

Public Works Agency

STEP 3: Benefits

Instructions:

- 1) Download this packet to your personal computer for easy reference and access.
- 2) Review the benefit materials, enclosed in this packet, before you begin completing any of the forms.
 - a) **2025 Flexible Benefits Program - Plan Rates and Flexible Credits Guide Sheet**
 - b) **2025 Flexible Benefits Program Enrollment & Change Form**
 - c) **2025 Employee Benefits Handbook**
 - d) **Domestic Partner Packet**
 - e) **Fidelity 401k/457 Plans** and County of Ventura 401k Match Information
 - f) **MetLife** - Life Insurance Plans & Forms
 - g) **County of Ventura Wellness Program**
- 3) Complete all **REQUIRED** forms as follows:
 - a) **Flexible Benefits Program Enrollment & Change Form**
NOTE: *If adding dependents, please make sure you bring any required support documentation to your Onboarding Meeting with PWA HR (birth certificates for dependents and marriage/domestic partner certificates for spouse/registered domestic partners).*
 - b) **MetLife - Group Life Insurance Enrollment Form**
Only complete if you want additional life insurance for you or your family (more than the basic county-provided life insurance for employees -"c" below).
 - c) **MetLife - Basic/Optional Life Insurance Beneficiary Designation Form**
This is the county-provided life insurance policy provided to all employees. All employees must complete this form and provide primary & contingent beneficiary information.

NOTE: You will have 30 days (from hire date) to enroll in the benefits of your choosing. By law, all employees must have medical coverage; therefore, if you do not complete the **Flexible Benefits Program Enrollment & Change Form** ("3a" above) timely, it will result in automatic enrollment into the Ventura County Health Care Plan (with coverage for employee only) and any changes must wait until the next Open Enrollment period in November.



County of Ventura OPT OUT CERTIFICATION FORM

Please Check One

- New Opt-Out Updating Current Opt-Out Info New Opt-Out Open Enrollment

This form is to be completed by all employees newly enrolling in the Medical Plan Opt-Out option OR who are currently enrolled in the Medical Plan Opt-Out option and have experienced a change in their other eligible medical plan coverage. This form must be submitted with mid-year change paperwork and within 60 days of a mid-year change, or a mid-year change will not be approved, no exceptions.

Employee ID Number: _____ Agency: _____

Employee Name: _____ DOB: _____

If you are covered as a dependent under another County of Ventura employee's medical plan, please skip to Section II.

- I. Please complete the following for your other eligible group medical plan coverage and attach a copy of the front and back of your ID card or a letter from the insurer with information on your new coverage. This form must be submitted within 60 days of a mid-year change, including the event date (the effective start date of outside coverage), no exceptions:**

Primary Subscriber's Name: _____ Zip Code: _____

Primary Subscriber's Social Security Number: _____ Subscriber's DOB: _____

Spouse Registered Domestic Partner Parent Self Other: _____

Primary Subscriber's Sponsoring Employer: _____

Subscriber ID No: _____ Group No: _____

Medical Plan Insurance Company: _____

Medical Plan Telephone Number: _____

Coverage Effective Date: _____

- II. If you are covered as a dependent under another County of Ventura employee's medical plan, please complete this section (no further documentation is necessary).**

Subscriber's Employee ID Number: _____

Subscriber's Name: _____

- III. I certify that I have read, understand, and agree to the terms outlined on this form.**

I authorize the County of Ventura HR/Benefits to perform any investigation necessary to verify my current enrollment/eligibility for the above-named medical insurance plan, and I attest to the accuracy of the information contained within this form. I further acknowledge that at any time while opting out of medical coverage, if I lose other eligible group medical plan coverage, I will notify County Benefits within 60 days, to enroll in an available County medical plan.

I agree to comply with the County's Flexible Benefit Program, which includes providing updated proof of other eligible group medical plan coverage and meeting eligibility requirements. Failure to comply with these terms and annual audit requirements may result in collection of retroactive medical premiums and/or repayment of cash back received for any period in which I was not able to demonstrate eligibility.

Signature

Date



COUNTY of VENTURA

County Executive Office
Human Resources/Benefits

EE# _____ Last Name: _____ First Name: _____

COV HR Benefits is providing this form based on your request.

WAIVER OF PARTICIPATION IN THE FLEXIBLE BENEFITS PROGRAM (NOT THE SAME AS OPTING OUT OF MEDICAL COVERAGE)

Read this WAIVER OF BENEFITS and sign and date if you choose to move forward with waiving participation in the County's Flexible Benefits Program for the 2025 Plan Year.

WAIVER OF BENEFITS: I have been informed about the County's Flexible Benefits Program. I understand that I am entitled to a Flexible Credit Allowance or Opt-Out Allowance each pay period if I am enrolled in the Ventura County Flexible Benefits Program, including an eligible medical Opt-Out. I choose not to enroll in the County's Flexible Benefits Program and thereby waive and forfeit the County Flexible Credit Allowance and Opt-Out Allowance. I understand that this decision is binding and that I will not have another opportunity to enroll until the next annual Flexible Benefits Program open enrollment period.

Employee Signature: _____ Date: _____

Employee's Printed Name: _____



2025 Flexible Benefits Program

PLAN RATES & FLEXIBLE CREDITS GUIDE

Flexible Benefits Program Eligibility - You are eligible if you are a regular County of Ventura employee and you have a regular Work Schedule ("Standard Hours" in VCHRP) of at least 40 hours per biweekly pay period. If you are not eligible for the Flexible Benefits Program, you may still be eligible for a medical plan. Contact County Benefits for more information – Benefits.ServiceRep@ventura.org or (805) 654-2570. For specific plan information, please visit our website: <https://hr.ventura.org/benefits>.

County-Sponsored Plans

Plan Name	Biweekly Premiums
COUNTY-SPONSORED MEDICAL	
Ventura County Health Care Plan (Full HMO Network)	
Employee Only	\$ 412.59
Employee + 1	\$ 824.26
Employee + 2 or more	\$ 1071.26
Blue Shield Trio HMO (ACO Network)	
Employee Only	\$ 344.18
Employee + 1	\$ 687.45
Employee + 2 or more	\$ 893.40
Blue Shield Access+ HMO (Full HMO Network)	
Employee Only	\$ 440.66
Employee + 1	\$ 880.40
Employee + 2 or more	\$1,144.25
Blue Shield High-Deductible PPO	
Employee Only	\$ 532.25
Employee + 1	\$ 984.40
Employee + 2 or more	\$ 1,279.03
COUNTY-SPONSORED DENTAL	
MetLife Dental PPO	
Employee Only	\$ 22.22
Employee + 1	\$ 42.35
Employee + 2 or more	\$ 64.04
COUNTY-SPONSORED VISION	
EyeMed Vision Plan	
Employee Only	\$ 2.03
Employee + 1	\$ 3.66
Employee + 2 or more	\$ 5.24
FLEXIBLE SPENDING ACCOUNTS & HEALTH SAVINGS ACCOUNT ¹	
Health Care and Limited Purpose FSAs - Annual Maximum \$3,199.92	
Dependent Care FSA - Annual Maximum \$4,999.92	
Health Savings Account – Annual Maximums:	
\$4,299.84 individual (\$5,299.92 if age 55 or over)	
\$8,550.00 family (\$9,549.84 if age 55 or over)	

¹ - Deductions for FSAs & HSAs are not taken on any 3rd paycheck in a month (PPs 24-11 & 24-24. The first deduction for the 2024 plan year for these plans will be in PP24-01 Payday 01/12/24).

Union-Sponsored Plans

Plan Name	Biweekly Premiums
VCDSA-SPONSORED MEDICAL	
Anthem Basic HMO	
Employee Only	\$ 219.85
Employee + 1	\$ 473.84
Employee + 2 or more	\$ 681.63
Anthem HMO Select	
Employee Only	\$ 252.67
Employee + 1	\$ 542.74
Employee + 2 or more	\$ 780.08
Anthem HMO Traditional	
Employee Only	\$ 398.54
Employee + 1	\$ 849.07
Employee + 2 or more	\$ 1,217.68
Anthem PPO	
Employee Only	\$ 718.99
Employee + 1	\$ 1,522.03
Employee + 2 or more	\$ 2,179.04
Anthem HDHP PPO (HSA)	
Employee Only	\$ 503.95
Employee + 1	\$1,070.42
Employee + 2 or more	\$ 1,533.92
VCPFA-SPONSORED MEDICAL	
Blue Shield Trio Low HMO (Narrow Network)	
Employee Only	\$ 256.41
Employee + 1	\$ 510.32
Employee + 2 or more	\$ 635.26
Blue Shield Low HMO (Full Network)	
Employee Only	\$ 305.63
Employee + 1	\$ 603.85
Employee + 2 or more	\$ 745.54
Blue Shield Full High HMO (Full Network)	
Employee Only	\$ 375.24
Employee + 1	\$ 736.11
Employee + 2 or more	\$ 919.69
Blue Shield High-Deductible PPO	
Employee Only	\$ 428.50
Employee + 1	\$ 837.31
Employee + 2 or more	\$ 1,199.83

Biweekly Flexible Credit Allowance

When you enroll, you are given a Flexible Credit Allowance that you can use to purchase the plans listed above for which you are eligible. Your Flexible Credit Allowance is negotiated by the Bargaining Unit that represents your job classification. Approved Medical Opt-Outs receive an Opt-Out Allowance (OOA) which varies by each bargaining agreement. The Opt-Out Allowance is not applicable to part-time employees.

Bargaining Unit	Flex Credit Allowance Full-time - (60+ hours per biweek) / OOA	Bargaining Unit	Flexible Credit Allowance - Part-time (40-59 hours per biweek) / OOA for Part-Time EEs
CNA, VEA	\$702/\$303.43	CNA, VEA	\$491
VCDSA	\$582/\$229.94	VCDSA	\$429
VCPFA	\$567/\$191.78	VCPFA	\$567
VCPPOA Probation Unit	\$642/\$236	VCPPOA Probation Unit	\$449
The following Bargaining Units have Flexible Credit Allowance amounts that vary by medical plan tier: OOA / Employee Only / Employee + 1 / Employee + 2 or more			
APCD, IUOE, MGMT, SEIU, UAPD	\$150 / \$509 / \$779 / \$983	APCD, IUOE, MGMT, SEIU, UAPD	\$356 / \$545 / \$688
CJAAVC	\$209 / \$509 / \$779 / \$983	CJAAVC	\$356 / \$545 / \$688
VCPPOA Patrol Unit	\$145 / \$509 / \$779 / \$983	VCPPOA Patrol Unit	\$356 / \$545 / \$688
SPOAVC	\$147 / \$502 / \$730 / \$905	SPOAVC	\$351 / \$511 / \$634
VCSCOA	\$140 / \$509 / \$700 / \$847	VCSCOA	\$356 / \$490 / \$593



Flexible Benefits Program Enrollment & Change Form Plan Year 2025

Instructions: After completion, please return this form, along with any required back-up documentation, to your agency/department's Benefits Representative.

County of Ventura Human Resources/Benefits
800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 654-2570 · FAX (805) 654-2665
Email: Benefits.ServiceRep@ventura.org
Intranet: <http://myvcweb/index.php/benefits>
Internet: www.ventura.org/benefits

Type of Enrollment

- New Enrollment
- Mid-Year Change Request *(must also complete page 3 of this form)*
- Add Dependent/Date & Reason _____
- Cancel Dependent/Date & Reason _____
- Other _____

1. Employee Data (please print)

NAME (LAST, FIRST, M.I.)	EMPLOYEE ID NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS (NUMBER & STREET)	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE	GENDER (M/F)	HIRE DATE
AGENCY/DEPARTMENT NAME	BARGAINING UNIT	EMAIL ADDRESS	

2. Medical Plan Coverage (pre-tax rates; see last page of this form for your biweekly flexible credit amount)

- Ventura County Health Care Plan HMO (EE only = \$412.59/biweek, EE+1 = \$824.26/biweek, EE + 2 or more = \$1,071.26/biweek)
- Blue Shield Trio HMO (EE only = \$344.18/biweek, EE+1 = \$687.45/biweek, EE + 2 or more = \$893.40/biweek)
- Blue Shield Access+ HMO (EE only = \$440.66/biweek, EE+1 = \$880.40/biweek, EE + 2 or more = \$1,044.25/biweek)
- Blue Shield High-Deductible PPO (EE only = \$532.25/biweek, EE+1 = \$984.40/biweek, EE + 2 or more = \$1,279.03/biweek)
- Medical Plan Opt-Out** - Must submit Opt-Out Certification Form with proof of eligibility (Opt-Out Allowance dollar amounts vary by bargaining agreement. See page four of this form for Opt-Out Allowance biweek amounts.)

OR***DO NOT COMPLETE BELOW UNLESS YOU ARE WAIVING ENROLLMENT IN THE COUNTY'S FLEXIBLE BENEFIT PROGRAM**

- Waiver of Participation in the Flexible Benefits Program (Not the same as Opting Out)** (\$0.00 prem or Flex Credits provided /biweek) Caution: By checking this box, initialing, and dating at the end of this paragraph, and signing and dating page two of this form, you confirm you've been informed about the County's Flexible Benefits Program. Furthermore, you understand that, if eligible, you are entitled to a Flexible Credit Allowance or Opt-Out Allowance each pay period if you were to enroll in the Ventura County Flexible Benefits Program by electing at least one of the Medical Plans or Medical Opt-Out Plan above. You choose not to enroll, waiving and forfeiting the County Flexible Credit Allowance/Opt-Out Allowance. You also understand that this decision is binding and that you will not have another opportunity to enroll until the next annual Flexible Benefits Program open enrollment period.
Initial _____ Date _____ here only if you wish to Waive participation in the Flexible Benefits Program.
(You cannot elect any other plans on this form if you elect this option.)

3. Dental Plan Coverage (pre-tax tiered rates)

- MetLife Dental PPO (EE only = \$22.22/biweek, EE + 1 = \$42.35/biweek, EE + 2 or more = \$64.04/biweek)

4. Vision Plan Coverage (pre-tax)

- EyeMed Vision (EE only = \$2.03/biweek, EE+1 = \$3.66/biweek, EE + 2 or more = \$5.24/biweek)

5. Health Savings Account (pre-tax; only available if enrolling in the High Deductible PPO)

- I elect a Health Savings Account with a semi-monthly pledge of \$ _____
Individual Coverage – Maximum Biweekly Pledge is \$179.16 semi-monthly (\$220.83 if age 55 or older)
Family Coverage - Maximum Biweekly Pledge is \$356.25 semi-monthly (397.91 if age 55 or older)

6. Flexible Spending Accounts (FSA pre-tax; annual re-election is required)

Health Care FSA (not available if enrolling in the High Deductible PPO):

I elect a Health Care Flexible Spending Account with a semi-monthly pledge of \$_____ (\$1.00 - \$133.33/semi-monthly).

Dependent Care FSA:

I elect a Dependent Care Flexible Spending Account with a semi-monthly pledge of \$_____ (\$1.00 - \$208.33/semi-monthly).

Limited-Purpose FSA (only available if enrolling in the Health Savings Account):

I elect a Limited-Purpose Health Care Flexible Spending Account with a semi-monthly pledge of \$_____ (\$1.00 - \$133.33/semi-monthly).

7. Employee/Dependent Information (If enrolling in an HMO medical plan, please be sure to designate a primary care physician for yourself and your dependents. You may add additional dependents on a separate sheet of paper. Also, you must attach documentation that supports the relationship for each dependent; required documentation is listed on the following page.)

NAME (LAST, FIRST, M.I.)	RELATIONSHIP	DATE OF BIRTH	GENDER (M/F)	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VISION	PHYSICIAN NAME (HMO only)	Previously seen?
Employee	Self	See Page 1							

8. Signature

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable. I also understand and agree that:

- I have the website URL to the Flexible Benefits Program Benefit Plans Handbook, and I have read descriptions of benefits plans in which I am enrolling.
- My coverage elections on this form cannot be revoked or modified until the next open enrollment period, unless I have a qualifying change in status as defined by the IRS (see Benefit Plans Handbook, Chapter 1).
- I will verify that the enrollments and deductions I have authorized on this form have been implemented by reviewing my paystub for accuracy during the first pay period my selections are effective. I agree that failure to report an error within 30 days of the error's first appearance on my biweekly paystub is an affirmative election of the benefits listed on the paystub.
- I will notify the County immediately if I and/or my dependents become ineligible. In the event ineligibility is determined, I understand and agree that coverage will be terminated retroactive to the date I/we became ineligible. I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments.
- My pre-tax pay will be reduced by the amount of any required contributions noted for the coverage(s) elected after my flexible credits have been applied (flexible credit amounts are listed on page 4 of this form). My unspent flexible credits will be taxed and added to my paycheck as "Cash Back."
- My enrolled dependents and I are bound by all the terms and conditions of the plans in which I am enrolling.
- The plan administrator and health care professionals/facilities/representatives are authorized to obtain and/or release medical information from/to appropriate providers/agencies if needed to provide necessary health care services and/or administrative services and/or claim adjudication for myself and my enrolled dependent(s).
- A photocopy of this form is as valid as the original.
- If a disagreement arises regarding coverage under a plan, the dispute or claim shall be submitted to the grievance and/or binding arbitration process as specified by the plan, and not by lawsuit or resort to court process, except as provided by California law.
- If you initialed and dated on page one, section one, to waive participation in the County's Flexible Benefits Program, you are signing below acknowledging that election. You will not receive any Flexible Credit/Opt-Out Allowance from the County. You will be unable to enroll in any of the Flexible Benefits Program's plans, for any reason, until the next open enrollment period.



Signature

Date

FOR OFFICE USE ONLY

Department Authorization (Sign & Date)	HR/Benefits Authorization (Sign & Date)	Effective Date	Medical Plan Group ID #

LTD Cert. Sent

Life Ins. Cert. Sent

COBRA Rights Sent (new spouse)



Flexible Benefits Program Mid-Plan Year Change Request Form

**TO BE COMPLETED FOR MID-YEAR CHANGES ONLY
(Not applicable for new employees' initial enrollment)**

County of Ventura Human Resources/Benefits
800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 654-2570 · FAX (805) 654-2665
Email: Benefits.ServiceRep@ventura.org
Intranet: <http://myvcweb/index.php/benefits>
Internet: www.ventura.org/benefits

The Qualified Event Deadline will not be any later than (60) calendar days from the Qualified Event Date:

Qualified Event Date: _____

Qualified Event Deadline: _____

1. Employee Data (please print)

NAME (LAST, FIRST, M.I.)

EMPLOYEE ID NUMBER

2. Qualifying Mid-Year Event: _____

3. Requested Plan Election Changes (please check all that apply)

Current Plan Year Elections	Requested Mid-Plan Year Elections
Medical Plan Coverage:	Medical Plan Coverage:
Dental Plan Coverage:	Dental Plan Coverage:
Vision Plan Coverage:	Vision Plan Coverage:
Health Care Flexible Spending Account:	Health Care Flexible Spending Account:
Dependent Care Flexible Spending Account:	Dependent Care Flexible Spending Account:
Limited-Purpose Flexible Spending Account:	Limited-Purpose Flexible Spending Account:
Health Equity Health Savings Account:	Health Equity Health Savings Account:

4. Employee Signature

All life events and mid-year changes must be submitted within 60 days, including the date of the event, this includes gain or loss of dependents coverage under Medi-Cal, Medicaid, or CHIP programs. To process a change, complete and return the Mid-Year Change Request page of this form (including sign and date) and the Enrollment and Change section of this form where applicable (including sign and date) within 60 days of the qualifying event (including the life event/effective date of the event that warrants the change request). The forms must be received within 60 days, even if supporting documentation is not yet available. The event date, which starts the period to request a change, is the effective date of coverage gain or loss, or the event date in the case of (marriage, birth, adoptions, etc.).

The IRS has specific rules governing when an employee may make a change to benefit elections. Therefore, we must receive the required supporting documentation when canceling or adding coverage. The change in plan selections must be because of and consistent with the reason for the change and with the consequence that there is a gain or loss of coverage due to the change. Employees have 60 days, including the date of the qualifying event, to enroll, cancel or make changes to their benefit elections. Employees must notify the County immediately if they/or their dependents become ineligible. If ineligibility is determined, I understand and agree that coverage will be terminated retroactively to the date I/we became ineligible. I authorize the Auditor-Controller to adjust the amount of payroll deductions/reductions/credits (including retroactive adjustments) necessary to correct any premium over-payments or under-payments. I understand that if I miss the deadline, I must wait until the next open enrollment to make any changes to my benefits.

I certify the information on this form is complete and correct and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I authorize the County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). I understand that misstatements, material misrepresentations, or omissions may result in my coverage being void as of its effective date with no benefits payable.

Signature

Date

FOR OFFICE USE ONLY

Department Authorization (Sign & Date)	HR/Benefits Authorization (Sign & Date)	Effective Date	Medical Plan Group ID #

ELIGIBILITY CATEGORIES	REQUIRED DOCUMENTS
<p>SPOUSE</p> <p>Your current legal husband or wife</p>	<ul style="list-style-type: none"> • Copy of page 1 of your most-recently filed federal tax return (as filed) listing spouse (financial data may be blacked out), OR • Copy of official marriage certificate
<p>REGISTERED DOMESTIC PARTNER</p> <p>Your domestic partner who is registered with you through the State of California or any other California County or Municipality's domestic partner registry</p>	<ul style="list-style-type: none"> • Copy of Declaration of Domestic Partnership (as filed with the official domestic partner registry), AND • Proof relationship is still current (a copy of a utility bill with your registered domestic partner's name on it that is mailed to your home on a regular basis and dated within the past 60 days.)
<p>CHILD* under the age of 26</p> <p>Your child under the age of 26</p> <p>(Certain unmarried children, if handicapped prior to age 26 and continuously covered by a County-sponsored medical plan since prior to age 26, and incapable of self-support may be eligible beyond age 26, if proper documentation of disability is submitted)</p>	<p>One of the following:</p> <ul style="list-style-type: none"> • Copy of page 1 of your most-recently filed federal tax return (as filed) listing child as dependent, OR • Copy of birth/adoption certificate, Qualified Medical Child Support Order. <p>AND</p> <ul style="list-style-type: none"> • Current residence and mailing address, if different than employee

*** The basic definition of "child" is the same for all plans: Any natural child, stepchild, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, of either you or your current spouse or registered domestic partner, or both.**

***In the event of a discrepancy between what is stated on this form and what is stated in the County of Ventura's Benefit Plans Handbook, the information indicated in the Benefit Plans Handbook shall be the deciding authority.**

Most birth certificates and marriage certificates can be ordered online at www.vitalchek.com, if you don't already have a copy. For copies of court documents such as adoption or guardianship proceedings, you can contact the Clerk of Court's office where the proceedings took place. Any costs you may incur to obtain your documents will be at your expense.

If you are unable to obtain any of the required documents, please contact County Benefits as soon as possible to determine if there are acceptable alternatives.

Opt-Out Allowance Bi-weekly amounts provided per bargaining agreement for employees with a work schedule of 60 or more hours per pay period. Part-time employees working less than 60 hours per pay period are not eligible for the Opt-Out Allowance. **Courts employees have not opted into the Opt-Out Allowance and are still receiving the full flex credit and are charged the Opt-Out Fee.

- CNA & VEA \$303.43
- CJAAVC \$209.00
- VCDSA \$229.94
- VCPFA \$191.78
- VCPPOA Probation Unit \$236.00
- VCPPOA Patrol Unit \$145.00
- SPOAVC \$147.00
- VCSCOA \$140.00
- APCD, IUOE, MGMT, SEIU, UAPD \$150.00

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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▪ Employee Assistance Program	▪ Absence Management Program
▪ Wellness Program	▪ Life & Disability Insurance Programs
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▪ Employee Commuter Benefits	▪ Employee Emergency Assistance Program
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APPENDICES

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On-Line Resources

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

✓ *Appendix B – Employee Notices*

- ❖ **Family and Medical Leave Act of 1993 (FMLA)**
- ❖ **Your Rights and Obligations as a Pregnant Employee**
- ❖ **Family Care and Medical Leave and Pregnancy Disability Leave**
- ❖ **Paid Family Leave Benefits Program (PFL)**
- ❖ **The Uniformed Services Employment and Reemployment Rights Act (USERRA)**
- ❖ **Women's Health and Cancer Rights Act of 1998**
- ❖ **Organ and Bone Marrow Donation Protection Act**
- ❖ **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**
- ❖ **California AB 1401—additional extension of medical insurance (Cal-COBRA)**
- ❖ **Mental Health Parity Act (MHPA)**
- ❖ **The Newborns' and Mothers' Health Protection Act**
- ❖ **Important Notice about Your Prescription Drug Coverage and Medicare (Medicare Part D)**
- ❖ **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- ❖ **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.

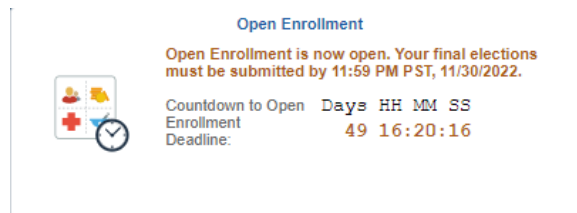
SIGNING ON TO VCHRP

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.

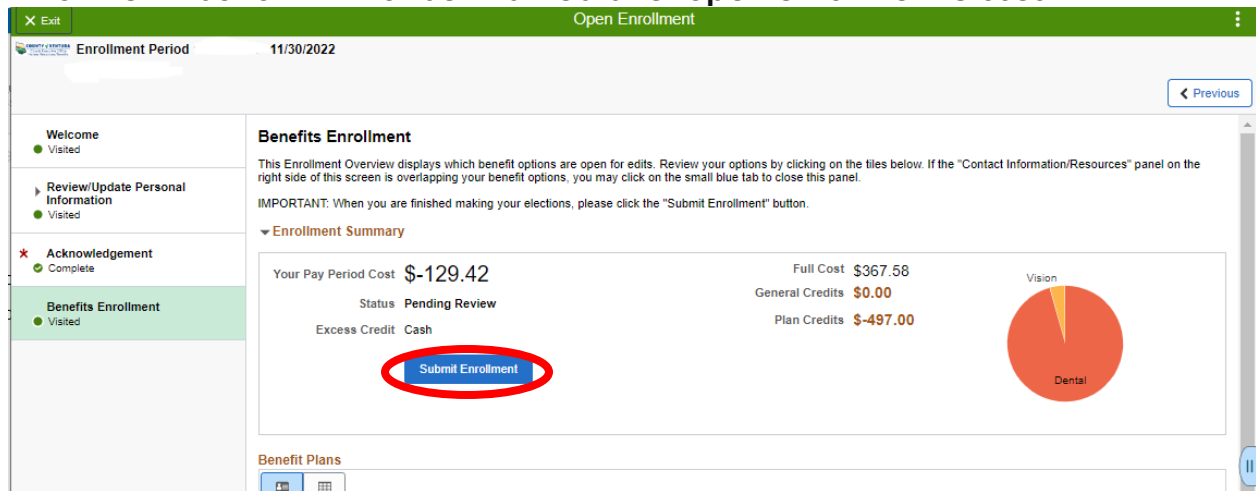
ONLINE ENROLLMENT

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 VCHR 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 <ul style="list-style-type: none"> • New Hire • From Optimum Census Staffing (OCS) • From Extra-Help • From Per-Diem Pool 	<ul style="list-style-type: none"> ■ 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: <ul style="list-style-type: none"> ✓ Flexible Benefits Program (submit <i>enrollment or waive participation</i> 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: <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> ■ Enter your new address in VCHR (Employee Self Service > Personal Details > Addresses) or notify your department representative to update your address and your name in VCHR. 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	<ul style="list-style-type: none"> ■ 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	<ul style="list-style-type: none"> ■ 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: <ul style="list-style-type: none"> ✓ 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
<p>Marriage</p> <p>Registration of Domestic Partner</p> <p>New dependent child as a result of birth, legal adoption, or marriage</p>	<ul style="list-style-type: none"> ■ 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.
<p>Legal Separation or Divorce</p> <p>Child no longer meets eligibility criteria</p>	<ul style="list-style-type: none"> ■ 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. <ul style="list-style-type: none"> ■ 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.
<p>Loss of Other Health Insurance</p>	<ul style="list-style-type: none"> ■ 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 & VDSA 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.
<p>Change in Other Health Insurance</p>	<ul style="list-style-type: none"> ■ 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.
<p>Standard Hours Decrease</p> <ul style="list-style-type: none"> • From 60 hours or more to between 40 & 59 hours per pay period 	<ul style="list-style-type: none"> ■ 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.
<p>Standard Hours Decrease</p> <ul style="list-style-type: none"> • To fewer than 40 hours per pay period 	<ul style="list-style-type: none"> ■ 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.
<p>Standard Hours Increase</p> <ul style="list-style-type: none"> • To between 40 & 59 hours per pay period 	<ul style="list-style-type: none"> ■ 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.
<p>Standard Hours Increase</p> <ul style="list-style-type: none"> • To 60 hours or more per pay period 	<ul style="list-style-type: none"> ■ 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	<ul style="list-style-type: none"> ■ 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	<ul style="list-style-type: none"> ■ 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: <ul style="list-style-type: none"> ✓ Ventura County Employees' Retirement Plan (VCERA) members - call (805) 339-4250 ✓ Safe Harbor Retirement Plan members - call (805) 654-2921
Death of a Dependent	<ul style="list-style-type: none"> ■ 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	<ul style="list-style-type: none"> ■ 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	<p>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. <i>Note: DO NOT change any dependent relationship status that currently shows in the Dependent/Beneficiary Info area, for example "Child" to "Adult Child."</i> 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.</p> <ul style="list-style-type: none"> ■ You may access beneficiary change forms on the following websites: <ul style="list-style-type: none"> • 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.

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.



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).

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

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.

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

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

The change in your plan selections must be because of, and consistent with, the reason for the change. Consistency is met if the election change affects eligibility for coverage under the plan. The election change 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 QMCSO 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](https://www.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+ SpecialistSM 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 \$3,200 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 <i>(Per Member/Per Family; per Calendar Year)</i>	None	None	None	Applies to all medical and pharmacy expenses except preventative care: \$3,300/\$6,000 ⁴	
Maximum Out-of-Pocket Expense <i>(Per Member/Per Family; per Calendar Year)</i>	Includes copayments made to providers for covered medical, pharmacy, and behavioral health services \$3,000/\$6,000	Excludes premiums and health care expenses that this plan doesn't cover \$1,500/\$3,000	Excludes premiums and health care expenses that this plan doesn't cover \$1,500/\$3,000	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. \$5,000/\$10,000 \$10,000/\$20,000	
PHYSICIAN SERVICES					
Office visits <i>(consultations & in-office procedures)</i>	\$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 <i>(covers emergency services only)</i>	\$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 <i>(when medically necessary)</i>	\$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 <i>(includes physical, speech, occupational, and respiratory therapy)</i>	\$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 <i>Limits: Chiropractic Services – 30 visits/year-combined in/out of network Acupuncture – 20 visits/year combined in/out of network r</i>	40% coinsurance ³ <i>Limits: Chiropractic Services – 30 visits/year-combined in/out of network Acupuncture – 20 visits/year combined in/out of network r</i>
Imaging (MRI, CT, PET)	\$100 per test	\$0 per test (\$100 per test for other radiological and nuclear imaging services ⁹)	\$0 per test (\$100 per test for other radiological and nuclear imaging services ⁹)	20% coinsurance ²	40% coinsurance ^{3, 4}
Diagnostic/ X-Ray, Ultrasound <i>(Outpatient)</i>	\$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 <i>(Retail Pharmacy)</i>	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 (HCFA) 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 online, 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

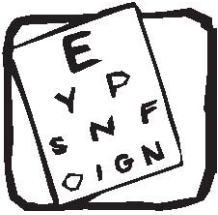
MetLife Dental PPO Plan Limitations and Exclusions are listed in the Summary of Benefits/Evidence of Coverage Booklet.

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			
Porcelain	Plan pays 50% (See MetLife Dental PPO Plan Exclusions and Limitations)	Plan pays 40% (See MetLife Dental PPO Plan Exclusions and Limitations)	
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
<u>Frequency</u>	12 / 12 / 24	
Exam at PLUS Providers	\$0 copay	Up to \$40
Exam with dilation	\$20 copay	
Retinal Imaging	Up to \$39	Not covered
<u>Frame</u>		
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	
<u>Standard plastic lenses</u>		
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
<u>Lens options</u>		
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
<u>Contact lens fit & follow-up (In lieu of lenses)</u>		
Standard	Up to \$40	Not covered
Premium	10% off retail price	Not covered
<u>Contact lenses</u>		
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, 2025.
- 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	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). **For Health Care FSAs only**, the County offers an IRS-approved 2½-month grace period that begins on January 1 and ends on March 15, during which you may incur additional expenses to claim against your remaining 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 24-26).

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.

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.

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 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 \$3,049.92 per year (\$127.08 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 Contribution¹	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 Contributions¹	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 <i>(In most circumstances, you cannot withdraw funds while you are still employed by the County)</i>	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	<p>Pre-Tax Option - Distributions are taxed as regular income when they are withdrawn from your account.</p> <p>After-Tax Roth Option – Distributions are tax free if you meet the requirements of a Qualified Distribution.²</p> <p>No penalties for distribution prior to age 59½.</p>	<p>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.</p> <p>After-Tax Roth option – Distributions are tax free if you meet the requirements of a Qualified Distribution.²</p>
Distribution Options at Termination or Retirement	<p>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.</p> <p>You do not have a deadline to choose your payout date and option until you are subject to IRS minimum required distribution rules.</p>	<p>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.</p> <p>You do not have a deadline to choose your payout date and option until you are subject to IRS minimum required distribution rules.</p>

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

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



Pregnancy Disability Leave (PDL)



YOUR RIGHTS AND OBLIGATIONS AS A PREGNANT EMPLOYEE

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.

*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.

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

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.cacivilrights.ca.gov/posters/required

CRD-100-212761 / 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, ds, and/or alternate formats need to be made by calling 1-866-490-8879 (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 \(edd.ca.gov/Disability/Contact_SDI.htm\)](https://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 \(edd.ca.gov/SDI_Online\)](https://edd.ca.gov/SDI_Online).

You may also apply using a paper form. Visit [EDD Forms and Publications \(edd.ca.gov/Forms\)](https://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 \(edd.ca.gov/Disability/Appeals.htm\)](https://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 \(edd.ca.gov/PFL_Calculator\)](https://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 CardSM 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.



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 (WHCRA). 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 balance 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/countyoventura 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
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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
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Short Term Disability Insurance – COV Wage Supplement Plan (WSP)

Website: https://hr.ventura.org/benefits/absence-management-disability-plans	(805) 654-2780
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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
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Employee Emergency Assistance Program (EEAP)

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

Website: https://vcwell.ventura.org/	(805) 654-2628
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Lactation Accommodation Information

Website: https://hr.ventura.org/benefits Email: WorkLife@ventura.org	(805) 677-8785
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Deferred Compensation Program (401k and 457 Plans)

Website: https://dc.ventura.org/	(805) 654-2620
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COBRA/Direct Bill Administrator – Optum Financial

Website: https://cobra.optumfinancial.com	(855) 687-2021
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County of Ventura – CEO/HR/Benefits

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

PHONE (805) 654-2570 FAX (805) 654-2665

Email: Benefits.ServiceRep@ventura.org

Internet: <https://hr.ventura.org/benefits>

Intranet: <http://myvcweb/index.php/hr/benefits/home>



County of Ventura

Domestic Partner Group Health Insurance Information Packet

Administrative Policy

This policy applies to group medical, dental and vision insurance plans offered through the County of Ventura (“The County”), including Flexible Benefits Program medical plans offered by the Ventura County Deputy Sheriffs’ Association and the Ventura County Professional Firefighters’ Association. This policy also applies to coverage under the County’s Retiree Health Benefits Program. The availability of coverage or enrollment of a Domestic Partner or his/her dependent children for coverage under these County and/or association plans does not confer or imply any rights, such as family member status, with respect to other benefit plans or programs offered by or through the County or associations. The implementation of this policy does not extend any vested rights to a Domestic Partner or his/her dependent children. The County reserves the right to modify or repeal any or all provisions of this policy at any time.

Information gathered in the course of administration of benefits will be respected as confidential and will be disclosed only as necessary in the course of the administration of benefits.

Preface

On September 19, 2000, the Board of Supervisors, upon the recommendation of the Joint Labor-Management Health Care Committee, voted to extend eligibility for County-sponsored medical, dental and vision group insurance plan coverage to registered domestic partners of County of Ventura employees and the Domestic Partner’s eligible dependent children. On November 14, 2000, this eligibility was extended to the County’s Retiree Health Benefits Program. The Committee’s recommendation was based on:

- Fairness (equal pay for equal work); married employees receive benefits for their spouses.
- Non-discrimination on the basis of marital status or sexual orientation.
- The County-sponsored medical, dental and vision group insurance plans have agreed to coverage with no increase in rates.
- Many other private and public employers already offer coverage, including the County of Los Angeles and the County of Santa Barbara. All public entities that contract with CalPERS for medical plan coverage also have the option of providing this coverage.
- The positive impact of recognition of workforce diversity on the County’s ability to attract and retain qualified employees.

Definitions

COBRA Participant: An employee or former employee who is currently enrolled in a County-sponsored group health insurance plan through enrollment in the COBRA program maintained in compliance with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Dependent: Dependents who are eligible to be enrolled in a group medical, dental or vision group insurance plan through the County of Ventura include the employee's spouse or registered Domestic Partner. Dependent children of the Domestic Partner are eligible for coverage on the same basis as dependent children of a spouse.

Domestic Partner: The County of Ventura defines Domestic Partners as persons who have officially registered as one another's domestic partner with the State of California or any other California county or municipality official domestic partner registry. The County of Ventura does not itself maintain a domestic partner registry or define eligibility for domestic partnership and accepts the eligibility criteria used by the government agency registry selected by the employee/retiree. The Domestic Partnership is dissolved when either partner files an official Notice of Termination of Domestic Partnership with the registry, or upon the death or marriage of either partner.

Employee: Except where specified, the term Employee refers to a County of Ventura current employee, and a retired employee currently participating in the Retiree Health Benefits Program.

Retiree: A former County of Ventura employee who is currently receiving a monthly pension payment from the Ventura County Employee's Retirement Association (VCERA).

Registry Locations and Parameters

The County will accept an official Certificate of Domestic Partnership from any California state, county or municipality registry that is listed in the City and County of San Francisco Human Rights Commission's *State and Local Domestic Partner Registries* document at the time the employee applies for County-sponsored or association group health insurance plan Domestic Partner coverage.

Registry Requirements for Domestic Partner status vary among government agencies maintaining registries. Some standard registry criteria include:

- Partners must be involved in a committed relationship,
- Partners must live together,
- Partners must be financially interdependent,
- Partners must be over age 18,
- Partners must be unmarried,
- Partners must be competent to contract,
- Partner must not be a blood relative of the employee.

Depending on the registry, the domestic partners can be same or opposite sex. Some registries have additional restrictions, such as the State of California registry's restriction on opposite sex registration to partners age 62 and above.

County Eligibility Criteria

Documentation Required:

- Enrollment: To enroll a domestic partner and/or the eligible dependent children of a domestic partner in a group medical, dental or vision group insurance plan, the employee must complete a **Flexible Benefits Program Enrollment & Change Form** and a **Payroll Notice of Tax Implications for Domestic Partner Coverage** and attach an official **Certificate of Domestic Partner Registration** from the State of California or other California county or municipality registry.

- Cancellation: No documentation, other than a completed Flexible Benefits Program Enrollment & Change Form, is required to cancel coverage for a domestic partner or dependent child. There does not have to have been a loss of eligibility. If cancellation is due to a loss of eligibility, it is recommended that documentation be attached, if available. See Replacement Enrollment, below.
- Replacement Enrollment: If the employee subsequently submits an enrollment form for a spouse or different domestic partner, he/she must attach an official Notice of Termination of the prior Domestic Partnership, a death certificate for the former partner, or a marriage certificate for one of the partners. This documentation requirement does not apply if the documentation was provided at the time of cancellation of a prior partner's coverage.

Timing of dependent enrollment:

- Can enroll a new dependent within 60 days of date on Certificate of domestic partner registration.
- Can enroll an existing dependent upon the County's initial implementation of domestic partner eligibility or during an open enrollment period that includes enrollment of that category of existing dependent.

The Initial Eligibility Date for existing domestic partners and their dependents is

- December 24, 2000 for active employees and
- January 1, 2001 for retirees

Taxation and the Payroll System

There are tax differences between health care benefits provided by employers for spouses and Domestic Partners. When employers provide health care benefits for a spouse and/or the dependent children of a spouse or employee, the Internal Revenue Code (IRC) allows the money paid by the employer for these benefits to be excluded from the employee's gross income (Internal Revenue Code Sections 105 and 106). No such exclusion exists for benefits given to an employee for his/her domestic partner or the partner's dependents.

Employee and Domestic Partner Responsibilities and Considerations

Before enrolling a Domestic Partner, employees are advised to consult an attorney regarding the possibility that domestic partner registration may have other legal and/or financial consequences, including the fact that it may, in the event of the termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for purposes of establishing and dividing community property, assigning community debt, and for the payment of support. Employees considering domestic partner registration should also keep in mind other factors:

- Where the premium is deducted from a pre-tax credit allowance, the fair market value of the coverage for the domestic partner and his/her dependent children is added to the employee's taxable income and is subject to income tax and Social Security withholding. This will not apply if the employee certifies that the domestic partner has been and is anticipated to continue to be the employee's dependent for tax purposes under Section 152 of the Internal Revenue Code.
- Employees may not wish to reveal sexual preference or living arrangements. Note: Employees may submit domestic partner enrollment documentation directly to the Human Resources Benefits Unit. No domestic partner coverage information will appear on the employee's paystub.

- Many partners have their own employer-provided coverage, making County coverage unnecessary.
- Federal COBRA laws and regulations do not apply to domestic partners.
- Under IRC regulations, domestic partners are not considered qualified Flexible Spending Account dependents, and the employee is not eligible for reimbursement of health care and dependent care expenses incurred by or on behalf of the Domestic Partner and his/her dependent children.
- The employee may be required to reimburse the employer or the health plan for any expenditure made by the employer or the health plan for medical claims, administrative charges, costs and attorney's fees on behalf of the domestic partner if any of the submitted documentation is found to be incomplete, inaccurate or fraudulent.

Continuation of Coverage

In no event shall the Domestic Partner (and his or her eligible dependent children) be permitted to continue group health plan coverage beyond the date that any of the following occur:

- ✓ The County of Ventura health plan subscriber's health plan coverage ends.
- ✓ Dissolution of Domestic Partner relationship, whether or not a formal termination notice has been filed with the registry.
- ✓ The County discontinues coverage for Domestic Partners.
- ✓ Premiums are not paid on a timely basis.
- ✓ The employer ceases to maintain any group health plan.

Consolidated Omnibus Budget Reconciliation Act (COBRA) regulations on continuation of coverage do not apply to Domestic Partners and their dependent children. Neither Domestic Partners of terminated employees, nor the partner's children, may participate in group health insurance plans offered through the County on a continuation of coverage basis. Individual conversion coverage may be available through the health plan that covered the Domestic Partner as a dependent.

Domestic Partners of Retiree Health Benefits Program participants, and the partner's eligible children, may participate in group health insurance plans under the same parameters as a retiree's spouse and the spouse's dependent children.

County of Ventura
Fair Market Value of Domestic Partner Health Plan Coverage ¹
Plan Year 2025

<u>Plan Name</u>	<u>Fair Market Value</u>	<u>Indicator</u>	<u>Plan Name</u>	<u>Fair Market Value</u>	<u>Indicator</u>
<u>Ventura County Health Care Plan</u>			<u>VCDSA Anthem PPO</u>		
Partner	\$437.66	(01)	Partner	\$803.04	(01)
Partner + Partner Dependent (s)	\$700.25	(02)	Partner + Partner Dependent (s)	\$1,460.05	(02)
<u>OCS - Ventura County Health Care Plan</u>			<u>VCDSA Anthem HDHP PPO</u>		
Partner	\$437.66	(01)	Partner	\$566.47	(01)
Partner + Partner Dependent (s)	\$700.25	(02)	Partner + Partner Dependent (s)	\$1,029.97	(02)
<u>Blue Shield HMO Access+</u>			<u>VCPFA - BlueShield Trio Low HMO</u>		
Partner	\$465.72	(01)	Partner	\$253.91	(01)
Partner + Partner Dependent (s)	\$745.16	(02)	Partner + Partner Dependent (s)	\$378.85	(02)
<u>Blue Shield HMO Trio</u>			<u>VCPFA - BlueShield Full Low HMO</u>		
Partner	\$362.01	(01)	Partner	\$298.22	(01)
Partner + Partner Dependent (s)	\$579.21	(02)	Partner + Partner Dependent (s)	\$439.91	(02)
<u>Blue Shield PPO/HDHP</u>			<u>VCPFA - BlueShield Full High HMO</u>		
Partner	\$555.96	(01)	Partner	\$360.87	(01)
Partner + Partner Dependent (s)	\$889.53	(02)	Partner + Partner Dependent (s)	\$544.45	(02)
<u>VCDSA Anthem HMO Select</u>			<u>VCPFA - BlueShield Full PPO</u>		
Partner	\$290.07	(01)	Partner	\$408.81	(01)
Partner + Partner Dependent (s)	\$527.41	(02)	Partner + Partner Dependent (s)	\$771.33	(02)
<u>VCDSA Anthem HMO Traditional</u>			<u>MetLife Dental</u>		
Partner	\$450.53	(01)	Partner	\$20.13	(01)
Partner + Partner Dependent (s)	\$819.14	(02)	Partner + Partner Dependent (s)	\$41.82	(02)
<u>VCDSA Anthem Basic HMO</u>			<u>EyeMed Vision</u>		
Partner	\$253.99	(01)	Partner	\$1.63	(01)
Partner + Partner Dependent (s)	\$461.78	(02)	Partner + Partner Dependent (s)	\$3.21	(02)

¹ Fair Market Value Taxation (Applies to Section A of this Payroll Notice)

There are tax differences between health care benefits provided by employers for spouses and Domestic Partners. When employers provide health care benefits for a spouse and/or the dependent children of a spouse or employee, the Internal Revenue Code (IRC) allows the money paid by the employer for those benefits to be excluded from the employee's gross income (Internal Revenue Code Sections 105 and 106). No such exclusion exists for benefits given to an employee for his/her domestic partner or the partner's dependents.

PAYROLL NOTICE OF TAX IMPLICATIONS FOR DOMESTIC PARTNER COVERAGE

Please review the following information and complete either Section A or B

Deliver to: County of Ventura, Human Resources Division, Benefits Unit
800 S. Victoria Avenue
Hall of Administration - Main Plaza
Ventura, CA 93009-1970

For new enrollments, attach the Certificate of Domestic Partner Registration and an Enrollment and Change Form.

A. I declare that the person I am enrolling as a domestic partner, including any dependents of a domestic partner, is/are not tax dependents as **defined** by the Internal Revenue Code Section 152. I understand that the Internal Revenue Service regulations require that the fair market value of domestic partner coverage will be included in my taxable income for FICA, Medicare, and Federal withholding, and that the County of Ventura is obligated to withhold and report taxes on the fair market value of the domestic partner coverage. Beginning in 2002, the cost of employer provided domestic partner coverage is not includable in the employee California taxable income.

I understand that each pay period the imputed income on the fair market value of domestic partner coverage, based on my Plan election from the list on the reverse of this Payroll Notice, will be included in my taxable income. Applicable FICA, Medicare and Federal withholding tax will be applied to the increased taxable income as a result of the fair market value of domestic partner coverage. I understand that I am responsible for reviewing and adjusting my withholding allowances.

I elect the following Plan(s) from the list on the reverse side of this Payroll Notice:

- Partner
- Partner + Partner Dependent(s)

_____ Plan Name(s)/Payroll Code(s)

_____ Print Employee's Name

_____ Date

_____ Employee's Signature

_____ Employee's Social Security Number

B. I declare that the person I am enrolling as a domestic partner, including any dependents of a domestic partner, has been and I anticipate will continue to be a tax dependent. I understand that no imputed income on the fair market value of domestic partner coverage will be allocated to my gross taxable salary due to this status. Should this status change, I will immediately complete and file a revised Payroll Notice with the Benefits Unit of County Human Resources. I agree to provide proof of tax dependent eligibility upon request.

_____ Print Employee's Name

_____ Date

_____ Employee's Signature

_____ Employee's Social Security Number

BENEFITS USE ONLY:

DP Coverage Effective Date: _____ Authorization: _____

About Maximum Annual Contributions

Plan contribution maximums are adjusted to reflect the maximums allowed by federal law. If you reach the annual contribution limit prior to the end of the year, the payroll system is programmed to stop your contributions, and we will make every effort to ensure you don't exceed the contribution limit. However, it is your responsibility to check your W-2 to make sure you don't over contribute. According to the IRS, you are responsible for monitoring the total you defer to ensure that your deferrals are not more than the overall limit.

For all participants, except those covered by CJAAVC, UAPD, or the Management Resolution, the County only provides a 401(k) Plan matching contribution for the pay periods you make a contribution. When deciding how much to contribute, you will maximize your 401(k) Plan benefit if you make a contribution each pay period of the year. For assistance in spreading your contributions throughout the year, you can complete a *Contribution Worksheet for 401(k) Shared Savings Plan and Section 457 Plan* available at dc.ventura.org/resource.

If you are buying back retirement service credit through payroll deduction, this could impact the amount you can contribute to the 401(k) Shared Savings Plan due to the Internal Revenue Code Section 415 limit. Contact the Deferred Compensation Program for more information.

For More Information

Plan information and resources are available on the Deferred Compensation website: dc.ventura.org.

You can check your account balance and update your beneficiaries by logging into your Fidelity account at: netbenefits.com/ventura or call Fidelity at (800) 343-0860. To schedule a complimentary appointment with our dedicated Workplace Financial Consultant, go to: fidelity.com/schedule.

MINIMUM AND MAXIMUM BIWEEKLY CONTRIBUTIONS

401(k) Shared Savings Plan

Minimum: 1.5% for CNA and VCPFA
2.5% for VCSCOA
1% for all others

Maximum: 100% of available income after mandatory deductions

Section 457 Plan (both options)

Minimum: \$10.00

Maximum: All available income after mandatory deductions

MAXIMUM ANNUAL CONTRIBUTIONS

401(k) Shared Savings Plan

Lesser of \$23,500 or 100% of available income

Section 457 Plan (both options)

Lesser of \$23,500 or 100% of available income

457 Plan Special Catch-Up

Up to \$47,000

401(k)/457 Plan Age 50+ Catch-Up

Lesser of \$31,000 (to each Plan) or 100% of available income

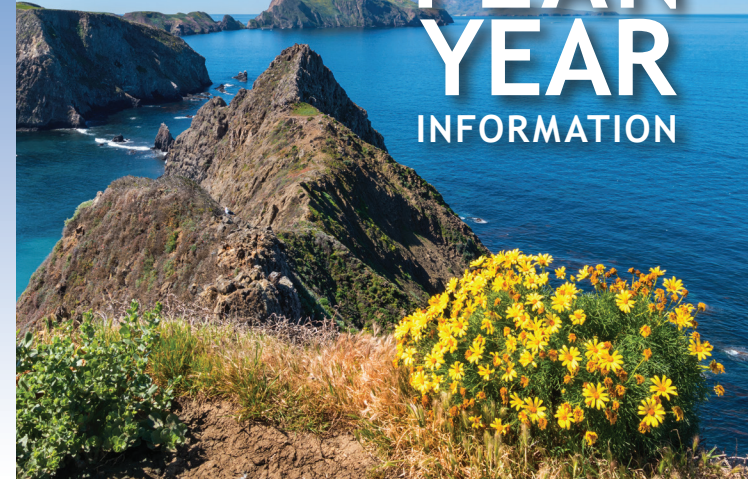


800 South Victoria Avenue #1970 • Ventura, CA 93009
Phone: 805.654.2620 • Fax: 805.658.4528
E-mail: deferred.compensation@ventura.org
Website: dc.ventura.org



Updated 11/13/24

2025 PLAN YEAR INFORMATION



401(k) Shared Savings and Section 457 Plans

Minimum and Maximum Biweekly Contributions
Maximum Annual Contributions

- 401(k) and 457 Plan Eligibility
- County Matching Contributions
- Investment Option Information
- Sources of Further Information

If you are a regular County employee with a job title represented by CNA, SPOAVC, or IUOE, you are eligible to participate in the 457 Plan if you have a regular work schedule of 40 hours or more per pay period. All other regular employees, and employees in the CNA Per Diem Unit, and UAPD Per Diem Unit are eligible to participate regardless of work schedule.

To be eligible to participate in the 401(k) plan, you must be a regular County employee with a regular work schedule of at least 40 hours per pay period. Regular employees represented by UAPD are eligible to participate regardless of work schedule. If you participate in the 401(k) Plan, you will receive County matching contributions according to the following schedules:

SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU)	
Employee Contributes	County Matches
1% - 1.99%	1%
2% - 2.99%	1.5%
3% - 3.99%	1.75%
4% - 4.99%	2%
5% - 5.99%	2.5%
6% or more	3%

MANAGEMENT, CONFIDENTIAL CLERICAL, AND OTHER UNREPRESENTED RESOLUTION UNION OF AMERICAN PHYSICIANS AND DENTISTS (UAPD) CRIMINAL JUSTICE ATTORNEYS' ASSOCIATION (CJAAVC)*	
Employee Contributes	County Matches
1% - 1.99%	1%
2% - 2.99%	1.5%
3% - 3.99%	1.75%
4% - 4.99%	2%
5% - 5.99%	2.5%
6% - 100%	3%

*For employees who have not opted out of the Deferred Compensation Program by participating in the CJAAVC Student Loan Reimbursement Program pursuant to Section 1901.4 of their bargaining agreement.

CALIFORNIA NURSES ASSOCIATION (CNA)	
Employee Contributes	County Matches
1.5% - 1.99%	1.5%
2% - 100%	2%

2025 Plan Year Information

VENTURA COUNTY DEPUTY SHERIFFS' ASSOCIATION (VCDSA)	
VENTURA COUNTY PROFESSIONAL PEACE OFFICERS' ASSOCIATION (VCPPOA)	
Employee Contributes	County Matches
1% - 1.99%	1%
2% - 2.99%	2%
3% - 100%	2.5%

VENTURA COUNTY PROFESSIONAL FIREFIGHTERS' ASSOCIATION (VCPFA)	
Employee Contributes	County Matches
1.5% - 100%	1.5%

SPECIALIZED POLICE OFFICERS' ASSOCIATION (SPOAVC)	
Employee Contributes	County Matches
1% - 1.49%	1%
1.5% - 1.99%	1.5%
2% - 2.49%	2%
2.5% - 100%	2.5%

INTERNATIONAL UNION OF OPERATING ENGINEERS (IUOE)	
Employee Contributes	County Matches
1% - 1.99%	1%
2% - 2.99%	1.5%
3% - 3.99%	1.75%
4% - 4.99%	2%
5% - 5.99%	2.5%
6% - 100%	3%

Pursuant to Section 6.06-C of their bargaining agreement, eligible IUOE-represented employees receive a \$32.00 bi-weekly contribution to their 401(k). This contribution is in lieu of County contributions previously made to the Union's Insurance Trust Subsidy.

VENTURA COUNTY SHERIFF'S CORRECTIONAL OFFICERS' ASSOCIATION (VCSOA)	
Employee Contributes	County Matches
2.5% - 100%	2.5%

VENTURA EMPLOYEES ASSOCIATION (VEA)	
Employee Contributes	County Matches
1% - 1.99%	1%
2% - 2.99%	1.5%
3% - 3.99%	1.75%
4% - 4.99%	2%
5% - 5.99%	2.5%
6% or more	3%

Investment Options

The County provides Plan participants with a wide variety of investment options from which you can build a diversified portfolio. They cover most asset classes in the investment option spectrum and include funds that potentially have more inflation risk and less investment risk and conversely, funds that potentially have more investment risk and less inflation risk. The Deferred Compensation Committee monitors these investment options for investment performance, investment risk, management style, investment objectives, and investment expenses.

In addition, the County offers a brokerage account option, and a managed account service. The Deferred Compensation Committee does not monitor these options for investment performance, investment risk, management style, investment objectives, or investment expenses. The brokerage account option is appropriate only for participants who understand diversification and all costs and risks involved.

FOR MORE INFORMATION ON THE PLANS' INVESTMENT OPTIONS:
CALL Fidelity Investments AT (800) 343-0860
OR LOGON TO netbenefits.com/ventura

VENTURA COUNTY 401(K) PLAN HIGHLIGHTS

Key Features of Your Ventura County 401(k) Plan

Eligibility	Regular County employees with a regular work schedule of at least 40 hours per pay period. Regular County employees represented by UAPD are eligible to participate regardless of work schedule.
How to Enroll	You can enroll in the Plan by visiting www.netbenefits.com/ventura , calling 800-343-0860 or by texting “start” to 343898 .
County Matching Contributions	You will be eligible to receive County matching contributions based on the schedule included in the <i>Plan Year Information Brochure</i> .
Annual Contribution Limit	You can contribute up to the IRS maximum each year. For the current annual limit, please refer to the <i>Plan Year Information Brochure</i> . Note you can contribute up to the full limit to both the 401(k) and 457 Plans.
Vesting	You are immediately 100% vested in your own contributions and any employer contributions to your Plan account, as well as any earnings on them.
Rollovers	You are permitted to roll over eligible pretax contributions from another 401(a), 401(k), 403(b), or governmental 457(b) retirement plan account, or eligible pretax contributions from individual retirement accounts (IRAs). Rollovers from Roth and after-tax sources are not allowed. Additional information can be obtained online, or by calling Fidelity Investments® at 800-343-0860 . Be sure to consider all your available options and the applicable fees and features of each before moving your retirement assets.
Online Beneficiary Designation	It’s important to designate a beneficiary for your Plan account. Log on to www.netbenefits.com/ventura . Select <i>Profile</i> , then <i>Beneficiaries</i> , and follow the steps to designate your beneficiary online.
One-on-One consultations	Your dedicated Fidelity Workplace Financial Consultant is available and can help with retirement planning and other questions you have about the Plan. Call 800-642-7131 to schedule a complimentary appointment or register online at www.fidelity.com/schedule .
Loans	Should an unexpected financial need arise, your 401(k) Plan offers you the option of borrowing from your account after you have participated in the plan for one year. Contact Fidelity Investments® at 800-343-0860 for details.



Accessing your account

Access your account online at www.netbenefits.com/ventura. Download the NetBenefits® app from the App Store®, Google Play™ Store, or Windows Store to access your account on your mobile device.



Fidelity is here to help! If you have questions, call **800-343-0860** Monday through Friday, 5:30 a.m. to 9:00 p.m. Pacific time (excluding most holidays). You can also use the automated voice response system, virtually 24 hours, 7 days a week. Para español, llame al **800-587-5282**.

THE COUNTY OF VENTURA SECTION 457 PLAN HIGHLIGHTS

Key Features of Your County of Ventura Section 457 Plan	
Eligibility	Regular County employees with a job title represented by CNA, SPOAVC, or IUOE, are eligible to participate in the 457 Plan, if you have a regular work schedule of 40 hours or more per pay period. All other regular employees, and employees in the CNA Per Diem Unit, and UAPD Per Diem Unit are eligible to participate regardless of work schedule.
How to Enroll	You can enroll in the Plan by visiting www.netbenefits.com/ventura , or by calling 800-343-0860 .
Contributions	The minimum bi-weekly contribution amount is \$10.00.
Annual Contribution Limit	You can contribute up to the IRS maximum each year. For the current annual limit, please refer to the <i>Plan Year Information Brochure</i> . Note you can contribute up to the full limit to both the 401(k) and 457 Plans.
County Matching Contributions	There is no employer match in the 457 Plan.
Roth Option	An after-tax, Roth contribution option is available in the 457 Plan.
Vesting	You are immediately 100% vested in the Plan.
Rollovers	You are permitted to roll over eligible pretax contributions from another 401(a), 401(k), 403(b), or governmental 457(b) retirement plan account, or eligible pretax contributions from individual retirement accounts (IRAs). Rollovers from Roth and after-tax sources are also allowed. Additional information can be obtained online, or by calling Fidelity Investments® at 800-343-0860 . Be sure to consider all your available options and the applicable fees and features of each before moving your retirement assets.
Online Beneficiary Designation	It's important to designate a beneficiary for your Plan account. Log on to www.netbenefits.com/ventura . Select <i>Profile</i> , then <i>Beneficiaries</i> , and follow the steps to designate your beneficiary online.
One-on-One consultations	Your dedicated Fidelity Workplace Financial Consultant is available and can help with retirement planning and other questions you have about the Plan. Call 800-642-7131 to schedule a complimentary appointment or register online at www.fidelity.com/schedule .
Loans	The 457 Plan does not allow loans.
Unforeseeable Emergency Withdrawals	The 457 Plan does allow unforeseeable emergency distributions. For more information, visit www.netbenefits.com/ventura or contact Fidelity Investments® at 800-343-0860 .

Investing involves risk, including risk of loss.

This document provides only a summary of the main features of the Ventura County 401(k) Plan and Section 457 Plans, and the Plan Documents will govern in the event of discrepancies.

Fidelity Brokerage Services LLC, Member NYSE, SIPC, 900 Salem Street, Smithfield, RI 02917

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Comparison of the Ventura County 401(k) Shared Savings Plan and Section 457 Plan

These Plans are regulated by different sections of the Internal Revenue Code (IRC) and have different features and benefits. Review the information available regarding the Plans to determine which Plan or combination of Plans will help you meet your retirement goals.

401(K) SHARED SAVINGS PLAN

SECTION 457 PLAN

Matching Contributions

The County may make a matching contribution if you contribute to the Plan. The amount of the match varies by bargaining unit. Refer to the current year's *Deferred Compensation Program Plan Year Information* for more information.

There are currently no matching contributions for the Section 457 Plan.

Maximum Annual Contributions

The Internal Revenue Service sets the limit annually. You may also be able to make additional contributions under the "catch-up" provision. Refer to the current year's *Deferred Compensation Program Plan Year Information* for more information.

The Internal Revenue Service sets the limit annually. You may also be able to make additional contributions under the "catch-up" or "special catch-up" provisions. Refer to the *Deferred Compensation Program Plan Year Information* for more information.

Fund Withdrawals While Employed by the County

In most circumstances, you cannot withdraw funds while you are still employed. A hardship withdrawal may be allowed for an immediate and heavy financial need. Approval of a hardship withdrawal is subject to approval by the Deferred Compensation Committee or Deferred Compensation Program staff, who will make their determination based on whether or not your request meets the Internal Revenue Code guidelines.

In most circumstances, you cannot withdraw funds while you are still employed. An emergency withdrawal may be allowed for a severe financial need due to an unforeseeable emergency. Approval of an emergency withdrawal is subject to approval by the Deferred Compensation Committee, who will make their determination based on whether or not your request meets the Internal Revenue Code guidelines. The balance in a small, inactive account may be withdrawn if you have not contributed for at least two years.

401(K) SHARED SAVINGS PLAN

SECTION 457 PLAN

Loans Against Your Account Balance

Active participants, who have been Plan participants for at least 12 months, and who have not defaulted on any prior Plan loans in the preceding 3 years may borrow against their accounts without regard to need or hardship.

Not available.

Roth Option

Not Available.

You are able to make after-tax contributions through the Roth option available in the 457 Plan.

Taxes and Penalties on Distributions

Distributions are subject to 20% withholding for federal income taxes, plus applicable state taxes. A 10% penalty tax may apply to distributions before age 59½.

Distributions are taxed as regular income. There are no penalties for early distribution.

Distribution Options at Termination or Retirement

Systematic withdrawals, lump sum distribution of all or part of your account balance, rollover to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, or a combination of options.

There is no default distribution under this Plan. You may choose your payout date and option at any time after separation.

You can leave your funds in the Plan as long as you choose, subject to the minimum distribution requirements established by the Internal Revenue Service.

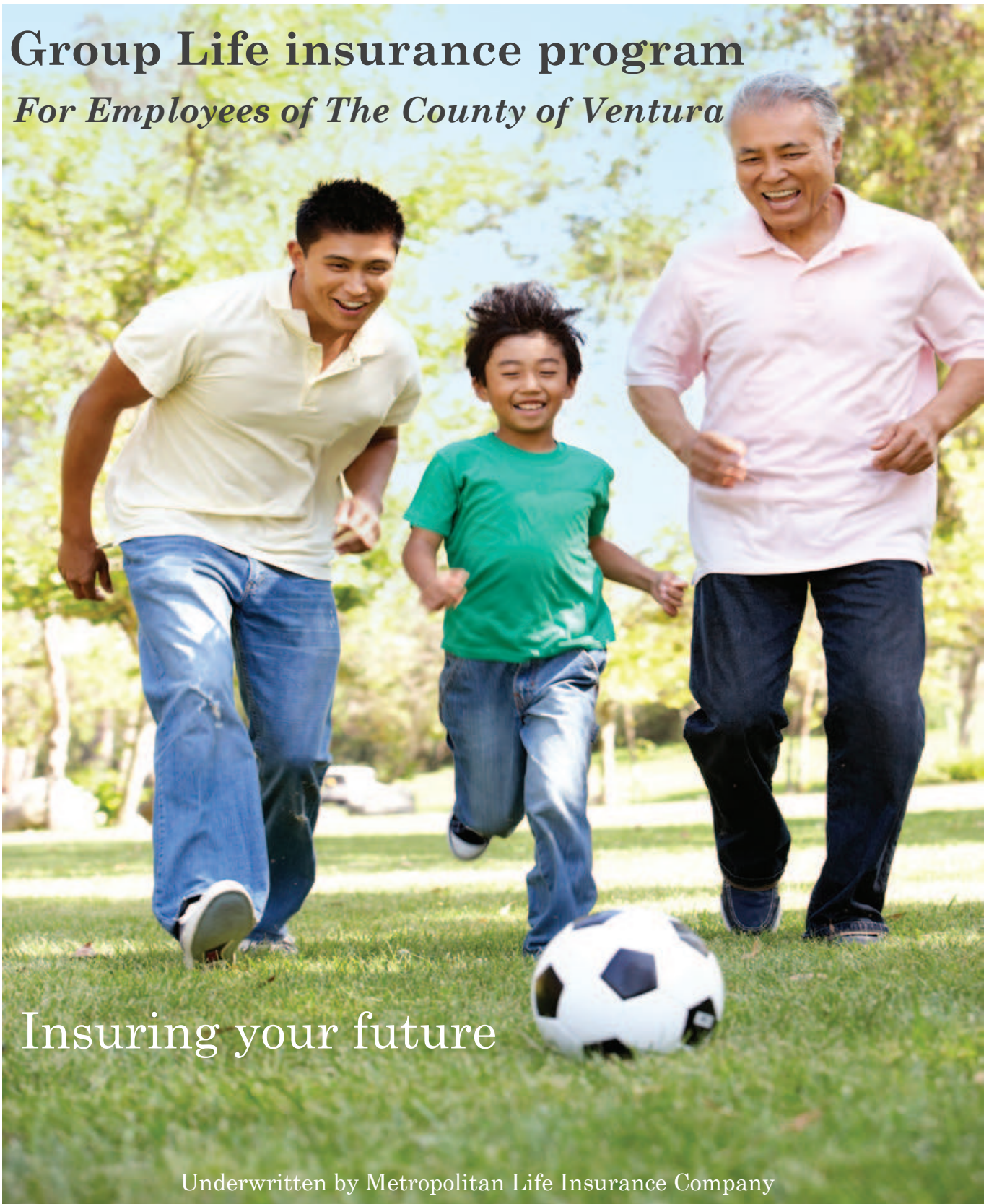
Systematic withdrawals, lump sum distribution of all or part of your account balance, rollover to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, purchase an annuity option, or a combination of options.

There is no default distribution under this Plan. You may choose your payout date and option at any time after separation.

You can leave your funds in the Plan as long as you choose, subject to the minimum distribution requirements established by the Internal Revenue Service.

Group Life insurance program

For Employees of The County of Ventura



Insuring your future

Underwritten by Metropolitan Life Insurance Company



MetLife[®]

Welcome

What do I need to do?

The County of Ventura is proud to partner with Metropolitan Life Insurance Company to provide group life insurance benefits. The County of Ventura group life insurance program offers you an affordable way to provide protection for your family.

Before enrolling, there are two very important questions you need to answer: Why do I need life insurance? and How much do I need?

Why do I need life insurance?

Think about it. If you died what would happen to the people who depend on you for financial support?

Group Term Life insurance provides a base level of protection that can be enhanced by personal savings, individual life insurance and Social Security benefits. This coverage will help protect your family against the unexpected loss of your life and income during your working years.

Insurance proceeds may be used as supplemental income for your family to pay off debts such as mortgage or medical expenses, or could be used to pay for your funeral/burial costs. Other popular uses of proceeds include establishing a college fund for your children or leaving funds for your favorite charities.

How much life insurance do I need?

Everyone's needs are unique and it helps to evaluate your family's financial situation before choosing the exact amount.

Visit our online insurance needs calculator on <http://www.lifeonlinecalculator.com/> to estimate how much.

How do I elect coverage?

This booklet provides information to help you answer those questions and the instructions to enroll for coverage. Enrolling is easy and can be done in four simple steps:

- Step 1:** Determine your needs
- Step 2:** Review your coverage options
- Step 3:** Calculate your costs
- Step 4:** Enroll



Step 1

Determine your needs

To estimate the amount of life insurance you need, you'll want to determine what you must protect in the event of your death.

Assets & Income

What would be available to your family now, if you weren't here to provide for them?

Spouse/Domestic Partner's annual income x number of years to age 65	\$ _____
Cash, savings bonds, stocks, securities (current value)	\$ _____
Company savings plan (401(k), 457, Roth IRA or other)	\$ _____
Cash value of life insurance	\$ _____
Other assets* or income (other than your own)	\$ _____

*Equity in your home, if you plan to sell or borrow against it for cash.

A = \$ _____

Basic Necessities

What basic needs do you and your family have?

(multiply the items below by the number of years required, if applicable)

Home - remaining mortgage or rent (120 months is a basic rule of thumb)	\$ _____
Annual household operating expenses (utilities, food, clothing, insurance, repairs, property taxes, etc.)	\$ _____
Childcare	\$ _____
Health - health insurance premiums or medical/hospital expenses not covered by insurance	\$ _____
Debt - balances on credit cards, car loans, etc	\$ _____

B = \$ _____

Comfort Zone

What kind of special or one-time expenses may come along?

Tuition	\$ _____
Wedding	\$ _____
New residence	\$ _____
Elder care x number of years	\$ _____
Estate taxes, probate fees, attorney fees	\$ _____
Emergency fund	\$ _____
Funeral expenses (average is \$5,000 - \$10,000)	\$ _____
Golden years (money put aside for survivor's retirement)	\$ _____

Complete the Equation

Complete the equation that most closely reflects your particular needs:

Basic Necessities

B - A = \$ _____
(Compare to current Life Insurance amount)

Comfort Zone

(B + C) - A = \$ _____
(Compare to current Life Insurance amount)

Remember, your calculation is based on today's costs and doesn't account for inflation or changes in annual earnings. Review your needs periodically to ensure that your needs will be met now and in the future.

Step 2

Review your coverage options

Now that you understand your need for life insurance and know how much may be enough, you're ready to consider the options available to you under The County of Ventura's group life insurance plan.

Guaranteed coverage opportunity

You may elect guaranteed optional life coverage within the first 90 days of initial eligibility – with no Supplemental Enrollment/Statement of Health (SOH) Form required.

Coverages and amounts available include:

- **For you (Life and AD&D):** \$10,000, one times your base annual earnings, two times your base annual earnings, or three times your base annual earnings - not to exceed \$500,000.
- **For your spouse/Domestic Partner:** Up to \$10,000
- **For your children:** Up to \$5,000



What coverage is available?

If eligible, you are automatically enrolled in Basic Life coverage (but must complete the *Basic/Optional Life Insurance Beneficiary Designation Form* to designate your beneficiaries). You may also elect optional coverage for you and your dependents. Electing or increasing coverage after the initial 90-day enrollment period will require you to also complete the *Supplemental Enrollment/Statement of Health (SOH) Form*.

Coverage type	Coverage options	Additional information
Basic Life and Accidental Death and Dismemberment (AD&D)	<ul style="list-style-type: none">• \$50,000	<ul style="list-style-type: none">• All coverage guaranteed• Includes matching AD&D amount
Optional Life and AD&D	<ul style="list-style-type: none">• Choice of \$10,000, or one, two, or three times your base annual earnings to a maximum of \$500,000	<ul style="list-style-type: none">• Includes matching AD&D amount• Coverage increases due to salary increase are guaranteed to the plan maximum
Dependent Life	<ul style="list-style-type: none">• Option 1: Spouse/Domestic Partner \$5,000 Child \$2,000• Option 2: Spouse/Domestic Partner \$10,000 Child \$5,000	<ul style="list-style-type: none">• An employee must be participating in the Optional Life plan to elect dependent coverage• Children are eligible from live birth up to age 26• Spouses/Domestic Partners and Children can be added within 31 days of marriage/DP or birth/adoption.

Will my benefits reduce?

Reductions in your basic and optional life insurance amount will occur on the beginning of the pay period following your 70th and 75th birthdays. Your life insurance coverage reduces to 65 percent of the face amount on your 70th birthday. It further reduces to 50 percent of the original amount at age 75. All coverage terminates at retirement.

Step 3

Calculate your costs

Review this section to learn about costs associated with coverage. Please note that rates shown are biweekly.

What is the cost for coverage?

Employee Optional Term Life and AD&D

Please note rates increase with age.

Age	Biweekly rate per \$1,000
Under 25	\$0.030
25-29	0.035
30-34	0.044
35-39	0.049
40-44	0.073
45-49	0.099
50-54	0.141
55-59	0.246
60-64	0.360
65-69	0.593
70 and over	0.958

All rates shown are subject to change.

Dependent Life (biweekly rates)

Option 1: \$0.87
Option 2: \$1.15

Calculate your costs

Example:

Step 1: Calculate your annual earnings:

$$\begin{array}{r} \$ \\ \hline \end{array} \times 26 \text{ pay periods} = \$ \begin{array}{r} \\ \hline \end{array}$$

Regular biweekly pay (no overtime)* Annual Earnings

*For full-time employees, biweekly base salary; For part-time employees, biweekly scheduled hours times hourly rate.

Step 2: Calculate your cost:

$$\begin{array}{r} \$ \\ \hline \end{array} \times \begin{array}{r} \text{Increments} \\ (1x, 2x \text{ or } 3x) \\ \hline \end{array} = \$ \begin{array}{r} \\ \hline \end{array}$$

Annual Earnings Coverage Amount (Round to next \$1,000)

$$\begin{array}{r} \$ \\ \hline \end{array} \div \$1,000 = \begin{array}{r} \\ \hline \end{array} \times \begin{array}{r} \\ \hline \end{array} = \$ \begin{array}{r} \\ \hline \end{array}$$

Coverage Amount Coverage Units Biweekly Rate Biweekly Premium

Step 4

Enroll

To take advantage of guaranteed coverage amounts, you must enroll within 90 days of your initial eligibility.

Step 1: To elect Optional Life Insurance for yourself, please complete sections A, B, and E on the *Group Life Insurance Enrollment* form.

Step 2: If electing coverage for your dependents, please also complete sections C and/or D on the *Group Life Insurance Enrollment* form.

Step 3: Return completed *Group Life Insurance Enrollment* form to CEO/HR/Benefits (email to Benefits.ServiceRep@ventura.org or brown mail to L#1970).

Step 4: If electing coverage beyond your initial eligibility period or increasing current coverage, please also complete the *Supplemental Enrollment/Statement of Health (SOH) Form* and fax/mail it to MetLife.

**Don't forget
to sign your
completed forms!**



Questions?

Please contact the central Benefits Staff at **(805) 654-2570**, or email **Benefits.ServiceRep@ventura.org**.



Frequently asked questions

What is Term Life insurance?

Group Term Life insurance provides affordable protection that is available for a specified period of time. The benefit would be paid if the insured were to die during that “term”.

You can buy large amounts of insurance, at a reasonable cost. There is no cash value build up. This coverage can be enhanced by your personal savings, individual life insurance, and social security benefits. If eligible, you are automatically enrolled in Basic Life coverage however, you must enroll in Optional Life coverage.

What is Accidental Death and Dismemberment (AD&D) insurance?

AD&D coverage provides beneficiaries with additional financial protection if an insured person’s death is due to a covered accident or provides a benefit if dismemberment occurs as a result of a covered accident. AD&D provides protection for covered accidents occurring at any time, whether at work or elsewhere.

What is included in my life insurance plan?

Beyond paying a benefit in the event of your death, your group life insurance plan has other important features.

- **Waiver of premium** – If you become disabled before age 60, your life insurance premiums may be waived.
- **Accelerated Death Benefit** – If an insured employee becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100 percent of the life insurance amount (Basic and Optional combined).

Can I take my coverage with me if I leave or retire?

If you are no longer eligible for coverage as an active employee, you may port your group life insurance coverage (portable coverage ends at age 70) or you may convert your coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Can I elect additional coverage if I experience a family status change?

Yes. You may add coverage for a newly born or newly adopted child or a new spouse or domestic partner without completing the Supplemental Enrollment/Statement of Health (SOH) Form if coverage is elected within 31 days of the birth/adoption or marriage/registration.

How do I pay premiums?

Your life insurance premiums are deducted directly from your paycheck.

Why do I need to designate a beneficiary?

By naming a beneficiary, you are able to ensure that your life insurance benefit is being passed on to those you want to help the most.

Events such as marriage, birth/adoption of children, divorce, or death may dramatically change the intent of how you would want your life insurance benefit paid.

Some common beneficiary choices are:

- **Primary beneficiary** – The person or persons named will receive the benefit.
- **Contingent beneficiary** – If the primary beneficiary is no longer living, the benefit is paid to this person.
- **Default beneficiary** – If you do not name a beneficiary, policy benefits will be paid in order of the policy’s default beneficiary definition, as follows – spouse/Domestic Partner, children, parents, brothers and sisters, your estate.

Medical Underwriting process

How does the medical underwriting process work?

- If medical underwriting is required, the applicant will fill out the *Supplemental Enrollment/Statement of Health (SOH) Form* and fax/mail to MetLife.
- Underwriting may approve the coverage without needing additional information, or
- If additional underwriting is required, the applicant may be asked to complete a questionnaire, provide access to medical records, take a medical exam, etc. MetLife will directly notify the applicant of any additional medical requirements and will incur all of the costs associated with the entire underwriting process.
 - If it's determined that an exam is necessary, the applicant is able to schedule an exam over the phone using the instructions provided by MetLife.
- Once all medical underwriting is complete, you will receive written notification from MetLife regarding the underwriting decision.

Tip: To complete the Supplemental Enrollment/Statement of Health (SOH) Form, you should first gather your medical records, including the name and address of physicians, hospitals and clinics you've visited in the past three years, as well as any details regarding diagnosis and treatment.

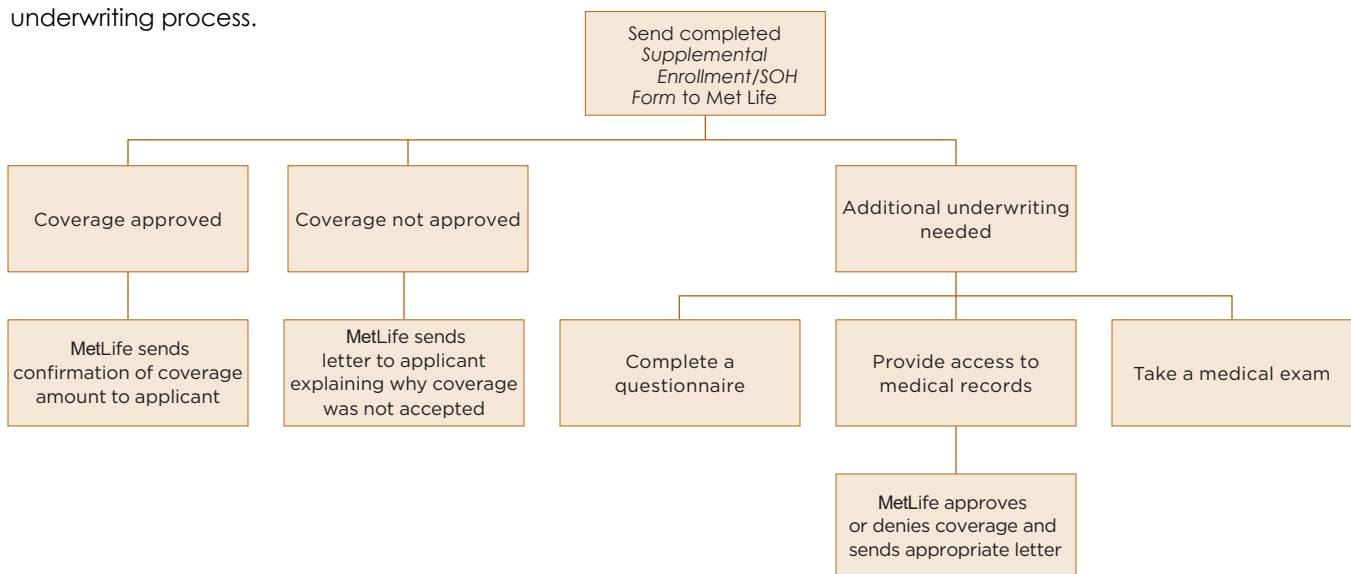
What is Medical Underwriting?

The process by which MetLife evaluates an applicant's eligibility based on age, answers on the Supplemental Enrollment/Statement of Health (SOH) Form and additional medical information, if applicable.

- a) electing an insurance amount that exceeds the guaranteed issue limit; or
- b) if the employee is applying after the guaranteed issue window; or
- c) adding a new spouse/ Domestic Partner to existing dependent life insurance.

Medical underwriting flow chart

The following flow chart provides an overview of the medical underwriting process.



SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
 County of Ventura, 800 S Victoria Ave, #1970, Ventura, CA 93009-1970
 Phone: 805-654-2570 Fax: 805-654-2665 Email: Benefits.ServiceRep@ventura.org

**MetLife**

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM**GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)**

Name of Group Customer/Employer County of Ventura	Group Customer # 0154209	Report # 0154209	Sub Code 0005	Branch <input type="checkbox"/> 0001 <input type="checkbox"/> 0002 <input type="checkbox"/> 0003
Date of Hire (MM/DD/YYYY)		Coverage Effective Date (MM/DD/YYYY)		

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)			
Phone #	Date of Birth (MM/DD/YYYY)	Employee ID	
Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)		

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that as described in my enrollment materials, contributions may be required for the benefits I select below. If you enroll for certain Contributory Insurance, a portion of your contributions for such insurance will be allocated to reduce the Policyholder's cost of certain Noncontributory Insurance under the Group Policy.

- ▶ You must complete the Supplemental Enrollment Form (provided separately) including the Health Information section and the Authorization form:
- If you are enrolling for more than \$500,000 of Optional Life Insurance.
 - If you are currently enrolled and increasing your Optional Life Insurance, Dependent Spouse/Domestic Partner Life Insurance, and/or Dependent Child Life Insurance by any amount.
 - If you are enrolling due to a Qualifying Event and enrolling after the 31-day enrollment period for Dependent Spouse/Domestic Partner Life Insurance and/or Dependent Child Life Insurance.
 - If you are enrolling after the initial 90-day enrollment period and enrolling for any amount of Optional Life Insurance, Dependent Spouse/Domestic Partner Life Insurance, and/or Dependent Child Life Insurance.

Term Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

- Optional Life¹ and Optional AD&D
 \$10,000 1x 2x 3x Basic Annual Earnings up to a maximum of \$1,000,000
- Dependent Life:
 Option 1 – Dependent Spouse/Domestic Partner² Life^{1,3} \$5,000 / Dependent Child Life³ \$2,000
 Option 2 - Dependent Spouse/Domestic Partner² Life^{1,3} \$10,000 / Dependent Child Life³ \$5,000

¹ Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

² Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

³ Amounts will be subject to state limits, if applicable.

**GEF02-1
ADM**

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

GEF02-1

ADM applies to residents of Connecticut, North Dakota, and Utah)

Dependent Information			
If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:			
Name of your Spouse/Domestic Partner (First, Middle, Last)		Date of Birth (MM/DD/YYYY)	
_____		_____	
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Full Time Student ¹ ?	
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.			

¹ Full Time Student means your dependent child, age 18 or older, enrolled as a full-time student in an accredited college, university, or secondary school, or a vocational or trade school. Age limits will be subject to state limits, as applicable.

GEF02-1

ADM

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF02-1

ADM applies to residents of Connecticut, North Dakota, and Utah)

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE				
I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.				
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.				
<input type="checkbox"/> Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%
If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

DEC applies to residents of Connecticut, North Dakota and Utah)

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.



_____ Signature of Employee	_____ Print Name	_____ Date Signed (MM/DD/YYYY)
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PAYMENT AUTHORIZATION

By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.



_____ Signature of Employee	_____ Print Name	_____ Date Signed (MM/DD/YYYY)
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GEF09-1a
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; GEF09-1 DEC applies to residents of Connecticut, North Dakota and Utah)

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
 County of Ventura, 800 S Victoria Ave, #1970, Ventura, CA 93009-1970
 Phone: 805-654-2570 Fax: 805-654-2665 Email: Benefits.ServiceRep@ventura.org

**Basic/Optional Life Insurance
Beneficiary Designation Form**

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166



EMPLOYERNAME: The County of Ventura

POLICY NUMBER: 01 20

Insured's name (last, first, middle initial)	Insured's employee ID
--	-----------------------

Address (street, city, state, zip)	
------------------------------------	--

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address
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INSTRUCTIONS:

1. Clearly print or type the information below.
2. Sign and date the completed form.
3. Return to CEO/HR/Benefits (Benefits.ServiceRep@ventura.org or L#1970).

This beneficiary designation applies to the coverages noted below:

All group term life coverages **OR** Basic Life/AD&D only Optional Life/AD&D only

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children", without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY (IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY (IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature X	Date
-------------------------------------	------

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%
Total = 100%					

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%
Total = 100%					

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%
Total = 100%					

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%
Total = 100%					

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Henry Doe - Trustee, his successors or successor in trust under the John Henry Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008. Trust Tax ID number 99-555555.			N/A	Trust	100%
Total = 100%					

Example 4: If the beneficiary is a charity/organization.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit					
Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Charity/Organization Name, 20 Main Street, Anywhere, CA 99999, 805-555-1919			N/A	Charity/Organization	100%
Total = 100%					

Frequently Asked Questions

Supplemental Enrollment/Statement of Health (SOH) Form

Q. Where do I start?

Complete the Supplemental Enrollment Form/Statement of Health for all amounts you are requesting.

1) Determine Your Coverage Election:

Optional Life

- \$10,000 1x, 2x, 3x Base Annual Earnings, up to a maximum of \$500,000

Dependent Life (Spouse/Domestic Partner, Child)

- Option 1: \$5,000 / \$2,000
 Option 2: \$10,000 / \$5,000

2) Determine Amount Subject to Underwriting

A) How much coverage are you electing? _____

B) How much coverage do you have today? _____

C) A-B = _____ (place this amount on the Supplemental Enrollment form)

Q. What is a Statement of Health (SOH)?

A Statement of Health (SOH) is a document that includes a series of questions about your overall health. Depending on your employer/group's plan and the amount of coverage you request, you may be asked to complete an SOH form in order for MetLife to evaluate your life insurance application.

Q. Why would I be asked to complete a Statement of Health (SOH)?

If you applied for group insurance coverage, you may be required to complete a Statement of Health based on MetLife's rules for your company's group life insurance plan.

Examples of SOH triggers may include:

- You requested coverage after the first 90 days of initial eligibility
- You are currently enrolled and increasing your coverage

Q. What is medical underwriting?

The process by which MetLife evaluates an applicant's eligibility for the group insurance requested based on age, answers on the SOH form and additional medical information, if applicable.

Q. Is the information on my Statement of Health (SOH) form kept confidential?

Yes. We apply strict standards for privacy and confidentiality as with all of our MetLife processes and data.

Q. If I answer "yes" to one of the SOH questions, will I be required to submit additional medical information?

You may be required to provide details explaining your response on the SOH. Once submitted, some answers may require additional medical information in the form of an Attending Physician's Statement (APS) or a paramedical exam, which MetLife will order.

CONTINUED

Q. What is a paramedical exam?

A paramedical exam is a simple physical exam performed by a medical professional that takes approximately 30 minutes, at no cost to you. The exam includes blood and urine samples. If you are required to complete a paramedical exam, you will be contacted by a MetLife approved vendor to schedule an appointment by telephone, e-mail or U.S. mail. You may also initiate scheduling your paramedical exam online if you completed your SOH form online.

Q. Why would I need a paramedical exam?

The need for a paramedical exam is determined by your age, the amount of insurance coverage you are requesting, and your answers on the SOH form. An exam and other medical testing may be required to provide MetLife with the information needed to determine your insurability under the plan.

Q. If I have an existing medical condition and I'm required to complete an SOH, should I still continue with the process?

Yes. Even individuals with relatively serious medical conditions may still be eligible for insurance coverage.

Q. What happens to my Statement of Health (SOH) form once I complete it?

MetLife will review the form and generate a response within 10 business days after receiving the information. The response will either notify you of the final determination regarding your requested insurance coverage or request additional information.

Q. Once I submit my Statement of Health (SOH) form, how can I make changes, if necessary? Please contact the MetLife Statement of Health Unit at 1-800-638-6420 (prompt 1).

Q. What happens if I am declined for this coverage?

If your Statement of Health is declined, it will not affect any coverage already in existence.

Q. Can I dispute a declination?

Yes. You may dispute a declination subject to the terms identified in the declination letter which must include medical documentation to support the reason for the dispute.

Q. If I have questions, who may I contact for help?

For any questions relating to your Statement of Health form, please call 1-800-638-6420, prompt 1. [Learn more about Statement of Health process through our interactive online tutorial, by visiting www.metlife.com/sohtutorial.](http://www.metlife.com/sohtutorial)

ACCIDENTAL DEATHS & DIMEMBERMENT BENEFITS

Accidental death and dismemberment benefits are provided for all participants in the Wage Supplement Plan.

The maximum benefit provided is \$2,500.00 per accidental injury. Actual benefit amounts are as follows:

<u>For Loss of</u>	<u>The Benefit Will Be</u>
Life.....	\$ 2,500.00
Both hands or both feet.....	\$ 2,500.00
The sight of both eyes.....	\$ 2,500.00
One hand and one foot.....	\$ 2,500.00
One hand or one foot and the sight of one eye.....	\$ 2,500.00
One hand or one foot.....	\$ 1,250.00
The sight of one eye.....	\$ 1,250.00

The County will pay the applicable benefit amount upon receipt of due proof that:

1. You were accidentally injured while insured under the Plan; and
2. The loss occurred as a direct result of the injury and within 90 days after the accidental injury.

DISABILITY, DEATH OR DISMEMBERMENT GENERAL EXCEPTIONS AND LIMITATIONS

This plan does **NOT** cover disability, death or dismemberment resulting from:

1. Accidental injury arising out of or in the course of any occupation or employment for remuneration or profit, or any accidental injury or any sickness for which you are entitled to benefits under any Workers' Compensation law, Employers' Liability law, or similar law.
2. Disease, bodily or mental infirmity or infection.
3. Suicide, attempted suicide or intentionally self-inflicted injury whether sane or insane.
4. Being in or on, descending from or following with or from any aircraft which is in flight or motion unless insured is a fare-paying passenger on a commercial airline flying a regularly scheduled route.
5. Use of any drug, narcotic or hallucinogenic agent unless prescribed by a physician.

6. Injury or sickness resulting from war or any act of war; whether declared or undeclared, or from participation in a riot or from commission of a felony.

TERMINATION OF COVERAGE

Your Wage Supplement Plan coverage will automatically terminate on the earliest of :

1. the day the Plan terminates;
2. the day you cease to be eligible;
3. the day you enter the armed forces or accept a government agency position outside the United States;
4. the end of the pay period in which you discontinue payment of premiums.

TO FILE A CLAIM

Obtain a WSP Claim Statement from your Department's Human Resources Benefits Representative. Follow the instructions on the Statement. To expedite your claim, make a copy of Part I, complete it and send it directly to Human Resources Benefits Unit. Give Part II to your Department to complete and send to Benefits. Give Part III to you physician to complete and send directly to Benefits. Your claim will be processed as soon as all three (3) parts have been received and the information has been verified.

IF YOU HAVE QUESTIONS

County of Ventura

Human Resources Department, Benefits Unit

Hall of Administration, 4th Floor

800 South Victoria Avenue, # 1970

Ventura, CA 93009

(805) 654-3837

IMPORTANT

This brochure is a brief summary of the plan. Statements in this brochure are subject to the provisions of the County of Ventura's Wage Supplement Plan for Short-Term Disability and cannot modify or affect the Plan in any way, nor shall you accrue any right because of a statement or omission from this brochure.

The Plan Document is available for review in the County of Ventura's Human Resources Department.

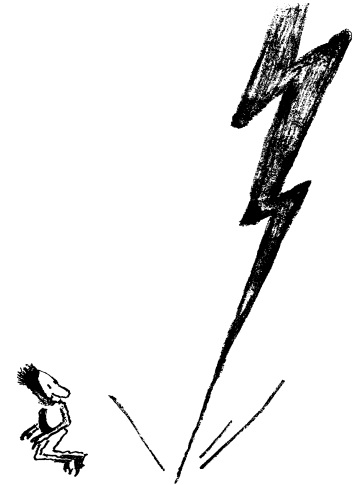
COUNTY OF VENTURA



Wage Supplement Plan

For
Short-Term
Disability
Benefits

An
Optional
Program



County Executive Office
Human Resources Department

Benefits Division

COUNTY OF VENTURA WAGE SUPPLEMENT PLAN ENROLLMENT FORM			
EMPLOYEE I.D. NUMBER	DEPARTMENT NAME	SCHEDULED HOURS PER WEEK	
EMPLOYEE NAME (Last, First, Middle Initial)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	
ADDRESS (Last, First, Middle Initial)		ADDRESS (Number and Street or P.O. Box, City, State, Zip Code)	
<input type="checkbox"/> I CHOOSE LOW OPTION – Maximum Benefit Period 13 weeks	DATE OF BIRTH	\$	Salary Biweekly
<input type="checkbox"/> I CHOOSE HIGH OPTION – Maximum Benefit Period 26 weeks	DATE EMPLOYED	\$	Salary Per Hour
FULL NAME OF BENEFICIARY (First, Middle, Last)	SSN	RELATIONSHIP	
Primary		ADDRESS (Number and Street or P.O. Box, City, State, Zip Code)	
Contingent			
SIGNATURE OF SPOUSE AND TODAY'S DATE (If you are married and you designate a primary beneficiary other than your spouse, your spouse must give consent by signing this form.)			
I designate the beneficiary shown above to receive all sums which may become due on account of my death under the Accidental Death and Dismemberment Benefit provided by this Plan. I have a regular work schedule of 20 or more hours per week (40 hours or more each pay period). I hereby request coverage under the Wage Supplement Plan and authorize the County to deduct from my earnings any required contributions. I certify that any information shown on this form is correct.			
SIGNATURE OF EMPLOYEE:		TODAY'S DATE:	
Human Resources Department Name and Date Processed:		Pay Period Deduction and Coverage Effective:	
G:\HR\Benefits\New Employee Orientation\NEO Packet\WSP Enrollment Form 2010.doc			



Wage Supplement Plan

For Short-Term Disability Benefits

An Optional Program

This plan brochure describes your plan benefits and the procedure for filing a claim. Keep it with your important papers for future reference.

WHY DISABILITY INCOME INSURANCE?

All the essentials of life depend on your most valuable possession – your earning ability. What would happen if you were disabled and stopped receiving a paycheck? When you're disabled, most of your bills and expenses continue and you may even need household help to care for you, your family and your home. This plan can help you minimize your financial loss while you recover from a serious non-work-related illness or injury.

ELIGIBILITY AND ENROLLMENT

All regular employees are eligible to participate as long as you are regularly scheduled to work 20 hours or more per week (40 hours per pay period). Evidence of insurability is not required. New and current employees can enroll as soon as they meet the eligibility requirements.

To enroll, you must detach and complete the Enrollment Form and return it to your Department's Human Resources Benefits Representative in time to be forwarded to the Human Resources Benefits Unit during the first **90 days** you are eligible, or you will not be a participant in the plan. There are no regular open enrollment periods. Coverage begins the second day of the pay period in which your Enrollment Form is processed. You can cancel your enrollment at any time by submitting a Payroll Authorization/Cancellation Deduction Card. Once you drop your coverage, you cannot reenroll.

DEFINITION OF TOTAL DISABILITY

You are considered to be totally disabled if you are unable to perform each and every duty of your regular occupation at your customary place of employment each and every day and you are under the regular care of a physician.

PLAN PROVISIONS

If you become totally disabled while enrolled in this plan and submit a completed Claim Statement as described elsewhere in this brochure, benefits will begin on the first day of your injury or hospitalization, or on the 8th day of an illness not requiring hospitalization. Benefits are paid bi-weekly.

The dollar amount of weekly benefits and the maximum benefit period are determined by the premium and level of coverage you select, as follows:

Premium Per Pay Period	Maximum Weekly \$ Benefit	Maximum Period	Maximum Benefit Per Disability
\$3.13	\$45.00	13 weeks	\$5 85.00
\$7.00	\$80.00	26 weeks	\$2,080.00

Premium rates are subject to change. The higher level of coverage is available only for employees whose regular bi-weekly earnings exceed \$369.00.

WSP Benefits are not reduced by any other insurance you may have, and do not affect the amount of State Disability Insurance (SDI) Benefits to which you may be entitled. However, if you also have other group disability insurance, you may wish to check with that plan to see whether those benefits would be reduced by the amount of your WSP Benefit. For example, the County's Long Term Disability (LTD) Benefits would be reduced by the amount of the WSP Benefit.

DISABILITY INSURANCE EXCEPTIONS

Successive periods of disability will be considered as one continuous period of total disability if they result from, or are contributed to by, the same or related causes. However, if you performed your regular occupation at your customary place of employment for at least 20 hours a week for a period of at least two weeks between periods of total disability, the periods are considered separate periods of disability.

Members age 70 or over will be paid the Weekly Benefit, for up to the maximum benefit period specified, for any one disability during any period of twelve (12) consecutive months.



PRE-DESIGNATION OF PERSONAL PHYSICIAN
(Medical Treatment for a Work Related Injury or Illness)

Workers' Compensation law grants an employee, who has sustained an occupational injury or illness, the right to medical care and disability benefits. The Workers' Compensation law also grants an employee the right to be treated by a "personal physician". The law defines "personal physician" as the employee's regular physician and surgeon, who has previously directed the medical treatment of the employee and who retains the employee's medical records.

Employee's Name _____ Agency _____
Please Print Full Name

EMPLOYEE DESIGNATION OF A PERSONAL PHYSICIAN

I, _____, request to be treated by my personal physician in case of an occupational injury or illness occurring during the course of employment with the County of Ventura.

My personal physician is:

Name: _____

Address: _____

Phone Number: (_____) _____

Employee Signature: _____ Date _____

This section is required per LC §4600(d)(2)(c), effective 4/19/04; the physician who is pre-designated MUST agree to be pre-designated and MUST be your "regular physician and surgeon".

PERSONAL PHYSICIAN ACCEPTANCE OF EMPLOYEE DESIGNATION

I agree to treat _____; in the case he/she sustains an occupational injury or illness occurring during the course of employment with _____. I will abide by the current applicable Workers' Compensation Laws regarding **Utilization Review** – LC 4610 and Fee schedule and furnish the required reports and forms required in accordance with the **Duties of the Employee's Elected Physician** – CRR 9785

Physician's Name _____ Phone #: _____
(Please type or print)

Physician's Signature _____ Date _____

RETURN THIS FORM TO YOUR HUMAN RESOURCES DEPARTMENT



NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

In the event of a Workers' Compensation Claim, you may be able to change your treating physician to your personal chiropractor or acupuncturist. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Further, the personal chiropractor or acupuncturist must be licensed to practice as such and must have previously directed treatment for you and retains your medical records, including chiropractic or acupuncture history.

Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visits" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the post-surgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

(Employee Name)

(Agency)

Your Chiropractor or Acupuncturist's Information:

(Name of chiropractor or acupuncturist)

(Street address, city, state, zip code)

(Telephone number)

(Employee's signature)

(Date)



The Ventura County Wellness Program (VC-WELL) provides and encourages workplace programs and practices to promote the overall health and well-being of County employees. Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance are eligible to participate in VC-WELL. Participants have access to a wide variety of valuable programs and offerings including annual biometric health screenings, well-being apps, physical activity classes and challenges, health coaching, and other resources to support healthy living.

WELLthy Reward\$

Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance can earn a cash award up to \$300 for completing various VC-WELL activities throughout the year. First time cash award earners receive a \$50 bonus added to their 2025 award! Participants can choose from a list of qualifying VC-WELL activities to earn points toward Bronze, Silver, or Gold status.



- Annual biometric health screening = 50 points
- Online health risk assessment = 50 points
- Be Well Million Step March = 80 points
- Be Well Two Million Step March = 40 points
- Be Well Golden Sneaker Inter-Agency Competition = 40 points

To view the full list of qualifying activities, visit the VC-WELL website at vcwell.ventura.org/rewards

Personal Wellness Profile

Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance and their spouses/domestic partners can participate in a Personal Wellness Profile, which consists of an annual biometric health screening and online health risk assessment questionnaire.

To schedule a screening and complete the questionnaire, visit the VC-WELL website at vcwell.ventura.org/profile



Health Club Discounts

All County employees and their spouses/domestic partners are eligible to receive discounts to local health clubs.

To find a list of participating health clubs, visit the VC-WELL website at vcwell.ventura.org/gym-discounts



Activity Competitions

All County employees and their spouses/domestic partners can register for personal accounts on the Be Well app and participate in various virtual activity challenges. Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance can earn points toward WELLthy Reward\$ by completing challenges such as the Million Step March and Golden Sneaker Inter-Agency Competition. To register for or log in to your Be Well account, or use the QR code, or visit vcwelltrek.walkertracker.com



Health Coaching

Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance and their spouses/domestic partners can participate in health coaching provided by the American Institute for Preventive Medicine (AIPM). AIPM offers five health and well-being coaching programs: general well-being, healthy weight, stress management, quality sleep, and tobacco cessation. To enroll in health coaching, call AIPM at 800-345-2476 ext. 1, or use the QR code, or visit <https://tinyurl.com/VC-AIPM>



Headspace

Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance can register for a free premium subscription to Headspace, which provides users with mindfulness tools for everyday life, including meditations, sleepcasts, mindful movement, and focus exercises.



Wellbeats

Regular County employees who receive a bi-weekly Flexible Credit or Opt-Out Allowance and their spouses/domestic partners can access Wellbeats, which provides on-demand fitness and health classes available 24/7. To register for Wellbeats, use the QR code or visit the VC-Well website at vcwell.ventura.org/healthy-resources



Health Resources

All County employees and their spouses/domestic partners have access to various online health resources through the VC-WELL website including maps of walking paths near County worksites, health education, healthy recipes, and health plan information.



For more info on the Ventura County Wellness Program, visit vcwell.ventura.org