per visit Facility Charges No cost share	Office Visit Not covered Facility Charges Not covered	Office Visit --------none-------- Facility Charges --------none--------
	Substance use disorder inpatient services	No cost share	Not covered	This is for facility professional services only. Refer to hospital stay for facility fees.
If you are pregnant	Prenatal and postnatal care	$15 copay per visit	Not covered	--------none--------
	Delivery and all inpatient services	$100 copay per admission	Not covered	--------none--------
If you need help recovering or have other special health needs	Home health care	$15 copay per visit	Not covered	Coverage is limited to 100 visits per benefit period; one visit by a home health aide equals four hours or less.
	Rehabilitation services	$15 copay per visit	Not covered	--------none--------
	Habilitation services	$15 copay per visit	Not covered	--------none--------
	Skilled nursing care	No cost share	Not covered	Coverage is limited to 100 days limit per benefit period.
	Durable medical equipment	20% coinsurance	Not covered	--------none--------
	Hospice service	No cost share	Not covered	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery for morbid obesity only.
- Chiropractic care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (800) 727-2762. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Doo bee a'tah ni'liigoo ei dooda'í, shikáa adoołwoł íinízinigo t'áá diné k'éjíigo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíilkiid. Ei doo biigha daago ni ba'nija'go ho'aalagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

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Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm.Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,160
- **Patient pays** $380

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$230
Coinsurance	$0
Limits or exclusions	$150
Total	$380

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,520
- **Patient pays** $880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$550
Coinsurance	$250
Limits or exclusions	$80
Total	$880

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (800) 727-2762 to request a copy.

CA/L/A/PACE:CUSTOM15(0/15/0)-EPO/NA/NA/10-17

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Anthem High Deductible Health Plan (PPO)

Anthem Blue Cross Life and Health Insurance Company
VENTURA COUNTY
High-Deductible PPO - Lumenos 3000 20/40 (LHSA291) Embedded

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 12/31/2017 – 12/29/2018
Coverage for: Individual + Family | **Plan Type:** CDHP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/ca/aso or by calling (800) 727-2762.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual member / **$6,000** family for In-Network Providers. Does not apply to Preventive care. **$3,000** individual member/**$6,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are combined.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$5,000** individual member/**$10,000** family for In-Network Providers. **$10,000** individual member/**$20,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are separate and do not count towards each other.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

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CA/L/A/PACELUMENOS-CDHP/NA/NA/10-17

1 of 13

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Prudent Buyer PPO. For a list of In-Network providers, see www.anthem.com/ca or call **(800) 727-2762**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	--------none--------
	Specialist visit	20% coinsurance	40% coinsurance	--------none--------
	Other practitioner office visit	Chiropractor 20% coinsurance Acupuncture 20% coinsurance	Chiropractor 40% coinsurance Acupuncture 40% coinsurance	Chiropractor Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 visits per benefit period. Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services. Acupuncture Coverage for In-Network Providers and Non-Network Providers combined is limited to 20 visits per benefit period.
	Preventive care/ screening/immunization	No cost share	40% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Coverage for Out-of-Network Providers is limited to $800 maximum per procedure.
	Tier 1 - Typically Generic	$10 copay per prescription	40% coinsurance (retail only) of the	Until the benefit period deductible is satisfied, the

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/ca/pharmacyinformation/		(retail only) and $10 copay per prescription (home delivery only)	prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	member pays the prescription drug covered expense, and not the copays. 30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies) Covers up to a 90 day supply (home delivery program) (includes diabetic supplies).
	Tier 2 - Typically Preferred / Brand	$30 copay per prescription (retail only) and $60 copay per prescription (home delivery only)	40% coinsurance (retail only) of the prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	Until the benefit period deductible is satisfied, the member pays the prescription drug covered expense, and not the copays. 30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				Covers up to a 90 day supply (home delivery program). If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The preferred generic program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply for In-Network Providers.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$50 copay per prescription (retail only) and $100 copay per prescription (home delivery only)	40% coinsurance (retail only) of the prescription drug maximum allowed amount and costs in excess of the	Until the benefit period deductible is satisfied, the member pays the prescription drug covered expense, and not the copays. 30-day supply; 60-day supply

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
			prescription drug maximum allowed amount	for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies). Covers up to a 90 day supply (home delivery program). If a member requests a brand name drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of our average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				such case, the applicable copay for the dispensed drug will apply for In-Network Providers. Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies. (includes compound drugs).
	Tier 4 - Typically Specialty Drugs	30% coinsurance up to $150 per prescription (retail only) and 30% coinsurance up to $300 per prescription (home delivery only)	Not covered	Until the benefit period deductible is satisfied, the member pays the prescription drug covered expense, and not the coinsurance. 30-day supply for specialty pharmacy. Certain specialty pharmacy drugs may only be obtained through the specialty pharmacy program and are limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Coverage for Out-of-Network is limited to $350 maximum per admission.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	20% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	20% coinsurance	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Coverage for Out-of-Network is limited to $1,000

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				maximum per day limit for non-emergency admission.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit 20% coinsurance Facility Charges 20% coinsurance	Office Visit 40% coinsurance Facility Charges 40% coinsurance	Office Visit --------none-------- Facility Charges --------none--------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	This is for facility professional services only. Refer to hospital stay for facility fees.
	Substance use disorder outpatient services	Office Visit 20% coinsurance Facility Charges 20% coinsurance	Office Visit 40% coinsurance Facility Charges 40% coinsurance	Office Visit --------none-------- Facility Charges --------none--------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	This is for facility professional services only. Refer to hospital stay for facility fees.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	--------none--------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Coverage for Out-of-Network is limited to $1,000 maximum per day limit for non-emergency admission.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage for In-Network and Non-Network Providers combined is limited to 100 visits per benefit period. One visit by a home health aide equals four hours or less.
	Rehabilitation services	20% coinsurance	40% coinsurance	--------none--------
	Habilitation services	20% coinsurance	40% coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 days limit per benefit period.
	Durable medical equipment	50% coinsurance	50% coinsurance	--------none--------
	Hospice service	20% coinsurance	40% coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

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- Long- term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

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- Acupuncture
- Bariatric surgery for morbid obesity only.
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

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1-800-482-4TDD (4633)
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Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm.Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,520
- **Patient pays** $4,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$20
Coinsurance	$850
Limits or exclusions	$150
Total	$4,020

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,750
- **Patient pays** $3,650

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,000
Copays	$200
Coinsurance	$370
Limits or exclusions	$80
Total	$3,650

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (800) 727-2762 to request a copy.

CA/L/A/PACELUMENOS-CDHP/NA/NA/10-17

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Who Do I Contact?

Your benefits are provided by a combination of organizations. Be sure you are contacting the right vendor when you have questions, and be prepared to specify which plan you are calling about.

Ventura County Health Care Plan (HMO)
Member Services E-Mail: vchcp.memberservices@ventura.org Website: http://www.vchealthcareplan.org
Local Phone Number: (805) 981-5050
Toll-Free Number: (800) 600-8247
24/7 Nurse Advice/Health Information (no copayment): (800) 334-9023
Mail Order Pharmacy – Express Scripts (www.express-scripts.com) (800) 233-8065

Anthem Medical Plans (EPO and High-Deductible PPO)
Policy# C18449
Customer Service: (800) 727-2762
24/7 NurseLine (no copayment): (800) 977-0027
TelaDoc (24/7 doctor visit via telephone, web, or mobile app; no copayment): (800) 835-2362
Mail Order Pharmacy – EmpiRx Health (www.empirxhealth.com/members) (877) 241-7123
Website: www.anthem.com/ca (for provider search, use "Blue Cross PPO–Prudent Buyer–Large Group" for both the EPO & PPO plans)

MetLife Dental PPO Plan
Group# 0154209 (PDP Plus Plan)
Customer Service (Member Services office for Eligibility/Claims/Benefits/Pre-certifications) (800) 438-6388
Website: www.metlife.com/mybenefits

Medical Eye Services (MES) – Vision Plan
Group# 20434; Policy# 290-004
Customer Service: (800) 877-6372
Customer Service e-mail: customerservice@mesvision.com or (714) 619-4660
Website: http://www.mesvision.com

Flexible Spending Accounts (Health Care and Dependent Care)
Email: FSA.Account@ventura.org (805) 677-8785
Website: http://www.ventura.org/benefits/flexible-spending-accounts

HealthEquity HSA (for Anthem HDHP-PPO enrollees only)
Website: http://www.healthequity.com (866) 346-5800

County Retiree Health Benefits Coordinator (805) 662-6791

Optional Life Insurance/Basic Life Insurance – MetLife
(Group Policy# 154209-1-G) – Customer Service (800) 638-6420

Long Term Disability Insurance – MetLife
(Group Policy# 154209-1-G) – Customer Service (800) 638-2242

Short Term Disability Insurance – COV Wage Supplement Plan (805) 654-3636

Leave of Absence Program
Absence Management Analyst (Last Names A-L) (805) 654-2780
Absence Management Analyst (Last Names M-Z) (805) 654-3636
Website: http://www.ventura.org/benefits/leave-of-absence

Employee Assistance Program (EAP)
Lincoln's Inn, 950 County Square Drive, Suite 200, Ventura, CA 93003 (805) 654-4327
Website: http://www.ventura.org/benefits/eap

Wellness Program
Website: http://www.ventura.org/vcwell (805) 654-2628

Work/Life Program
Website: http://www.ventura.org/benefits/work/life-program (805) 477-7234

Deferred Compensation Program (401k and 457 Plans)
Website: http://www.ventura.org/benefits/deferred-compensation (805) 654-2620

County of Ventura- CEO/HR/Benefits
800 S. Victoria Avenue, Loc. 1970, Ventura CA 93009
805.654.2570 (phone)
805.654.2665 (fax)
Benefits.ServiceRep@ventura.org (email)
http://myvcweb/index.php/hr/benefits/home (intranet)
www.ventura.org/benefits (internet)