2025
EMPLOYEE BENEFITS HANDBOOK

HEALTH INSURANCE PLANS
MEDICAL, DENTAL & VISION
DECEMBER 22, 2024 - DECEMBER 20, 2025

FLEXIBLE SPENDING & HEALTH SAVINGS ACCOUNTS
JANUARY 1 - DECEMBER 31, 2025

*HANDBOOK INCLUDES IMPORTANT EMPLOYEE NOTICES AND INFORMATION

COUNTY of VENTURA
Human Resources

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On-Line Resources

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- **http://myvcweb/index.php/benefits**
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- **Health Plan websites**
  - VCHCP (http://www.vchealthcareplan.org)
  - BlueShield or (https://myoptions.blueshieldca.com/ventura) OR (http://www.blueshieldca.com)
  - MetLife Dental (https://www.metlife.com/countyofventura)
  - EyeMed Vision (www.eyemed.com)
  - Chard Snyder (FSA) (http://www.chard-snyder.com)
  - Health Equity (HSA) (https://healthequity.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.

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- **Your Rights and Obligations as a Pregnant Employee**
- **Family Care and Medical Leave and Pregnancy Disability Leave**
- **Paid Family Leave Benefits Program (PFL)**
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- **Availability of Privacy Practices Notices**
- **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 Enrollment Instructions

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

Link to VCHRP - https://vchrp.co.ventura.ca.us you must have DUO to login from an out-of-network computer. See Benefits Bulletin for more information.

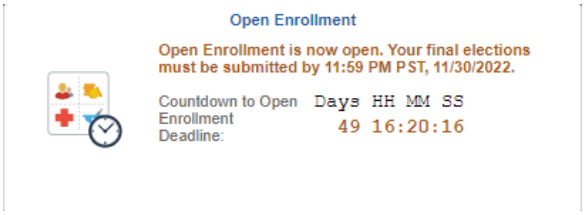
SIGNING ON TO VCHRP

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

If you need to reset your password, please contact your agency IT Representative or Agency Benefit Representative.

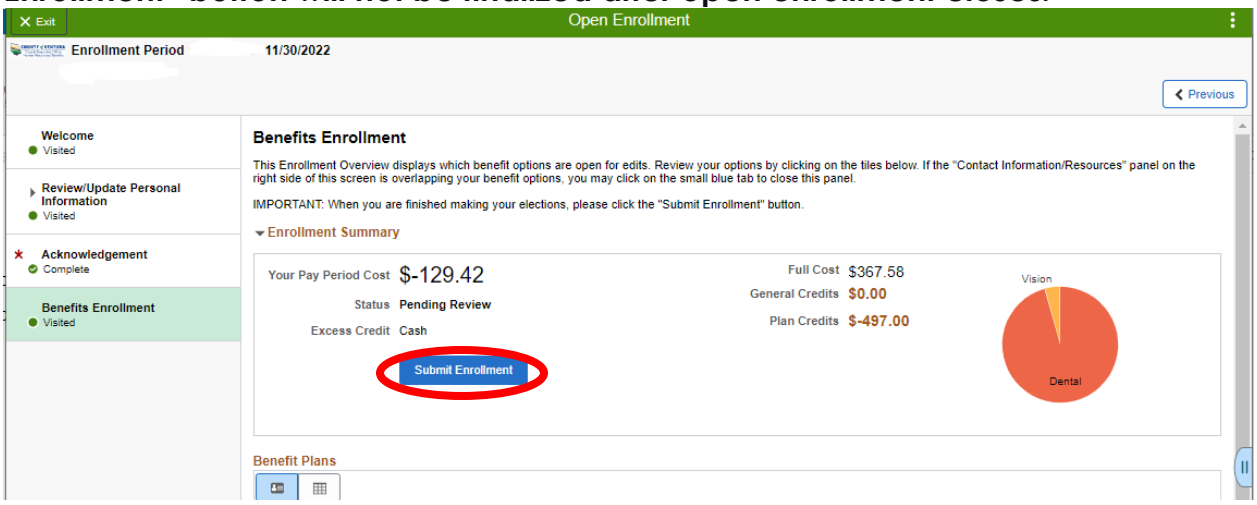
ONLINE ENROLLMENT

From the Employee Self Service home page, click on the Open Enrollment tile:



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

IMPORTANT! **Be sure to click the blue "Submit Enrollment" button after you've made your selections and review the Election Preview Statement option that will appear after you click the button to submit. You can submit elections until the close of open enrollment, but any changes made without clicking the "Submit Enrollment" button will not be finalized after open enrollment closes.**



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)

Review this chapter for more information. If you need to make a mid-year change to your benefits, you may do so through VCHRP Employee Self Service - Benefits - Life Events, or you may complete an Enrollment & Change Form and Mid-Year Change Request Form. You have up to 60 days to submit a mid-year change, including the event date (for example, birth or marriage). Additional information can be found on our websites: http://myvcweb/index.php/benefits (intranet), https://hr.ventura.org/benefits (internet), or contact your Department's Human Resources/Benefits Representative. *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 (submit *enrollment or waive participation within **31 days** including the date of hire*). ✓ 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.
Address Change Name Change	■ Enter your new address in VCHRP (Employee Self Service > Personal Details > Addresses) 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. ■ 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 to 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 union may have a different minimum 401(k) contribution. Employer match information can be found on the plan brochure at: https://dc.ventura.org/resource-page/ . To change your 457 or 401(k) Plan contribution amount, log on to Fidelity Net Benefits at http://netbenefits.com/ventura. ✓ You have gained or lost eligibility to Long-Term and/or Short-Term Disability Plans.

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 up to ***60 days*** to submit a mid-year change to add your new dependent(s) to your medical, dental, and vision plans. Otherwise, you will have to wait for the next open enrollment period. ■ If you are currently enrolled in Optional Life Insurance, you have up to ***31 days*** to enroll a new dependent in a Dependent Life Insurance plan. If you have existing Dependent Life Insurance coverage on other dependents, you have 90 days to complete a Dependent Life Enrollment Change Request Form to add your new dependent without providing evidence of insurability. ■ 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 on our website. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Legal Separation or Divorce Child no longer meets eligibility criteria	■ You must formally cancel coverage for your dependent if they become ineligible. This will trigger an offer of continued coverage through COBRA, but only if the mid-year change request to drop the dependent is received within 60 days of the event. Be sure to include the dependent's current mailing address, if different than the employee's address. Although you have up to 60 days, you should notify Benefits to drop your ineligible dependents as soon as possible. You may be liable for claims paid after eligibility ends. ■ You do not need to formally cancel coverage for your overage dependent (age 26 and over). They will be automatically dropped, and coverage will be terminated. This will trigger an offer of continued coverage through COBRA. ■ Consequences of the failure to request removal of dependents that no longer meet the eligibility requirements (other than dependents reaching age 26 noted above) for enrollment under health plans. Those dependents will be terminated as of the original date of ineligibility, and all expenses will be the responsibility of the employee/dependent(s). Furthermore, health plans have the right to collect any claims paid during any ineligible period, including the use of collections and adverse credit reporting. ■ You may want to drop or change 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 opt-out of County-sponsored medical insurance coverage, you must notify County Benefits (contact your HR Dept. Rep) if you lose your other group health coverage. Employees are required to enroll in one of the County-sponsored medical plans with no lapse in coverage. Failure to notify the County and enroll in a medical plan will lead to retro default enrollment in an employee-only VCHCP HMO plan (VCPFA & VCDSA will default into their lowest cost HMO plan), and possible repayment of ineligible Opt-Out cashback, and/or employee disciplinary actions. Dependents who show loss of outside coverage are enrolled in prospective coverage only based on the processing period received.
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 per pay period, or at least 40 hours per pay period if covered under the Management Resolution or in UAPD. ■ 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	■ Your Flexible Credit Allowance may increase. 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, verify on your paystub contributions have stopped. You'll be in the Ventura County Employees' Retirement Association (VCERA) from now on. VCERA will mail you plan information.

Event	Actions
Leave of Absence Request	■ Ask your department or check online sources for an Absence Management Handbook; read it thoroughly. ■ For you to maintain continuity of your health plan(s), optional life insurance(s) and Flexible Spending Account during your approved unpaid leave of absence. Your Agency's leave coordinator will provide initial information on the County's Direct Bill services through Optum Financial, our third-party administrator. You will receive direct correspondence from Optum Financial with more information on amounts due and payment schedules. ■ 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 reduce your annual pledge when your leave starts and complete another form upon your return, if you wish to increase your pledge. 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 will 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 have time sensitive options to continue your current Group Life coverage and maintain this important protection for you and your family. See the MetLife Certificate of Insurance for more information. ■ 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, notify County Benefits and the health plan(s). ■ 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 County 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.
Beneficiary Update	Beneficiaries are tracked separately by Plan or Plan Administrator. The preferred method to designate the below beneficiaries except Deferred Compensation, VCERA, and Safe Harbor plans is to access **VCHRP > Employee Self-Service > Benefit Detail tile**. The first step is to provide the Dependent/Beneficiary Info in that tab. The second step is to access the Designate Beneficiaries tab. Click on the drop-down box under Select Benefits for each plan. Read the information on each plan type and designate. If you are unsure of previous beneficiary plan designations, provide a new/updated election in this area. You can view and update this information at any time. *Note: DO NOT change any dependent relationship status that currently shows in the Dependent/Beneficiary Info area, for example "Child" to "Adult Child." Changing a dependent relationship in this area will cause health plan enrollment issues. Contact your agency's HR Rep or Benefits.ServiceRep@ventura.org if you need to make a dependent relationship change.* ■ 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 • Basic and/or Optional Life Insurance – http://vcportal.ventura.org/CEO/benefits/docs/Basic&Optional_Life_Beneficiary_Designation_Form.pdf • Deferred Compensation (401k and 457 plans) –Log into Fidelity NetBenefits or call Fidelity at 800-343-0860. See instructions: 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 – https://www.vcera.org/sites/main/files/file-attachments/beneficiary_designation_form_3-27-2019f.pdf?1689958196 • Safe Harbor Retirement Plan –https://dc.ventura.org/safe-harbor/ • 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

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 chapter 6, Miscellaneous Benefits, later in this handbook.

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 Chapter 2, Medical Plan Options. If you opt-out now, you must enroll later if you lose your other coverage. See *"Can I Change My Mind about the Plans I've Chosen?"* later in this chapter.

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

- **To enroll in any medical, dental or vision plan**: Go online (through VCHRP Employee Self Service, Benefits tile, and Life Events) or complete, sign, and submit the Enrollment & Change form. Attach proof of eligibility for all dependents.
- **To opt out of medical coverage:** Go online (through VCHRP Employee Self Service, Benefits tile, and Opt-Out Certification) or complete, sign, and submit the Enrollment & Change Form, the Opt-Out Certification form, and include your proof of other employer group medical coverage.
- **To waive all coverage:** Go online (through VCHRP Employee Self Service, Benefits tile, and Life Events) or complete, sign, and submit 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/hr/benefits/home
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. Online Enrollment and Manual Enrollment

Go online (through VCHRP Employee Self Service, Benefits tile, and Life Events) and attach the documentation within the deadlines discussed under *"Employee Enrollments"* and/or *"Can I Change My Mind about the Plans I've Chosen?"* 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. For manual enrollment, 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 which includes your date of hire.

1. Eligible New Employees

The 31-day period begins on your date of hire that is listed in VCHRP. The sooner you make your plan elections, 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 make your plan elections within 31 days of becoming eligible, you will be automatically enrolled in the lowest-cost County-sponsored HMO medical plan or the lowest-cost Association-sponsored HMO medical plan at employee-only coverage for which you are eligible.

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 be unable to choose your medical plan enrollment election.
- 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 *"Mid-Year Changes"* section under *"Can I Change My Mind about the Plans I've Chosen?"* 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 eligible newborn children of current plan members ends at 30 days after birth if action is not taken to enroll them on your plans).* 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 aged 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 or permanent legal guardianship 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, you must enroll all eligible dependents you wish to cover for the current Plan Year. Generally, employee and dependent coverage begin on the same coverage effective date (see *"When Coverage Begins"* under *"Employee Enrollments"*) unless an employee submits incomplete paperwork missing the necessary dependent proof, and it is not provided before the payroll processing deadline. If the missing dependent proof is received within the 31-day deadline, enrollment for the dependent(s) will be processed based on the payroll processing period received.

• ***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 60 days of eligibility; for example, marriage, registration of domestic partnership, birth of a child, adoption placement, or loss of the dependent's other coverage. Newborns, adoptions, and placement for adoption received within 60 days of the event date will be enrolled to the event date (ex., birth/adoption). While you have a 60-day window to enroll a newborn, requests received after 31 days can result in unavoidable delays in the insurance company's acknowledgment of the newborn's coverage for necessary services. Examples of potential access to care issues include delayed appointment authorizations, referrals, and prescription payment denials. **We strongly urge employees to submit enrollment paperwork within 25 days of a newborn's date of birth.** All other mid-year changes are prospective based on the payroll processing period during which the mid-year change is received.

• ***Existing Dependent***: For all plans, existing dependents can only be enrolled during the annual Open Enrollment period or if a qualified mid-year event occurs. See *"Open Enrollment"* and *"Mid-Year Changes"* under *"Can I Change My Mind about the Plans I've Chosen?"*

When you acquire a new dependent, enroll them online (through VCHRP Employee Self Service, Benefits tile, and Life Events) or submit an Enrollment & Change Form, making sure to submit the proof of dependent documentation. 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 is submitted timely, coverage for new dependents begins on the event date for newborns (date of birth) or placement for adoption, and the first day of the following pay period (from the County Payroll Calendar) for which a change was input into our payroll system for a marriage or registration for domestic partnership.

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?

You must cancel a dependent's coverage by going online (through VCHRP Employee Self Service, Benefits tile, and Life Events) or submitting an Enrollment & Change Form whenever a dependent becomes ineligible.

Examples:

- Divorce or legal separation
- Termination of a Domestic Partnership
- Dependent child turns age 26 (*automatically dropped and coverage terminated*)
- Death of a dependent

Cancel the dependent in VCHRP or turn in forms ***within 60 calendar days of the event*** (date eligibility ends). For divorces and termination of domestic partnerships it is strongly advised to notify us as soon as you receive your dissolution date. Notifying us promptly upon becoming aware of ineligibility is crucial. Failure to do so could result in liability for claims incurred after the dependent's eligibility ended and may 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 **need** to review your options and decide whether your current selections continue to 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

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.

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 60 days** of certain qualified mid-year events, such as changes in your family/employment status. See below for more information and review the Mid-Year Change Spreadsheet found on the Benefits Page for more detailed information and what documentation is required to request a mid-year change.

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 must 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, 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 not 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 60 days of the date of the event (marriage, birth, etc.).

Revised forms *must be received by CEO/Human Resources/Benefits* ***within 60 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 is a delay in obtaining the documentation, submit the form within 60 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 because 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 or submit a VCHRP Employee Self-Service Life Event ***within a maximum of 60 days*** of the date your dependent becomes ineligible. The dependent will be terminated from coverage as of their ineligibility date. The completed form/VCHRP Life Event must be submitted to CEO/Human Resources/Benefits within 60 days of the event. **You do not need to cancel coverage for your overage dependent.** They will be automatically dropped, and coverage will be terminated.

CEO/Human Resources/Benefits will 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) 477-1580 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/hr/benefits/home (under "Retiree Health Benefits")

- http://www.ventura.org/benefits (under "Open Enrollment - Health Plans Information")

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 or the County's Direct Bill services third-party administrator.

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 as bargained by your bargaining unit, 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's Direct Bill services third-party administrator. Their contact information can be found on the back cover of this book.

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 *Absence Management Program* section on Miscellaneous Benefits in Chapter 6 and Employee Notices in Appendix B. You should also review a copy of the County's Absence Management Program Handbook (https://hr.ventura.org/benefits/absence-management-disability-plans).

[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

- **https://hr.ventura.org/benefits**
- **http://myvcweb/index.php/benefits**
- **VCHRP**
  - *Self-Service → Benefits*
- **Health Plan websites**
  - VCHCP (http://www.vchealthcareplan.org)
  - BlueShield or (https://myoptions.blueshieldca.com/ventura) OR (http://www.blueshieldca.com)
  - MetLife Dental (https://www.metlife.com/countyofventura)
  - EyeMed Vision (https://www.eyemed.com/en-us)
  - Chard Snyder (FSA) (http://www.chard-snyder.com)
  - Health Equity (HSA) (https://healthequity.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.

Please note that all VCPFA and VCDSA represented employees have Association-sponsored medical plans. See your association for more information regarding these plans. These plans fall under the County's Flexible Benefit Plan guidelines as outlined in Chapter 1 of the Benefit Plans Handbook.

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) - An 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 HMO plans, you will almost always 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 by contacting the plan directly. Please note, depending on the plan, there are limits to the mileage from the home address. See each plan below and contact the plan directly to confirm PCP eligibility if you have any concerns. If your PCP leaves the plan during the Plan Year, you must select a new PCP within the plan.

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. Please note that some services require pre-authorization, an example of this is a PET scan. Please refer to your plan document or contact the plan directly if you have any questions about specific coverage and preauthorization requirements, if any, that may apply when seeking services.

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 an HMO, or they do not like the provider and referral restrictions of an 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 four medical plans to choose from:

- Ventura County Health Care Plan (full HMO network)
- Blue Shield Trio HMO (ACO network)
- Blue Shield Access+ HMO (full HMO network)
- Blue Shield 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. It is critical to review your cards as soon as you receive them. If there are any errors in enrollment, contact the Benefits Service Rep immediately. For HMO plans, if you were enrolled in the correct plan, but with an incorrect PCP or Medical Group/IPA, contact the specific plan directly immediately to review your options.

❖ Ventura County Health Care Plan (full HMO network)

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 can provide you with a direct referral in most cases; otherwise, your PCP will 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 in-network primary care and specialty care physicians, hospitals, and facilities.

To see a list of VCHCP contracted providers, visit http://www.vchealthcareplan.org, and click on "Find a Provider."

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 chiropractic and acupuncture services. (Reimbursement varies; for benefit details, see Comparison Chart in this chapter.)
- Members may self-refer for Mental Health and Substance Abuse Services to a contracted physician.

VCHCP's geographic service area is Ventura County. You must live or work in the service area at the time of enrollment to be eligible for coverage under VCHCP. You cannot be enrolled as a Subscriber or

Dependent if you live in or move to a region outside Ventura County, 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, behavioral health services, and prescriptions are covered outside of the Plan's service area. No mid-year changes will be approved due to a dependent who moves outside of the service area.

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

- Nurse Advice Line, which is available to you and your family 24 hours per day, 7 days per week at no cost. The Nurse Advice Line can be reached by calling (800) 334-9023.
- Teladoc, which allows you to talk to a licensed, board-certified doctor anytime, anywhere. Go to Teladoc.com or call (800) 835-2362.

❖ Blue Shield Trio ACO (HMO)

Blue Shield's Trio HMO offers a broad range of benefits and low out-of-pocket expenses. It uses Blue Shield's Accountable Care Organizations (ACO), which are made up of a network of local doctors, specialists, and hospitals. Through coordination, care is delivered more efficiently, and this helps to lower premiums and improve the patient experience. You need to select a primary care physician, who is part of a medical group or IPA, who is responsible for the overall coordination of your care. Note: Blue Shield's plans will have a maximum service area of between 15-25 miles depending on the plan selected. Contact the plan directly to confirm you will be able to select your PCP if they are near 15 miles or more from your home address to verify.

With the Trio ACO HMO plan, you have access to a select network of medical groups and IPAs who are contracted with high-quality local physicians, specialists, and hospitals near your home and workplace. And you can self-refer to a specialist within your personal physician's medical group or IPA. You will pay a slightly higher copayment; however, you can't self-refer to Physical Therapy, Occupational Therapy, Speech-Language Therapy, Dermatology, Allergist, Podiatry, Endoscopic procedures, Diagnostic and nuclear imaging including CT, MRI, or bone density measurement.

To see a list of the providers who participate in the Blue Shield Trio HMO network:

1. Go to https://myoptions.blueshieldca.com/ventura or blueshieldca.com/networktriohmo
2. Select the type of provider you are looking for.
3. Enter your location, then click Continue.
4. If you need to select a primary care physician, click on the name of the PCP, then click "view details," note the PCP ID# which you will need to enroll.

Through the BlueCard® Program, HMO plan members can access emergency and urgent care services across the country and around the world. Getting urgent care with the BlueCard Program can be more cost-effective. It may also eliminate the need to pay for the services at the time you receive them.

1. To find a provider in the U.S., visit provider.bcbs.com, or call **(800) 810-BLUE (2583)**.
2. To find a provider outside the U.S., visit bcbsglobalcore.com, or call **(804) 673-1177** collect from outside the U.S.

Away From Home Care Program – You and your family can stay covered with HMO benefits for extended periods with the Away From Home Care® program. Students, long-term travelers, and families

living apart can rely on access to health care across the country. Away From Home Care is available in most states but not all. For more information on which states participate, please call Blue Shield at **(800) 622-9402.**

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

- Shield Concierge – for 360° high-touch member support through one dedicated support team.
- Teladoc Program – Access to Teladoc's national network of U.S. board-certified physicians, licensed in California. Whenever you need care, Teladoc doctors are available 24/7 by phone or video.
- NurseHelp 24/7 – Registered nurses are available to answer your health questions at any time.

❖ Blue Shield Access+ HMO (full HMO network)

With the Access+ HMO plan, you have fixed copays for most services, no deductibles, and almost no claim forms. You need to select a primary care physician (PCP) who is contracted with a medical group or Independent Practice Association (IPA) and is responsible for the overall coordination of your care. Note: this plan has a maximum allowable service area to enroll with a provider or medical group. Contact the plan for specific details if you are considering enrolling with a provider or medical group greater than a 15-mile radius of your home address.

If your primary care physician participates in our Access+ Specialist SM program, you may go directly to a specialist within your physician's medical group or IPA without a referral. You will pay a slightly higher copayment; however, you can't self-refer to Physical Therapy, Occupational Therapy, Speech-Language Therapy, Dermatology, Allergist, Podiatry, Endoscopic procedures, Diagnostic and nuclear imaging including CT, MRI, or bone density measurement. Medical groups and IPAs that participate in the Access+ Specialist program are identified in BlueShield's online directories.

To see a list of the providers who participate in the Blue Shield Access+ HMO network:

1. Go to blueshieldca.com/networkhmo
2. Select the type of provider you are looking for.
3. Enter your location, then click Continue.
4. If you need to select a primary care physician, click on the name of the PCP, then click "view details," note the PCP ID# which you will need to enroll.

Through the BlueCard® Program, HMO plan members can access emergency and urgent care services across the country and around the world. Getting urgent care with the BlueCard Program can be more cost-effective. It may also eliminate the need to pay for the services at the time you receive them.

1. To find a provider in the U.S., visit https://myoptions.blueshieldca.com/ventura or provider.bcbs.com, or call **(800) 810-BLUE (2583)**.
2. To find a provider outside the U.S., visit bcbsglobalcore.com, or call **(804) 673-1177** collect from outside the U.S.

Away From Home Care Program **–** You and your family can stay covered with HMO benefits for extended periods with the Away From Home Care® program. Students, long-term travelers, and families living apart can rely on access to health care across the country. Away From Home Care is available in most states but not all. For more information on which states participate, please call Blue Shield at **(800) 622-9402.**

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

- Blue Shield's Walkadoo Program – a fun, interactive program designed and proven to help increase your daily steps.
- Teladoc Program – Access to Teladoc's national network of U.S. board-certified physicians, licensed in California. Whenever you need care, Teladoc doctors are available 24/7 by phone or video.
- NurseHelp 24/7 – Registered nurses are available to answer your health questions at any time.

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

Blue Shield'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 BlueShield 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 $3,300 for employee-only coverage and $6,000 for family coverage. Family coverage has an individual deductible within the family deductible. This means that the deductible will be met for an individual who meets the individual deductible prior to family meeting the family deductible within a calendar year. 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 Blue Shield PPO provider. For most in-network services, you pay 20% after the deductible has been met.

1. **To find providers within California**, go to COV Blue Shield site at https://myoptions.blueshieldca.com/ventura or visit blueshieldca.com/pponetwork
2. Select the provider type you are looking for.
3. Enter your location, then click Continue.
4. **To find providers outside of California**, go to provider.bcbs.com and enter XEA. Search for the type of provider you need.

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 also be responsible for filing your own claims. Most hospitals contract with Blue Shield; however, in order to be covered, hospital admissions and surgeries require prior authorization.

If you are enrolled in this plan, you have the option to enroll in the Health Savings Account (HSA) and the Limited-Purpose Flexible Spending Account (LPFSA). More details about these plans can be found in Chapter 5 of this book.

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

- Blue Shield's Walkadoo Program – a fun, interactive program designed and proven to help increase your daily steps.
- Teladoc Program – Access to Teladoc's national network of U.S. board-certified physicians, licensed in California. Whenever you need care, Teladoc doctors are available 24/7 by phone or video.
- NurseHelp 24/7 – Registered nurses are available to answer your health questions at any time.

❖ 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, 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 and 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 about your coverage), and submit/upload in Employer Self-Service > Benefit Details > Opt-Out Certification. This page is not available to you to submit to until the day after you make an Opt-Out election. You should also receive a reminder email. **If Opting Out of medical during open enrollment, make sure your other group coverage begins on or before the County plan year effective date; if not, your event would be a mid-year change rather than an open enrollment election. If this is the case, do not elect medical Opt-Out during open enrollment because you will be taken out of that option and returned to whatever medical plan and coverage level you had prior to your open enrollment election.**

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 WorkLife Program, and Employee Health Services.

If you opt-out of County-sponsored medical coverage due to Medicare A/B 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. Please note that as an **active** employee who is Medicare A/B eligible, you can choose to remain on the County sponsored medical plan without enrolling in Medicare. This is up to the employee and their circumstances. If you need help understanding your options for coverage when reaching Medicare eligibility, you can contact Area Agency on Aging/HICAP at 805-477-7300 for information about supplemental plan options if you choose to Opt-Out of County-sponsored medical insurance.

Employees who opt-out of a County medical plan must be continuously enrolled in a qualifying group plan and must report any loss of coverage as soon as known and no more than 60 days. Failure to report a loss could result in repayment of any Opt-Out Allowances provided when an employee was not eligible, and/or disciplinary action. If this occurs, the employee will be enrolled in employee-only coverage based upon administrative policies.

❖ Waive Participation in the Flexible Benefits Program

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 a Flex Credit or Opt-Out Allowance.** If you choose no medical coverage, you must sign a waiver agreement when you first become eligible for a medical plan or during Open Enrollment. If you do not turn in a waiver, you will be automatically assigned coverage in the lowest cost employee-only HMO coverage, 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 BlueShield can provide an EOB upon request.
- If your secondary plan is an 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; however, they usually will not pay above a group's plan.

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 earliest 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. The following represents the patients/member's responsibility.

	Ventura County Health Care Plan (Full HMO Network)	**Blue Shield Trio HMO** (Limited ACO Network)	**Blue Shield Access+ HMO** (Full HMO Network)	**Blue Shield High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
				Participating Provider	**Non-Participating Provider**
Deductible *(Per Member/Per Family; per Calendar Year)*	None	None	None	Applies to all medical and pharmacy expenses except preventative care: $3,300/$6,000 [4]	
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 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	$1,500/$3,000	$5,000/$10,000	$10,000/$20,000
PHYSICIAN SERVICES					
Office visits *(consultations & in-office procedures)*	$15 copay/visit	$15 copay per visit	$35 copay per visit	20% coinsurance [2]	40% coinsurance [3]
Preventative Care	no copay	no copay	no copay	no copay	40% coinsurance [3]
Specialist	$30 copay/visit	$15 copay (PCP referral) $20 copay (Self-referral) Limited – Contact Insurance Carrier	$35 copay (PCP referral) $40 copay (Self-referral) Limited – Contact Insurance Carrier	20% coinsurance[2]	40% coinsurance [3]
HOSPITAL/FACILITY					
Inpatient Services and Supplies [5]	$100 per day copay (up to $500 maximum)	$100 per admit	$500 per admit	20% coinsurance[2]	40% coinsurance [3, 4]
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)	100% coverage (limited to 100 days per calendar year)	20% coinsurance[2]	40% coinsurance [3, 4]
Outpatient Surgery [5]	10% up to $250 copay	$50 copay – per surgery	$250 copay – per surgery	20% coinsurance[2]	40% coinsurance [3, 4]
Emergency Room *(covers emergency services only)*	$100 copay (copay waived if directly admitted)	$100 copay (copay waived if directly admitted)	$100 copay (copay waived if directly admitted)	20% coinsurance[2]	20% coinsurance[3, 4] (deductible waived if directly admitted)

Footnote descriptions are on page 2-13

	Ventura County Health Care Plan (Full HMO Network)	**Blue Shield Trio HMO** (Limited ACO Network)	**Blue Shield Access+ HMO** (Full HMO Network)	**Blue Shield High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
				Participating Provider	**Non-Participating Provider**
OTHER SERVICES					
Ambulance *(when medically necessary)*	$150 copay (air and ground)	$100 copay- per transport (air and ground)	$100 copay- per transport (air and ground)	20% coinsurance[2]	20% coinsurance[2]
Urgent Care	$35 copay per visit (no PCP or Plan referral required)	$15 copay per visit	$35 copay per visit	20% coinsurance[2]	40% coinsurance[3]
Teladoc	$15 copay	no copay	no copay	no copay	Not Covered
Rehabilitation Therapy *(includes physical, speech, occupational, and respiratory therapy)*	$15 copay/visit	$15 copay per visit	$35 copay per visit	20% coinsurance[2]	40% coinsurance[3, 4]
Chiropractic/ Acupuncture	Plan reimburses $20/visit for any chiropractor/acupuncturist (limited to 15 combined chiropractor/ acupuncturist visits per Plan Year) [6]	$15 copay per visit (chiropractic/acupuncture services limited to 30 visits per year-combined visit limit)	$15 copay per visit (chiropractic/acupuncture services limited to 30 visits per year-combined visit limit)	20% coinsurance[2] *Limits: Chiropractic Services – 30 visits/year-combined in/out of network Acupuncture – 20 visits/year combined in/out of network r*	40% coinsurance[3] *Limits: Chiropractic Services – 30 visits/year-combined in/out of network Acupuncture – 20 visits/year combined in/out of network r*
Imaging (MRI, CT, PET)	$100 per test	$0 per test ($100 per test for other radiological and nuclear imaging services[8])	$0 per test ($100 per test for other radiological and nuclear imaging services[8])	20% coinsurance[2]	40% coinsurance[3, 4]
Diagnostic/ X-Ray, Ultrasound *(Outpatient)*	$15 copay	no copay	no copay	20% coinsurance[2]	40% coinsurance[3, 4]

Footnote descriptions are on page 2-13

	Ventura County Health Care Plan (Full HMO Network)	**Blue Shield Trio HMO** (Limited ACO Network)	**Blue Shield Access+ HMO** (Full HMO Network)	**Blue Shield High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
				Participating Provider	**Non-Participating Provider**
Hospice	no copay	no copay	no copay	20% coinsurance[2]	Not Covered
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)	$35/visit (limited to 100 visits per calendar year)	20% coinsurance[2]	Not Covered
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% 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	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
BEHAVIORAL HEALTH					
Mental Health & Substance Abuse Services	Self-referral to any "OptumHealth Behavioral Solutions (Life Strategies)" provider; PCP referral not required	Self-referral to any Blue Shield mental health service administrator (MHSA); PCP referral not required	Self-referral to any Blue Shield mental health service administrator (MHSA); PCP referral not required	Self-referral to any Blue Shield mental health service administrator (MHSA); PCP referral not required	
Inpatient [1, 5, 7]	$100 per day copay (up to $500 maximum)	$100/admit (subject to utilization review)	$500/admit	20% coinsurance[2]	40% coinsurance[3, 4]
Residential/ Alternative Treatment [1, 5, 7]	$50 per day copay ($500 maximum)	$100/admit	$500/admit	20% coinsurance[2]	40% coinsurance[3, 4]
Outpatient [1, 7]	$15/visit	$15/visit	$35/visit	20% coinsurance[2]	40% coinsurance[3, 4]

Footnote descriptions are on page 2-13

	Ventura County Health Care Plan (Full HMO Network)	**Blue Shield Trio HMO** (Limited ACO Network)	**Blue Shield Access+ HMO** (Full HMO Network)	**Blue Shield 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.	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 (Specialty Drugs) Generic- 10% up to $100/script/month Brand- 10% up to $250/script/month 50% for covered infertility drugs	100% for 30-day supply after copay[1] of: Tier 1- $10 Tier 2- $25 Tier 3- $45 Tier 4 (excluding Specialty Drugs) 20% coinsurance, up to $150 per fill Specialty Drugs - 20% coinsurance, up to $150 per fill See Plan for Retail RX 90-day supply copays	100% for 30-day supply after copay[1] of: Tier 1- $10 Tier 2- $25 Tier 3- $45 Tier 4 (excluding Specialty Drugs) 20% coinsurance, up to $150 per fill Specialty Drugs - 20% coinsurance, up to $150 per fill See Plan for Retail RX 90-day supply copays	**Contracting Pharmacies:** 100% for 30-day supply after copay[1] of: Tier 1- $10 Tier 2- $30 Tier 3- $50 Tier 4 (excluding Specialty Drugs) $30% coinsurance, up to $200 per fill Specialty Drugs - 30% coinsurance, up to $200 per fill See Plan for Retail RX 90-day supply	**Non-Contracting Pharmacies:** Tier 1 - $10 + 25% Tier 2 - $30 + 25% Tier 3 - $50 + 25% Tier 4 (excluding Specialty Drugs) – 25% + 30% coinsurance, up to $200 per fill Specialty Drugs Not Covered
Plan's Mail-Service	100% for up to a 90-day supply* after copay of: Tier 1- $18 Tier 2- $60 Tier 3- $90 * 90-day supply of maintenance medication also available at participating Smart 90 retail locations. 50% for covered infertility drugs	100% for 90-day supply after copay[1] of: Tier 1- $10 Tier 2- $50 Tier 3- $90 Tier 4 (excluding Specialty Drugs) - 20% coinsurance, up to $300 per fill Specialty Drugs (limited to a 30-day supply) - 20% coinsurance, up to $150 per fill	100% for 90-day supply after copay[1] of: Tier 1- $10 Tier 2- $50 Tier 3- $90 Tier 4 (excluding Specialty Drugs) - 20% coinsurance, up to $300 per fill Specialty Drugs (limited to a 30-day supply) - 20% coinsurance, up to $150 per fill	100% for 90-day supply after copay[1] of: Tier 1- $10 Tier 2- $60 Tier 3- $100 Tier 4 (excluding Specialty Drugs) - 30% coinsurance, up to $400 per fill Specialty Drugs (limited to a 30-day supply)- 30% coinsurance, up to $200 per fill	Not covered

Footnote descriptions are on page 2-13

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(ren), stepchild(ren), adopted child(ren), child(ren) of domestic partners, child(ren) placed with you for permanent adoption, or child(ren) 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 aged 26 and over if handicapped, incapable of self-support, continuously covered by a County-sponsored (same type i.e., medical, dental, or vision) 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 BlueShield'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 Blue Shield'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 will pay a maximum daily amount based on the "Allowable Amount" as defined in the EOC. You are responsible for any charges above the Allowable Amount, as summarized in the "Summary of Benefits" and defined in the EOC.

4 "Allowable Amounts" are daily amounts per BlueShield of CA and as follows:

- $350 per day maximum for, Hospital/Facility- Outpatient Surgery, Other Services- Rehabilitation Therapy (outpatient department of a hospital), Imaging: MRI, CT, PET (outpatient department of a hospital), Diagnostic/X-Ray & Ultrasound (outpatient department of a hospital), Behavioral Health- Outpatient (Hospitalization Program).
- $1,000 per day maximum for, Hospital/Facility- Inpatient Services and Supplies, Skilled Nursing Facility (Hospital based), Behavioral Health- Inpatient, Residential/Alternative Treatment.

5 Prior authorizations 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.

6 VCHCP: Chiropractic and Acupuncture claims must be submitted within 180 days from the date of service.

7 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.

8. Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG will be charged a $100 copayment.

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 the following in mind:

- Regular dental checkups have been proven to reduce the need for later extensive dental procedures.
- 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 (HCFSA) to fund any expected dental expenses. See Chapter 5 of this handbook for more information about FSAs if applicable.

▪ 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 Expenses are either the customary and reasonable charges 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.

MetLife does not mail out member identification cards. Eligibility and benefit information are available on-line, including the ability to print an ID card: https://www.metlife.com/countyofventura/. 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 contracted 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 PDP Plus dentist provider directory, you can call MetLife at (800) 438-6388, or find a dentist online: www.metlife.com/mybenefits.

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 provider, payment is made based on the provider's fee charged or the Reasonable & Customary (R&C) charge which is based on the lowest of 1) the dentist's actual charge, 2) the dentists' usual charge for the same or similar services or 3) the usual charge of most dentists in the same geographical area for the same or similar services as determine by MetLife. If the dentist charges a higher amount than the R&C 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 $300.00, 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.

Per compliance with California Insurance Code Section 10603.04 and California Code Regulation Section 1300.63.4, you can access the County of Ventura's MetLife Dental Plan's Summary of Dental Benefits and Coverage ("SDBC") for the current plan year on the 2025 Health Plans Benefits page: https://hr.ventura.org/benefits/py2025 or navigate to the main COV Benefits page: https://hr.ventura.org/benefits and click on the Health Plans Information page for the current plan year. You can request a copy of the plan's SDBC free of charge by contacting MetLife directly at 800-438-6388 or requesting a copy by contacting Benefits.ServiceRep@ventura.org.

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

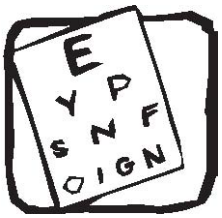
MetLife Dental PPO Plan Limitations and Exclusions are listed in the Summary of Benefits/Evidence of Coverage Booklet.

	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)	$2,500 per person	$1,500 per person
SEPARATE LIFETIME MAXIMUM: Orthodontic Benefits	$1,500 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)		
BASIC BENEFITS		
Oral Surgery: Simple/Surgical Extractions; General 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		
Space maintainers		
Fillings (amalgam and resin/composite)		
Emergency Palliative Treatment		
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 $1,500 lifetime maximum	Plan pays 50%; up to $1,500 lifetime maximum

	MetLife Dental PPO Group Number 0154209	
Benefits Coverage	**In or Out of DPO Network**	
CROWNS, JACKETS, AND CAST RESTORATIONS		
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		
Re-cementation: 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)		
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	

Please note: This MetLife Dental Plan does not mail out member identification cards. You will either need to register and log onto MetLife's website to view your coverage information or provide your insurance carrier information to your dental provider so they can verify your coverage.

This is a summary only. The Plan's Evidence of Coverage booklet should be consulted to determine the exact nature of governing contractual provisions. Plan Summary and Summary of Dental Benefits and Coverage (SDBC) are available at hr.ventura.org/Benefits (click on the correct plan year link). The plan descriptions in this Handbook are general in nature and cannot modify or affect the Plan in any way.



Chapter 4
Vision Coverage Option

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 Plan is Available?

The County offers a voluntary vision plan through EyeMed Vision.

❖ **EyeMed Vision Plan**

EyeMed offers the largest and most comprehensive network in California and nationally through its provider network, including a greater number of independent providers and national and regional retailers plus online in-network locations.

Members have the freedom to choose from a variety of eye care providers and 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.

EyeMed offers enhanced benefits when utilizing PLUS Providers. They also provide enhanced benefits to contact lens wearers and extra ways to save, including 40% off additional pairs of glasses and Special Offers.

▪ 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 expense if they utilize an EyeMed in-network 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 visit www.eyemed.com, and register first or contact EyeMed directly at (866) 800-5457.

2. At the time of the vision appointment, please make sure you notify the provider you are an EyeMed member. The Participating Provider will contact EyeMed 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 EyeMed. Please go to www.eyemed.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.

There is a $0 copayment for an annual exam with a PLUS Provider and a $20 copayment for all other in-network providers, which is 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.

EyeMed Summary of Benefits

Vision Service	EyeMed	***Out-of Network*** *Reimbursement*
Frequency	12 / 12 / 24	
Exam at PLUS Providers	$0 copay	Up to $40
Exam with dilation	$20 copay	
Retinal Imaging	Up to $39	Not covered
Frame		
Any available frame at PLUS Providers	$150 allowance, 20% off balance	Up to $70
Retail allowance	$100 allowance, 20% off balance	Up to $70
Wholesale allowance	$70 allowance	
Standard plastic lenses		
SV, Bi, Tri	$20 copay	Up to $30, $50, $70
Standard progressive	$20 copay	Up to $50
Premium progressives (Tier 1 – 4)	$105, $115, $130, $195 copay	Up to $50
Lens options		
UV treatment	$15 copay	Not covered
Tint	$15 copay	Not covered
Standard scratch coating	$15 copay	Not covered
Polycarbonate (adults)	$40 copay	Not covered
Polycarbonate (kids <19)	$0 copay	Up to $20
Standard AR	$45 copay	Up to $23
Premium AR (Tier 1 -3)	$57, $68, $85 copay	Up to $23
Photochromic	$75 copay	Not covered
Other	20% off retail	Not covered
Contact lens fit & follow-up (In lieu of lenses)		
Standard	Up to $40	Not covered
Premium	10% off retail price	Not covered
Contact lenses		
Conventional	$105 allowance, 15% off balance over $105	Up to $74
Disposable	$105 allowance	Up to $74
Medically necessary	Paid in full	Up to $300

EyeMed Limitations & Exclusions

EyeMed – 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.

EyeMed – 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 Insurance;
- 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.

▪ 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 & Health Savings 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 about the Plans I've Chosen?" Be sure to review your elections carefully for accuracy before you submit them.*

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.**

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

IMPORTANT!

Chard Snyder is the administrator for Dependent Care Flexible Spending Accounts and Health Care Flexible Spending Accounts. Their contact information can be found on the back cover of this handbook.

Before enrolling in a Flexible Spending Account (FSA), be sure you have read this chapter and have estimated the amount of expenses you will have in the Plan Year. You may wish to visit Chard Snyder's website, www.chard-snyder.com, and check out their Expense Estimate Worksheet as well as complete the Tax-Savings Calculator to estimate your tax savings. ***Prior to enrolling in the Dependent Care FSA, you should consult your tax advisor to determine whether it is more advantageous for you to utilize the Dependent Care FSA or the tax credit.***

- **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 an FSA 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 of each month, so you will not have a deduction on any 3rd paycheck in a month. If you are enrolling mid-year, divide your annual pledge amount by the number of contribution periods remaining in the year. See the coverage period chart below. Your contributions will appear on your paychecks under the "Before-Tax Deductions" section.

    - Be sure to make allowances for:
        - coverage and reimbursements provided by all medical, dental, and vision plans.
        - vacations, sick days, leaves of absence, or other times dependent care services will not be eligible for reimbursement.

- As required by the IRS, you forfeit to the County all funds remaining in your FSA after all claims for qualified 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 Chard Snyder 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 2025 must be submitted by April 15, 2026.

- 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 2025 (01/01/25-12/31/25)	Coverage Period
	25-01	12/22/24-01/04/25	01/10/25		01/01/25-01/15/25
	25-02	01/05/25-01/18/25	01/24/25		01/16/25- 01/31/25
	25-03	01/19/25-02/01/25	02/07/25		02/01/25 - 02/15/25
	25-04	02/02/25-02/15/25	02/21/25		02/16/25- 02/28/25
	25-05	02/16/25-03/01/25	03/07/25		03/01/25 - 03/15/25
	25-06	03/02/25-03/15/25	03/21/25		03/16/25 - 03/31/25
	25-07	03/16/25- 03/29/25	04/04/25		04/01/25 - 04/15/25
	25-08	03/30/25-04/12/25	04/18/25		04/16/25 - 04/30/25
	25-09	04/13/25-04/26/25	05/02/25		05/01/25- 05/15/25
	25-10	04/27/25-05/10/25	05/16/25		05/16/25 - 05/31/25
	25-11	05/11/25-05/24/25	05/30/25		NO DEDUCTION
	25-12	05/25/25-06/07/25	06/13/25		06/01/25 - 06/15/25
	25-13	06/08/25-06/21/25	06/27/25		06/16/25- 06/30/25
	25-14	06/22/25-07/05/25	07/11/25		07/01/25 - 07/15/25
	25-15	07/06/25-07/19/25	07/25/25		07/16/25 - 07/31/25
	25-16	07/20/25-08/02/25	08/08/25		08/01/25- 08/15/25
	25-17	08/03/25-08/16/25	08/22/24		08/16/25 - 08/31/25
	25-18	08/17/25-08/30/25	09/05/25		09/01/25 - 09/15/25
	25-19	08/31/25-09/13/25	09/19/25		09/16/25 - 09/30/25
	25-20	09/14/25-09/27/25	10/03/25		10/01/25 - 10/15/25
	25-21	09/28/25-10/11/25	10/17/25		10/16/25 - 10/31/25
	25-22	10/12/25-10/25/25	10/31/25		NO DEDUCTION
	25-23	10/26/25-11/08/25	11/14/25		11/01/25- 11/15/25
	25-24	11/09/25-11/22/25	11/26/25		11/16/25- 11/30/25
	25-25	11/23/25-12/06/25	12/12/25		12/01/25 - 12/15/25
	25-26	12/07/25-12/20/25	12/26/25		12/16/25 - 12/31/25

The contribution deducted from the:

- First paycheck of the month covers qualified expenses for dates of service that fall between the 1st and 15th of the month.
- Second paycheck of the month covers qualified expenses for dates of service that fall between the 16th and last day of the month.
- If your Health Care FSA 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 FSAs are separate.** ***Under no circumstance can dollars be transferred between your Dependent Care and your Health Care FSAs.***
- The FSA Plan Year is the calendar and tax year (January 1 through December 31). <u>For Health Care FSAs only</u>, 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 FSA 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 2025, this is pay period 25-26).

Chard Snyder Benefit Card

Use your Chard Snyder Benefit Card for a simple way to pay. The money comes right out of your account. Many stores and medical offices can confirm eligible merchandise and services at the point of sale. If you re-enroll in an FSA each year, you keep the same benefit card until it expires. In other words, a new card will not be issued to you every year.

Employees that newly enroll (never enrolled or have not been enrolled since Chard Snyder has been the plan administrator) in the Flexible Spending Account Program during Open Enrollment, could expect to receive their Debit Card by January 22, 2025. Please watch your mail carefully and open the envelope to ensure the card is not thrown away.

Employees that newly enroll (never enrolled or have not been enrolled since Chard Snyder has been the plan administrator) in the Flexible Spending Account Program during December, could expect to receive their Debit Card within 7-14 days. Please watch your mail carefully and open the envelope to ensure the card is not thrown away.

Employees that newly enroll (never enrolled or have not been enrolled since Chard Snyder has been the plan administrator) in the Flexible Spending Account Program after December, could expect to receive their Debit Card within 7-10 days. Please watch your mail carefully and open the envelope to ensure the card is not thrown away.

Submitting a Claim

Your receipts must be for dates of service within the plan year.

What Do "Date of Service" and "Expense Incurred" Mean?

Date care was provided, services received, or date pharmacy filled the prescription.

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.

Using the Mobile App

You may submit your healthcare or dependent care claim using your phone or tablet and save time.

- Log in (once you've downloaded the Chard Snyder app from your app store):
  - Click the app icon.
  - Enter your online account username and password.
  - Create a four-digit passcode to use each time you log in through your mobile device.
- Choose Flexible Spending Account.
- Click New Claim.
- Click Upload Receipt (device camera will take a picture of your receipt; ***make sure the picture is clear and writing is legible***).
- Click the Add Claim button.

Using the Website

Save postage and time by filing your claim online.

- Scan your receipt and save it in one of the following formats: JPEG (.jpeg), GIF (.gif), or PDF (.pdf). Each file may not be larger than 2MB. ***Make sure the scan is clear and writing is legible***.
- Log in to www.chard-snyder.com.
  - Click the bright blue Login button in the upper-right corner of the page.
  - Go to *Employees* in the blue upper-left area and click *Access Your FSA, HRA, HSA Advantage, TRP Accounts.*

  - Enter your social security number (no dashes) or Username (if already created). Use Employee ID if directed to do so.
  - Enter your password. The first time you log in, your password is the last four digits of your social security number.
- Choose File a Claim.
- Enter your claim information.
- Click Upload Receipt to attach your receipt to your claim. Be sure to upload the correct receipt file, as attaching the wrong file will delay your payment.
- Click Add Claim.
- Read Terms & Conditions, then click that you have done so.
- Click Submit Claim(s) or continue adding claims.

Sending a Paper Claim

- Complete an FSA claim form, available at www.chard-snyder.com.
- Keep a copy of your completed claim form, receipts, and Explanation of Benefits for your records.
- Fax: (513) 459-9947 or (888) 245-8452
- Mail: Chard Snyder, P.O. Box 249, Fort Washington, PA 19034

IMPORTANT Proof of Expenses Information!

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 service(s) provided,
- Itemized expense(s),
- Amount of un-reimbursed/un-reimbursable expenses.

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 obtained from Chard Snyder at www.chard-snyder.com or by phone: (513) 459-9997 or (800) 982-7715 Monday – Friday, 8 am – 8 pm ET.

▪ Dependent Care Flexible Spending Account (DCFSA)

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 *up to the annual maximum*. The maximums are restricted to:

- Married couples filing a joint return, OR a single individual: $4,999.92 per year ($208.33 semi-monthly)
- Married couples filing separate returns $2,499.84 per year ($104.16 semi-monthly)

Your elected contribution will appear in the Chard Snyder portal after it has been payroll deducted from your pay advice and reported to Chard Snyder on Pay Dates.

All unused account balances will be forfeited after the end of the Plan Year, so estimate your needs carefully. Chard Snyder has an Expense Estimate Worksheet on their website to help choose an amount.

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.

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

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 employment-related dependent care expenses that qualify for a credit on your federal tax return. The requirements were adopted by IRS Code Section 129 (and expenses are listed in Internal Revenue Service (IRS) Publication 503).

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 will not get a tax credit for the balance of your expenses.

▪ Health Care Flexible Spending Account (HCFSA)

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 set up your account for any amount *up to the annual maximum*. The maximum is restricted to $3,199.92 per year ($133.33 semi-monthly). *All unclaimed account balances are forfeited after the end of the Plan Year, so estimate your needs carefully. Chard Snyder has an Expense Estimate Worksheet on their website to help choose an amount.*

Your elected annual pledge will appear in the Chard Snyder portal on January 1 of the new plan year. 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 in 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 15.

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.

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

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 and Ineligible Expenses:

Visit Chard Snyder's website for a sample list of both Eligible and Ineligible expenses. Their Mobile App also has a feature that allows users to scan products for eligibility.

Certain expenses are prohibited by IRS Code section 105(b), which governs Health Care Flexible Spending Accounts. Prior to making purchases/receiving care, be sure to review the examples of ineligible expenses list for expenses that are ineligible under Section 105(b). When in doubt, ask Chard Snyder at (513) 459-9997 or (800) 982-7715 Monday – Friday, 8 am – 8 pm ET, Fax: (513) 459-9947 or (888) 245-8452, or email Chard Snyder at askpenny@chard-snyder.com.

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 visit Chard Snyder's website for a sample list of both Eligible and Ineligible expenses. 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 still cannot ascertain whether an expense is eligible for reimbursement, please contact Chard Snyder, our Flexible Spending Account Administrator, at (513) 459-9997 or (800) 982-7715 Monday – Friday, 8 am – 8 pm ET, Fax: (513) 459-9947 or (888) 245-8452, or email Chard Snyder at askpenny@chard-snyder.com and they will be glad to help you.

▪ Limited-Purpose Flexible Spending Account (LPFSA)

To establish a Limited-Purpose Flexible Spending Account (LPFSA), you must be enrolled in both the High-Deductible PPO plan and the HealthEquity Health Savings Account (HSA). Under current IRS rules, you cannot deposit money into an HSA if you participate in a standard healthcare FSA. However, because an LPFSA restricts reimbursements to specific dental and vision care expenses, the IRS allows you to participate in both an LPFSA and an HSA at the same time. By having both accounts, you can maximize your tax and savings benefits.

Reimbursements are only issued for eligible expenses incurred by the employee, their spouse, or their eligible dependents. With the Limited-Purpose FSA, the entire balance is available to you at the beginning of the Plan Year. Expenses that occur before the beginning of the FSA plan year are not eligible.

Per IRS guidelines there is no double-dipping allowed. It's important to understand that you cannot use funds from both your LPFSA and HSA to cover the same eligible expense, even if the expense is considered eligible under both plans. Instead, you must decide which account will reimburse each expense. Plan accordingly and only set aside as much as you expect to incur in a plan year.

Eligible Expenses

- Dental coinsurance & copays
- Dental deductibles
- Dental treatments
- Dental visits
- Orthodontia
- Eye exams & eyeglasses
- Optical coinsurance & copays

- Optical deductibles
- Optical surgeries (LASIK/RK)
- Contact lenses and more

Ineligible Expenses

- Medical expenses that are not dental or vision related
- Chiropractic expenses
- Insurance premiums
- Mental health expenses
- Cosmetic dental & health services

Please refer to the Health Care Flexible Spending Account program parameters for further information pertaining to annual and semi-monthly contribution limits, plan year, grace periods, forfeitures, eligible dependents, coverage periods, IRS code(s), using the Chard Snyder Benefit Card, and options for submitting a claim.

You may wish to visit Chard Snyder's website, www.chard-snyder.com, and check out their Expense Estimate Worksheet as well as complete the Tax-Savings Calculator to estimate your tax savings. When in doubt, ask Chard Snyder at (513) 459-9997 or (800) 982-7715 Monday – Friday, 8 am – 8 pm ET, Fax: (513) 459-9947 or (888) 245-8452, or email them at askpenny@chard-snyder.com.

▪ What happens to my Flexible Spending Account when I separate from County service (Retirement, Resignation, or Termination)?

The IRS does not permit refunds for unutilized funds, and any remaining funds will be forfeited. Please note that the deadline for submitting claims for qualified expenses remains unchanged, as outlined under the "IMPORTANT" section on page 5-1.

The last date of service to *incur* qualified expenses depends upon the last contribution made to your FSA. The Payroll Calendar on page 5-2 will help to determine the last date to incur qualified expenses. If you separate from County service in 2025, you will still have until April 15, 2026, to submit your claims. We strongly encourage submitting your claims as soon as possible.

▪ Health Savings Account (HSA)

Only employees enrolled or enrolling in a qualified High Deductible Health Plan are eligible to enroll in a Health Savings Account (HSA) through HealthEquity. For more information about this account, please visit HealthEquity's website (www.healthequity.com/**)** and click on "Members". You can also contact HealthEquity directly if you have additional questions regarding an HSA.

- HSA payroll deductions follow the same payroll deduction schedule and effective dates of coverage as the FSA accounts. There are 24 contribution periods during each Plan Year. Account contributions are only taken on your 1st and 2nd paychecks each month, so you will not have a deduction on any 3rd paycheck in a month. Please see the coverage period chart at the beginning of this chapter for applicable deductions and effective dates.

- There are maximum contributions allowable per pay period via payroll deduction as follows:
    - Employee Only Enrollment: $179.16
    - Employee Only Enrollment; 55 years or older (account holder): $220.83
    - Employee + 1 or more Enrollment: $356.25
    - Employee + 1 or more Enrollment; 55 years or older (account holder): $397.91
- Unlike FSA plans, you can make enrollment and election changes mid-year, if you wish.
- Unlike FSAs, HSAs are considered an individual's property. The balance in an HSA rolls over from year to year and you do not lose the funds in an HSA if you do not have claims that meet the balance in a plan year.
- You must not be covered by another medical insurance plan that is not a high-deductible health plan (dental, vision, life, and disability plans are okay).
- Once enrolled in an HSA through HealthEquity, you will receive a welcome packet with information regarding your account, how to use it, and contact information for HealthEquity if you have questions or need help at any time.
- It is an enrollee's responsibility to follow IRS guidelines for HSA plans.

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
- Lactation Accommodation
- Employee Commuter Benefits
- Deferred Compensation Program
- Retirement Pension Plans
- Absence Management Program
- Life & Disability Insurance Programs
- $1,000 Employee Death Benefit
- Employee Emergency Assistance Program
- 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

Employee Health Services (EHS) is staffed by licensed medical professionals, providing convenient healthcare services to regular Ventura County employees. EHS offers services such as, pre-employment medical exams, DOT exams, minor work or non-work-related injuries, basic first-aid, blood pressure/glucose checks, limited acute care, hearing tests, N-95 mask fit tests, TB tests, EKGs, pulmonary function tests (PFTs). EHS also offers vaccinations such as Hepatitis A & B, Varicella, MMR, TDAP, Rabies and Influenza (during flu season). Most of the services mentioned above require pre-approval from employee's H.R. Department.

Employees seeking minor acute medical care or treatment may be seen based on provider availability. If illness or injury requires additional tests (not offered at EHS), employee will be directed to an outside clinic. Illnesses/injuries needing higher level of care, will be referred to the nearest hospital or urgent care clinic.

EHS providers are not Primary Care Physicians (PCPs) and cannot manage chronic health problems. For management of chronic health issues, please contact your health insurance provider to connect with a Primary Care Physician (PCP).

EHS is conveniently located in the Lower Plaza of the Hall of Administration (HOA) at the Government Center. Open Monday through Friday (except holidays) 8:00am-4:30pm closed between 12pm-1pm (lunch break). Walk-Ins are not permitted. Services are provided by appointment only.

For more information or to schedule an appointment, please call (805) 654-3813 or email EHS@ventura.org.

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 (https://hr.ventura.org/benefits/employee-assistance-program).

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 (VC-Well) 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. Regular County employees who receive a Flex Credit are eligible and encouraged to participate. Spouses of eligible employees are eligible for some programs and encouraged to participate in those in which they are eligible. Employees who don't receive a Flex Credit are eligible for the free resources on our webpage and access to health club discounts.

Eligible employees and their spouses are invited to participate in an annual Wellness Profile and Screening to evaluate their cholesterol, glucose, blood pressure, and other important risk factors. You'll get an extensive results report to help you improve your health. If risks are identified, you can choose to meet with a personal Health Coach through our Health Coaching Program, free of charge. Be sure to take advantage of the wide variety of programs & resources available to you through the Wellness Program. Programs include virtual courses on various well-being topics, physical activity challenges on the WELLtrek platform, health club discounts, recreation events, and free premium subscriptions to apps such as Wellbeats (fitness & nutrition classes) and Headspace (meditation & mindfulness). The Wellness Program also strives to create an

environment supportive of healthy lifestyles and provides resources to help employees eat well and move more.

In addition, VC-WELL has a cash incentive program known as WELLthy Reward$, where employees who participate and complete various wellness activities between January – August can earn cash awards up to $300 paid in their paycheck in November. Cash awards are considered taxable income by the IRS and will be taxed during the pay period it is disbursed. Regular employees receiving a Flex Credit are eligible to receive a cash award. If you are unable to participate in any of the activities required to earn an incentive because it is unreasonably difficult to do so due to a medical condition or because it is medically inadvisable for you to attempt to do so, you may be entitled to a reasonable accommodation or alternative standard. You may request a reasonable accommodation or alternative standard by contacting VC-WELL using the contact information below.

To view VC-WELL's programs and resources visit the Wellness Program website at https://vcwell.ventura.org/.

▪ Lactation Accommodation

The County of Ventura understands the importance of supporting employed mothers to continue breastfeeding after they return to work. Lactation rooms are available throughout all County facilities. A comprehensive Lactation Accommodation policy outlines the resources available and can be found on the County's main Benefits site.

For more information on the County of Ventura's Lactation Accommodation policy:

- Visit: https://hr.ventura.org/benefits
- Email: worklife@ventura.org

▪ Employee Commuter Benefits

The County of Ventura provides commuter benefits for employees. Take advantage of these options to save money while reducing greenhouse gas emissions. More information on commuter benefits can be found on the County's Commuter Benefits page at https://hr.ventura.org/benefits/commuter-benefits.

- **Green Fleet Motor Pool:** The General Service Agency (GSA) has over 60 rental vehicles available for employees to utilize for County business. Use their all-electric Chevy Bolt or Plug-In Hybrid Electric Chevy Volt on your next trip!
- **Bike Lockers:** The General Service Agency (GSA) has bike lockers for County employees to reserve. Anyone who bikes to work can safely store their bikes inside one of these spacious bike lockers. Newer lockers are Bluetooth-connected.
- **Carpool Preferential Parking Permit:** Employees who carpool to work can obtain a carpool permit for designated parking spaces closer to County buildings.

▪ Deferred Compensation Program

The County offers eligible employees tax-deferred retirement savings plans through the 401(k) and 457 Plans. Your contributions to the plans are made directly from your paycheck before income taxes are deducted. This means that your retirement income can accumulate faster than if you invested it in a regular savings account. In addition to pre-tax contributions, you also have the option to make after-tax contributions through the Roth option available in both plans.

As another incentive to save, the County offers most eligible employees a matching contribution in the 401(k) Plan. This means that if you contribute to the Plan, the County will make a contribution to your account. This match is free money to you just for contributing a small percentage of your pay and the match maximizes your overall retirement savings!

You may think you can't afford to participate in the Plans but, on the other hand, can you afford not to participate? Remember, you can start small – every little bit helps. It's never too late to start!

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).

401 (k) 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 biweekly. If you are a regular employee represented by UAPD, you are eligible to participate regardless of your work schedule.

457 Eligibility: 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 biweekly. 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.

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
Internet https://dc.ventura.org

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 age 50+ Catch-up contributions.	In addition to the regular IRS annual contribution limit, you may be able to make age 50 + 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.	Pre-tax Option – 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. After-Tax Roth option – Distributions are tax free if you meet the requirements of a Qualified Distribution.[2]
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 and/or 401(k) contribution and you have attained age 59 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 or Per Diem Pool (PDP) employee with a work Schedule of 64 hours per 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 per pay period, you will continue to participate in the plan. VCERA sends a plan description to all new participants. For more information on the VCERA retirement plan, visit their website (https://www.vcera.org/) or call (805) 339-4250.

If you are part-time, extra-help, or an intermittent employee (except rehired annuitants and Reserve Firefighters) you are in one of two Supplemental Retirement Plans (SRP):

- Hired on or after April 17, 2021, you are automatically participating in the SRP 457 Deferred Compensation Plan.
- Hired before April 17, 2021, and elected to opt-out of the SRP 457 Deferred Compensation Plan, you are in the Safe Harbor Retirement Plan.
- Hired before April 17, 2021, and elected to convert to the SRP 457 Deferred Compensation Plan.

For further information, visit (https://dc.ventura.org/safe-harbor), call (805) 654-2921, or e-mail safe.harbor@ventura.org.

Absence Management Program

The County provides an Absence Management Program (Leave of Absence) for all employees. 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
- Public Health Emergency 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) workdays unless the absence is due to a pre-approved vacation.

The Leave of Absence Request Form and other leave information can be found on the Benefits intranet and internet websites (website addresses are listed on the back cover of this book).

NEW-- You will no longer be remitting your leave of absence premiums directly to the County of Ventura. The County now uses a Direct Bill service from our third-party administrator for you to maintain continuity of your health plan(s), optional life insurance(s), and Flexible Spending Account(s) during your approved, unpaid leave of absence. The County's third-party administrator will provide you with more information when your unpaid leave begins.

▪ Life & Disability Insurance Programs

▪ Optional Life Insurance

The Optional Life Insurance plan offers 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 an employee enrolls within your first 90 days of eligibility, they may elect guaranteed Optional Life Insurance coverage of $10,000, one times, two times, or three times their base annual earnings, with no Statement of Health or additional underwriting required when the limit does not exceed $500,000. 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 into your department's Benefits Representative for enrollment.

If an employee's optional life insurance election (1x, 2x, or 3x) exceeds the $500,000 limit either as a new hire or anytime during employment, they can go through MetLife's underwriting process to increase their limit of one time, two times, or three times their base annual earnings up to a maximum of $1,000,000. If desired, please contact the Benefits Service Representative regarding interest. MetLife will provide the employee with an email link to submit additional information to review before rendering a decision. If approved, MetLife will notify the County of the approval, and we will process the new or updated plan enrollment.

If an employee enrolls after the first 90 days of eligibility, you must complete the Group Enrollment Form for any level of coverage and an electronic Supplemental Enrollment/Statement of Health form will be sent to the email submitted on the enrollment form. 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 handbook). You may also change your beneficiaries in VCHRP. Log into VCHRP > Employee Self-Service > Benefit Details Tile. Complete the Dependent/Beneficiary Info tile for everyone you plan to designate as a beneficiary. All personal information is required for dependents and beneficiaries, including a Social Security number/ITIN, which should be entered into the National ID field of the Dependent/Beneficiary tab. Do not duplicate, change, or override any dependent/beneficiary information currently reflected in VCHRP. If a change needs to be made to an existing record, contact your agency HR department or CEO/HR-Benefits. Next, from the Benefit Details tile, select the Designate Beneficiaries tile, click on the magnifying search glass, and select the beneficiary you wish to designate. Elections will need to be made and saved for all benefits that require a designated beneficiary (life insurance, wages/salary, death benefit, etc.).

These are term life policies, which means when you stop paying premiums, there is no cash value built up and your coverage ends on the last day of the pay period during which a premium contribution was taken from your pay. After you leave County employment, you will receive a Portability Option notice about when your group life benefits end, including coverage amounts and eligibility dates. Enrollment is time sensitive, usually within 31 days from when coverage ended, and exclusions apply. Please contact MetLife to inquire about the Portability Option (contact information is listed on the back cover of this handbook).

- **Optional 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 stepchildren who are living with you. A small, biweekly premium covers all your eligible dependents regardless of the number you enroll. If at any time you no longer have qualified dependents, it is the employee's responsibility to request to cancel the Dependent Life Deduction by submitting a payroll deduction card.

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 your dependents in a Dependent Life Insurance plan within your initial enrollment, you are not required to provide evidence of insurability.

If you enroll your dependent(s) in your existing Dependent Life Insurance plan within 90 days from when you newly acquire a dependent, you are not required to provide evidence of insurability. Be sure to complete a new Dependent Life Insurance Change Request form so their name is on file.

If enrolled in an Optional Life Insurance plan you may enroll in Dependent Life Insurance within 31 days of a qualifying event, such as birth, adoption, or marriage. Any other dependents enrolled at this time not related to the qualifying event, would be subject to a health assessment and MetLife approval. For the dependent(s) directly related to the qualifying event, they will not be required to provide evidence of insurability. Be sure to complete a new Dependent Life Insurance Change Request form so their name is on file, additional premiums will apply.

Option 1 - Low Option: $5,000 spouse; $2,000 on each dependent
Option 2 - High Option: $10,000 spouse; $5,000 on each dependent

- **Basic Life Insurance**

Except where noted employees in the following groups who are scheduled for and working at least 40 hours per pay period are automatically covered by a $50,000 group term life insurance/AD&D policy. Managers,

Confidential Clerical, and Unrepresented Others covered under the Management Resolution, CJAAVC-represented employees, SEIU-represented employees, IUOE-represented employees, SPOAVC-represented employees, UAPD-represented employees (at least 1 hour per pay period), VCPPOA-represented Patrol Unit employees, VCPPOA-represented Probation Unit employees, VCERA-represented employees, and VEA-represented. 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 handbook).

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

You are automatically enrolled in LTD if you are a Manager, Confidential Clerical, Unrepresented Other, CJAAVC-represented employee, CNA-represented employee, IUOE-represented employee, UAPD-represented employee, VEA-represented employee, or Sheriff's Service Technician. Nurses, Nursing Care Coordinators I-II, Clinical Coordinators, and Clinical Coordinators-Surgical Services employees 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 biweekly, and for eligible employees represented by UAPD or covered by the County of Ventura's Management Resolution, you must be scheduled for and working at least 40 hours per pay period.

For eligible employees covered under the Management Resolution, UAPD, CJAAVC, and Professional Engineers represented by VEA, the LTD Core plan automatically protects your monthly base earnings of up to $12,000, providing a maximum benefit of $8,000 at 66.67% for up to 60 months upon approval of a disability claim.

For eligible CNA, IUOE, Personal Property Appraisers Unit employees represented by VEA, Sheriff Service Technicians represented by VCSCOA, and Nursing Care Coordinators I-II represented by SEIU, the LTD Core plan automatically protects your monthly base earnings of up to $3,500, providing a maximum benefit of $2,100 at 60% for up to 60 months upon approval of a disability claim.

Your LTD benefit has a waiting (elimination) period of 30 days.

A certificate for this policy is available on our internet and intranet websites (links listed on the back cover of this book). Some unions offer similar plans to the employees they represent. For information on these plans, contact the union directly.

- **Optional Long-Term Disability Buy-Up (LTD Buy-Up)**

If you are enrolled in the Long-Term Disability Core plan as defined above, you can enroll in the employee-paid Long-Term Disability Buy-Up plan. You can enroll in this plan for the first 90 days of eligibility (New Hire, rehire more than 30 days or not previously eligible, or employee status changes and the employee is newly eligible for the plan) with no health assessment requirement. You may also enroll in this plan with no health assessment within 60 days once your base monthly compensation meets or exceeds the benefit base coverage maximum of the LTD core plan ($12,000 or $3,500 as defined by the employee group in the above information). Employees are responsible for requesting enrollment during a non-health assessment period; the county is not obligated to provide any further correspondence regarding eligibility for a non-health assessment period. Employees may also request enrollment in this plan outside the above-noted timeframes with a health assessment and MetLife approval. This plan has the same waiting and maximum benefit duration periods as the LTD Core plan.

For eligible employees covered under the Management Resolution UAPD, CJAAVC, and Professional Engineers represented by VEA this plan can extend your LTD coverage beyond that under the LTD Core plan to your base income exceeding $12,000 per month, up to 66.67% of $22,500, with a maximum monthly benefit of up to $15,000 for an approved disability claim.

For CNA, IUOE, Personal Property Appraisers Unit employees represented by VEA, Sheriff Service Technicians represented by VCSCOA, and Nursing Care Coordinators I-II represented by SEIU, this plan can extend your LTD coverage beyond that under the LTD Core plan to your base income exceeding $3,500 per month, up to 60% of $6,667.00, with a maximum monthly benefit of up to $4,000 for an approved disability claim.

Additional information and a certificate for this policy is available on our internet and intranet websites (links listed on the back cover of this book). Some unions offer similar plans to the employees they represent. For information on these plans, contact the union directly.

- **Optional Wage Supplement Plan (WSP)**

All regular employees are eligible to participate in the Wage Supplement Plan (WSP) if 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.

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

The following employees are eligible for this plan and may enroll within the first 90 calendar days of hire (or initial eligibility) with no health assessment. Regular Status employees with a regular schedule of at least 40 hours per pay period covered under the Management Resolution, and employees with a regular schedule of at least 60 hours per pay period represented by the Criminal Justice Attorneys Association of Ventura County (CJAAVC) and Professional Engineers represented by the Ventura Employees Association (VEA). After your initial eligibility period ends, employees may also request enrollment in this plan outside of the above noted timeframes with a health assessment and MetLife approval. If approved, you will be notified by MetLife, and the County will enroll you in the plan.

Additional plan information and a certificate for this policy is available on our internet and intranet websites (https://hr.ventura.org/benefits).

- **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 for employees who have a loss of wages when they need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, registered domestic partner, or to bond with a new child entering the family through birth, adoption, or foster care placement.

For Information on the Paid Family Leave Program contact: (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**

Note: Beginning January 1, 2021, PFL will expand by adding a new claim type called Military Assist. PFL Military Assist benefits will be available to eligible Californians who need time off work to participate in a qualifying event because of the military deployment of their spouse, registered domestic partner, parent, or child to a foreign country.

This legislation established the Paid Family Leave insurance program administered by the State Disability Insurance (SDI) program. See Appendix B for Employee Notices. 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 Program

The Employee Emergency Assistance Program 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 (links listed on the back cover of this handbook) for the appropriate forms.

Transportation Benefit Reimbursement Program

Chard Snyder is the administrator for the Transportation Benefits Reimbursement Program. Chard Snyder's contact information is listed on the back cover of this handbook.

The Transportation Benefit Reimbursement Program is a voluntary benefit option available to all regular full-time and part-time employees of the County of Ventura who perform services and receive wages. The account allows eligible employees to set aside money in a special nontaxable account from which your funds are released for *eligible* mass transit expenses to and from work. Employees can contribute up to the monthly maximum amount set by the IRS. You may wish to visit Chard Snyder's website (link listed on the back cover of this handbook) and complete the Tax-Savings Calculator to estimate your tax savings.

Employees that newly enroll; your elected contribution will appear in the Chard Snyder portal after it has been payroll deducted from your pay advice and reported to Chard Snyder on Pay Dates.

The transportation program covers:

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

The transportation program does not cover:

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

The transportation benefit is similar to the pre-tax flexible spending accounts available for health care and dependent care expenses. However, there are two important differences:

1. 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).
2. There are 26 contribution periods during each plan year.

To enroll in the Transportation Benefit Reimbursement Program, you will need to complete:

1. A Program Acknowledgement Form, email FSA.Account@ventura.org or Benefits.ServiceRep@ventura.org for a form **and**,
2. A Payroll Deduction Authorization / Cancellation Card (PAOF-837); this can be obtained from your department's HR Representative or email FSA.Account@ventura.org or Benefits.ServiceRep@ventura.org to request the card. This card must have a wet signature.

Once both are completed, submit them to County Benefits at Brown Mail #1970-FSA, to be processed.

On a quarterly basis, participants can increase, decrease, suspend, or reinstate the contribution amount, subject to submitting a Payroll Deduction Authorization / Cancellation Card (PAOF-837) 30 days in advance of effective date. Newly eligible participants can elect to participate in the program within 31 days from their date of eligibility and quarterly thereafter. All changes will take effect on the normal payroll cycle.

The IRS requires that you use the Benefit Card to purchase mass transit passes. You may purchase passes at transit vendor locations, such as fare-pass kiosks, transit authority ticket offices, or online pass purchases. You may not use your card to purchase transit passes at locations such as grocery stores, drug stores, or convenience stores. If your transit system allows you to 'link' a credit card to a reloadable mass transit card, you may do so with the Benefit Card.

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 day) 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 per 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 staff. 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 PCPs are usually family practice specialists, general practitioners, internists, or pediatricians.

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

- PCPs 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 PCPs than specialists.
- PCPs 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 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 non-preferred drugs only if there is no viable preferred drug alternative, or the non-formulary drug is pre-authorized 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.

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 are compliant with regulations. The County provides its eligible new employees with the notices listed below. This Benefit Plans Handbook is posted on our website https://hr.ventura.org/benefits annually. In addition, annual employee notices are mailed out to all eligible employees.

Whenever there is a new law or changes establishing new regulations or benefits information is provided to all eligible employees. Revisions to our website will be updated accordingly and as necessary.

NOTICES TO COUNTY OF VENTURA EMPLOYEES

- **Family and Medical Leave Act of 1993 (FMLA)**
- **Your Rights and Obligations as a Pregnant Employee (PDL)**
- **Family Care and Medical Leave and Pregnancy Disability Leave (CFRA)**
- **Paid Family Leave Benefits Program (PFL)**
- **The Uniformed Services Employment and Reemployment Rights Act (USERRA)**
- **Women's Health and Cancer Rights Act of 1998 (WHCRA)**
- **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 (MHPA)**
- **The Newborns' and Mothers' Health Protection Act**
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **Availability of Privacy Practices Notices**
- **Your Rights & Protections Against Surprise Medical Bills**
- **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.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

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

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

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.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

WH1420 REV 04/23

Pregnancy Disability Leave (PDL)

IF YOU ARE PREGNANT, HAVE A PREGNANCY-RELATED MEDICAL CONDITION, OR ARE RECOVERING FROM CHILDBIRTH, PLEASE READ THIS NOTICE.

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 (if 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 1/3 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;
- 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 the Labor Code; and
- Never discriminate, harass, or retaliate on the basis of pregnancy.

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, childbirth, or related medical condition. 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 or a comparable 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, and doctor-ordered bed rest, and covers conditions such as 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.
- 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 same level and under the same 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. Sufficient notice means 30 days advance notice if the need for the reasonable accommodation, transfer, or PDL is foreseeable, or 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 if your employer has 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.

ADDITIONAL LEAVE UNDER THE CALIFORNIA FAMILY RIGHTS ACT (CFRA)

Under the California Family Rights Act (CFRA), if you have more than 12 months of service with an 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 a 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***, spouse, domestic partner, grandparent, grandchild, sibling, or someone else related by blood or in family-like relationship with the employee ("designated person"). Employers may pay their employees while taking CFRA leave, but employers are not required to do so, unless the employee is taking accrued paid time-off while on CFRA leave. Employees taking CFRA leave may be eligible for benefits administered by Employment Development Department.

TO FILE A COMPLAINT

Civil Rights Department
calcivilrights.ca.gov/complaintprocess
Toll Free: 800.884.1684 / TTY: 800.700.2320
California Relay Service (711)

Have a disability that requires a reasonable accommodation? CRD can assist you with your complaint.

For translations of this guidance, visit:
www.calcivilrights.ca.gov/posters/required

*PDL, CFRA leave, and anti-discrimination protections apply to employers of 5 or more employees; anti-harassment protections apply to employers of 1 or more.
** "Child" means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of an employee or the employee's domestic partner, or a person to whom the employee stands in loco parentis.
*** "Parent" includes a biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

California Family Rights Act (CFRA)

Under California law, an employee may have the right to take job-protected leave to care for their own serious health condition or a family member with a serious health condition, or to bond with a new child (via birth, adoption, or foster care). California law also requires employers to provide job-protected leave and accommodations to employees who are disabled by pregnancy, childbirth, or a related medical condition.

Under the California Family Rights Act of 1993 (CFRA), many employees have the right to take job-protected leave, which is leave that will allow them to return to their job or a similar job after their leave ends. This leave may be up to 12 work weeks in a 12-month period for:

- the employee's own serious health condition;
- the serious health condition of a child, spouse, domestic partner, parent, parent-in-law, grandparent, grandchild, sibling, or someone else with a blood or family-like relationship with the employee ("designated person"); or
- the birth, adoption, or foster care placement of a child.

If an employee takes leave for their own or a family member's serious health condition, leave may be taken on an intermittent or reduced work schedule when medically necessary, among other circumstances.

Eligibility. To be eligible for CFRA leave, an employee must have more than 12 months of service with their employer, have worked at least 1,250 hours in the 12-month period before the date they want to begin their leave, and their employer must have five or more employees.

Pay and Benefits During Leave. While the law provides only unpaid leave, some employers pay their employees during CFRA leave. In addition, employees may choose (or employers may require) use of accrued paid leave while taking CFRA leave under certain circumstances. Employees on CFRA leave may also be eligible for benefits administered by the Employment Development Department.

Taking CFRA leave may impact certain employee benefits and seniority date. If employees want more information regarding eligibility for a leave and/or the impact of the leave on seniority and benefits, they should contact their employer.

Pregnancy Disability Leave. Even if an employee is not eligible for CFRA leave, if disabled by pregnancy, childbirth or a related medical condition, the employee is entitled to take a pregnancy disability leave of up to four months, depending on their period(s) of actual disability. If the employee is CFRA-eligible, they have certain rights to take *both* a pregnancy disability leave and a CFRA leave for reason of the birth of their child.

Reinstatement. Both CFRA leave and pregnancy disability leave contain a guarantee of reinstatement to the same position or, in certain instances, a comparable position at the end of the leave, subject to any defense allowed under the law.

Notice. For foreseeable events (such as the expected birth of a child or a planned medical treatment for the employee or of a family member), the employee must provide, if possible, at least 30 days' advance notice to their employer that they will be taking leave. For events that are unforeseeable, employees should notify their employers, at least verbally, as soon as they 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 the employee complies with this notice policy.

Certification. Employers may require certification from an employee's health care provider before allowing leave for pregnancy disability or for the employee's own serious health condition. Employers may also require certification from the health care provider of the employee's family member, including a designated person, who has a serious health condition, before granting leave to take care of that family member.

Want to learn more?
Visit: calcivilrights.ca.gov/family-medical-pregnancy-leave/

If you have been subjected to discrimination, harassment, or retaliation at work, or have been improperly denied protected leave, file a complaint with the Civil Rights Department (CRD).

TO FILE A COMPLAINT

Civil Rights Department
calcivilrights.ca.gov/complaintprocess
Toll Free: 800.884.1684 / TTY: 800.700.2320
California Relay Service (711)

Have a disability that requires a reasonable accommodation? CRD can assist you with your complaint.

For additional translations of this guidance, visit: www.calcivilrights.ca.gov/posters/required

CRD-100-21ENG / January 2023

California Paid Family Leave (PFL)

About California Paid Family Leave

For many working Californians, finding time to be with a loved one when they need it most can be difficult. California's Paid Family Leave program was created for those moments that matter. Benefits are available to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying military event.

Fast Facts About California Paid Family Leave

- Provides up to eight weeks of partial wage replacement benefits to bond with a new child (either by birth, adoption, or foster care placement), to care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner), or to participate in a qualifying event resulting from a family member's (spouse, registered domestic partner, parent, or child) military deployment to a foreign country.
- Doesn't have to be taken all at once.
- Provides approximately 60 to 70 percent of your salary during your leave.
- Funded through your State Disability Insurance tax withholding, so you are most likely eligible if you've paid into State Disability Insurance (noted as "CASDI" on paystubs) or a qualifying voluntary plan in the past 5 to 18 months.
- To bond with a new child, leave can be taken anytime within the first 12 months of a child entering your family.

For more information, visit:
CaliforniaPaidFamilyLeave.com

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8679 (voice). TTY users, please call the California Relay Service at 711.

moments matter.

Paid Family Leave:
Giving Californians the benefits 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

Individuals can also visit a Paid Family Leave or Disability Insurance office to obtain claim forms, receive information, or speak to a representative.

Visit a **State Disability Insurance office (edd.ca.gov/Disability/Contact_SDI.htm)** near you.

How Do I Apply For Benefits?

Apply for Paid Family Leave benefits by visiting **SDI Online (edd.ca.gov/SDI_Online)**.

You may also apply using a paper form. Visit **EDD Forms and Publications (edd.ca.gov/Forms)** to request a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) form.

For caregiving claims, you must provide medical certification showing that the care recipient has a serious health condition and requires your care. This needs to be completed by the care recipient's physician/practitioner. Information about the care recipient and their signature are also required.

For bonding claims, you must provide documentation showing proof of relationship between you and the child (e.g., a copy of the child's birth certificate, adoptive placement agreement, or foster care placement record).

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

For military assist claims, you must provide supporting military documentation (e.g., proof of covered active duty or call to covered active duty and documentation of the qualifying event).

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

If your claim is denied, you have the right to:

- Know the reason for denial.
- Appeal decisions about your eligibility for benefits. Visit **Appeals (edd.ca.gov/Disability/Appeals.htm)** for information.

All claim information is confidential except for purposes allowed by law.

Do I Qualify For California Paid Family Leave?

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

- Need to take time off from work to care for a seriously ill family member, to bond with a new child, or to participate in a qualifying military event.
- Be covered by State Disability Insurance (or a voluntary plan in lieu of State Disability Insurance).
- Have earned at least $300 in the past 5 to 18 months.
- Submit your claim no later than 41 days after you begin your family leave. Do not file before your first day of leave.

If required by your employer, you must use up to two weeks of unused vacation leave or paid time off. Check with your human resources department to confirm your employer's requirements.

How Are Benefit Amounts Calculated?

California Paid Family Leave provides approximately 60 to 70 percent of your weekly salary.

The benefit amount is calculated from your highest quarterly earnings over the past 5 to 18 months, before the start of your claim. The Employment Development Department (EDD) has an online calculator that can help you estimate your weekly benefit amount. Visit the **Disability Insurance and Paid Family Leave Calculator (edd.ca.gov/PFL_Calculator)** to estimate your benefit.

If you are found eligible to receive benefits, you have an option on how you receive your benefit payments: by the EDD Debit Card℠ through Bank of America or by check, mailed from the EDD.

Does Paid Family Leave Provide Job Protection?

California Paid Family Leave does not provide job protection or a right to return to work.

However, job protection may be provided under other laws such as the federal Family and Medical Leave Act, the California Family Rights Act, or the New Parent Leave Act (if you qualify).

Notify your employer of your plan to take leave and the reason for taking leave according to your company's policy.

YOUR RIGHTS UNDER USERRA
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: https://www.dol.gov/agencies/vets/programs/userra/poster Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date – May 2022

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

SECTION 1. Organ and Bone Marrow Donation shall be administered in accordance with Section 1510 of the Labor Code:
(a) Subject to subdivision (b), an employer shall grant to an employee the following paid leaves of absence:
(1) A leave of absence not exceeding 30 business days to an employee who is an organ donor in any one-year period, for the purpose of donating his or her organ to another person. The one-year period is measured from the date the employee's leave begins and shall consist of 12 consecutive months.
(2) A leave of absence not exceeding five business days to an 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. The one-year period is measured from the date the employee's leave begins and shall consist of 12 consecutive months.
(b) In order to receive a leave of absence pursuant to subdivision (a), an employee shall provide written verification to his or her employer 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, paid time off, annual leave, or seniority. During any period that an employee takes leave pursuant to subdivision (a), the employer shall maintain and pay for coverage under a group health plan, as defined in Section 5000(b) of the Internal Revenue Code of 1986, for the full duration of the leave, in the same manner the coverage would have been maintained if the employee had been actively at work during the leave period.
(d) This part does not affect the obligation of an employer to comply with a collective bargaining agreement or employee benefit plan that provides greater leave rights to employees than the rights provided under this part.
(e) The rights provided under this part shall not be diminished by a collective bargaining agreement or employee benefit plan entered into on or after January 1, 2011.
(f) An employer may require, as a condition of an employee's initial receipt of bone marrow or organ donation leave, that an employee take up to five days of earned but unused sick leave, vacation, or paid time off for bone marrow donation and up to two weeks of earned but unused sick leave, vacation, or paid time off for organ donation, unless doing so would violate the provisions of any applicable collective bargaining agreement.
(g) Notwithstanding existing law, bone marrow and organ donation leave shall not be taken concurrently with any leave taken pursuant to the federal Family and Medical Leave Act of 1993 (29 U.S.C. Sec. 2601 et seq.) or the Moore-Brown-Roberti Family Rights Act (Sections 12945.2 and 19702.3 of the Government Code).
(h) Leave provided for pursuant to this section may be taken in one or more periods, but in no event shall exceed the amount of leave prescribed in subdivision (a).
SECTION 2. The amendment of Section 1510 of the Labor Code made by this act does not constitute a change in, but is declaratory of, existing law.

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

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: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Cal-COBRA 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

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).

Important Notice from The County of Ventura About Your Prescription Drug Coverage and Medicare

Read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the County of Ventura-sponsored medical plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan.

If you are considering enrolling, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is on this notice.

The County of Ventura has determined that your prescription drug coverage with County-sponsored medical plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage.

Effective January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer additional coverage for a higher monthly premium.

Because the County-sponsored medical plans and prescription coverage are 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 of each year. However, if you lose your current County-sponsored medical plan and prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to enroll in a Medicare drug plan.

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 will 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 you go 63 days or longer without creditable prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% of the Medicare base beneficiary premium per month for every month 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 October to enroll.*

For more information about this notice or your current prescription drug coverage, please contact our office by email at Patty.Vandewater@ventura.org or by phone 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 may also request a copy at any time.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare or you can get a copy of this handbook by contacting Medicare or visiting their website. 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 the "Medicare & You" handbook).
- 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: 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to enroll in a plan with Medicare prescription drug coverage, you may be required to provide a copy of this notice when you enroll to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

County of Ventura CEO/Human Resources/Benefits
800 South Victoria Avenue, Ventura, CA 93009-1970
Tel.: 805-477-1580 Fax: 805-654-2665
www.ventura.org/benefits

Date: October 15, 2024

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.

Health Insurance Portability & Accountability Act of 1996 (HIPAA), cont'd

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.

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.

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.

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES
Availability of Privacy Practices Notices

We maintain the HIPAA Notice of Privacy Practices for County of Ventura describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected by federal law from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as deductibles, copayments, and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Air Ambulance Services

If you have an emergency medical condition and get emergency transport through an out-of-network air ambulance service, the most the provider may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency air ambulance services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing.
You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact UnitedHealthcare at 877-BEN-YMCA or you may contact the Department of Health and Human Services (HHS). Visit: https://www.cms.gov/nosurprises/consumers or call 1-800-985-3059 for more information about your rights under federal law.

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, STALKING, CRIMES THAT CAUSE PHYSICAL INJURY OR MENTAL INJURY, AND CRIMES INVOLVING A THREAT OF PHYSICAL INJURY; AND OF PERSONS WHOSE IMMEDIATE FAMILY MEMBER IS DECEASED AS A DIRECT RESULT OF A CRIME

Your Right to Take Time Off:

- You have the right to take time off from work to obtain relief from a court, including obtaining a restraining order, to protect you and your children's health, safety or welfare.
- If your company has 25 or more workers, you can take time off from work to get medical attention for injuries caused by crime or abuse, receive services from a domestic violence shelter, program, rape crisis center, or victim services organization or agency as a result of the crime or abuse, receive psychological counseling or mental health services related to an experience of crime or abuse, or participate in safety planning and take other actions to increase safety from future crime or abuse.
- You may use accrued paid sick leave or vacation, personal leave, or compensatory time off that is otherwise available 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 beforehand, 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, a court order, a document from a licensed medical professional, a victim advocate, a licensed health care provider, or counselor showing that you were undergoing treatment for domestic violence related trauma, or a written statement signed by you, or an individual acting on your behalf, certifying that the absence is for an authorized purpose.

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, stalking, a crime that caused physical injury or mental injury, or a crime involving threat of physical injury; or are someone whose immediate family member is deceased as a direct result of a crime.
- 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

3/2021

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 summaries are designed to help you better understand and evaluate your health insurance choices.

The Summaries of Benefits and Coverage (SBCs) for County-sponsored health insurance plans can be found on the following County Benefits intranet and internet websites:

(Intranet)
http://myvcweb/index.php/benefits

(Internet)
https://hr.ventura.org/benefits/py2025

Hard copies are available upon request:

County of Ventura – CEO/HR Benefits

800 S. Victoria Avenue, Loc. 1970, Ventura CA 93009

805.654.2570 (phone)

Benefits.ServiceRep@ventura.org (email)

Who Do I Contact?

Ventura County Health Care Plan (HMO)

Website: http://www.vchealthcareplan.org, Member Services Email: vchcp.memberservices@ventura.org

Customer Service	**(805) 981-5050 or (800) 600-8247**
24/7 Nurse Advice/Health Information (no copayment)	**(800) 334-9023**
Teladoc (24/7 doctor visit via telephone or web; typically no co-payment)	**(800) 835-2362**
Mail Order Pharmacy – Express Scripts (https://www.express-scripts.com)	**(800) 811-0293**
Behavioral Health – Optum Health Behavioral Solutions – Life Strategies	**(800) 851-7407**

Blue Shield Medical Plans (Trio ACO HMO, Access+ HMO, and High-Deductible PPO)

Group# W0067449, Website: www.blueshieldca.com, myoptions.blueshieldca.com/Ventura

TRIO ACO HMO Customer Service	**(855) 747-5800**
Access+ HMO and High-Deductible PPO Customer Service	**(855) 256-9404**
NurseHelp (available 24/7; no copayment)	**(877) 304-0504**
TelaDoc (24/7 doctor visit via telephone or web; typically, no copayment)	**(800) 835-2362**
Mail Order Pharmacy – Caremark (https://www.blueshieldca.com/wellness/drugs/mail-service-prescriptions)	**(866) 346-7200**
Blue Shield Mental Health Services	**(877) 263-9952**

MetLife Dental PPO Plan

Group# 0154209 (PDP Plus Plan), Website: www.metlife.com/countyofventura or www.metlife.com/mybenefits

Customer Service (Member Services office for Eligibility/Claims/Benefits/Pre-certifications)	**(800) 438-6388**

EyeMed – Vision Plan

Group# 1041070, Website: https://eyemed.com/en-us

Customer Service	**(866) 800-5457**

Chard Snyder Flexible Spending Accounts (Dependent Care, Health Care, Limited-Purpose, and Transportation)

Website: http://www.chard-snyder.com, Customer Service Email: askpenny@chard-snyder.com

Customer Service	**(800) 982-7715**

HealthEquity HSA (for BlueShield HDHP-PPO enrollees only)

Website: http://www.healthequity.com

Customer Service	**(866) 346-5800**

County Retiree Health Benefits

Website: https://hr.ventura.org/benefits/retiree-health-benefits;	**Email: retiree.benefits@ventura.org**	**(805) 477-1580**

Optional Life Insurance/Basic Life Insurance – MetLife

Customer Service (Group Policy# 154209)	**(800) 638-6420**
Portability Customer Service	**(888) 252-3607**

Long Term & Short Term Disability Insurance – MetLife

Customer Service (Group Policy# 154209)	**(800) 638-2242**

Short Term Disability Insurance – COV Wage Supplement Plan (WSP)

Website: https://hr.ventura.org/benefits/absence-management-disability-plans	**(805) 654-2780**

Absence Management Program

Website: https://hr.ventura.org/benefits/absence-management-disability-plans

Absence Management Analyst Email: LOA.Benefits@ventura.org	**(805) 677-8785**

Employee Assistance Program (EAP)

Website: https://hr.ventura.org/benefits/employee-assistance-program	**(805) 654-4327**

Employee Emergency Assistance Program (EEAP)

Website: https://hr.ventura.org/benefits/employee-emergency-assistance-program	**(805) 654-2269**

Wellness Program

Website: https://vcwell.ventura.org/	**(805) 654-2628**

Lactation Accommodation Information

Website: https://hr.ventura.org/benefits	**Email: WorkLife@ventura.org**	**(805) 677-8785**

Deferred Compensation Program (401k and 457 Plans)

Website: https://dc.ventura.org/	**(805) 654-2620**

COBRA/Direct Bill Administrator – Optum Financial

Website: https://cobra.optumfinancial.com	**(855) 687-2021**

County of Ventura – CEO/HR/Benefits

800 S. Victoria Avenue, Loc# 1970, Ventura, CA 93009-1970

PHONE (805) 654-2570 FAX (805) 654-2665 Internet: https://hr.ventura.org/benefits

Email: Benefits.ServiceRep@ventura.org Intranet: http://myvcweb/index.php/hr/benefits/home

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