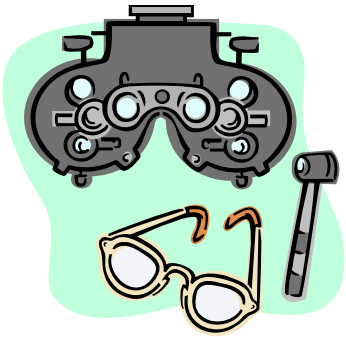
Ventura Superior Court 2007 Flexible Benefits Program Handbook



The 2007 Benefit Plan Year begins on December 31, 2006 and ends on December 29, 2007

2007 Flexible Benefits Program Handbook distributed by:

Superior Court of California, County of Ventura, Human Resources Department in conjunction with the County of Ventura Benefits Unit

Important Information About This Handbook

Please read this page.

This Handbook is designed to assist you in selecting the benefits that fit your individual needs and using them effectively once you're enrolled.

The Handbook discusses most of the benefit plan for which you are eligible within the Flexible Benefits program. Since plan benefits may change from year to year, it is in your best interest to review each new edition of the handbook for changes that may affect you and your eligible dependents.

In the event that you or your dependents should experience a qualified mid-year event such as a change in legal marital status, number of tax dependents or a change in a child's dependent status, please review the Life Events Checklist section in the handbook. This section explains how that event may affect your benefits and what actions you may need to take.

The plan descriptions in this booklet are general, and are not intended to modify or affect the Plan contracts in any way. For more details on plan benefits or to verify eligibility or coverage, please call the plan carrier directly or refer to the "Evidence of Coverage" booklet that is given to each new enrollee. To order a duplicate copy of your "Evidence of Coverage" booklet, please call the health plan carrier directly.

The majority of this handbook has been created by the County of Ventura and some parts may apply only to county employees.

If you require more information on the Flexible Benefits program, please call the Court Human Resources Benefits Administrator at (805) 339-2928.

This book replaces the 2006 Benefits Plans handbook and any earlier Handbook versions.

Please keep this book with your insurance papers for future reference.

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)

Your Department's Personnel Representative has the forms and brochures you may need, or see the self-serve rack in Human Resources at the Government Center. See the Flexible Benefits program Information and Miscellaneous Benefits chapters for descriptions of the plans and program that appear below.

Life Events Checklist

Event	Actions
New Regular Employee • New Hire • From Optimum Census Staffing (OCS) • From Extra-help	■ Attend a County Human Resources New Employee Orientation for an overview of County benefits. If your work schedule is 40 hours a pay period or more, you are now eligible for: ✓ The Flexible Benefits Program (apply within 31 days of eligibility) ✓ Optional term life insurance (best to apply within 90 days of eligibility) ✓ Deferred compensation plans (you may be eligible for County 401(k) match) ✓ Wage Supplement short-term disability plan (apply within 90 days of eligibility) ✓ Defined Benefit Pension Plans: • If your work schedule is at least 64 hours a 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; complete and return the form.
Changed your Address Changed your Name	■ Notify your department representative to update payroll information. Notification will go to your insurance and retirement plans and to the Auditor/Controller to update your annual W-2 form. ■ Have a 457 Plan or 401(k) Plan account? If you are not currently making payroll contributions, complete the top section of a new 457 and/or 401(k) Participation Agreement. ■ If you have funds on deposit in the Safe Harbor Retirement Plan, but aren't currently contributing, notify the Plan at (805) 654-2921. ■ You may need to update your beneficiaries. See "Beneficiary Update" at the bottom of checklist.
Marriage Registration of Domestic Partner New dependent child as a result of birth, marriage or legal adoption	■ You have 31 days to turn in an enrollment form to add your new dependents to your medical, dental and vision plans. Otherwise, you may have to wait for the next open enrollment period. ■ If you have Dependent Life Insurance coverage on other dependents, you have 31 days to complete a Dependents Life Enrollment Form to add your new dependent children. New spouses must complete a Statement of Health, and coverage is conditional upon approval by Standard Insurance. ■ You may be eligible to add, drop or change Flex plans, or change your Dependent Care or Health Care Flexible Spending Account contribution. 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. ■ You may need to update your beneficiaries. See "Beneficiary Update" at the bottom of checklist.

Life Events Checklist (continued)

Event	Actions
Legal Separation or Divorce Child is age 19 Child is age 19 - 24 but no longer a student Child is age 25	■ Complete an enrollment form to formally cancel coverage on your dependent and trigger an offer of continued coverage through COBRA. **COBRA can only be offered if the dependent is dropped within 60 days of the event.** Be sure to include the dependent's current mailing address, if different than employee's. Until you turn in the form, you may be liable for claims paid after eligibility ends. ■ You may need to change or modify a Dependent Care or Health Care Flexible Spending Account. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ You may want to drop your life insurance or dependent life insurance. ■ You may need to update your beneficiaries. See "Beneficiary Update" at the bottom of the checklist.
Job Change	■ If your new position is represented by a different Bargaining Unit (union), check with your department to see if you have gained or lost eligibility for any benefits. For example: ✓ Your Flexible Credit Allowance 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. You new job may have a different minimum 401(k) contribution. To change your 457 or 401(k) Plan contribution amount, complete a new Participation Agreement.
Loss of Other Health Insurance	■ If you are Opting Out of County medical insurance, you must notify County Human Resources (contact your department representative) if you lose your other health coverage. You are required to enroll in one of the County's health plans or waive participation in the Flexible Benefits Program.
Change in Other Health Insurance	■ In some instances where you gain, lose or have a change in health insurance from another source, you may be eligible to add, drop or change Flex plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions.
Work Schedule Decrease • From 64 hours or more to between 40 & 63 hours per pay period	■ If you are in a union-represented job title, your Flexible Credit Allowance amount probably changed, and you may be eligible to drop a health plan, change to a lower cost plan, and/or reduce your Flexible Spending Account contributions. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ Covered employees lose County Long-Term Disability Plan (LTD) eligibility at Work Schedules of fewer than 60 hours a pay period; no form needed.
Work Schedule Decrease • To fewer than 40 hours per pay period	■ You lose eligibility for the Flexible Benefits Program. You'll be sent an application for continuation of group health insurance under COBRA. See the Flexible Benefits Program Information chapter and COBRA appendix for eligibility, deadlines and instructions. ■ You lose eligibility for Optional Life insurance, 401(k) contributions, Wage Supplement Plan, County Long-Term Disability Plan (LTD). Some groups lose 457 Plan eligibility.
Work Schedule Increase • To between 40 & 63 hours per pay period	■ You are now eligible for the Flexible Benefits Program. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ Covered job titles have a County Long-term Disability Plan (LTD) if the Work Schedule is at least 60 hours a pay period. ■ 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.
Work Schedule Increase • To 64 hours or more per pay period	■ If you are in a union-represented job title, your Flexible Credit Allowance amount may increase, and you may be eligible to add a health plan or change to a higher cost plan. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ If you are in the Safe Harbor Retirement Plan, check your pay stub to be sure contributions stopped. You'll be in the Ventura County Employees' Retirement Association (VCERA) from now on. VCERA will mail you plan information.

Life Events Checklist (continued)

Event	Actions
Salary Change	■ You may want to change your 457 Plan or 401(k) Plan contribution amount. Complete a new Participation Agreement. ■ You may want to adjust your tax-withholding amount. Ask your department for a W-4 form.
Pregnant, Ill or Injured	■ You must complete a *Leave of Absence Request* form when you are off work for more than three days. ✓ Even if you are going to be off work less than a full pay period. ✓ Even if you are out on a work-related injury. ■ Read the Leave of Absence overview in the *Miscellaneous Benefits* chapter. ■ Ask your department for a Leave of Absence Handbook; read it thoroughly. ■ Check for disability insurance and/or accidental dismemberment benefit eligibility under LTD, SDI, Wage Supplement Plan or union-sponsored plan.
Leave of Absence Request	■ Ask your department for a Leave of Absence handbook; read it thoroughly. ■ You may be required to immediately begin payment of part or all of your health plan premiums. Check with your department Personnel Representative. ■ 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 form now to drop your account when your leave starts, and complete another form upon your return. You may not file claims for services incurred while you are not working.
Leaving County Employment or Retiring	■ You'll receive a letter from Human Resources explaining your options to continue your health insurance and life insurance, and what actions to take on your 457 and 401(k) Plans. ■ If you are changing jobs, in most circumstances you can continue your basic and optional life insurance for up to two years unless you become covered by another group plan. See the Life Insurance Certificate for information. ■ If you're retiring soon: ✓ Ventura County Employees' Retirement Plan (VCERA) members call (805) 339-4250. ✓ Safe Harbor Retirement Plan members call (805) 654-2921. ✓ To sign up for a meeting on County-sponsored retiree health insurance and 457 and 401(k) Plan options three to six months prior to your termination date, call (805) 654-3636.
Death of a Dependent	■ If the dependent is covered under County health insurance, complete an enrollment form to notify Benefits and the health plan. ■ If the dependent is covered under County dependent life insurance through Standard Insurance, notify Human Resources at (805) 654-2570. ■ You may need to update your beneficiaries. See "Beneficiary Update" at the bottom of the checklist.
Death of a Regular County Employee ***Write in the name & telephone number of the department representative your family should notify in the event of your death:*** **Name:** _____ **Telephone:** _____	■ Your department will pay a $1,000 death benefit to your beneficiary. ■ If the employee has County health insurance, life insurance or disability insurance (LTD or Wage Supplement Plan), notify Human Resources 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 contribution to 457 or 401(k) with the County, call Fidelity at (800) 343-0860 or ING at (805) 642-6190.
Beneficiary Update	■ For 457 & 401(k) deferred compensation plans, notify Fidelity at (800) 343-0860 or ING at (805) 642-6190. ■ For the Ventura County Employees' Retirement Association (VCERA) call (805) 339-4250. ■ For the Safe Harbor Retirement Plan call (805) 654-2921. ■ Obtain forms from your department Personnel Representative to update the beneficiary information on the $1,000 department death benefit and any County life or accidental death insurance plans you have (Standard Insurance Basic and/or Optional Term Life, WSP).

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

A Flexible Benefits Program is an Internal Revenue Service (IRS)-approved program (sometimes called a cafeteria plan) that allows you to choose how to spend your benefit dollars.

Participation is optional. You decide whether to participate or waive your right to enrollment and the Flexible Credit Allowance.

Here's how it works: When you enroll in the Flexible Benefits Program, the County provides you with a Flexible Credit Allowance to spend on your choice of plans.

If your choices cost more than your Flexible Credit Allowance, you pay the rest through pre-tax salary reduction. This means you get a tax break—your share of the cost is deducted from your pay before federal and state income taxes and Social Security taxes are calculated, so you don't pay taxes on the money you spend on benefits.

Depending on the plan(s) you choose, you may get "Cash Back" added to your taxable pay because of Flexible Credits not spent.

Your Flexible Credit Allowance is not taxed, except for the portion taken as "Cash Back" in your paycheck.

"Cash Back" gives you additional income. If this is the case, you may wish to lower your current tax liability and invest in your own future by channeling those extra dollars into a tax-deferred savings program. The Deferred Compensation Program is one of the topics covered in the chapter on Miscellaneous Benefits.

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 of Standard Hours of at least 40 hours each biweekly pay period.

Exception: Employees in job titles represented by the Ventura County Professional Firefighters' Association (VCPFA) must have a regular Work Schedule of 64 hours or more per 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 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, Flexible Credit Allowance and plan options 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 Plans
- A Vision Plan
- A Health Care Flexible Spending Account
- A Dependent Care Flexible Spending Account
- A 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. Learn About Your Plan Options

Chapters 2 through 5 of this Handbook have basic information on the plans. If you require more detail on a specific health plan, review the information materials provided by the plan.

2. Make Your Flexible Benefits Program Selections

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

Then, choose what other benefits (dental plan, vision plan and/or flexible spending accounts), if any, you want to purchase 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 purchase, part of your salary will be converted to additional Credits to cover the cost of the benefits you choose.

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

3. Fill Out Your Forms

Complete the proper enrollment forms and return them within the deadlines discussed under *"Employee Enrollments"* and/or *"Can I Change My Mind?"* later in this chapter. To complete the forms, you'll need an *Information Worksheet* specific to your collective bargaining representation, unless you enroll through Employee Self Service.

The Worksheet lists everything you will need to complete your forms: the County's biweekly contribution amount, the plan names and the biweekly premium costs for each plan.

Online access to plan comparisons in Employee Self Service (click on MyBenefits) was introduced in November 2005.

All of the County-sponsored health plan premiums are priced on a "composite rate" basis, which means everyone shares equally in the risks and benefits of our plans. You pay the same premium regardless of your health, age, or the number of dependents you enroll. Before you decide whether to enroll a dependent, be sure to read *"When and How Can I Enroll Dependents?"* later in this chapter.

The Personnel Representative for your department can provide you with the forms you need and your *Information Worksheet*, as well as assistance with the enrollment process.

Employee Enrollments

From the date you become eligible for the Flexible Benefits Program, you have 31 calendar days to turn in your enrollment forms or sign a Waiver of Benefits Authorization. You can also enroll during the annual Open Enrollment period, which is discussed later in this chapter.

1. Eligible New Employees

The 31-day period begins on your date of hire. The sooner you turn in your forms, the sooner coverage begins for you and your enrolled dependents. Don't delay! 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 below, *"When Coverage Begins."*

For your protection, if you fail to turn in your enrollment forms or a Waiver of Benefits within 31 days of becoming eligible, you will be automatically enrolled in the lowest cost County or Association-sponsored medical plan for which you are eligible. In Plan Year 2007, this is the Ventura County Health Care Plan (VCHCP) for most employees.

2. Consequences of Not Submitting Your Forms on Time

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

- You will lose up to two months of medical coverage if you miss the 31-day deadline; your coverage will become effective in the pay period that includes your 60th day of eligibility.

- You will forfeit immediate medical coverage for your dependents. Some plans will accept a late dependent enrollment once you complete an enrollment form and it has been processed, but a preexisting condition limitation may apply. Other plans will not accept a late enrollment until the next annual Open Enrollment, except under special circumstances.
- You will lose your opportunity to opt-out of County medical coverage, which might 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.

COMPLETE THE FORM(S) FOR YOUR INITIAL ENROLLMENT IN THE FLEXIBLE BENEFITS PROGRAM:

- **To enroll in any medical, dental or vision plan**: Complete, sign and submit the enrollment form. Attach proof of student status if enrolling a dependent child age19 or over.
- **To opt out of medical coverage:** Complete, sign and submit the enrollment form, and include your proof of other group medical coverage.
- **To waive all coverage:** Complete, and sign the ***Waiver Authorization Form*** or the waiver section of the enrollment form, and submit the form to your department Personnel Representative.

All required forms and required documentation must be submitted to your department's Personnel Representative.

3. Changing from Extra-Help or Optimum Census Staffing (OCS)

If your employee class changes from Extra-Help or OCS 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

Follow the same steps as item 3 above.

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

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

6. When Coverage Begins

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

Dependent Enrollments

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

1. Whom Can I Enroll as a Dependent?

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

- Your current legal husband or wife,
- Domestic partners officially registered with the State of California or any other California County or Municipality official domestic partner registry,
- Your unmarried children from birth through age 18,
- Dependent children of an officially registered domestic partner who meet the same eligibility requirements as other dependent children,
- Certain unmarried children age 19 and over if handicapped prior to age 19, continuously

covered by this or a similar County plan since prior to age 19, and incapable of self-support,

- Your unmarried children age 19 through age 24 if they meet the plan's requirements as full-time students.

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

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

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

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

• ***New Dependent***: If you want new dependents covered under your health plan(s) for the remainder of the Plan Year, you must enroll them within 31 days of eligibility; for example, marriage, registration of domestic partner, birth of a child, adoption placement or beginning of the quarter/semester for full-time student.

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

Submit a new enrollment form immediately whenever you acquire a new dependent. Except for 31 days coverage from the date of birth for a newborn child, coverage for dependents is never automatic. Coverage is not retroactive. Preexisting condition limits and other restrictions may apply in some cases, for some plans. See the medical, dental and vision option chapters for further information.

Coverage for new dependent children begins at the date of birth or placement for adoption. The effective date for coverage of dependents resulting from a marriage or registration of domestic partnership varies by plan.

Children added due to gain of student status are generally covered effective with the County pay period following the beginning of the school quarter or semester, or the receipt of the enrollment form, whichever is later.

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

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

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

Submit a revised enrollment form immediately whenever a dependent becomes ineligible.

Examples:

- Divorce
- Legal separation
- Loss of student status for child age 19 or over (students remain covered during regular school breaks)
- Marriage of dependent child
- Death of the dependent
- Termination of a Domestic Partnership

Turn in forms WITHIN 31 DAYS OF THE EVENT (date eligibility ends). If you do not cancel coverage for ineligible dependents, you may be liable for claims incurred after the date dependent eligibility ended and you jeopardize their eligibility for extension 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, changes in Flexible Spending Account contribution levels, and the addition of existing dependents. During each Open Enrollment, you'll want to review your options and decide whether your current selections still fit your needs. For instance:

- Do you have any new dependents?
- Have any of your dependents become ineligible?
- Is a dental or vision plan cost-effective for you?
- Would a Flexible Spending Account save you money?

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.

If you are on 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 leave of absence and your coverage has lapsed, your coverage effective date will be delayed until the County pay period following your return to work.

See if you need to re-enroll online through Employee Self Service in VCHRP, by completing new forms or by other methods as directed by the County.

Read your Open Enrollment materials very carefully! Open Enrollment procedures vary from year to year. Find out what you need to do.

- **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 selections continue if you take no action.**

2. Mid-Year Changes

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

The change in your plan selections must be because of, and consistent with, the reason for the change. 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 IRS regulations for mid-year health insurance changes (i.e. outside of open enrollment period) restrict any changes to your plan or coverage unless you have a qualified mid-year event or change in status.

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;
- **Change in number of tax dependents**, including birth, adoption, placement for adoption or death of a dependent;
- **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;

- **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, student status, marriage of the tax dependent, 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 preexisting dependents or spouse), or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:

  - Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation;

  - Termination of employer contributions toward the other coverage, OR

  - If the other coverage was COBRA Continuation Coverage, exhaustion of the coverage

- A significant increase or decrease in premium cost or coverage, the elimination of an existing plan, or the availability of a new group plan (applies to health plans and Dependent Care Flexible Spending Accounts; does 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).

- 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 amount previously elected.

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 the end of *your* Plan Year.

■ **Summary:**

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

Revised forms must be received by County Human Resources **within 31 days** of the qualified change in status, or you may not be able to make the requested change until the next Open Enrollment period. Depending on the nature of the change, documentation may be required (such as a copy of a marriage or birth certificate, court documents, or a letter from a current or former employer).

If there will be a delay in obtaining the documentation, submit the form within the 31 days and attach a note of explanation. Follow-up as soon as possible with the documentation.

Qualified Medical Child Support Order (QMCSO)

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

When Does Coverage End?

1. New Plan Year

If you make changes to your plan selections during Open Enrollment, the changes become effective at the beginning of the pay period that includes January first of the next year. If you are on a 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. If you change or drop a medical plan, you will be sent a *Certification of Prior Coverage*.[1]

2. Dependent Coverage

Dependent coverage ends when your coverage ends, or on the date the dependent becomes ineligible (divorce, 19th birthday, loss of student status, etc.), whichever occurs first.

If your dependent becomes ineligible, you must complete a County of Ventura enrollment form and cancel coverage for the dependent within 31 days of the date your dependent becomes ineligible. The completed form must be submitted to your department's Personnel Representative, or directly to County Human Resources, within 31 days of the event.

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

Direct Notification to the Plan is not Sufficient.

Once your County form is received by Human Resources and your plan(s):

- You help to protect yourself from further claim payment liability.
- Your medical plan will send your dependent a *Certification of Prior Coverage*. [i]
- 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[i].
- Federal COBRA laws and regulations do not apply to domestic partners or their dependent children.

On the Job Injury?

To ensure that County contributions continue for all your health plan premiums, make sure your department puts you on FMLA leave of absence if you qualify for FMLA leave and are receiving Temporary Total Disability benefits from the County's workers compensation administrator; otherwise, your collective bargaining agreement determines if some County contributions continue. See Appendix B for further information.

3. Work Schedule Reduction

Follow the same steps as item 4 below.

4. Termination of Employment

If you are terminating or retiring, 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:

- Your medical plan will send you a *Certification of Prior Coverage.*[1]
- The County's COBRA Administrator will send you information on continuation of coverage options.[2]

5. Eligible for Retirement with a Pension?

If you are retiring and want information on County retiree health plan options, call (805) 654-2570 for a Retiree Health Benefits Program brochure and rate sheet, or call (805) 654-3636 to reserve a space in a one-hour Pre-Retirement Meeting where health plan and deferred compensation program options are discussed.

Retiree Health Benefits Program

To be eligible for County-sponsored retiree health plans after retirement, you must be covered by a County-sponsored employee health plan when you retire.

6. Leave of Absence

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

While you are on a paid or unpaid medical or maternity leave, or on certain *Family and Medical Leave Act of 1993* (FMLA) leaves to care for sick family members, your department will continue to contribute the amount it normally pays toward some or all of your health plan premium(s) for a number of pay periods, providing that you make timely premium copayments as required.

To continue coverage once your County contributions end, or if the County contribution is less than the cost of your premiums, you must make biweekly premium payments directly to the County. After one year on leave, if you have continued your health plan premiums payments, you may qualify for extended health coverage under COBRA continuation of coverage provisions.[2] If your medical coverage lapses while you are on leave, you will be sent a *Certification of Prior Coverage*.[i]

If you are considering a Leave of Absence, be sure to read the *Leave of Absence* section of the chapter on Miscellaneous Benefits.

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[1] A Certification of Prior Coverage will be sent by the medical plan where coverage has ended. Keep the Certificate with your important papers. Use it as proof of prior coverage if a future plan includes a Preexisting Condition Clause. See the Employee Notices Section, HIPAA, for further information.

[2] 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.

Chapter 2
Medical Plan Options

The medical plans offered through the County's Flexible Benefits Program vary in the coverage and providers available to you. In selecting a plan, be sure to compare benefits, copayments and out-of-pocket expenses 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 that follows and comparing the premiums in the *Information Worksheet* available through your department's Personnel Representative, you can determine which plan is best for you and your family. This chapter also reviews your options if you do not wish to enroll in medical coverage through the County.

Included at the end of the Comparison Chart in this chapter are each medical plan's 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 Organizations (HMOs)

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

Typically, when you need medical care, your first call is to your PCP. If you need a specialist, your PCP will refer you to one within the plan. For some plans, you will be referred to a specialist within the PCP's medical group or Independent Practice Association (IPA).

Should you choose to receive services without a referral, or out side 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, which includes general and family practitioners, internists and pediatricians.

You may choose a different PCP for each member of your family, and you can change providers during the year. If your PCP leaves the plan during the Plan Year, you must select a new PCP within the plan.

HMO advantages include coverage for routine and preventive services, small or no copayments, no deductibles, and no claim forms.

Preferred Provider Organizations (PPOs)

With a Preferred Provider Organization (PPO) plan, you don't need to select a Primary Care Provider (PCP), or obtain a referral to see a specialist. Each time you need medical services, you choose whether to self-refer to a PPO provider and receive in-network benefits or a non-participating provider and receive out-of-network benefits.

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

The freedom of choice that comes with a Preferred Provider Organization plan has a price – a higher premium, as well as an annual deductible for many services.

When you self-refer to a non-network provider, you pay a percentage of the customary cost of care, plus any provider charges above the amount the plan considers customary and reasonable fees for the services provided. 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 you four medical plans to choose from:

- Health Net High HMO
- Health Net Low HMO
- Health Net PPO
- Ventura County Health Care Plan - HMO

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

Health Net High HMO

Health Net Low HMO

These Health Maintenance Organizations (HMOs) offer a broad range of benefits and low out-of-pocket expenses. Members do not pay an annual deductible and most expenses are covered in full except for copayments for some services, such as doctor's office visits, hospital inpatient admissions, and prescriptions.

The Health Net High HMO has lower copayments for physician services, hospital inpatient services and prescriptions than the Health Net Low HMO, with a higher premium rate.

The Health Net Low HMO has higher copayments for physician services, hospital inpatient services and prescriptions than the Health Net High HMO plan, with a lower premium rate.

For both of these HMOs, members select a Primary Care Provider (PCP), and associated Independent Practice Association (IPA) or medical group, from the plan's list of primary care doctors. That physician provides basic medical care and coordinates referrals to other providers, when needed. The network includes specialists, hospitals, and allied health professionals. You can select different physicians for yourself and each family member.

If your physician's medical group or IPA participates in *Rapid Access*, your physician can refer you to selected specialty practices without preauthorization from the group or IPA. To verify participation, consult your Health Net HMO directory, access the Health Net Website listed on the back of this handbook, or call Health Net Customer Service at the number on the back of this handbook.

There are provider networks in most areas of California. Except for out-of-area emergency care, members never see a claim form.

Dependent Out-of-Area Option

If you live in the HMO's service area, and you have a dependent attending school or permanently living away from home but within the HMO service area, your dependent will have the same benefits you have, but will have a separate I.D. card with their local medical group's telephone number.

If your dependent is outside the HMO service area, you have choices for that dependent's coverage:

1. If you select a PCP in your local area for the dependent, only emergencies are covered out of the area. The dependent must return to your area for coverage of routine physical exams and medical services.

2. If your dependent is outside the Health Net HMO service areas, you can enroll your dependent in the Out-of-Area Plan. After a $250 annual deductible, for most covered services the plan pays 90% if a Preferred Provider is used and 70% for a non-participating provider.

You cannot switch the dependent back and forth between the local and the Out-of-Area plans (except at Open Enrollment) unless there is a permanent change in circumstances.

The split family coverage is approved as long as the dependent falls into one of the following categories:

1. Court Order for coverage of dependent children.

2. Dependent children who reside out of State due to separation or divorce.

3. Dependent attends school and resides out of State.

For more information on the Health Net Out-of-Area Plans, call the Benefits Service Representative at (805) 654-2570.

Health Net PPO

This is a Preferred Provider Organization (PPO) plan, which offers greater flexibility in obtaining care than the Health Net HMO Plans or the Ventura County Health Care Plan. You have the option of obtaining

care from any Health Net PPO provider or any non-PPO provider. Each time care is needed, you decide where to receive treatment and who will provide it.

Self-Referral to PPO Provider:

You may seek care from any one of 50,000 PPO providers. For basic physician services, you pay a $20 copayment, with no deductible. For most other services, you pay 10% of the negotiated rate, plus the annual deductible amount. Your PPO provider will file claims on your behalf.

Self-Referral to Any Non-Network Provider:

For most covered services, the plan pays 70% of customary and reasonable charges, and you pay the remainder, plus the annual deductible amount. You may be responsible for filing your own claims.

Most hospitals contract with Health Net. If you use a non-participating hospital, there is a separate deductible of $500 per inpatient hospitalization, subject to additional $250 deductible if not preauthorized. This is in addition to the annual plan deductible. In order to be covered, hospital admissions and surgeries require prior authorization.

Family Out-of-State Option:

The Health Net PPO Plan is available in California as well as out-of-state.

Ventura County Health Care Plan

The Ventura County Health Care Plan (VCHCP) is a licensed health maintenance organization 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 primary care physicians for themselves and each of their dependents. If specialty services are required, your PCP may need to submit a request for authorization to VCHCP for the required service.

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

Required copayments for various services are listed on the comparison chart in this chapter.

Additional Plan benefits include, but are not limited to:

- Members may self-refer to any Urgent Care Center in the County, State or United States, for an *Urgent Care need.*
- Female members may self-refer for OB/GYN services by selecting a listed Direct Access OB/GYN in the Provider Directory, which is identified with a ♦ symbol.
- Members may self-refer for an annual vision refraction exam, and for chiropractic and acupuncture services. (Reimbursement varies; see Comparison Chart in this chapter).
- Except for reimbursement claims for chiropractic and acupuncture care, refraction exam, and out-of-area emergency care, members do not have to submit claim forms.

Dependent Living Outside Ventura County

VCHCP's geographic service area is the County of Ventura. You must live or work in the service area at the time of enrollment to be eligible for coverage under VCHCP. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a region outside the County of Ventura, except as described below.

Exception:

- A subscriber who works in the County of Ventura
- An unmarried dependent attending school full-time in an accredited school outside of Ventura County and under the age of *25.*

(Please see Chapter 1 for eligible dependent requirements.)

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

For more information on VCHCP, please call VCHCP Member Services at (805) 677-8787.

Medical Plan Opt-Out

If you are covered under another comprehensive group medical plan, you decide whether or not to enroll for medical coverage under a County-sponsored plan. Examples of medical plan coverage, which qualify you for Opt-Out includes CHAMPUS, 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.

IMPORTANT!

If you are a two-County-employee family, one employee can elect to Opt-Out and be covered under the other's County-sponsored medical plan.

If you are not in a medical plan at the time you leave County employment (terminate or retire), you are not eligible for continuation of medical coverage through COBRA or the Retiree Health Benefits Program.

To opt-out, write "Opt-Out" on the medical plan line of your *Plan Selection and Authorization Form.* Attach proof that you have other group medical coverage (for example, a copy of the front and back of your medical plan identification card or a letter from the insurer with information on your coverage).

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

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

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

No Medical Coverage

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

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

If you are married and your spouse works, it's 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.

Here's 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.
- The standard coordination of benefits rules does 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. Note: In some circumstances, VCHCP and Health Net 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 that secondary plan, your secondary plan probably won't cover those services, unless they were out-of the-area emergency services.

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

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

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

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

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

Benefit Comparison Examples*

USING THE PCP IN-NETWORK

Four-year-old Cindy has an earache. Her mother takes her to Cindy's Primary Care Provider (PCP), a network pediatrician.

Q1. How much will Cindy's parents pay for her health care?

A1. VCHCP: They pay nothing at a VCMC associated clinic, otherwise, they pay a $10 office visit copay at a network provider, then the Plan pays 100%.

A2. Health Net HMOs***:*** They pay a $10 or a $30 office visit copay, and then the Plan pays 100%.

A3. Health Net PPO: There is no designated PCP. They pay either $20 copay for *PPO providers* or 30% of C&R after deductible for *non-PPO providers.*

USING SELF-REFERRAL

Bob suffers from back problems. A friend told him about a new doctor in the area who specializes in treating back pain. Bob immediately went to see the new doctor. He did not call his Primary Care Provider for a referral.

Q2. How much will Bob's out-of-network care cost him?

A1. VCHCP: Bob pays 100%

A2. Health Net HMOs**:** Bob pays 100%

A3. Health Net PPO**:** There is no designated PCP. Bob pays either a $20 copay for *PPO providers* or 30% of C&R after deductible for *non-PPO providers*.

* Copayments/out-of-pocket expenses may vary for some services

USING PCP AND SELF-REFERRAL

Marsha goes to her Primary Care Provider (PCP) for most of her health care. Occasionally, however, she would like to see a doctor without going through her PCP for a referral, or she would like to see a doctor who is not available through her plan.

Q3. How does Marsha's choice of a doctor affect her health care costs?

A1. For Care Through Her PCP:

VCHCP: Marsha pays nothing at a VCMC associated clinic; otherwise, she pays a $10 office visit copay for network providers, then the Plan pays 100%.

Health Net HMOs: Marsha pays a $10 or a $30 office visit copay, and then the Plan pays 100%.

Health Net PPO: There is no designated PCP. Marsha pays either a $20 copay for *PPO providers* or 30% of C&R after deductible for *non-PPO providers*.

A2. For Self-Referred Care:

VCHCP: Marsha pays 100%.

Health Net HMOs: Marsha pays 100%.

Health Net PPO:

For self-referral to a *PPO Provider*, Marsha pays a $20 office visit copay, and then the plan pays 100%.

For self-referral to a *non-PPO Provider*, Marsha pays 30% of covered charges, once she has met her $250 annual deductible, plus she pays 100% of any charges above those the Plan considers customary and reasonable charges.

Comparison of Medical Plan Benefits

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

	Ventura County Health Care Plan **HMO**	***Health Net High Option*** **HMO**	***Health Net Low Option*** **HMO**	***Health Net PPO***	***Health Net PPO***
				Participating Provider	***Non-Participating Provider***
Plan Year Deductible Per Member/Per Family	None	None	None	Applies to all expenses except those with copays: $250/$500 [5]	
Maximum Annual/Plan Year					
Out-of-Pocket Expense	Applies to copayments made to contracted providers, excludes RX, some mental health/substance abuse services, non-covered services	Excludes supplemental benefits such as vision, hearing aids, chiropractor, some mental health/ substance abuse services [9], prescription copayments, non-covered services	Excludes supplemental benefits such as vision, hearing aids, chiropractor, some mental health/ substance abuse services [9], prescription copayments, non-covered services	Excludes deductibles, copayments, infertility services, some mental health/substance abuse services [9], non-covered services, hearing aids and prescriptions	Excludes deductibles, copayments, infertility services, some mental health/substance abuse services [9], non-covered services, hearing aids and prescriptions
Per Member/Per Family	$3,000/$6,000	$1,000-$3,000	$2,000-$6,000	$2,000-$4,000	$6,000-$12,000
Preexisting Condition Limit	None	None	None	None	None
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	$5,000,000 per individual [5]	$5,000,000 per individual [5]
BENEFITS COVERAGE	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
PHYSICIAN SERVICES					
Office/home visits (consultations and in-office procedures, except mental health services)	100% Coverage at VCMC facility; $10 copay per visit at other contracted offices	100% Coverage after $10 copay per visit	100% Coverage after $30 copay per visit	100% Coverage after $20 copay per visit [1]	70% of C & R [3]
Maternity Care	100% coverage at VCMC Provider; $10 copay for initial visit at other contracted Providers	100% Coverage	100% Coverage	$20 copay for initial visit, then 90% of Negotiated Allowance [2]	70% of C & R [3]
Specialist	$15 copay; waived if services from VCMC Specialist	Same as office visit, referral needed	Same as office visit, referral needed	100% coverage after $20 copay per visit [1]	70% of C & R [3]
Hospital Visits	100% Coverage	100% Coverage	100% Coverage	90% of Negotiated Allowance [2]	70% of C & R [3]

	Ventura County Health Care Plan **HMO**	***Health Net High Option*** **HMO**	***Health Net Low Option*** **HMO**	***Health Net PPO***	***Health Net PPO***
BENEFITS COVERAGE	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
Allergy Testing & Treatment (includes antigen)	Same as Office Visit	100% Coverage after $10 copay per visit (Allergy Serum Covered)	100% Coverage after $30 copay per visit (Allergy Serum Covered)	100% Coverage after $20 copay per visit [1]	70% of C & R [3]
Adult Immunizations (excluding travel & occupational)	Same as Office Visit	100% Coverage after $10 copay per visit	100% Coverage after $30 copay per visit	100% Coverage after $20 copay per visit [1]	70% of C & R [3]
Infertility Testing/Treatment Of Underlying Cause [4]	50% of Covered Expense [1]	50% of Covered Expense [1]	50% of Covered Expense [1]	90% Coverage after $500 lifetime deductible; combined lifetime maximum of $2,000 [1]	70% Coverage after $500 lifetime deductible; combined lifetime maximum of $2,000 [1]
Periodic Health Evaluation	$10 copay – waived at VCMC	100% Coverage after $10 copay per visit	100% Coverage after $30 copay per visit	100% Coverage after $20 copay per visit [1]; $400 combined benefit per covered person per calendar year	70% of C & R [3] up to $400 combined benefit per covered person per calendar year
Hearing Screening	$10 copay per visit	100% Coverage after $10 copay per visit	100% Coverage after $30 copay per visit	100% Coverage after $20 copay	70% of C & R [3]
Hearing Aids	Not Covered	100% Coverage up to $750 every thirty-six (36) months	Not Covered	90% Coverage up to $2,000 maximum [5] every thirty-six (36) months. Requires physician written recommendation	70% of C & R [3] up to $2,000 maximum [5] every thirty-six (36) months. Requires physician written recommendation
OB/GYN Services, including Well Woman Annual Exam *(exam, pap smear and associated tests)*	100% Coverage at VCMC facility; $10 copay per visit at other contracted offices; may self-refer to any OB/GYN who participates in the Plan's Self-Referral Program for most OB/GYN services	100% Coverage after $10 copay per visit; may self-refer to any OB/GYN in PCP's IPA for any OB/GYN services	100% Coverage after $30 copay per visit, may self-refer to any OB/GYN in PCP's IPA for any OB/GYN services	100% Coverage after $20 copay per visit [1]	70% of C & R [3]
Well child, including immunizations *(birth through age 18)*	100% Coverage at VCMC facility; $10 copay per visit at other contracted offices	100% Coverage for children under age two; 100% Coverage after $10 copay for children age 2 through age 18	100% Coverage for children under age two; 100% Coverage after $30 copay for children age 2 through age 18	100% Coverage after $20 copay per visit [1]	70% of C & R [3]
HOSPITAL/FACILITY					
Inpatient [6] **Services and Supplies**	100% Coverage at VCMC. $100 per day to $500 maximum copay at other contracted facilities when preauthorized Weight-Loss (Bariatric) surgery: $3,000 copay per surgery	100% Coverage after $250 copay	100% Coverage after $500 copay	90% of Negotiated Allowance [2] if preauthorized. $250 [1] additional deductible if not preauthorized	70% of C & R [3]. $500 [1] deductible per inpatient confinement if preauthorized; additional $250 [1] deductible if not preauthorized

	Ventura County Health Care Plan **HMO**	***Health Net High Option*** **HMO**	***Health Net Low Option*** **HMO**	***Health Net PPO***	***Health Net PPO***
BENEFITS COVERAGE	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
Outpatient [6] Services	100% Coverage at VCMC; Some services may have a copay of 20%, up to a maximum of $500 at other contracted facilities when preauthorized	100% Coverage	100% Coverage	90% of Negotiated Allowance [2]	70% of C & R [3]
Outpatient Surgery [6]	100% Coverage at VCMC; Coverage after copay of 20%, up to a maximum of $500 at other contracted facilities when preauthorized	100% Coverage	100% Coverage after $250 copay	90% of Negotiated Allowance [2] if preauthorized, $250 deductible if not preauthorized	70% of C & R [3] after $250 deductible per occurrence, additional $250 deductible if not preauthorized. Up to $750 maximum benefit per day
Emergency Room (covers emergency services only)	100% Coverage after $50 copay at VCMC or other facility; copay waived if directly admitted	100% Coverage after $50 copay; copay waived if directly admitted	100% Coverage after $100 copay; copay waived if directly admitted	100% of Negotiated Allowance after $75 copay[1]; deductible and copay waived if directly admitted [2]	100% of C & R after $75 copay; deductible and copay waived if directly admitted [3]
URGENT CARE FACILITY	100% Coverage after $20 copay at any Urgent Care facility. No PCP or Plan referral required	100% Coverage after $10 copay when referred by PCP to facility within PCP's IPA, otherwise $50 copay; copay waived if directly admitted	100% Coverage after $30 copay when referred by PCP to facility within PCP's IPA, otherwise $100 copay; copay waived if directly admitted	100% Coverage after $50 copay per visit [1]	70% of C & R [3]
AMBULANCE *(medically necessary)*	100% Coverage after $50 copay by ground; $200 copay by air	100% Coverage	100% Coverage after $50 copay	80% of C & R [3]	80% of C & R [3]
SKILLED NURSING FACILITY	100% Coverage after $50 per day copay, to $500 maximum. Up to 100 consecutive days from the first treatment per disability	100% Coverage after $250 copay per admission. Up to 100 consecutive days from the first treatment per disability	100% Coverage after $200 copay per admission. Up to 100 consecutive days from the first treatment per disability	90% of Negotiated Allowance [2] Combined 100-day maximum per year [5]	70% of C & R [3] Combined 100-day maximum per year [5]
HOSPICE	**Inpatient:** 100% Coverage **Outpatient:** Covered under Home Health Service. Prognosis of life expectancy of one year or less	**Inpatient:** 100% Coverage after $250 copay per admission **Outpatient:** 100% Coverage. Prognosis of life expectancy of one year or less	**Inpatient:** 100% Coverage after $500 copay per admission **Outpatient:** 100% Coverage. Prognosis of life expectancy of one year or less	90% of C & R [3] ,up to $10,000 lifetime combined maximum [5]	70% of C & R [3] ,up to $10,000 lifetime combined maximum [5]
HOME HEALTH SERVICE	100% Coverage after $15 copay per visit; 100 visits per calendar year	100% Coverage; 100 visits per calendar year	$10 copay per visit, 100 visits per calendar year	90% of Negotiated Allowance [2] , up to 100 visits per calendar year [5] ,not covered while receiving hospice care	70% of C & R [3] , up to 100 visits per calendar year [5] ,not covered while receiving hospice care

	Ventura County Health Care Plan **HMO**	***Health Net High Option*** **HMO**	***Health Net Low Option*** **HMO**	***Health Net PPO***	***Health Net PPO***
BENEFITS COVERAGE	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
PHYSICAL/OCCUPATIONAL THERAPY	100% Coverage after $10 copay at VCMC or $15 copay per visit at other contracted facilities; up to a combined maximum of 30 visits per plan year	100% Coverage after $10 copay per visit	100% Coverage after $30 copay per visit	90% of Negotiated Allowance [2] Limited to 12 visits. Additional visits may be approved if deemed medically necessary	70% of C & R [3] Limited to 12 visits. Additional visits may be approved if deemed medically necessary
SPEECH THERAPY	Included in Physical/ Occupational Therapy	Included in Physical/ Occupational Therapy	Included in Physical/ Occupational Therapy	Included in Physical/Occupational Therapy	
CHIROPRACTIC	Plan reimburses $15 per visit to any chiropractor, limited to 15 combined chiropractor/ acupuncturist visits per Plan Year [7]	100% Coverage after $10 copay per visit; up to 20 visits per year	Not Covered	$20 copay per visit [2], up to combined maximum of 12 visits per calendar year [5]	70% of C & R [3], up to combined maximum of 12 visits per calendar year [5]
ACUPUNCTURE	Plan reimburses $15 per visit to any acupuncturist, limited to 15 combined acupuncturist/ chiropractor visits per Plan Year [7]	Not Covered	Not Covered	Not Covered	Not Covered
PROSTHETICS	100% Coverage after $50 copayment; 50% coverage for replacements	100% Coverage	100% Coverage after $50 copay per item	90% of Negotiated Allowance [2], up to $2,000 combined maximum per calendar year [5]	70% of C & R [3], up to $2,000 combined maximum per calendar year [5]
DURABLE MEDICAL EQUIPMENT	100% Coverage; $2,500 annual maximum, new or replacement	100% Coverage	100% Coverage after $50 copay per item	90% of Negotiated Allowance [2], up to $2,000 combined maximum per calendar year [5]	70% of C & R [3], up to $2,000 combined maximum per calendar year [5]
ORTHOTICS	No copay; Coverage limited to custom made orthotics. Foot orthotics are excluded except for members with diabetes. 50% coverage for replacements	Included in Durable Medical Equipment for corrective footwear [8] for member with diabetic foot disease	Included in Durable Medical Equipment for corrective footwear [8] for member with diabetic foot disease	Included in Durable Medical Equipment for corrective footwear [8] for member with diabetic foot disease	Included in Durable Medical Equipment for corrective footwear [8] for member with diabetic foot disease
X-RAY	100% coverage for routine diagnostic; no copay at VCMC for MRI, CT, PET Imaging; 20% contracted rate up to $500 maximum copay at contracted facilities for MRI, PET, CT Imaging.	100% Coverage	100% Coverage	90% of Negotiated Allowance [2]	70% of C & R [3]

	Ventura County Health Care Plan **HMO**	***Health Net High Option*** **HMO**	***Health Net Low Option*** **HMO**	***Health Net PPO***	***Health Net PPO***
BENEFITS COVERAGE	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
LAB *(Outpatient)*	100% Coverage at VCMC and contracted facilities	100% Coverage	100% Coverage	90% of Negotiated Allowance [2]	70% of C & R [3]
ANNUAL EYE REFRACTION EXAM *Limited to 1 per 12 months. See Chapter 4-Vision Options (Eye exams for medical problems are covered under medical benefits)*	Plan reimburses cost of refraction exam up to $50; no PCP referral needed; claims must be submitted within 90 days from the date of service [7]	100% Coverage after $10 copay [1] for exam with refraction; **PCP referral needed**	100% Coverage after $30 copay [1] for exam with refraction; **PCP referral needed**	Not Covered	Not Covered
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES Up to 5 free County Employee Assistance Program (EAP) visits *per Plan Year*	Member must call for prior authorization; refer to Member ID card. PCP referral not required	Must call for prior authorization; refer to Member ID card. PCP referral not required.	Must call for prior authorization; refer to Member ID card. PCP referral not required.	Self-referral to any Health Net Participating PPO Provider.	Self-referral to any licensed Provider.
Inpatient [1, 6, 9]	**Through VCHCP's "Life Strategies" program only.** 80% coverage/100% at VCMC; 14-day maximum per year. Maximum benefit for Chemical Dependency limited to $25,000 per plan year; $35,000 per lifetime	**Through Managed Health Network (MHN) Provider Only:** 100% Coverage after $250 copay per admission; up to 30 days per year	**Through Managed Health Network (MHN) Provider Only:** 100% Coverage after $500 copay per admission; up to 30 days per year	90% of Negotiated Allowance [2]. Up to 15 days per year combined in-network/out-network maximum [5]	70% of C & R [3]. Up to 15 days per year combined in-network out-network maximum [5]
Residential/Alternative Treatment [1, 6, 9]	**Through VCHCP's "Life Strategies" program only.** 80% coverage/100% at VCMC; 14-day maximum per year. Maximum benefit for Chemical Dependency limited to $25,000 per plan year; $35,000 per lifetime	**Through Managed Health Network (MHN) Provider Only:** 100% Coverage after $250 copay per admission	**Through Managed Health Network (MHN) Provider Only:** 100% Coverage after $500 copay per admission	90% of Negotiated Allowance [2]. Up to 15 days per year combined in-network/out-network maximum [5]	70% of C & R [3]. Up to 15 days per year combined in-network/out-network maximum [5]
Outpatient [1, 9]	**Through VCHCP's "Life Strategies" program only.** $15 copay per visit; 20 visit limit per plan year. For chemical dependency see inpatient limit.	**Through Managed Health Network (MNH) Provider Only:** 100% Coverage after $10 copay per visit; no visit maximum.	**Through Managed Health Network (MHN) Provider Only:** 100% Coverage after $30 copay per visit; no visit maximum.	90% of Negotiated Allowance [2]. Combined maximum of 20 visits [5]	70% of C & R [3]. Combined maximum of 20 visits [5]

	Ventura County Health Care Plan **HMO**	***Health Net High Option*** **HMO**	***Health Net Low Option*** **HMO**	***Health Net PPO***	***Health Net PPO***
BENEFITS COVERAGE	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
OUT-PATIENT PRESCRIPTIONS	Can be written by any licensed physician. Generic substitution and formulary rules apply	Must be written by network provider. Formulary rules apply	Must be written by network provider. Formulary rules apply	Can be written by any physician. Generic substitution and formulary rules apply **For Contracting Pharmacies Plan Pays**	Can be written by any physician. Generic substitution and formulary rules apply **For Non-Contracting Pharmacies Plan Pays**
Plan's Local Pharmacy Network (Retail Pharmacy)	100% for 30-day supply, after copay of: $10–Generic $25–Brand-Name $45–Approved Non-Formulary Separate copay for injectable drugs – see EOC for details 50% for covered infertility drugs	100% for 30-day supply, after copay[1] of: $10–Generic $20–Brand-Name Formulary $35–Approved Non-Formulary 50% for infertility drugs	100% for 30-day supply, after copay[1] of: $20–Generic $30–Brand-Name Formulary $50–Approved Non-Formulary 50% for infertility drugs	100% for 30-day supply, after copay[1] of: $10–Generic $20–Brand-Name Formulary $35–Approved Non-Formulary 50% for infertility drugs	80% for 30-day supply, after copay[1] of: $10–Generic $20–Brand-Name Formulary $35–Approved Non-Formulary 50% for infertility drugs
Plan's Mail-Service	100% for 90-day supply after copay of: $15–Generic $40–Brand $75–Approved Non-Formulary 50% for covered infertility drugs	100% for 90-day supply after copay[1] of: $15–Generic $20–Brand-Name Formulary $40–Approved Non-Formulary	100% for 90-day supply after copay[1] of: $40–Generic $60–Brand-Name Formulary $100–Approved Non-Formulary	100% for 90 day supply after copay[1] of: $20–Generic $40–Brand-Name Formulary $70–Approved Non-Formulary	Not Covered

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 unmarried natural child, stepchild, adopted children, children of domestic partners, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted, provided they depend upon you for support and maintenance. Unless stated otherwise for that plan, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews and non-relatives. Certain unmarried children age 19 and over if handicapped prior to age 19, continuously covered by this or a similar County plan since prior to age 19, incapable of self-sustaining employment and chiefly dependent upon you for support.

Your unmarried children age 19 through age 24 if they meet the plan's requirements as full-time students. If become disabled after age 18 while attending school, covered until end of semester in which disability ends, or age 25, whichever occurs first.

VCHCP *f*ollows the basic definition of **ELIGIBLE DEPENDENTS** with these variations:

- Dependent child must have never been married.
- Includes any never married child from birth through age 18, who is under the legal custody of you, your spouse, or your domestic partner.

HEALTH NET*,* in addition to the basic definition of **ELIGIBLE DEPENDENTS**, covers these dependents:

- Any unmarried child from birth through age 18, living with you on a full-time basis in regular child/parent relationship and who could be claimed as your dependent under IRS regulations, and for whom you can furnish satisfactory evidence of eligibility.

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 continuation of coverage (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 Deductibles and copayments for this benefit do not count in calculating the Maximum Out-of-Pocket expense.

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

3 These Out-of-Network Benefits are payable only after satisfaction of the annual deductible. Provider payments are based on customary and reasonable (C&R) fees for medically necessary services, as determined by Health Net. Member pays the applicable co-insurance and is also responsible for amounts charged by the provider in excess of C&R.

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

5 PPO Plan members have a combined network/non-network maximum for this benefit. Example: Skilled Nursing Facility benefit includes a 90-day per year maximum. If you use 20 days with a non-contracting provider under the non-network option of the plan, you are covered for up to 70 additional days at a contracted facility.

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

7 VCHCP: Chiropractic, Acupuncture, and Eye Refraction claims must be submitted within 90 days from the date of service.

8 Health Net HMO Plans and PPO Plan: Orthotics - Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.

9 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.

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 Options

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

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

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

With this in mind, you may want to consider one of the dental plans offered through the County. These plans vary in the coverage and providers available to you. Be sure to compare benefits, copayments, and out-of-pocket expenses as well as premiums. By studying the plan descriptions that follow and comparing the premiums in the *Information Worksheet* available through your department's Personnel Representative, you can determine which plan is best for you and your family.

If you decide not to participate in a dental plan, you may wish to consider a Health Care Flexible Spending Account to fund any expected dental expenses.

What Plans are Available?

If you decide to enroll in a dental plan, the County offers you three plans:

- Golden West Dental
- Blue Cross-BC Life & Health Dental-**Low Option**
- Blue Cross-BC Life & Health Dental-**High Option**

Included in the dental comparison chart are individual plan variations in dependent eligibility rules.

Rules for employee eligibility, enrollment procedures, the effective date of coverage and changing plans are the same for all dental plans, and can be found in the *Flexible Benefits Program Information* chapter of this handbook.

Golden West Dental Plan

Golden West offers a cost-effective dental plan for you and your dependents. The plan offers comprehensive benefits, and members pay only a copayment for most covered services.

Except for out-of-area emergency care, you never see a claim form.

Your Golden West dental provider will coordinate all treatment and services for you and your eligible dependents.

Providers

You must select a dental group or office from the plan's panel of providers when you complete your enrollment forms. You are encouraged to check with the provider of your choice before you enroll to ensure he or she is currently accepting new patients.

A list of plan providers is available from your department's Personnel Representative or the self-serve racks at County Human Resources.

- Dependents may choose a different panel provider than that of the employee.

- The plan allows up to three providers per family.

- You can change providers. Changes telephoned to the plan by the middle of the month go into effect the first day of the following month.

- If your provider leaves the plan, you must select a new provider from the current provider list in effect for the plan.

Covered Fees

Golden West is a prepaid dental plan. For most services, your provider receives a flat fee per subscriber per month, and you and your eligible dependents must go to your plan provider for all necessary dental treatment. When you use your Golden West plan provider, all basic preventive dental coverage is provided at no charge to you, while more complicated dental procedures may require a copayment or fee from you.

Out-of-Area Coverage

If you or a dependent you wish to cover lives outside the plan's service area, Golden West is probably not a good choice for you. The plan does not cover services rendered by a licensed dentist who is not your plan provider unless:

- Treatment was provided by an authorized specialist, or
- Treatment was recommended in writing by Golden West Dental Plan, or
- Treatment was for the relief of pain caused by a dental emergency, and treatment took place more than 30 miles from your plan provider's office.

For treatment of the relief of pain, Golden West will reimburse you up to fifty dollars ($50) per year.

Any charges you incur for dental services beyond what is necessary for the relief of pain will be your responsibility. Any further treatment beyond what is necessary for the relief of pain is not covered unless provided by your assigned plan provider.

Optional Treatment

If you or your dependent select a special optional treatment plan instead of the dental treatment plan that is customarily provided by the plan, you will pay the dentist's usual and customary fee.

Coordination of Benefits

If you or your covered dependent(s) are entitled to benefits under more than one plan, the combined benefits will not exceed the actual amount charged. If you and your covered dependents are covered by two or more prepaid plans and are utilizing the same participating provider under both, the lesser of the two copayments will be charged.

Limitations and Exclusions

Golden West Plan Limitations and Exclusions are listed following the comparison chart.

BC Life & Health Dental Plans (Blue Cross)

The County offers you a choice of two BC Life & Health Dental Plans (Blue Cross). These plans offer greater provider flexibility than the Golden West Dental Plan.

Each time care is needed, you decide where to receive treatment and who will provide it. You can go to any dentist you wish, change dentists at any time without pre-approval, and you do not need pre-approval to see a specialist.

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

Eligibility and benefit information are available on-line: **http://www.bluecrossca.com**

When you receive services from your dental provider, present the provider with your Blue Cross dental insurance card. For your information, the group numbers for the dental plans are listed on your ID card as well as on the back cover of this handbook.

The freedom of provider selection has its price. Plan premiums and some out-of-pocket expenses are higher than with Golden West.

Providers

Any Dentist – With either Blue Cross dental plan, you need not sign up for a specific dentist. The services listed in the dental plan comparison chart are covered by Blue Cross when they are provided by a licensed dentist, if the services meet generally accepted dental practice standards for necessary and customary services.

Blue Cross Dentist – When you use one of the 14,000 Blue Cross dentists in California, the dentist's fees have been pre-approved. The Blue Cross dentist bills BC Life & Health directly, so you have no claim forms to complete, and are responsible only for your portion of the bill. For a BC Life & Health dentist provider directory, call BC Life & Health at (800) 627-0004, or find a dentist online at: http://www.bluecrossca.com

Covered Fees

After an annual deductible, the Blue Cross plans pay a percentage of the negotiated fee, up to the plan maximum benefit per person per year. If you select a non-contracting dentist, payment is made based on the fee actually charged, or the customary and reasonable fee, which satisfies the majority of participating dentists, whichever is less. If the dentist charges a higher amount than the customary and reasonable amount, BC Life & Health's 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 BC Life & Health will reimburse you directly.

Where the two Blue Cross dental plans differ in levels of coverage is in the calendar year deductible amounts. Both plans offer the same 50% benefit for covered services related to crowns, bridges and dentures, orthodontia and TMJ services.

Blue Cross's Low Option

The Low Option Plan offers you two different levels of coverage for diagnostic, preventive and basic services, depending on whether or not you use a provider from BC Life & Health's PPO Dental Network. Each time you need services, you decide whether or not to use a DPO Dental Network provider. The chart that follows compares the two levels of Low Option coverage.

Blue Cross's High Option

The High Option Plan is an incentive program. Your basic services coverage increases each year, as long as you see your dentist at least once each year. You begin at 70% coverage, and increase by 10% a year if you go to the dentist, to 100% coverage in your fourth year in the plan. If you do not use the program in a calendar year, the percentage remains at the level you reached in the previous year. The percentage will drop back to 70% if you lose eligibility and then become eligible again.

When you use a dentist in the Dental PPO provider network, you pay a lower annual deductible, and the fees you are charged will often be less.

Predetermination of Costs

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

Coordination of Benefits (Dual Coverage)

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

Limitations and Exclusions

BC Life & Health Dental Plan Limitations and Exclusions are listed at the end of this chapter.

COMPARISON OF DENTAL 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.

COUNTY OF VENTURA DENTAL PLAN OPTIONS	GOLDEN WEST PLAN 89L3 HMO Type Plan Group Number GW877	BLUE CROSS LIFE & HEALTH DENTAL PLAN High Option Group Number 1751550001		BLUE CROSS LIFE & HEALTH DENTAL PLAN Low Option Group Number 1751550100	
CALENDAR YEAR DEDUCTIBLE Per Member/Per Family	No Deductible	**In DPO Network**	**Out of DPO Network**	**In DPO Network**	**Out of DPO Network**
		$15/$45	$25/$75	$25/$75	
MAXIMUM BENEFIT Each Calendar year (excluding MPD-TMJ and Orthodontics)	No Maximum	$1,000 per person		$750 per person	
SEPARATE LIFETIME MAXIMUM: Orthodontic Benefits MPD-TMJ Benefits	No Maximum Not Covered	$1,000 per person $1,000 per person		$1,000 per person $1,000 per person	
ELIGIBLE DEPENDENTS: (Basic eligibility requirements for all plans are listed in Chapter 1 under *"Dependent Enrollment")*	No variations from basic eligibility requirements	Variations from basic dependent eligibility requirements: • Child must be dependent on subscriber for support and maintenance • Can enroll foster child			
BENEFITS COVERAGE	Member pays	**In or Out of DPO Network Member pays**		**In DPO Network Member pays**	**Out of DPO Network Member pays**
Broken Appointment Charge (Less than 24-hour notice)	You pay $20 copay	Determined by provider		Determined by provider	Determined by provider
DIAGNOSTIC/PREVENTIVE		No charge for all diagnostic and/or preventive services Plan pays 100% Deductible does not apply		You pay 20% for all diagnostic and/or preventive services Plan pays 80% Deductible does not apply	You pay 50% for all diagnostic and/or preventive services Plan pays 50% Deductible does not apply
Oral exam, x-rays	No Charge[1]				
Biopsy/Tissue Exam, Study Models	Not Covered				
Prophylaxis (cleaning)	No Charge [1] (2 per year)				
Topical fluoride treatment To Age 18	No Charge				
Topical fluoride treatment Adult	You pay $5 copay				
Emergency Palliative Treatment Normal Office Hours After Hours	No Charge You Pay $25 copay				

[1] Some Dentists charge an equipment sterilization fee which is covered by the plan

	GOLDEN WEST PLAN 89L3	Blue Cross Life & Health Dental Plan		
	HMO Type Plan Group Number GW877	High Option Group Number 1751550001	Low Option Group Number 1751550100	
Benefits Coverage	Member Pays	**In or Out of DPO Network Member pays**	**In DPO Network Member pays**	**Out of DPO Network Member pays**
Space maintainers Fixed Removable	 You pay $30 copay You pay $40 copay	No charge for all diagnostic and/or preventive services Plan pays 100%; Deductible does not apply	You pay 20% for all diagnostic and/or preventive Services Plan pays 80% Deductible does not apply	You pay 50% for all diagnostic and/or preventive Services Plan pays 50% Deductible does not apply
BASIC BENEFITS		When you go to your dentist each year, coverage for all basic benefits increases by 10% each year, until you reach 100% Coverage. 1st Year: You pay 30%; Plan pays 70% 2nd Year: You pay 20%; Plan pays 80% 3rd Year: You pay 10%; Plan pays 90% 4th Year: You pay nothing Plan pays 100% (after you have met your deductible)	You pay 30%; Plan pays 70% For all Basic Benefits listed (after you have met your deductible)	You pay 50%; Plan pays 50% For all Basic Benefits listed (after you have met your deductible)
Oral Surgery: Simple Extraction; Local Anesthesia; Frenulectomy; Pre/Post-Operative visits	No Charge			
Impactions: Soft Partial Bony Complete Bony Alveolectomy (per quadrant) Alveoplasty with extractions Per quadrant 1-3 teeth Alveoplasty without extractions Per quadrant 1-3 teeth	 You pay $20 copay You pay $30 copay You pay $50 copay You pay $50 copay You pay $50 copay You pay $25 copay You pay $50 copay You pay $25 copay			
Restorative: (treatment of carious lesions resulting from dental decay)				
Amalgam	No Charge			
Resin/Composite [2]	You pay $8 per surface			
Endodontic – Tooth Pulp:				
Pulp capping; Pulpotomy	No Charge			
Recalcification/Apexification	Not Covered			
Root canal (per canal)	You pay $50 copay			
Apicoectomy Anterior &Bicuspid, first root Molar, first root Each additional root	 You pay $50 copay You pay $50 copay You pay $20 copay			
Retrograde filling, per root	You pay $60 copay			

[2] Benefit applies for anterior (front) teeth only

	GOLDEN WEST PLAN 89L3	Blue Cross Life & Health Dental Plan		
	HMO Type Plan Group Number GW877	**High Option** Group Number 1751550001	**Low Option** Group Number 1751550100	
Benefits Coverage	Member Pays	**In or Out of DPO Network** Member pays	**In DPO Network** Member pays	**Out of DPO Network** Member pays
BASIC BENEFITS *(continued)*		When you go to your dentist each year, coverage for all basic benefits increases by 10% each year, until you reach 100% coverage 1st Year: You pay 30% Plan pays 70% 2nd Year: You pay 20% Plan pays 80% 3rd Year: You pay 10% Plan pays 90% 4th Year: You pay nothing Plan pays 100%	You pay 30% Plan pays 70% For all basic benefits listed	You pay 50% Plan pays 50% For all basic Benefits listed
Sealants–Topically applied materials to permanent posterior molars to prevent decay	You pay $7 per tooth			
Periodontic–Treat gums & bones supporting teeth				
Emergency Treatment	No Charge			
Subgingival curettage & root planing 1 – 3 teeth Per quadrant	You pay $10 copay You pay $20 copay			
Gingivectomy/Gingivoplasty 1 – 3 teeth Per quadrant	You pay $20 copay You pay $40 copay			
Correction of occlusion	Not Covered			
Osseous Surgery 1 – 3 teeth Per quadrant	You pay $20 copay You pay $40 copay	After you have met your deductibles See Blue Cross Life and Dental Plan Exclusions and Limitations		
ORTHODONTIC BENEFITS – ADULT OR CHILD (Malalignment of teeth or jaws)				
Full banded case	You pay $1,795 copay	You pay 50% for all orthodontic benefits; Plan pays 50% to $1,000 lifetime maximum (separate from calendar year and TMJ maximums)	You pay 50% for all orthodontic benefits; Plan pays 50% to $1,000 lifetime maximum (separate from calendar year and TMJ maximums)	
Partial banded case	You pay $1,025 copay			
Consultation fee (including study models)	No Charge	See Blue Cross Life and Dental Plan Exclusions and Limitations		

	GOLDEN WEST PLAN 89L3 HMO Type Plan Group Number GW877	Blue Cross Life & Health Dental Plan		
		High Option Group Number 1751550001	Low Option Group Number 1751550100	
Benefits Coverage	Member Pays	**In or Out of DPO Network MEMBER PAYS**	**In DPO Network MEMBER PAYS**	**Out of DPO Network MEMBER PAYS**
CROWNS, JACKETS, CAST RESTORATIONS – Treatment of carious lesions (resulting from dental decay) which cannot be filled		You pay 50% for all crowns, jackets and cast restoration benefits Plan pays 50%	You pay 50% for all crowns, jackets and cast restoration benefits Plan pays 50%	
Crowns/bridges, per unit				
Porcelain	You pay $100 copay [3]			
Porcelain with metal	You pay $120 copay [3]			
Full cast metal	You pay $100 copay [3]			
Stainless steel (temporary)	You pay $10 copay [3]			
Cast post and core in addition to Crown/Prefabricated post and core in addition to crown	You pay $20 copay [3]			
Pin retention in addition to restoration, per tooth	You pay $8 copay	After you have met you deductibles		
Recementation: Inlay, Crown, Bridge	No Charge	See Blue Cross Life and Dental Plan Exclusions and Limitations		
PROSTHETIC (DENTURE) BENEFITS				
Complete or partial upper or lower Denture	You pay $150 copay [3]	You pay 50% for all prosthetic (denture) benefits Plan pays 50%	You pay 50% for all prosthetic (denture) benefits Plan pays 50%	
Interim partial denture, upper or lower	You pay $20 copay			
Teeth & clasps (per tooth/unit)	You pay $5 copay			
Simple stress breaker (each)	You pay $10 copay			
Stayplate	You pay $20 copay			
Adjust denture or partial; reline in office	No Charge			
Adjust denture or partial; reline in lab	You pay $30 copay [3]			
Repairs to denture/partial (no teeth)	No Charge[3]	After you have met your deductibles		
Add teeth or clasps to partial (per unit/tooth)	You pay $5 copay			
Replace/add denture clasp	You pay $5 copay	See Blue Cross Life and Dental Plan Exclusions and Limitations		
Extra Denture	Not Covered			

[3] Plus actual dental lab fees

	GOLDEN WEST PLAN 89L3 HMO Type Plan Group Number GW877	Blue Cross Life & Health Dental Plan		
		High Option Group Number 1751550001	Low Option Group Number 1751550100	
Benefits Coverage	Member Pays	**In or Out of DPO Network MEMBER PAYS**	**In DPO Network MEMBER PAYS**	**Out of DPO Network MEMBER PAYS**
MPD-TMJ BENEFITS Certain intra-oral dental symptoms associated with myofacial pain dysfunction (MPD) or malfunction of the temporomandibular (jaw) joint (TMJ)	Not Covered	You pay 50% for all MPD-TMJ benefits Plan pays 50% to $1,000 lifetime maximum (separate from calendar year and orthodontic maximums)	You pay 50% for all MPD-TMJ benefits Plan pays 50% to $1,000 lifetime maximum (separate from calendar year and orthodontic maximums)	
LIMITATIONS AND EXCLUSIONS (further limits and exclusions are listed on the following pages)	Excludes procedures started prior to joining the plan	Excludes most procedures started prior to joining the plan	Excludes most procedures started prior to joining the plan	

DENTAL PLAN LIMITATIONS AND EXCLUSIONS

GOLDEN WEST DENTAL PLAN 89L3 LIMITATIONS

A. GENERAL

Dental treatment must be received from MEMBER'S participating dental office unless specifically authorized in writing by PLAN.

Participating PROVIDERS shall have the right to discontinue further treatment of a MEMBER who continually fails to keep appointments or who fails to follow the prescribed course of treatment.

B. DIAGNOSTIC/PREVENTIVE

1. Routine and periodic examinations are limited to once every six (6) months.

2. Prophylaxis is limited to once every six (6) months.

~~3.~~ Bitewing radiographs (x-rays) in conjunction with periodic examinations are limited to one series of films in any twelve (12) consecutive month period.

4. Full mouth radiographs (x-rays) and Panorex are limited to once every three (3) years.

5. Fluoride treatment is limited to once every twelve (12) months.

6. Sealants are allowed in permanent first and second molars up to the age of sixteen (16).

C. RESTORATIVE/CROWNS

1. Space maintainers are allowed only for dependent children up to the age of sixteen (16).

2. Stainless steel crowns on permanent teeth are allowed up to the age of nineteen (19).

3. Temporary restorations, all adhesives (including amalgam bonding agents) liners and bases, impressions and local anesthesia are considered components of the fee for the completed restoration.

4. Benefits for the treatment of rampant caries are limited to the first seven (7) most severely decayed primary teeth, subject to all plan limitations. Rampant caries is defined as eight (8) or more decayed primary teeth.

5. Cast restorations and crowns are covered only when extensive coronal destruction is radio graphically evident and tooth cannot be restored with an intracoronal restoration, unless tooth is diagnosed as having cracked tooth syndrome.

6. The use of noble and high noble metal for any restorative procedure will be charged to the MEMBER at the additional laboratory cost of the noble or high noble metal. Copayments do not include charges for gold or dental laboratory fees.

D. PROSTHODONTICS

1. Complete and/or partial denture relines are limited to one per denture during any twelve (12) month period.

2. Complete or partial upper and/or lower dentures are limited to the benefit level for a standard procedure. If a more personalized or specialized treatment (such as precision attachments, overlays, implants, personalization or characterization) is chosen by the MEMBER and the dentist, the MEMBER will be responsible for all additional charges.

3. A bridge in any posterior quadrant, when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic, is considered elective. An alternate benefit for a partial denture would be allowed. See Alternate Benefit Provision, Section XVI.

E. PERIODONTAL

Periodontal Scaling and Root Planing are limited to four (4) quadrants per calendar year if periodontal disease is present. No more than two (2) quadrants per service date are allowed.

Osseous surgery is limited to four (4) quadrants per lifetime.

One treatment of Actisite for replacement of fiber material is allowed within ten (10) days of initial placement.

GOLDEN WEST DENTAL PLAN 89L3
EXCLUSIONS

The following treatment or services are not covered.

1. Any procedure not specifically listed as a covered service.

2. Any dental treatment, which, in the opinion of the attending dentist, is not necessary for the patient's dental health, will not produce a beneficial result, or has a poor prognosis.

3. Services for injuries or conditions for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, medical health insurance, Worker's Compensation or Employer's Liability Laws.

4. Services which are provided to the enrollee by any federal or state government agency or are provided without cost to the enrollee by any municipality, county, or other political subdivision, except as provided in Section XIII, Paragraph J of this Agreement.

5. Treatment rendered by a SPECIALIST if MEMBER is deemed unmanageable for treatment by any Network General Dentist, except for covered dependent children up to the age limit stated on Specialty Referral Exhibit D if specialty care is included.

6. Conditions resulting from disease or epidemic or injuries sustained as a result of a major disaster or war (declared or undeclared).

7. Dental procedures initiated prior to MEMBER'S eligibility under this benefit plan or started after MEMBER'S termination from the plan.

8. Services performed for cosmetic, elective, or aesthetic purposes, unless the policy includes a Cosmetic/Elective Benefit Rider (Exhibit E).

9. Dental laboratory fees including the cost of noble and high noble metal.

10. Services or supplies that do not meet accepted standards of dental practice, which are experimental in nature or are considered enhancements to standard dental care.

11. Implants and services incurred as part of implants, and fixed or removable prosthetics placed on implants.

12. Treatment related to temporomandibular joint syndrome (TMJ).

13. Appliances, restorations, or procedures to:

    - alter vertical dimension,
    - restore or maintain occlusion,
    - splint or stabilize teeth for periodontic reasons,
    - replace tooth structure lost as a result of abrasion, erosion, or attrition, or
    - treat bruxism (nightguards, harmful habit and thumbsucking devices).

14. Treatment and/or services (including biopsy) for malignancies, cysts, neoplasm, or congenital or developmental malformations, including but not limited to, cleft palate, enamel hypoplasia, fluorosis, anodontia, supernumerary or impacted teeth other than third molars.

15. General anesthesia, analgesia (including nitrous oxide), sedation, and prescription drugs.

16. Any inpatient/outpatient hospital or surgicenter charges of any kind including physician charges, prescriptions or medication.

17. Treatment for crown exposure, ligation, and crown lengthening.

18. Replacement of an appliance or fixed or removable prosthetic with a like appliance or prosthetic unless the appliance or prosthetic is at least 5 years old and cannot be made usable. Replacement of crowns unless existing crown is more than five (5) years old.

19. Replacement of a lost, stolen, or missing appliance or prosthetic device, glasses, or contacts.

20. Dental treatment or procedures requiring or associated with fixed prosthodontic restorations when part of extensive oral rehabilitation or reconstruction (six or more units of crown and/or bridgework in one arch or more than ten units total).

21. Resectioning of the bone and surgeries involving repositioning of the teeth or tooth implantation, re-implantation or transplantation.

22. Oral surgery for fractures or dislocations of the jaw, resectioning of the bone, repositioning of the teeth or bone implantation or transplantation,

salivary gland, duct or sinus. Orthognathic surgery and extractions for orthodontic purposes.

23. Elective oral surgery, including the extraction of non-pathologic, asymptomatic teeth, overretained deciduous teeth, and deciduous teeth that appear to be at or near exfoliation.

24. Orthodontic treatment unless specifically included. Under any applicable orthodontic benefits, treatment plans started before MEMBER enrolled with the PLAN are not covered.

BC LIFE & HEALTH DENTAL PLAN EXCLUSIONS AND LIMITATIONS

Duplicate Services or Supplies. Any covered services or supplies, or any services or supplies for which benefits would be provided under any other insurance policy, health care service plan or similar arrangement which the group sponsors to make dental benefits available.

Services Provided Before or After the Term of This Coverage. Services received before the insured person's effective date. Services received after the insured person's coverage ends, as specified as covered in the Certificate.

Experimental or Investigative Procedures. Any procedures which are considered experimental or investigative or which are not widely accepted as proven and effective procedures within the organized dental community.

Medically Necessary. Any services or supplies which are not medically necessary.

Workers' Compensation. Any work-related conditions if benefits are recovered or can be recovered either by adjudication, settlement or otherwise under any workers' compensation, employer's liability law or occupational disease law, even if the insured person does not claim those benefits.

Government Programs. Services provided by or payment made by any local, state, county or federal government agency, including Medicare and any foreign government agency.

No Charge Services. Services received for which no charge is made to the insured person or for which no charge would be made to the insured person in the absence of insurance coverage.

Results of War. Disease contracted or injuries sustained as a result of war, declared or undeclared, or from exposure to nuclear energy, whether or not the result of war.

Provider Related to Insured Person. Professional services received from a person who lives in the insured person's home or who is related to the insured person by blood or marriage.

Excess Expense. Any amounts in excess of covered dental expense or the Dental Benefit Maximums.

Professionally Acceptable Treatment. If more than one treatment plan would be considered acceptable services for a dental condition, any amount exceeding the cost of the least expensive professionally acceptable treatment plan is not covered.

Transfer of Care. If the insured person transfers from the care of one dentist to another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, we shall be liable only for the amount we would have been liable for had one dentist rendered the services.

Hospital Charges. Hospital costs and any additional charges by the dentist for hospital treatment.

Services Not Included as a Covered Procedure. Services not specifically provided for by the plan unless they are similar in nature to an included procedure. In such event, the benefit payable will be based on the most nearly comparable services included.

Treatment By An Unlicensed Dentist. Charges for treatment by other than a licensed dentist or physician except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.

Vertical Dimension and Attrition. Procedures requiring appliances or restorations (other than those for replacement of structure lost due to dental decay) that are necessary to alter, restore or maintain occlusion. These include, but are not limited to:

- changing the vertical dimension
- replacing or stabilizing tooth structure lost by attrition, abrasion, or erosion
- realignment of teeth
- gnathological recording
- occlusal equilibration
- periodontal splinting

Prosthetic Replacements. Replacement of an existing fixed or removable prosthesis, is not a benefit if the replacement occurs within five years of the original placement, unless the prosthesis is a stayplate used during the healing period for recently extracted anterior teeth. Replacement of a removable partial will be allowed if the partial is no longer useable, cannot be made serviceable and meets the five year requirement.

Orthodontics. Orthodontic braces, appliances and all related services.

Crown Replacements. Crowns, Inlays, onlays or cast restorations on the same tooth in excess of once every five years of the original replacement.

Denture Repairs, Adjustments or Relines. Repairs, adjustments or relines of full or partial dentures, or other prostheses are not covered for a period of six months from the initial placement if they were paid for under this plan.

Lost or Stolen Dentures or Appliances. Replacement of existing full or partial dentures or prosthetic appliances that have been lost or stolen if replacement occurs within five years of the original placement.

Prosthetics (patients under 16 years old). Fixed bridges, removable cast partials, cast crowns, with or without veneers and inlays for persons under 16 years of age.

Implants. Implants (materials implanted into or on bone or soft tissue) or the removal of implants. However, if implants are provided in connection with a covered prosthetic appliance, we will allow the cost of a standard complete or partial denture, or a bridge, toward the cost of the implants and the prosthetic appliances.

Malignancies and Neoplasms. Services for treatment of malignancies and neoplasms.

Cosmetic Dentistry. Any services performed for cosmetic purposes, unless they are for correction of functional disorders or as a result of an accidental injury occurring while the insured person was covered for dental benefits under this plan.

Congenital or Developmental Malformation. Services to correct a congenital or developmental malformation including, but not limited to, cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (discoloration of the teeth) and anodontia (congenitally missing teeth).

X-rays. More than one set of full-mouth X-rays or its equivalent in a three-year period. Periapical x-rays submitted individually will be combined and paid up to the amount of a full mouth series.

Bite Wing X-rays. Bite wing X-rays in excess of two series for standard or 8 films for vertical bite wings twice in any 12-month period.

Oral Exams. Oral exams are limited to two per calendar year.

Prophylaxis or Periodontal Prophylaxis. Prophylaxis or periodontal prophylaxis procedures are limited to two treatments per calendar year. Periodontal prophylaxis must be preceded by active periodontal treatment, such as scaling and root planing or osseous (gum) surgery.

Sealants. Sealants are limited to children under 14 years of age for molars and bicuspids. Treatment is limited to once every 36 months per tooth.

Prescription Drugs and Medications. Any prescribed drugs, pre-medication or analgesia.

Oral Hygiene. Oral hygiene instruction.

Space Maintainers. Use of space maintainers in excess of one treatment per lifetime, which includes one adjustment within six months of placement.

Periodontal Surgery. Periodontal surgery exceeding one time per quadrant in a 36-month period.

Root Canal Therapy. Root canal therapy in excess of one treatment per tooth for initial treatment and one retreatment per tooth.

Periodontal Scaling. Periodontal scaling exceeding one time per quadrant in a 24 month period.

Oral Surgery. Extraction of third molars (wisdom teeth).

Teeth Lost Prior to this Coverage. Teeth lost prior to coverage under this plan are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.

Restorations. Restorations exceeding one every 12 months per surface per tooth for patients under the age of 19, and one every 36 months per surface per tooth for patients over the age of 19.

Precision Attachments. Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.

Overdentures. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

Third Molars. The replacement of extracted or missing third molars/wisdom teeth.

Replacement of Existing Restorations. Replacement of existing restorations for any purpose other than restoring active decay.

Harmful Habit Appliances. Fixed and Removable appliances to inhibit thumb sucking.

Late Entrant Waiting Periods If the insured person does not enroll within 31 days of eligibility date, the following late entrant waiting periods will apply to services for:

- Preventive and Diagnostic – None
- Restorative, Periodontics, Endodontics, or Oral Surgery – 6 months
- Prosthodontics – 12 months

Third Party Liability BC Life & Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Coordination of Benefits The benefits of this plan may be reduced if the insured person has any other group dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Chapter 4
Vision Coverage Options

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

What Options are Available?

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

Medical Eye Services (MES) – Vision Plan

MES offers the largest and most comprehensive network in California and nationally through its provider network, The Eye Care Network (ECN). In California alone there are over 5,200 participating providers, with 16,400 providers nationally to choose from.

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

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

How to Use the Plan

Covered employees follow these steps to receive their vision benefits:

1. The employee makes an appointment with the eye care specialist of his/her choice.
2. A Participating Provider Directory and MES Claim Form can be obtained by one of the following three ways:
   a. Through the employer, MES claim forms are available in the Human Resources Benefits office, Hall of Administration, Main Plaza; **or**
   b. By visiting the MES website at **www.mesvision.com, or**
   c. By contacting MES directly at:

      (800) 877-6372 or

      (714) 619-4660
3. At the time of the vision appointment, eligible employees present the MES Claim Form with Part 1 completed to the provider. The Participating Provider will contact MES for benefit determination and eligibility verification and then submit the Claim Form for payment for Covered Services.
4. If Covered Services are received from a Non-Participating Provider, the eligible employee is responsible for paying the provider in full. The eligible employee or the provider must submit an itemized billing and a copy of his/her prescription with the Claim Form to MES. Reimbursement will be made to the eligible employee up to the Schedule of Allowances shown for Non-Participating Providers.

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

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

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

Summary of Benefits for MES Vision are shown on the chart below:

County of Ventura

Summary of Benefits

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

Note: $20 copayment for exam and $20 copayment for materials required at time of service

Medical Eye Services Limitations and Exclusions

MEDICAL EYE SERVICES – LIMITATIONS

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

MEDICAL EYE SERVICES – EXCLUSIONS

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

Medical Eye Services – Contact Information

For Patients and Members

Customer Service: Monday – Friday, 8:00 am – 5:00 pm PST

Telephone: **(800) 877-6372**
(714) 619-4660

E-mail: **customerservice@mesvision.com**

Coverage Through Your Medical Plan

If you are enrolled in any of the County-sponsored HMO medical plans, your plan covers all or part of the annual vision exam, with refraction, for you and your enrolled dependents.

Health Net

Health Net High Option HMO
Health Net Low Option HMO

There is no coverage through the Health Net PPO.

For the Health Net High HMO Plan, you pay a **$10 office visit copayment** for the annual eye examination with refraction.

For the Health Net Low HMO Plan, you pay a **$30 office visit copayment** for the annual eye examination with refraction.

A referral from your Primary Care Provider is required.

There are also discounts on materials.

VENTURA COUNTY HEALTH CARE PLAN (VCHCP)

VCHCP will reimburse you for the cost of your annual eye refraction exam, up to $50 for you and each covered dependent. You can go to any eye doctor you choose.

To file a claim for reimbursement, obtain a claim form from VCHCP or the self-serve rack in Human Resources, Main Plaza at the Government Center.

Claims must be presented to VCHCP within 90 days from the date of the exam.

VCHCP does not cover materials such as frames and lenses.

Vision-Related Discounts

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

Coverage Through Your Dental Plan

If you are a member of the Flexible Benefits Program's Golden West Dental Plan "89L3" option, you are covered by Golden West Vision Plan "89E." This plan offers members and their families discounted fees on vision exams and materials such as frames and lenses. Information on the "89E" vision plan is included in the Golden West Dental Plan brochure.

Health Care Flexible Spending Account

Flexible Benefits Program participants can set aside Flex Credits, 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 on Flexible Spending Account Options.

Chapter 5
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 Assistance Program
Employee Health Services
Deferred Compensation Program
Retirement Pension Plans
Leave of Absence Program
Life & Disability Insurance Programs
$1,000 Employee Death Benefit
Ventura County Employee Emergency Assistance Fund
Long-Term Care Plan
Wellness Program
Work and Family Program

Forms and/or further information are available from your department's Personnel Representative, who can also provide information on these other benefits:

- Paid Holidays
- Paid Vacation and Sick Leave
- Tuition Reimbursement
- Union-sponsored Programs

Employee Assistance Program

The Employee Assistance Program (EAP) offers employees and family members confidential mental health assistance. This service provides eligible employees and family members up to five visits each per Plan Year with an EAP licensed counselor. A panel of counselors is available to help employees and families in crisis, or individuals who wish to explore solutions to personal problems affecting their lives, such as marital or family conflicts, drug or alcohol abuse, bereavement, or work-related problems. The EAP is also a confidential referral source to help you find appropriate providers if further counseling or treatment is required.

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.

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) 654-5138. Refer to the back cover of this handbook for the office location. Brochures are also available through your department's Personnel Representative, or from the self-serve racks at County Human Resources, Main Plaza at the Government Center.

Employee Health Services

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

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

EHS is located in the Lower Plaza, Hall of Administration at the Government Center. Other sites may become available.

Ask your department's Personnel Representative for an EHS brochure, or obtain one from the self-serve rack in Human Resources at the Government Center. To contact EHS, call (805) 654-3813.

IMPORTANT: If you are seeking treatment for a work-related injury, notify your department immediately.

Deferred Compensation Program

The Deferred Compensation Program helps you plan for your future. With these Plans, you can provide yourself with extra retirement income. At the same time, they help you save on current taxes. When you put aside money in a deferred compensation plan, you aren't taxed on the dollars you invest, or the increase in your account value, until you take the money out. That means your dollars grow faster than they would in a similar investment that is not tax deferred.

Investment Options: You can choose from a variety of investment options offered through Fidelity Investments, including stock, bond and money market mutual funds.

Eligibility: The Plans are available to almost all regular employees. You are eligible to participate in the 401(k) Shared Savings Plan if your work schedule is 40 hours or more per pay period. Except for employees with job titles represented by CNA, SPOAVC or IUOE, you may participate in the Section 457 Plan even if you are working fewer than 40 hours per pay period.

401(k) County Match: The County provides a matching contribution for most employee groups. If you reach the annual contribution maximum prior to the end of the year, the payroll system will stop contributions. Except under limited circumstances, the County provides a matching 401(k) Shared Savings contribution only for those pay periods that you contribute. When deciding how much to contribute, you'll maximize your 401(k) Shared Savings Plan benefit if you make a contribution each pay period of the year.

Plan Information: The 401(k) Shared Savings Plan and the Section 457 Plan are two separate plans, which are named for the government codes that regulate them. When deciding whether to enroll, keep in mind that these are retirement plans. Except under special circumstances, your access to the money in these accounts is limited until you retire or terminate employment. *The Plans have different features. The chart on a following page highlights the major differences.*

If you are interested in learning about these plans, ask your department's Personnel Representative for information on the County's Deferred Compensation Program, or pick up the information at the self-serve racks in County Human Resources, Main Plaza at the Government Center. See the current *Deferred Compensation Program Information Worksheet* for a list of investment options, County matching contributions and annual contribution limits.

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 Optimum Census Staffing (OCS) employee with a Work Schedule of 64 hours a pay period or more, you automatically participate in the Ventura County Employees' Retirement Association (VCERA) retirement plan. If you later reduce your hours below 64, you will continue to participate in the plan. The Retirement Department sends a plan description to all new participants. For more information on the VCERA retirement plan, call (805) 339-4250.

All other part-time and extra-help employees, except rehired annuitants and Reserve Firefighters, participate in the Safe Harbor Retirement Plan. Your automatic participation begins upon employment. You'll be mailed a plan description within 30 days of eligibility for the plan. For further information, call (805) 654-2921.

Deferred Compensation Information

If you have further questions after reviewing the information, you may obtain more information as follows:

Fidelity Investments:

Telephone: (800) 343-0860, or
Logon to: www.fidelity.com/atwork

Deferred Compensation Program:

Telephone: (805) 654-2620, or
E-mail: deferred.compensation@ventura.org

Comparison of Deferred Compensation Plans

	Section 457 Plan	401(k) Shared Savings Plan
Matching Contribution[1]	Currently no matching County contribution	The County matches a percent of your contribution; amount varies by group
Annual Contributions[1]	Special and Baby Boomer Catch-Up provisions that allow you to raise your contributions. Contributions can be made in conjunction with the 401(k) plan.	Baby Boomer Catch-Up provisions that allow you to raise your contributions. Contributions can be made in conjunction with the 457 plan.
Loans Against your Account Balance	Not currently available.	Loans of up to 50% of balance are available after 12 months of participation.
Fund Withdrawals While Employed *(In most circumstances, you cannot withdraw funds while you are still employed by the County)*	May withdraw 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 due to unforeseeable emergency if the Deferred Compensation Committee finds request meets Internal Revenue Code 457 guidelines.	A hardship withdrawal may be allowed for an immediate and heavy financial need if the Deferred Compensation Committee finds request meets Internal Revenue Code 401(k) guidelines.
Taxes and Penalties on Distributions	Distributions taxed as regular income. No penalties for distribution prior to age 59 ½.	Distributions subject to 20% federal tax withholding. A 10% penalty tax will apply before age 59 ½, except at retirement at age 55 or over and other limited circumstances.
Distribution Options at Termination or Retirement	Remain in 457 Plan, systematic withdrawals, annuity purchase, transfer to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, a lump sum distribution. You do not have a deadline to choose your payout date and option.	Remain in 401(k) Plan, systematic withdrawals, transfer to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, a lump sum distribution. You do not have a deadline to choose your payout date and option.

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

Leave of Absence Program

The County provides a Leave of Absence (LOA) program for regular 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, and by legislation such as the Family Medical Leave Act (FMLA) and California Family Rights Act (CFRA) of 1991. For more information on FMLA and CFRA, see Appendix B.

Events that may qualify for a Leave of Absence include:

- Illness
- Injury
- Pregnancy/Maternity
- Military Service
- Educational Leave
- Family Care Leave
- Parenthood/Adoption
- Personal

Your department will provide you with a copy of the *Employee Leave of Absence Handbook* when you request a leave. If you are thinking about taking a Leave of Absence, ask your department for a copy in advance and review it thoroughly for important information on these topics, and more:

- Your rights and responsibilities
- How a leave may affect your paycheck and your health benefits
- Integrating your use of leave bank hours with Worker's Compensation temporary disability benefits and other group disability plan benefits

Important!

You must complete a *Leave of Absence Request form* if you are ill, injured or pregnant and are out of work for more than 3 days, even if you are out less than a full pay period, and even if you are out on a work-related injury (including 4850 time for safety members).

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 part of the benefit in advance if you became terminally ill. Premiums are based on your age and the amount of your insurance. If you are a regular employee, and your regular work schedule is 20 hours a week or more, you can apply at any time.

If you enroll within your first 90 days of eligibility – you don't need to complete a health statement if you enroll in a policy for $10,000 or the amount of your base salary (one times Annual Earnings). Complete the enrollment card at the back of the Optional Life Insurance brochures and the *Six Steps to Optional Life Worksheet,* and turn the forms in to your department's Personnel Representative.

If you wait until after the first 90 days of eligibility – you must complete an application and a statement of health for any level of coverage.

If you wish to enroll in two or three times your base salary, you must complete an application that includes a statement of health. Your application is subject to approval by Standard Insurance Company.

LIFE INSURANCE TIP

If you want coverage for two or three times your base salary, you can apply for both the guaranteed and the higher coverage within your first 90 days of eligibility. Then, if you are not approved for the higher level, you will still have some insurance. If you are approved for the higher level, the lower level plan will be canceled.

These are term life policies, which means when you stop paying premiums, there is no cash value built up, and your coverage ends the last day of the pay period following the last pay period during which a premium contribution was taken from your pay. In many cases, you can continue your insurance under the Portability Option for up to two years after you leave County employment. Optional Life Insurance brochures are available from your department's Personnel Representative, or from the self-serve racks in County Human Resources, Main Plaza at the Government Center.

Dependents Life Insurance

When you enroll yourself for life insurance, you can also add life insurance for your dependents. Eligible dependents are your current spouse, and eligible children up to their 25th birthday, including stepchildren who are living with you. A small biweekly premium covers all your eligible dependents, regardless of the number you enroll.

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

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

Low Option: $5,000 spouse and $2,000 on each dependent

High Option: $10,000 spouse and $5,000 on each dependent

The level of dependent coverage cannot exceed 50% of your employee coverage. For example, you are eligible for the dependent high option plan if you are covered for $20,000 or more.

Basic Life Insurance

Managers, Confidential Clerical and Unrepresented Others covered under the Management Resolution, and CJAAVC-represented employees, are automatically covered by a $50,000 group term life insurance policy. Ask your department's Personnel Representative for a beneficiary designation form.

Long-term Disability (LTD)

You are automatically enrolled in LTD if you are a Manager, Confidential Clerical, Unrepresented Other, CJAAVC-represented employee, Sheriff 's Service Technician, or Professional Engineer. Nurses, Nursing Care Coordinators I-II, Clinical Coordinators, and Clinical Coordinators-Surgical Services who are covered by the Annual Leave program also participate. To be eligible for benefits, you must be scheduled for and working at least 30 hours a week.

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

A certificate is sent to each new participant. Some unions offer similar plans to the employees they represent. For information on these plans, contact the union directly.

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 salary. 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, call the State Disability Insurance Program at (800) 480-3287.

You can draw benefits from both the County's Wage Supplement Plan and SDI concurrently.

Family Temporary Disability Insurance (FTDI) and Paid Family Leave

California Senate Bill 1661 was enacted to extend disability compensation to cover individuals who take time off of work to care for a seriously ill child, spouse, parent or domestic partner, or to bond with a new child. This legislation established the Paid Family Leave insurance program, also known as Family Temporary Disability Insurance (FTDI), administered by the State Disability Insurance (SDI) program.

Employees covered by the SDI program are also covered for Paid Family Leave insurance benefits, for qualified leaves that began on or after July 1, 2004. Mandatory employee contributions pay for the program.

For Information on:

Paid Family Leave Program call:

(877) Be There, or (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

$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 wish the benefit to go to a person other than the beneficiary you designated for your Retirement Plan, ask your department's Personnel Representative for a copy of the Death Benefit beneficiary form. Complete the form and return it to your department's Personnel Representative.

Ventura County Employee Emergency Assistance Fund

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

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

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

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

If you would like to contribute or apply for assistance, please contact your department Personnel Representative for all of the appropriate forms.

Long-Term Care Plan

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

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

The application period is normally held for a three-month period from April through June. Some years there is an extension of the application period, but there is no guarantee there will be an annual application period or extension.

To request a CalPERS Long-Term Care application, call: (800) 266-1050

For general information and claims for policy holders, call: (800) 982-1775

http://www.calpers.ca.gov/longtermcare/

Ventura County Wellness Program

The County's Wellness Program helps control increases in medical costs by helping participants identify and reduce their personal health risks before serious health problems occur. All regular County employees and their spouses are eligible to participate in the Wellness Program.

The Wellness Program invites you and your spouse to participate in an annual Wellness Profile to evaluate your current cholesterol, blood pressure, glucose and other risk factors. You may identify a potential problem early, and learn what to do to stay healthier. Those with high risks are encouraged to join Health Track, where they receive support and assistance with lifestyle changes from a personal Health Track coach.

The Wellness Program offers a wide variety of classes for employees and their spouses. Classes focus on topics such as healthy eating, weight reduction, diabetes management, prenatal care, medical consumerism, stress management, parenting and more. The Wellness Program also publishes a listing of health clubs offering discounts for County employees and their families.

To register you and your spouse for the Wellness Profile or Wellness classes**, visit the Wellness Program website at:**

http://ceo.countyofventura.org/benefits/wellness

Enter your employee identification number and password (same as for VCHRP) to log in.

The current Wellness Schedule and Health Club Discount list will also be available online.

For more information, contact your department's Personnel Representative or the **Wellness Program at (805) 654-2628.**

Work/Family Program

The County's Work/Family Program offers information about caring for children as well as aging relatives. Some of the resources available are:

- Family Guides to Elder Care
- Finding Quality Child Care (including before & after school care)
- Child Care Directories
- Various parenting guides

The Program has also arranged for lactation rooms at several sites around the county for moms who are working but want to cotinue to nurse their babies.

County employees are also eligible for discounts at numerous childcare centers throughout the County.

The Work/Family Program also sponsors Balancing Work and Family seminars and Positive Parenting classes through the Wellness Program, and an elder care support group.

For more information on elder care resources or childcare resources, contact:

The County's Work/Family Program at:

(805) 652-7835
or
(805) 652-7506

http://ceo.countyofventura.org/benefits/ link to Work/Family program

Appendix A
Consumer Issues

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

Frequently Used Terms

Coordination of Benefits

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

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

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

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

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

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

Capitation

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

Fee-For-Service

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

Formulary Drugs

See *Prescription Drug Coverage* information further in this section.

Generic Drugs

See *Prescription Drug Coverage* information further in this section.

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 and substantial portions of equipment and professional, technical, and administrative staffs. Patients will generally be referred to a specialist within the group.

Individual Practice Association (IPA)

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

Preferred Provider Organization

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

Primary Care Provider/Physician (PCP)

A primary care physician oversees the total health services of enrollees, arranges referrals, and supervises other care, such as specialist services and hospitalization. The PCP's services are usually covered by a monthly capitation, eliminating claims processing and collection.

Medical plan PCP's are usually family practice specialists, general practitioners, internists or pediatricians.

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

- 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, 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 health care 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 so you stay healthy
- Eat right
- Get adequate exercise

Use your Medical Plan Wisely

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

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

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

Ask your doctor and/or pharmacist for the least expensive form of medication available.

Discuss services you are to receive in advance with your doctor, whenever possible. Ask if all the services, including diagnostic tests, are medically necessary.

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

Check Your Medical Bills Carefully

Reviewing your health care bills can help you identify and prevent unnecessary health care costs. Many physicians and hospitals today send their bill directly to your health benefit provider or insurer, so you may not have a chance to review it before it goes through claim processing. But that doesn't mean it's too late. Physicians and their staff members are human, and billing errors do happen. Here's what to look for to determine if a bill is correct:

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

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

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

(Based on an article by Northwestern National Life)

Prescription Drug Coverage

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

Generic Drugs/Brand Name Drugs

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

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

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

Drug Formulary

Many medical plans now include a prescription drug formulary, which is a listing of preferred or recommended medications your doctor is authorized to prescribe under the plan.

There are various types of formularies, such as the "open formulary," whereby patients are encouraged to use formulary drugs but pay the same copay for preferred and non-preferred drugs. There is also the "incentive formulary," which provides incentives to use preferred drugs through lower copays. A "closed formulary" generally provides coverage of nonpreferred drugs only if there is no viable preferred drug alternative, or the non-formulary drug is preauthorized by the medical plan.

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

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

Mail Order Pharmacy Services

Many health plans have special programs that allow you to obtain a two or three-months 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 drugstore.

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-1998," and "Managing Pharmacy Benefits Cost," Merck-Medco Managed Care Report, 2000.)

For Further Information

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

Why a Medical Plan Opt-Out Charge?

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

Employees opting out of medical coverage also share in the benefits and costs of the Flexible Benefits Program, including Employee Assistance Program, Wellness, Work/Family, Employee Health Services, and administrative fees. The remainder of the Opt-Out fee is based on some basic assumptions about the County medical plan, County employees, and our responsibilities to one another:

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

Employees in the Flexible Benefits Program should have the option to decline medical coverage and use Flexible Credits to purchase other benefits as long as

they have adequate medical coverage through another group plan, and as long as their decision does not impact the medical rates of those remaining in the plan.

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

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

- Nationally, about 20% of a plan's participants generate 80% of the claims costs in any given year.
- In most cases, those who opt out of a medical plan are the healthier population; employees expecting high expenses prefer the extra coverage.
- Since sicker employees tend to stay in the plan, when employees opt-out there are fewer premium dollars coming into the plan, but claim and administrative costs do not go down in the same proportion. This results in higher premiums for those remaining in the plan, unless a charge is applied for the right to opt out.

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

Some Things to Think About When Looking For A Family Doctor

What is his or her Background?

Check out the backgrounds of doctors you are considering by calling the county medical society. You'll be given each doctor's list of credentials, including university medical school attended, hospital affiliations, and board certification – no questions asked.

Why is a Family Doctor Important?

Your own doctor is the person who knows you and your record best, and how to handle any situation that may arise. Tragedies have resulted from emergency room treatment or surgery performed in haste without proper consultation with the patient's personal physician.

Family Doctor or Specialist?

Patients who choose specialists on their own, without consulting a primary care doctor, too often are given medications to take that can nullify the drugs they are already taking or that can cause dangerous, even life-threatening, side effects. One person should monitor all the medications you take, as well as tests and procedures, and that person is your primary physician. Such monitoring may even save you money by protecting against unnecessary and costly medical procedures and tests, and unexpected out of pocket expenses.

Where to Look?

If you have recently moved to a new community, or changed plans, you may find that popular doctors to whom you're referred are difficult to see, with practices already full. In such circumstances, your plan or local hospital administrations can give you the names of new, younger doctors on their staffs who have more time for new patients.

Youth versus Age?

The most prestigious doctor is not necessarily your best choice. Young doctors have the benefit of a recent medical education and thus possess up-to-date knowledge of the latest diagnostic methods and treatments. They have plenty of energy and enthusiasm and are not yet too busy to give a lot of time to new patients and their particular problems.

Check Hospital Affiliations

Ideally, if you live near a teaching hospital and your primary doctor is on the roster, you are steps ahead of those people who have chosen doctors at random or on hearsay. The diplomas hanging on the walls of these doctors' offices reveal that they possess top-flight credentials from leading medical schools.

What Kind of Doctor?

Always remember that the doctor you choose is the manager of your medical care. Traditionally, this role

has been filled by a general practitioner (GP) with a basic medical education. Today, however, it's usual for a primary physician to have one or more years of graduate training and internship, and to be certified as a Family Physician by the American Board of Family Practice. Internists – physicians trained in the specialty of internal medicine – also often practice as GPs.

You Deserve the Best

Kindness, patience, and understanding are your just due as a patient. If these qualities are lacking in the doctor you're considering, better move on.

Changing Your Primary Care Doctor

Experts say you should not change doctors too often or for minor reasons, since you will be throwing away a lot of valuable information your doctor has learned over time about your health and your treatment preferences. But if you are unhappy, you should switch. Sometimes you may have to switch, if, for example, your doctor drops out or is dropped by your managed care plan. Most plans allow you to switch primary care doctors on the first day of the following month. However, you need to find out what the rules are and follow them exactly. You should also remember to ask your former doctor to transfer your medical records to your new doctor.

(Excerpts from The Best Medical Centers in America, by Herbert J. Dietrich, M.D.; Virginia H. Biddle, Consumers Digest, June, 1991; and AARP "9 Ways To Get The Most From Your Managed Health Care Plan," 1997.)

Appendix B
Employee Notices

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

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

FMLA	**Family and Medical Leave Act of 1993**
PDL	**Pregnancy Disability Leave**
CFRA	**California Family Rights Act of 1991 – Family Care and Medical Leave**
FTDI	**Family Temporary Disability Insurance**
NEWBORNS' ACT	**The Newborns' and Mothers' Health Protection Act**
WHCRA	**Women's Health and Cancer Rights Act of 1998**
COBRA	**Consolidated Omnibus Budget Reconciliation Act of 1985**
CalCOBRA	**California AB 1401–additional extension of medical insurance**
MHPA	**Mental Health Parity Act**
HIPAA	**Health Insurance Portability and Accountability Act of 1996**

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.

Policy Regarding the Family Medical Leave Act (FMLA)

FMLA requires covered employers to provide up to 12 weeks of unpaid job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons For Taking A Leave

Unpaid leave must be granted for *any* of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition. For purposes of qualifying for FMLA leave, son or daughter means "a biological, adopted, or foster child, a step child, a legal ward, or a child of a person standing in loco parentis, who is either under the age of 18 or age 18 or older and incapable of self care because of a mental or physical disability"; or
- For a serious health condition that makes the employee unable to perform the employee's job.

If available, you may be required to use sick or annual leave in place of unpaid leave.

At the employee's or employer's option, certain kinds of *paid* leave may be substituted for unpaid leave.

Advance Notice and Medical Certifications

The employee may be required to provide advance leave notice and medical certification. The request for leave may be denied if requirements are not met. The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable." If the leave is not foreseeable them employee must provide notice and medical certification within the prescribed legal time frame.

- An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employer's contribution toward the employee's health coverage under any "group health plan."

Upon return from FMLA leave

- Most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. The use of FMLA leave cannot result in loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

- The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Policy Regarding The "Pregnancy Disability Leave"

Pregnancy Disability Leave Summary:

A pregnant employee is entitled to up to four months of Pregnancy Disability Leave (PDL), if she works for an employer with five or more employees. The leave may be taken all at once during the few weeks before and after delivery or may be taken at any time throughout and after the pregnancy for morning sickness, prenatal visits, complications, recovery, etc.

California Family Rights Act (CFRA) - Employees who work for an employer with 50 or more employees, or for a public employer, can take CFRA family leave after their pregnancy related disability is over. For more information see Court Policy, "Policy Regarding The California Family Rights Act".

Family Medical Leave Act (FMLA) – Employees who are eligible for FMLA, anytime taken as PDL time off will simultaneously be counted toward any eligibility toward your FMLA allotment to which you may be eligible. For more information see Court Policy, "Policy Regarding The Family Medical Leave Act".

Benefits Protection – Pregnancy and Disability Leave does not provide for any benefits protections unless also certified under and running concurrently with the Family and Medical Leave Act (see the Court's policy on the Family and Medical Leave Act).

Advance Notice and Medical Certifications

The employee may be required to provide advance leave notice and medical certification. Request for leave may be denied if the requirements are not met. The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable." When leave notice is unforeseeable, employees are required to provided notice and medical certification within the prescribed legal time frame.

Note; Pregnancy in itself is <u>not</u> a qualifying event for PDL. In order to qualify for PDL, the employee must be able to prove that she is actually <u>disabled</u> by pregnancy by submitting a medical certification.

Upon return from PDL:

- Most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. The use of PDL leave cannot result in loss of any employment benefit that accrued prior to the start of an employee's leave.

Policy Regarding The "California Family Rights Act"

The "California Family Rights Act" (CFRA) requires covered employers to provide up to 12 weeks of unpaid job-protected leave to eligible employees for certain family and medical reasons. Employers subject to CFRA are those who do business in California and employ 50 or more part-time or full-time employees in any state, including non-profit religious organizations. Covered employers also include the State of California and any of its political and civil subdivisions, and cities and counties, regardless of the number of employees.

To be eligible for CFRA leave, an employee must be either a full-time or part-time employee working in California, have more than 12 months (52 weeks) of service with the employer, have worked at least 1,250 hours in the 12-month period before the date the leave begins, and work at a location in which the employer has at least 50 employees within 75 miles radius of the employee's work site.

Reasons for taking a leave:

Unpaid leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition(for purposes of qualifying for CFRA leave, son or daughter means "a biological, adopted, or foster child, a step child, a legal ward, or a child of a person standing in loco parentis, who is either under the age of 18 or age 18 or older and incapable of self care because of a mental or physical disability"); or
- For a serious health condition that makes the employee unable to perform the employee's job.

If available, you may be required to use sick or annual leave in place of unpaid leave.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

NOTE:

- Leave taken, which is related to disability due to pregnancy, is not covered under the CFRA. For more information please see the Court's policy on Pregnancy Disability leave.

Advance Notice and Medical Certifications

The employee may be required to provide advance leave notice and medical certification. The request for leave may be denied if requirements are not met. The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable." When the leave is unforeseeable, employees must provide notice and medical certification within the prescribed legal time frame.

- **An employer may require medical certification to support a request for leave because of a serious health condition, in the case of the employee's own serious health condition, the employer may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.**

Job Benefits and Protection:

- For the duration of CFRA leave, the employer must maintain the current employer's contribution toward the employee's health coverage under any group health plan.

Upon return from CFRA leave:

- Most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. The use of CFRA leave cannot result in loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

CFRA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under CFRA;
- Discharge or discriminate against any person for opposing any practice made unlawful by CFRA or for involvement in any proceeding under or relating to CFRA.

Enforcement:

- The "Department of Fair Employment and Housing" is authorized to investigate and resolve complaints of violations.
- An eligible employee may bring a civil action against an employer for violations.

CFRA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

Family Temporary Disability Insurance (FTDI) And Paid Family Leave

California Senate Bill 1661 was enacted to extend disability compensation to cover individuals who take time off of work to care for a seriously ill child, spouse, parent or domestic partner, or to bond with a new child. This legislation established the Paid Family Leave insurance program, also known as Family Temporary Disability Insurance (FTDI), administered by the State Disability Insurance (SDI) program.

Employees covered by the SDI program are also covered for Paid Family Leave insurance benefits, for qualified leaves that began on or after July 1, 2004. Mandatory employee contributions pay for the program.

For information, you may call: **1 (877) 238-4373**

Detailed information, including forms and publications and "Frequently Asked Questions," may be obtained from the EDD website at: **www.edd.ca.gov**

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).

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

WHCRA Enrollment Notice

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

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

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

WHCRA Annual Notice

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

Please see the Medical Plan Comparison Charts in Chapter 2 of this handbook for deductibles and coinsurance, or, if you would like more information on WHCRA benefits, call the Member Services telephone number of your medical plan:

PacifiCare HMOs	**(800) 624-8822**			
PacifiCare PPO	**(866) 316-9776**			
Ventura County Health Care Plan	**(805) 677-8787**	**or**	**(800)**	**600-8247**

Consolidation 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 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.

CalCOBRA Extension

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

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

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

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

Mental Health Parity Act (MHPA)

Overview

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

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

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

Coverage under MHPA

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

For further information, you may go to the Centers for Medicare and Medicaid Services (CMS) website at:
http://www.cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp

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: 1 (877) 267-2323
TTY: 1 (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,

call: 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.

Preexisting Conditions Exclusion Provision

This is to advise you that a preexisting condition exclusion period may apply to you, if a preexisting 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 "preexisting" 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 preexisting 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 preexisting condition. Preexisting condition clauses do not apply to a newborn or newly adopted child, as long as the child had health coverage on the last day of the 30-day period beginning with the child's date of birth or placement for adoption.

Creditable Coverage

Creditable coverage includes coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a state health benefit risk pool,

the Federal Employee Health Benefits Program (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under section 5(c) of the Peace Corps Act. Not included as creditable coverage is any coverage that is exempt from the law (e.g., dental only coverage or dental coverage that is provided in a separate policy or even in the same policy as medical, is separately elected and results in additional premium).

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

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

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

Providing Proof of Creditable Coverage to your New Plan

Generally, you will have received a *Certification of Prior Group Health Plan Coverage* from your prior plan as proof of your prior coverage. The Certification will be provided regardless of the reason for the loss of coverage, such as termination of employment, or change to a different plan during the employer's annual open enrollment period. You should retain the Certification with your important papers for 24 months. If you become covered under a new plan that has a preexisting condition clause, provide the new plan a copy of the Certification upon request, or upon denial of a claim for treatment of a preexisting condition. The Certification will be used to determine if you have creditable coverage at that time.

If you need a replacement Certification, you may request a *Certification of Prior Group Health Plan Coverage* from your prior carrier(s) with whom you had coverage within the past two years. There is no charge for the Certification.

Special Enrollment Periods Under HIPAA

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

Due to Loss of Coverage

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

• They exhaust COBRA coverage (coverage ends for other than failure of the individual to pay premiums on time or for cause, such as making a fraudulent claim or intentional misrepresentation of a material fact)

• They cease to be eligible for other coverage (includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment)

• Employer contributions for the other coverage cease

For Certain Dependent Beneficiaries

If you have an eligible new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependent under your plan prior to the next annual Open Enrollment period, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for

adoption. If you previously declined coverage, you are also eligible to enroll yourself during this special enrollment period even if only the dependent lost other coverage. In the case of the birth or adoption of a child, your spouse may also be enrolled as your dependent if the spouse is otherwise eligible for coverage but not already enrolled.

Special Enrollment Rules

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

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

Standards for Privacy of Identifiable Health Information

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

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

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

WHO DO I CALL?

Your benefits are provided by a combination of organizations. Be sure you are calling the right number when you have questions. When you call about a Health Net medical plan or Blue Cross dental plan, be sure to specify which plan you are calling about.

Health Net Plans

Member Services for Medical and Prescription Eligibility/Claims/Benefits/Pre-certifications
Website: http://www.healthnet.com

Health Net HMOs (High Group #68089A and Low Group #68088A)	**(800) 522-0088**
Health Net PPO (Group #N3923A)	**(800) 676-6976**
Out-of-Area Plans	**(800) 676-6976**
Pharmacy Member Service:	
Retail Stores http://www.advancerx.com/	**(800) 548-5524**
Mail Order Express Scripts	**(866) 265-9455**
Re-order online:	http://www.expressscripts.com

Ventura County Health Care Plan

Member Services office for Medical, Mental Health and Prescription Benefits/Questions and Eligibility/Preauthorization/Claims/Questions
Website: http://www.vchca.org/hcp
or e-mail at: vchcp.memberservices@ventura.org

Calls from within the County	**(805) 677-8787**
Toll-free Number	**(800) 600-8247**

Blue Cross Dental Plans

Customer Service	**(800) 627-0004**

Member Services office for Eligibility/Claims/Benefits/Pre-certifications
Website: www.bluecrossca.com
BC Life & Health – High Option Dental Plan: Group# 1751550001
BC Life & Health – Low Option Dental Plan: Group# 1751550100

Golden West Dental Plan

Member Services office for Eligibility/Claims/Benefits	**(805) 987-8941**

Website: http://www.goldenwestdental.com
Group #GW877
Dental Plan #89L3-includes Vision Plan 89E

Toll-Free Number	**(800) 995-4124**

Medical Eye Services (MES) – Vision Plan

Customer Services:		**(800) 877-6372**
	or	**(714) 619-4660**

Website: http://www.mesvision.com
Contact Customer Services at e-mail: customerservice@mesvision.com

Employee Assistance Program (EAP)

Lincoln's Inn, 950 County Square Drive, Suite 200 Ventura, CA 93003	**(805) 654-5138**

Optional Plans

Standard Long Term Disability Insurance (Group Policy #480883-E) – Group Benefits Department	**(800) 368-1135**
Standard Insurance Company – Optional Life Insurance/Management Life Insurance (Group Policy #480883-D) – Life Insurance Information	**(800) 628-8600**
Wage Supplement Plan (Short-Term Disability Benefits)	**(805) 654-3997**
CalPers Long Term Care Insurance (Account #5917734)-Information and Claims Website: **http://www.calpers.ca.gov/longtermcare/**	**(800) 982-1775**