



BENEFIT PLANS HANDBOOK

PLAN YEAR 2015



Hall of Administration circa 1978



Interior of HOA circa 1978



Government Center circa 1978

HEALTH INSURANCE PLANS

DECEMBER 21, 2014 –

DECEMBER 19, 2015

FLEXIBLE SPENDING ACCOUNTS

JANUARY 1, 2015 –

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On-Line Resources

-  www.ventura.org/benefits
-  vcweb/ceo/HR/Benefits
-  [VCHRP](#)
 - o Self-Service → Benefits
-  **Health Plan websites**
 - o VCHCP (www.vchealthcareplan.org)
 - o UnitedHealthcare
 - HMO (www.uhcwest.com)
 - PPO (www.myuhc.com)
 - o MetLife (www.metlife.com/mybenefits)
 - o MES Vision (www.mesvision.com)

This Benefit Plans Handbook was created by the County of Ventura Human Resources/ Benefits department and was written to address employees of the County of Ventura. It has been modified by the Ventura Superior Court Human Resources Department to remove or change information that is not applicable to employees of the Ventura Superior Court; however, some non-applicable information may still remain. For benefit information not covered in this handbook, please visit the Human Resources page of the Court intranet located at <http://courtweb/hr.html>.

References to County of Ventura employees, in this handbook, may also pertain to Ventura Superior Court employees. References to the County of Ventura as the employer, also apply to the Ventura Superior Court.

It is understood and agreed that this Benefit Plans Handbook is subject to all current and future applicable federal and state laws, Court memorandum of agreements, resolutions, personnel rules and regulations and policies. If any part or provision of this Handbook is in conflict or inconsistent with such applicable provisions of federal and state laws, memorandums, rules and regulations, policies or is otherwise held to be invalid or unenforceable by any tribunal of competent jurisdiction, such part or provision shall be suspended and superseded by such applicable law or regulations, and the remainder of this Handbook shall not be affected thereby.

If you have any questions or concerns regarding information contained in this handbook, please contact the Court Human Resources department at 805 289-8618 or by email at Court.Benefits@ventura.courts.ca.gov.

IMPORTANT SECTIONS TO CHECK

✓ **Life Events Checklist**

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

✓ **Appendix A – Consumer Issues**

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

✓ **Appendix B – Employee Notices**

FMLA	Family and Medical Leave Act of 1993
PDL	Pregnancy Disability Leave – “Notice A” Your Rights and Obligations as a Pregnant Employee
CFRA/PDL	California Family Rights Act of 1993 – “Notice B” Family Care and Medical Leave and Pregnancy Disability Leave
DPA	Organ and Bone Marrow Donation Protection Act
PFL	Paid Family Leave Benefits Program
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985 – continuation of health insurance
CAL-COBRA	California AB 1401 – additional extension of medical insurance
HIPAA	Health Insurance Portability and Accountability Act of 1996
WHCRA	Women’s Health and Cancer Rights Act of 1998 – benefits for mastectomy-related services
NEWBORNS’ ACT	The Newborns’ and Mothers’ Health Protection Act – group health plans that offer maternity hospital benefits for mothers and newborns are required to pay for a minimum amount of time following delivery
MHPA	Mental Health Parity Act – provides for parity in the application of annual and lifetime dollar limits on mental health benefits with annual and lifetime dollar limits on medical/surgical benefits
MEDICARE PART D	Important Notice About Your Prescription Drug Coverage and Medicare
PPACA/HCERA	Patient Protection and Affordable Care Act/Health Care and Education Reconciliation Act

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

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

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

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

**KEEP THIS HANDBOOK WITH YOUR
INSURANCE PAPERS FOR FUTURE REFERENCE**

Online Open Enrollment

The County of Ventura utilizes e-Benefits, an online enrollment system within the VCHRP system (Ventura County Human Resources & Payroll).

TO FIND e-BENEFITS

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

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

SIGNING ON TO e-BENEFITS

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

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

ONLINE ENROLLMENT

Once you are logged on:

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

Default Password (logging in after password reset)

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

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

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

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

Life Events Checklist

DO YOU KNOW WHAT TO DO AND WHO TO NOTIFY WHEN YOU:

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

You can either login to our Intranet website at <http://vcweb/ceo/HR/Benefits/>, our internet website at <http://www.ventura.org/benefits>, or contact your Department's Human Resources/Benefits Representative to obtain forms you may need. See the Flexible Benefits Program Information and Miscellaneous Benefits chapters for descriptions of the plans and programs that appear below.

Life Events Checklist

Event	Actions
<p>New Regular Employee</p> <ul style="list-style-type: none"> • New Hire • From Optimum Census Staffing (OCS) • From Extra-Help • From Per-Diem Pool 	<ul style="list-style-type: none"> ■ Attend a County Human Resources New Employee Orientation for an overview of County benefits. If your work schedule is 40 hours per pay period or more, you are now eligible for: <ul style="list-style-type: none"> ✓ The Flexible Benefits Program (enroll within 31 days of eligibility) ✓ Optional term life insurance (best to apply within 90 days of eligibility) ✓ Short-Term Disability Plan (apply within 90 days of eligibility) ✓ Deferred compensation plans (you may be eligible for County 401(k) match) ✓ Defined Benefit Pension Plans: <ul style="list-style-type: none"> • If your work schedule is at least 64 hours per pay period, you are in the Ventura County Employees' Retirement Association (VCERA) retirement plan. VCERA will mail you plan information. • All other employees, except rehired annuitants and reserve firefighters, participate in the Safe Harbor Retirement Plan. The Plan will mail you benefit information and a beneficiary designation form.
<p>Changed your Address</p> <p>Changed your Name</p>	<ul style="list-style-type: none"> ■ Enter your new address in VCHRP (Self Service > Personal Information > Home and Mailing Address), or notify your department representative to update information. Notification will go to your insurance and retirement plans and to the Auditor/Controller for your annual W-2 form. ■ Have a 457 Plan or 401(k) Plan account? If you are not currently making payroll contributions, complete the top section of a new 457 and/or 401(k) Participation Agreement. ■ If you have funds on deposit in the Safe Harbor Retirement Plan but aren't currently contributing, notify the Plan at (805) 654-2921. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
<p>Marriage</p> <p>Registration of Domestic Partner</p> <p>New dependent child as a result of birth, legal adoption, or marriage</p>	<ul style="list-style-type: none"> ■ You have 31 days to turn in an Enrollment & Change Form to add your new dependents to your medical, dental and vision plans. Otherwise, you may have to wait for the next open enrollment period. ■ If you have Dependent Life Insurance coverage on other dependents, you have 31 days to complete a Dependent Life Enrollment Form to add your new dependent children. New spouses must complete an Evidence of Insurability (EOI) form, and coverage is conditional upon approval by Minnesota Life. ■ You may be eligible to add or change Flexible Benefit Program plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions. ■ Is it time to apply for or increase life insurance coverage for yourself or your dependent(s)? For a description, see the Life Insurance section of the Miscellaneous Benefits chapter or the Optional Life Brochure (http://vcweb/ceo/HR/Benefits/). ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.

Life Events Checklist (continued)

Event	Actions
Legal Separation or Divorce Child no longer meets eligibility criteria	<ul style="list-style-type: none"> ■ Complete an Enrollment & Change Form to formally cancel coverage on your dependent and trigger an offer of continued coverage through COBRA. COBRA can only be offered if the dependent is dropped within 60 days of the event. Be sure to include the dependent's current mailing address, if different than employee's. Until you turn in the form, you may be liable for claims paid after eligibility ends. ■ You may want to drop your life insurance or dependent life insurance. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Job Change	<ul style="list-style-type: none"> ■ If your new position is represented by a different Bargaining Unit (union), check with your department to see if you have gained or lost eligibility for any benefits. For example: <ul style="list-style-type: none"> ✓ Your Flexible Benefit Plan Choices may have changed. If so, you may be eligible to add, drop or change plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ✓ Your 401(k) Plan County Match may have changed. Your new job may have a different minimum 401(k) contribution. To change your 457 or 401(k) Plan contribution amount, log on to Fidelity Net Benefits at www.fidelity.com/atwork.
Loss of Other Health Insurance	<ul style="list-style-type: none"> ■ If you are Opting Out of County medical insurance, you must notify County Human Resources (contact your department representative) if you lose your other group health coverage. You are required to enroll in one of the County's health plans or waive participation in the Flexible Benefits Program.
Change in Other Health Insurance	<ul style="list-style-type: none"> ■ In some instances where you gain, lose or have a change in health insurance from another source, you may be eligible to add, drop or change Flex plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions.
Standard Hours Decrease • From 60 hours or more to between 40 & 59 hours per pay period	<ul style="list-style-type: none"> ■ If you are in a union-represented job title, your Flexible Credit Allowance amount probably changed, and you may be eligible to drop a health plan or change to a lower cost plan. See the Flexible Benefits Program Information chapter for eligibility. ■ Covered employees lose County Long-Term Disability Plan (LTD) eligibility at Standard Hours of fewer than 60 hours a pay period (unless covered under the Management Resolution); no form needed.
Standard Hours Decrease • To fewer than 40 hours per pay period	<ul style="list-style-type: none"> ■ You lose eligibility for the Flexible Benefits Program. You'll be sent an application for continuation of group health insurance under COBRA. See the Flexible Benefits Program Information chapter and COBRA appendix for eligibility, deadlines and instructions. ■ You lose eligibility for Optional Life Insurance, 401(k) Plan contributions, Short-Term Disability Plan, and County Long-Term Disability Plan (LTD). Some groups lose 457 Plan eligibility.
Standard Hours Increase • To between 40 & 59 hours per pay period	<ul style="list-style-type: none"> ■ You are now eligible for the Flexible Benefits Program. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ Covered job titles have a County Long-Term Disability plan (LTD) if the Standard Hours is at least 60 hours a pay period, or at least 40 hours per pay period if covered under the Management Resolution. ■ You are eligible to enroll in the 401(k) Plan and Optional Term Life Insurance. If you are in CNA, SPOAVC or IUOE, you are now eligible to enroll in the Section 457 Plan.
Standard Hours Increase • To 60 hours or more per pay period	<ul style="list-style-type: none"> ■ If you are in a union-represented job title, your Flexible Credit Allowance amount may increase, and you may be eligible to add a health plan or change to a higher cost plan. See the Flexible Benefits Program Information chapter for eligibility, deadlines and instructions. ■ If you are in the Safe Harbor Retirement Plan and your hours increase to 64 or more per pay period, check your pay stub to be sure contributions stopped. You'll be in the Ventura County Employees' Retirement Association (VCERA) from now on. VCERA will mail you plan information.

Life Events Checklist (continued)

Event	Actions
Salary Change	<ul style="list-style-type: none"> ■ You may want to change your 457 Plan or 401(k) Plan contribution amount. Call Fidelity at 800/343-0860 or go online at www.fidelity.com/atwork. ■ You may want to adjust your tax-withholding amount.
Pregnant, Ill or Injured	<ul style="list-style-type: none"> ■ You must complete a <i>Leave of Absence Request</i> form when you are off work for more than three days. <ul style="list-style-type: none"> ✓ 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 <i>Miscellaneous Benefits</i> chapter. ■ Ask your department or check online sources for an Absence Management Handbook; read it thoroughly. ■ Check for disability insurance and/or accidental dismemberment benefit eligibility under LTD, SDI, Short-Term Disability Plan or union-sponsored plan.
Leave of Absence Request	<ul style="list-style-type: none"> ■ Ask your department or check online sources for an Absence Management handbook; read it thoroughly. ■ You may be required to immediately begin payment of part or all of your health plan premiums. Check with your department Personnel Representative for an Employee Premium Continuation Notice. ■ If you have a 401(k) loan, you may need to continue making loan payments. Contact the Deferred Compensation Program at (805) 654-2620. ■ If you have a Dependent Care Flexible Spending Account, unless your entire leave will be unpaid, you may complete an Enrollment & Change Form now to drop your account when your leave starts, and complete another form upon your return. You may not file claims for services incurred while you are not working.
Leaving County Employment or Retiring	<ul style="list-style-type: none"> ■ Should you experience a qualified federal COBRA event resulting in a loss of health coverage, you'll receive a COBRA Continuation Offer from our COBRA Administrator. Please contact Fidelity regarding 457 and 401(K) Plans at (800) 343-0860. ■ If you are changing jobs, in most circumstances you can continue your basic and optional life insurance for up to two years unless you become covered by another group plan. See the Minnesota Life Evidence of Insurance for more information (http://vcweb/ceo/HR/Benefits). ■ If you're retiring soon: <ul style="list-style-type: none"> ✓ Ventura County Employees' Retirement Plan (VCERA) members call (805) 339-4250. ✓ Safe Harbor Retirement Plan members call (805) 654-2921.
Death of a Dependent	<ul style="list-style-type: none"> ■ If the dependent is covered under County health insurance, complete an Enrollment & Change Form to notify Benefits and the health plan. ■ If the dependent is covered under County dependent life insurance through Minnesota Life, notify Benefits at (805) 654-2570. ■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.
Death of a Regular County Employee	<ul style="list-style-type: none"> ■ If you are enrolled in the County's Flexible Benefits Program, 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 Short-Term Disability Plan), notify Benefits at (805) 654-2570. The surviving spouse and/or dependent children may be eligible for continued health insurance coverage through COBRA. ■ Notify the Ventura County Employees' Retirement Association (VCERA) at (805) 339-4250. ■ If the employee was ever an extra-help or part-time employee, notify Safe Harbor Retirement Plan at (805) 654-2921. ■ If the employee ever made contributions to 457 or 401(k) with the County, call Fidelity at (800) 343-0860 or ING at (805) 642-6190.
Beneficiary Update	<ul style="list-style-type: none"> ■ For 457 & 401(k) deferred compensation plans, go to Fidelity online at www.fidelity.com/atwork. ■ 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 (Minnesota Life Basic and/or Optional Term Life). <p>NOTE: Beneficiaries are tracked separately by Plan or Plan Administrator and are <u>not</u> tracked in VCHRP</p>

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 (standard hours) of at least 40 hours each biweekly pay period.

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

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

■ Your Flexible Benefits Choices

You choose among:

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

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

■ How Do I Enroll In The Flexible Benefits Program?

1. Learning About Your Plan Options

Chapters 2 through 5 of this handbook have basic information on the plan options. If you require more detail on a specific health plan, please contact the plan's customer service center (contact information is listed on the back cover of this book).

2. Making Flexible Benefits Program Selections

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

Choose 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 cover, part of your salary will be taken on a pre-tax basis to cover the cost of the benefits you choose.

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

3. Filling Out Your Forms

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

Before you decide whether to enroll a dependent, be sure to read *"When and How Can I Enroll Dependents?"* later in this chapter. All forms are available at <http://vcweb/ceo/HR/Benefits/> (Benefits' intranet site) or <http://www.ventura.org/benefits> (Benefits' internet site).

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

■ Employee Enrollments

From the date you become eligible for the Flexible Benefits Program, you have 31 calendar days to submit your enrollment form(s) or sign a Waiver of Benefits Authorization.

1. Eligible New Employees

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

For your protection, if you fail to turn in your Enrollment & Change Form or a Waiver of Benefits 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. Currently, this is the Ventura County Health Care Plan (VCHCP) for most employees.

COMPLETE THE ENROLLMENT & CHANGE FORM FOR YOUR INITIAL ENROLLMENT IN THE FLEXIBLE BENEFITS PROGRAM:

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

All forms are available at <http://vcweb/ceo/HR/Benefits/> or <http://www.ventura.org/benefits>. All required forms and documentation must be received by CEO/Human Resources/Benefits by the enrollment deadline(s).

2. Consequences of Not Submitting Your Forms on Time

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

- You will lose up to two months of medical coverage if you miss the 31-day deadline; your coverage will become effective in the pay period that includes your 60th day of eligibility.
- You will forfeit medical coverage for your dependents. Some plans will accept a late dependent enrollment once you submit proof of eligibility with an Enrollment & Change form. 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 may have given you additional cash back in your pay.
- You will lose the opportunity to enroll in dental and vision plans and Flexible Spending Accounts until the next annual Open Enrollment.

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

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

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

Follow the same steps as item 3 above.

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

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

6. When Coverage Begins

Health premiums are paid one pay period in advance. Generally, coverage begins on the first day of the pay period after the pay period that the first premium deduction is taken from your paycheck. Example: If the first premium is deducted in Pay Period 04, your coverage begins the first day of Pay Period 05. For most plans, if you are on unpaid leave of absence on the day your coverage would go into effect, your coverage effective date could be delayed until the pay

period after you return to work (there may be an exception if there was no lapse in premium contributions during your leave).

■ Dependent Enrollments

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

1. Whom Can I Enroll as a Dependent?

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

- Your current legal husband or wife,
- Domestic partners officially registered with the appropriate entity such as the State of California or any other California County or Municipality official domestic partner registry,
- Your children under the age of 26,
- Dependent children of an officially-registered domestic partner who meet the same eligibility requirements as other dependent children,
- Certain unmarried dependent children age 26 and over if handicapped prior to age 19, continuously covered by this or a similar County plan since prior to age 19, and incapable of self-support.

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

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

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

- **New Employee:** When you first enroll, your Enrollment & Change Form must list all eligible dependents you wish to cover for the current Plan Year. Employee and dependent coverage begins on the same coverage effective date (see “*When Coverage Begins*” under “*Employee Enrollments*”).
- **New Dependent:** If you want new dependents covered under your health plan(s) for the remainder of the Plan Year, you must enroll them within 31 days of eligibility; for example, marriage, registration of domestic partner, birth of a child, or adoption placement.
- **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 & Change 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. 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 on the date of birth or placement for adoption. The effective date for coverage of dependents resulting from a marriage or registration of domestic partnership varies by plan.

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

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

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

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

Examples:

- Divorce or legal separation
- Dependent child turns age 26
- Death of a 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 continuation of coverage.

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

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

■ Can I Change My Mind about the Plans I’ve Chosen?

1. Open Enrollment

There is an annual Flexible Benefits Program Open Enrollment period, which generally takes place in November. New choices can be made at that time, including changes in plans, re-enrollment and enrollment in Flexible Spending Account(s), and the addition of existing dependents. During each Open Enrollment, you’ll want to review your options and decide whether your current selections still fit your needs. For instance:

- Is a dental or vision plan cost-effective for you?
- Would a Flexible Spending Account save you money?

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

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

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

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

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

- **Change in legal marital status**, including marriage, registration of domestic partnership, death of spouse, divorce, legal separation, termination of a domestic partnership, and annulment; **with the consequence that there is a gain or loss of coverage due to the change in marital status;**
- **Change in number of tax dependents**, including birth, adoption, placement for adoption or death of a dependent; **with the consequence that there is a gain or loss of coverage due to the change in tax dependents;**
- **Change in employment status or work schedule**, including the start or termination of employment by you, your spouse, or your dependent child; this could also include a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite; any other changes in employment status that change eligibility of the employee, spouse or tax dependent under the benefit plan, such as a change from part-time to full-time or full-time to part-time status, a change from salaried to hourly-paid, or hourly-paid to salaried employment, ***with the consequence that an individual becomes (or ceases to be) eligible under the plan, constitutes a change in employment status under this section;***
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them. Events that cause an employee's tax dependent to satisfy or cease to satisfy eligibility requirements for coverage are: attainment of age, or any similar circumstance as provided in the health plan under which the employee receives coverage; the change allowed is restricted to adding or dropping coverage for the dependent affected;
- **Change in the place of residence** of the employee, spouse or tax dependent that affects the employee's eligibility for coverage (e.g., moving out of the HMO service area of the employee's current plan, or change that affects the accessibility of network providers of the employee);
- **Change in an individual's eligibility for Medicaid or Medicare**, such as an employee, spouse or tax dependent becoming entitled to or losing coverage under Medicaid or Part A or Part B of Medicare;
- **A judgment, decree, or court order** resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for an employee's child, or for a foster child, or any other change in status that entitles an employee, spouse or tax dependent to change benefit elections pursuant to COBRA (Consolidated Omnibus Reconciliation Act), HIPAA (Health Insurance Portability and Accountability Act) or any other law;
- **An event that is a special enrollment event under HIPAA**, including acquisition of a new dependent (when an employee, spouse or new tax dependent is entitled to enroll in a health plan

under HIPAA's special enrollment rules, the employee may also elect to enroll other pre-existing dependents or spouse), or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:

- Voluntary or involuntary termination of employment or reduction in hours of employment, or death, divorce or legal separation;
 - Termination of employer contributions toward the other coverage, OR
 - If the other coverage was COBRA Continuation Coverage, exhaustion of the coverage;
- A significant increase or decrease in premium cost or coverage, the elimination of an existing plan, or the availability of a new group plan (applies to health plans and Dependent Care Flexible Spending Accounts; does 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 pledge 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 contributions end, or the end of *your* Plan Year.

■ Summary:

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

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

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

Qualified Medical Child Support Order (QMCSO)

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

■ When Does Coverage End?

1. New Plan Year

If you make changes to your plan selections during Open Enrollment, the health plan changes become

effective at the beginning of the pay period that includes January 1st of the next year. If you are on an approved Leave of Absence, see the “Open Enrollment” section earlier in this chapter.

Example: If the new Plan Year begins on January 1, coverage under the new plan begins on January 1, and your last day of coverage under the old plan would be December 31. 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, loss of eligibility as a dependent child, etc.), whichever occurs first.

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

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

Direct Notification to the Plan is not Sufficient.

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

- Your medical plan will send your dependent a *Certification of Prior Coverage*.¹
- 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.²
- Federal COBRA laws and regulations do not apply to domestic partners or their dependent children.

3. Termination of Employment

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

- 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

4. Eligible for Retirement with a Pension?

If you are retiring and want information on County retiree health plan options, call (805) 662-6791 for a Retiree Health Benefits Program handbook and rate sheet. The Retiree Health Benefits Program handbook and rate sheet are also available on the following websites: <http://vcweb/ceo/HR/Benefits> (under “Flexible Benefits Program”), or <http://www.ventura.org/benefits> (under “Medical, Dental, and Vision insurance”).

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.

5. Leave of Absence

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

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

To continue coverage once your County contributions end, or if the County contribution is less than the cost of your premiums, you must make biweekly premium payments directly to the County. After one year on leave, if you have continued your health plan premiums payments, you may qualify for extended health coverage under COBRA continuation of coverage provisions.² If your medical coverage lapses

while you are on leave, you will be sent a *Certification of Prior Coverage*.¹

If you are considering a Leave of Absence, be sure to read the *Leave of Absence* section of the chapter on Miscellaneous Benefits and Employee Notices in Appendix B.

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 Pre-existing 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.

On-Line Resources

-  www.ventura.org/benefits
-  vcweb/ceo/HR/Benefits
-  [VCHRP](#)
 - *Self-Service* → *Benefits*
-  **Health Plan websites**
 - VCHCP (www.vchealthcareplan.org)
 - UnitedHealthcare
 - HMO (www.uhcwest.com)
 - PPO (www.myuhc.com)
 - MetLife (www.metlife.com/mybenefits)
 - MES Vision (www.mesvision.com)

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, out-of-pocket expenses, and networks, as well as premiums. Depending on your family's needs, the "best" plan for you may not be the most expensive, or the least expensive plan. By studying the plan descriptions in the Comparison of Medical Plan Benefits Chart that follows, and comparing the networks and premiums, you can determine which plan is best for you and your family. This chapter also reviews your options if you do not wish to enroll in medical coverage through the County.

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

■ Types of Plans

Health Maintenance Organization (HMO)

A 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 outside the plan's network of providers, you will not be entitled to coverage by the plan.

At the time you enroll, you must choose a PCP for yourself and each eligible dependent from the plan's panel, 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 Organization (PPO)

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

■ What Plans are Available?

The County offers you four medical plans to choose from:

- UnitedHealthcare HMO – Network 1
- UnitedHealthcare HMO – Network 2
- UnitedHealthcare HMO – Network 3
- UnitedHealthcare High Deductible Health Plan (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.

■ UnitedHealthcare HMO – Networks 1, 2, & 3

UnitedHealthcare's HMO offers 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.

For the UnitedHealthcare HMO network plans, medical groups have been placed in one of three distinct HMO networks – Network 1, Network 2, or Network 3, based on how they meet specific health care costs and quality ratings (established annually by the California Office of the Patient Advocate). Members can help manage their own health care costs by selecting a plan and provider network to meet their specific needs and preferences.

Employees who enroll in one of the three UnitedHealthcare HMO plans will select one provider network (Network 1, Network 2, or Network 3) for themselves and their dependents. They and their dependents will remain in that network plan for the entire plan year. Each employee will also select his or her own Primary Care Physician (PCP) within the selected network, and each dependent must also select a Primary Care Physician within the same selected network. To search for specific doctors within each network plan, you may access the UHC provider directories on UHC's website: www.uhcwest.com (select "UnitedHealthcare Signature Value Flex – Network 1," "UnitedHealthcare Signature Value Flex – Network 2," or "UnitedHealthcare Signature Value Flex – Network 3"), or contact UHC directly using the contact information listed on the back cover of this handbook.

The primary care physician that you choose provides basic medical care and coordinates referrals to other providers, when needed. The network includes specialists, hospitals, and allied health professionals.

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 ID 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 UnitedHealthcare HMO service areas, you can enroll your dependent in the Out-of-Area Plan. After a \$3,000 annual deductible, the plan pays 70% for most covered services if using a Preferred Provider and 50% 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 UnitedHealthcare Out-of-Area Plans, call the Benefits Service Representative at (805) 654-2570.

■ UnitedHealthcare High Deductible Health Plan (PPO)

This is a Preferred Provider Organization (PPO) plan, which offers greater flexibility in obtaining care. Each time care is needed, you decide where to receive treatment and who will provide it. You have the option of obtaining care from any UnitedHealthcare PPO provider or any non-PPO provider, with your out-of-pocket expenses being less with a UHC provider.

It also is a High Deductible Health Plan, and the deductibles for Plan Year 2015 are \$3,000 for employee-only coverage and \$6,000 for family coverage (if you have family coverage, the \$6,000 deductible will apply regardless of the number of family members who are receiving treatment). Please note that the deductible, which must be met before the plan benefits are payable, applies to **all** expenses (except preventative care).

Self-Referral to PPO Provider:

You may seek care from any one of 50,000 UHC PPO providers. For basic physician services, you pay 30% after deductible. For most other services, you pay 30% 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 received from a non-network provider, the plan pays 50% of an amount based on 110% of the Medicare published rates, and you pay the remainder, plus the annual deductible amount. You may be responsible for filing your own claims.

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

If you are enrolled in this plan, you are also eligible to participate in a Health Savings Account (HSA), if you choose to do so. Once your enrollment in the UnitedHealthcare High Deductible Health Plan (PPO) is processed, we will send you information from HealthEquity, a third party administrator, on how to set-up an HSA with pre-tax contributions taken from your County paycheck, if you choose to have an HSA.

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

Family Out-of-State Option

The UnitedHealthcare High Deductible Health Plan (PPO) is available in California as well as out-of-state.

■ Ventura County Health Care Plan (HMO)

The Ventura County Health Care Plan (VCHCP) is a licensed HMO that arranges for the provision of cost-effective health care services for its members.

As a member of VCHCP, you will select a Primary Care Physician (PCP) who will oversee your health care needs. Members may select different 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, Ventura County Medical Center (VCMC)/Santa Paula Hospital, or an associated VCMC ambulatory care clinic. Services are also available, after any required copayment, from a variety of contracted community primary care and specialty care physicians, hospitals and facilities.

Additional Plan benefits include, but are not limited to:

- Members have access to a number of contracted urgent care facilities located throughout the County of Ventura.
- Female members may self-refer for OB/GYN services by selecting a listed Direct Access OB/GYN in the Provider Directory
- Members may self-refer for an annual vision refraction exam, and for chiropractic and acupuncture services. (Reimbursement varies; for benefit details, see Comparison Chart in this chapter).

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

Exception:

- A subscriber who works in the County of Ventura
- A child under the age of 26

(Please see Chapter 1 for eligible dependent requirements.)

Dependent Living Outside Ventura County

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

For more information on VCHCP, please call VCHCP Member Services at (805) 981-5050.

■ Medical Plan Opt-Out

If you are a covered dependent (as a spouse, registered domestic partner, or as a former employee/retiree) under another comprehensive employer 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 TRICARE, Medicare Parts A and B, and other employer group health plans. For more information, be sure to read the section titled “*If You and Your Family Are Covered by More Than One Plan*” later in this chapter.

To opt-out, select “Opt-Out” on the *Enrollment & Change Form*, complete the County’s *Proof to Opt-Out of County of Ventura Medical Plans* form, attach proof that you have other employer-group medical coverage (for example, a copy of the front and back of your medical plan identification card or a letter from the insurer with information on your coverage), and submit the documents to CEO-Human Resources/Benefits.

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

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

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

No Medical Coverage

There may be a reason, such as a religious principle, that you wish to decline medical coverage altogether. Unlike the Medical Plan Opt-Out option, you 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 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 UnitedHealthcare 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

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)	UnitedHealthcare HMO Networks 1, 2 & 3* <small>*See page 2-2 for an explanation of network differences</small>	UnitedHealthcare High Deductible Health Plan (PPO)	
			Participating Provider	Non-Participating Provider
Deductible <i>(Per Member/Per Family)</i>	None	None	Applies to all expenses except preventative care: \$3,000/\$6,000 ⁵	
Maximum Out-of-Pocket Expense	Copayments made to providers for covered medical, pharmacy, and behavioral health services apply toward OOPM	Excludes premiums and health care expenses that this plan doesn't cover	All deductibles, coinsurances and copayments for covered medical, mental health (severe & non-severe), chemical dependency and pharmacy apply towards OOPM. EXCEPTION: Deductibles, coinsurance and copayments paid for services for which certification was required but not obtained will not apply to the OOPM.	
Per Member/Per Family	\$3,000/\$6,000	\$2,000/\$4,000/\$6,000	\$5,000/\$10,000	
PHYSICIAN SERVICES				
Office visits <i>(consultations and in-office procedures)</i>	\$20 copay per visit at non-VCMC provider; no copay with VCMC provider	100% coverage after \$20 copay per visit	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Maternity Care	\$20 copay for initial visit only at non-VCMC provider; no copay with VCMC provider	Same as office visit	Same as office visit	Same as office visit
Specialist	\$30 copay per visit at non-VCMC provider; no copay with VCMC specialist	Same as office visit, referral needed	Same as office visit	Same as office visit
Periodic Health Evaluation <i>(includes annual preventative physical examinations)</i>	100% coverage with VCMC providers	100% coverage (no copay)	100% coverage (no copay)	Not covered
OB/GYN Services, including Well Woman Annual Exam <i>(exam, pap smear & associated tests)</i>	100% coverage with VCMC providers; may self-refer to any OB/GYN who participates in the Plan's Self-Referral Program for most OB/GYN services	100% coverage (no copay); may self-refer to any OB/GYN in PCP's IPA for any OB/GYN services	100% coverage (no copay)	Not covered
Well child, including immunizations <i>(birth through age 18)</i>	100% coverage (no copay)	100% coverage (no copay)	100% coverage (no copay)	Not covered
Adult Immunizations	100% coverage (no copay) <i>(excluding occupational; ACIP-approved travel immunizations are covered)</i>	100% coverage <i>(excluding travel & occupational)</i>	100% coverage <i>(excluding travel & occupational)</i>	Not covered
Allergy Testing & Treatment <i>(includes injections/serum)</i>	100% coverage	100% coverage after \$20 office visit copay	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³

	Ventura County Health Care Plan (HMO)	UnitedHealthcare HMO Networks 1, 2 & 3* <small>*See page 2-2 for an explanation of network differences</small>	UnitedHealthcare High Deductible Health Plan (PPO)	
			Participating Provider	Non-Participating Provider
HOSPITAL/FACILITY				
Inpatient Services and Supplies ⁶	\$150 per day copay, up to \$600 maximum; no copay at VCMC/SPH \$3,000 copay for bariatric surgery	100% coverage after \$500 copay per admit	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Skilled Nursing Facility	\$50 per day copay, \$500 maximum, up to 100 combined days for all stays.	100% coverage Limited to 100 consecutive days per member, per calendar year.	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Outpatient Surgery ⁶	\$250 copay at non-VCMC ¹⁰ facilities when preauthorized; no copay at VCMC/SPH	100% coverage after \$500 copay	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Emergency Room <i>(covers emergency services only)</i>	\$75 copay; copay waived if directly admitted	100% coverage after \$100 copay; copay waived if directly admitted	70% of Negotiated Allowance ² (deductible waived if directly admitted)	70% coverage ³ (deductible waived if directly admitted)
OTHER SERVICES				
Ambulance <i>(when medically necessary)</i>	\$50 copay by ground; \$200 copay by air	100% coverage after \$100 copay (air and ground)	70% of Negotiated Allowance ² (air and ground)	70% coverage ³ (air and ground)
Urgent Care	\$50 copay, no PCP or Plan referral required	100% coverage after \$20 copay; copay waived if directly admitted	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Rehabilitation Therapy <i>(includes physical, speech, occupational, cardiac, and respiratory therapy)</i>	\$10 copay at VCMC/SPH or \$20 copay per visit at other contracted facilities	100% coverage after \$20 copay	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Chiropractic/Acupuncture	Plan reimburses \$20 per visit to any chiropractor/acupuncturist, limited to 15 combined chiropractor/acupuncturist visits per Plan Year ⁷	Not covered	24 Manipulative Treatments covered as part of Rehabilitation Services Benefit (30% coinsurance) Acupuncture Not Covered	24 Manipulative Treatments covered as part of Rehabilitation Services Benefit (50% coinsurance) Acupuncture Not Covered
Imaging (MRI, CT, PET)	No copay at VCMC/SPH; \$125 copay at contracted, non-VCMC facilities	100% coverage after \$100 copay	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Diagnostic/screening X-ray, Ultrasound, Laboratory <i>(Outpatient)</i>	100% coverage at VCMC/SPH and contracted facilities	100% coverage (no copay)	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³

	Ventura County Health Care Plan (HMO)	UnitedHealthcare HMO Networks 1, 2 & 3* <small>*See page 2-2 for an explanation of network differences</small>	UnitedHealthcare High Deductible Health Plan (PPO)	
			Participating Provider	Non-Participating Provider
Hospice	Inpatient: 100% coverage Outpatient: 100% coverage; prognosis of life expectancy of one year or less	Inpatient: 100% coverage Outpatient: 100% coverage; prognosis of life expectancy of one year or less	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Home Health Services	\$15 copay per visit; 100 visits per calendar year (max does not apply to Behavioral Health treatment)	100% coverage after \$20 copay. (limited to 100 visits per calendar year)	70% of Negotiated Allowance ²	50% coverage ³
Durable Medical Equipment	100% coverage (no copay); 50% copay for replacement when medically necessary	100% coverage (no copay). (limited to a benefit maximum of \$5,000 each calendar year)	70% of Negotiated Allowance ² (limited to a combined PPO/OON benefit maximum of \$5,000 each calendar year)	50% coverage ³ (limited to a combined PPO/OON benefit maximum of \$5,000 each calendar year)
Annual Eye Refraction Exam	Plan reimburses cost of refraction exam, up to \$50 per person per calendar year; no PCP referral needed; claims must be submitted within 180 days from the date of service ⁷	100% coverage after \$20 copay for exam with refraction; requires referral from PCP	70% coverage (30% coinsurance)	Not Covered
BEHAVIORAL HEALTH				
Mental Health & Substance Abuse Services <i>(Up to 5 free County Employee Assistance Program (EAP) visits per Plan Year)</i>	Self-referral to any “Life Strategies” provider; PCP referral not required	Contact U.S. Behavioral Health Plan, California (USBHPC) for prior authorization - (800) 999-9585	Self-referral to any UnitedHealthcare Participating PPO Provider	Contact U.S. Behavioral Health Plan, California (USBHPC) for prior authorization - (800) 999-9585
Inpatient ^{1, 6, 9}	Through VCHCP’s “Life Strategies” Program only \$150 per day, up to \$600 maximum per stay	With UnitedHealthcare-contracted Providers only 100% coverage after \$500 copay per admission	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Residential/Alternative Treatment ^{1, 6, 9}	Through VCHCP’s “Life Strategies” Program only \$50 per day, up to \$500 maximum per stay	With UnitedHealthcare-contracted Providers only 100% coverage after \$500 copay per admission	70% of Negotiated Allowance ² (30% coinsurance)	50% coverage ³
Outpatient ^{1, 9}	Through VCHCP’s “Life Strategies” Program only \$20 copay per visit	With UnitedHealthcare-contracted Providers only 100% coverage after \$20 copay per visit; no visit maximum	With UnitedHealthcare-contracted Providers only 70% of Negotiated Allowance ² (30% coinsurance); no visit maximum	50% coverage ³

	Ventura County Health Care Plan (HMO)	UnitedHealthcare HMO Networks 1, 2 & 3* <small>*See page 2-2 for an explanation of network differences</small>	UnitedHealthcare High Deductible Health Plan (PPO)	
			Participating Provider	Non-Participating Provider
PRESCRIPTION BENEFITS				
Outpatient Prescriptions	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.
Plan’s Local Pharmacy Network <i>(Retail Pharmacy)</i>	100% for 30-day supply, after copay ¹ of: Tier 1 - \$9 Tier 2 - \$30 Tier 3 - \$45 Tier 4* - 25% up to \$150, \$300 max per month if multiple prescriptions * Specialty Drugs 50% for covered infertility drugs	100% for 30-day supply, after copay ¹ of: \$15–Generic \$30–Brand-Name Formulary \$50–Approved Non-Formulary Injectable Specialty Drugs covered as a medical benefit at 20% coinsurance up to \$100; oral Specialty Drugs follows Rx copay above 50% for infertility drugs (covered under infertility rider)	Contracting Pharmacies: 100% for 30-day supply, after copay ¹ of: \$15–Generic \$30–Brand-Name Formulary \$50–Approved Non-Formulary Specialty Drugs covered via mail order for a 30-day supply 70% for infertility drugs (\$2,000 lifetime max)	Non-Contracting Pharmacies: 50% for 30-day supply, after copay ¹ of: \$15–Generic \$30–Brand-Name Formulary \$50–Approved Non-Formulary Specialty Drugs covered via mail order for a 30-day supply 50% for infertility drugs (\$2,000 lifetime max)
Plan’s Mail-Service	100% for 90-day supply after copay ¹ of: Tier 1- \$20 Tier 2- \$60 Tier 3- \$90 50% for covered infertility drugs	100% for 90-day supply after copay ¹ of: \$30–Generic \$60–Brand-Name Formulary \$100–Approved Non-Formulary	100% for 90 day supply after copay ¹ of: \$30–Generic \$60–Brand-Name Formulary \$100–Approved Non-Formulary	Not covered; must use OptumRx for mail-order pharmacy services (see Participating Provider section)

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.

*See page 2-2 for an explanation of network differences between UnitedHealthcare HMO Networks 1, 2, and 3.

ELIGIBLE DEPENDENTS

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

- * Your current legal husband or wife.
- * Your domestic partner, **if** you provide documentation that you and your partner have registered a Declaration of Domestic Partnership with the Secretary of State or a California county or municipality.
- * Any natural child, stepchild, adopted children, children of domestic partners, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted up to age 26. Unless stated otherwise for that plan, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews and non-relatives. Certain children age 26 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.

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 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 **110% of the Medicare published rates**. Member pays the applicable co-insurance and is also responsible for amounts charged by the provider in excess of this co-insurance.
- 4 Coverage for diagnosis and treatment of infertility does not include laboratory medical procedures involving the actual in vitro fertilization process.
- 5 There is no per member deductible accumulation/accrual. It is a single comprehensive family deductible. If a member changes plan status from family to individual, any family deductible amount will be applied to the new individual deductible. In addition, if a member changes plan status from individual to family, any individual deductible amount will be applied to the new family deductible. No one in the family is eligible for benefits until the family coverage deductible is met.
- 6 Prior authorization may be required, except under emergency conditions. Prior authorization arrangements will be made by your plan provider or plan-authorized specialist. If prior authorization is not obtained for scheduled hospital admissions and surgeries, services will not be covered.
- 7 VCHCP: Chiropractic, Acupuncture, and Eye Refraction claims must be submitted within 180 days from the date of service.
- 8 UnitedHealthcare HMO and PPO Plans: 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.
- 10 There is no copayment to the member for services if the service is available and obtained at VCMC/SPH. If the service is not available at VCMC/SPH, for whatever reason, the member will need to obtain the service at another contracted facility and a copay will apply.

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

Chapter 3

Dental Plan Option

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

- Regular dental checkups have been proven to reduce the need for later extensive dental procedures. Not going to the dentist regularly could result not only in more cost, but also in more pain and discomfort in the future.
- Studies have also shown that there is a link between your oral health and your overall general health. Specifically, good oral health has been associated with decreased risk of coronary heart disease and lower incidence of premature delivery of low birth weight babies.

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

■ What Plan is Available?

If you decide to enroll in a dental plan, the County offers the MetLife Dental PPO.

■ MetLife Dental PPO

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

Please note: If you choose a licensed dentist who does not participate in the PPO Dental network, your out-of-pocket expenses will be greater. You will be responsible for your annual deductible and for your portion of the Covered Expenses plus charges in excess of Covered Expenses. Covered Expense is either the customary and reasonable charge or the Maximum Allowable Fee Schedule for professional services, depending on your plan. Please see your Certificate of Insurance (Certificate) for details. You 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 online, including the ability to print an ID card: www.metlife.com/mybenefits. You may also call their customer service department at (800) 438-6388.

Providers

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

MetLife Dentist – When you use one of the MetLife dentists in California, the dentist's fees have been pre-approved. The MetLife dentist bills MetLife directly, so you have no claim forms to complete, and are responsible only for your portion of the bill. For a MetLife dentist provider directory, you can call MetLife at (800) 438-6388, or find a dentist online at: www.metlife.com/mybenefits. When asked to select Network Type, select the "PDP Plus" option.

Covered Fees

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

Predetermination of Costs

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

Coordination of Benefits (Dual Coverage)

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

Limitations and Exclusions

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

MetLife Dental PPO Group Number 0154209		
	In DPO Network	Out of DPO Network
CALENDAR YEAR DEDUCTIBLE Per Member/Per Family	\$15/\$45	\$25/\$75
MAXIMUM BENEFIT Each Calendar year (excluding MPD-TMJ and Orthodontics)	\$2,000 per person	\$1,000 per person
SEPARATE LIFETIME MAXIMUM: Orthodontic Benefits	\$1,000 per person	
Benefits Coverage	In DPO Network	Out of DPO Network
DIAGNOSTIC/PREVENTIVE SERVICES		
Oral exam, x-rays	No charge for all diagnostic and/or preventive services	Plan pays 80% Deductible does not apply
Biopsy/Tissue Exam, Study Models		
Prophylaxis (cleaning)		
Topical fluoride treatment Up to age 18 Adult		
Emergency Palliative Treatment Normal Office Hours After Hours		
Space maintainers Fixed Removable		
BASIC BENEFITS		
Oral Surgery: Simple Extraction; Local Anesthesia; Frenulectomy; Pre/Post-Operative visits	100% Coverage (after copay, if applicable)	Plan pays 80% (after you have met your deductible)
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		

		MetLife Dental PPO Group Number 0154209	
Benefits Coverage	In DPO Network	Out of DPO Network	
BASIC BENEFITS (continued)			
Restorative: (treatment of carious lesions results from dental decay)	100% Coverage (after copay, if applicable)	Plan pays 80% (after you have met your deductible)	
Amalgam			
Resin/Composite ¹			
Endodontic – Tooth Pulp:			
Pulp capping; Pulpotomy			
Recalcification/Apexification			
Root Canal (per canal)			
Apicoectomy Anterior & Bicuspid, first root Molar, first root Each additional root			
Retrograde filling, per root			
Sealants – Topically applied materials to permanent posterior molars to prevent decay			
Periodontic – treat gums, bones, and supporting teeth:			
Emergency Treatment			
Subgingival curettage & root planning 1-3 teeth Per quadrant			
Gingivectomy/Gingivoplasty 1-3 teeth Per quadrant			
Correction of occlusion			
Osseous Surgery 1-3 contiguous/bounded teeth (per quad) 4+ contiguous/bounded teeth (per quad)			
ORTHODONTIC BENEFITS – ADULT OR CHILD (Malalignment of teeth or jaws)			
Full banded case	Plan pays 50%, up to \$1,000 lifetime maximum		
Partial banded case			
Consultation fee (including study models)			

¹ Benefit applies to anterior (front) teeth only

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

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

Chapter 4

Vision Coverage Options

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

■ What Options are Available?

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

Medical Eye Services (MES) – Vision Plan

MES offers the largest and most comprehensive network in California and nationally through its provider network, The Eye Care Network (ECN). In California alone there are over 6,000 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. A Participating Provider Directory and MES Claim Form can be obtained by visiting the MES website at www.mesvision.com, or by contacting MES directly at (800) 877-6372 or (714) 619-4660.

2. 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.

3. 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 can be 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.

Medical Eye Services (MES)

Summary of Benefits

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

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

■ Medical Eye Services Limitations & Exclusions

MEDICAL EYE SERVICES – LIMITATIONS

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

MEDICAL EYE SERVICES – EXCLUSIONS

- Any eye examinations required by an employer as a condition of employment;
- Any covered services provided by another vision plan;
- Conditions covered by Workers' Compensation;
- Contact lens insurance or care kits;
- Covered services which began prior to the insured's effective date, or after the benefit has terminated;
- Covered services for which the insured is not legally obligated to pay;
- Covered services required by any government agency or program, federal, state or subdivision thereof;
- Covered services performed by a close relative or by an individual who ordinarily resides in the insured's home;

- Medical or surgical treatment of the eyes;
- Non-prescription (plano) eyewear;
- Orthoptics, subnormal vision aids or vision training;
- Services that are experimental or investigational in nature;
- Services for treatment directly related to any totally disabling condition, illness or injury.

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.

UnitedHealthcare HMO – Networks 1, 2, & 3

For the UnitedHealthcare HMO plans, you pay a **\$20 office visit copayment** for the annual eye examination with refraction. **A referral from your Primary Care Provider is required.**

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's website (<http://www.vchealthcareplan.org>).

Claims must be presented to VCHCP within 180 days from the date of the exam.

VCHCP does not cover materials such as frames and lenses.

■ Vision-Related Discounts

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

■ Health Care Flexible Spending Account

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

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

Chapter 5

Flexible Spending Account Options

For information on the Court's Flexible Spending Account, refer to the Court's intranet at http://courtweb/hr_emp_benefits.html.

Chapter 6

Miscellaneous Benefits

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

Programs described in this chapter:

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

Forms and information can be found on the Court Human Resources' intranet <http://courtweb/hr.html>)

■ Employee Assistance Program

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

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

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

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

■ 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.

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

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

■ Deferred Compensation Program

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

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

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

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

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

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

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

Deferred Compensation Contact Information

Fidelity Investments:

Telephone: (800) 343-0860

Website: <http://netbenefits.com/ventura>

Deferred Compensation Program:

Telephone: (805) 654-2620

E-mail: deferred.compensation@ventura.org

Intranet: http://vcweb/ceo/HR/Benefits/Deferred_Comp.htm

Internet: <http://www.ventura.org/benefits/deferred-compensation>

Comparison of Deferred Compensation Plans

	Section 457 Plan	401(k) Shared Savings Plan
Matching Contribution¹	No matching County contribution	For most employees, the County provides a matching contribution when you participate in the Plan. The amount varies by group.
Annual Contributions¹	In addition to the regular IRS annual contribution limit, you may be able to make Special and Baby Boomer Catch-up contributions.	In addition to the regular IRS annual contribution limit, you may be able to make Baby Boomer Catch-up contributions.
Loans Against Your Account Balance	Not available	Loans of up to \$50,000 or 50% of your vested account balance are available after 12 months of participation.
Fund Withdrawals While Employed <i>(In most circumstances, you cannot withdraw funds while you are still employed by the County)</i>	You may withdraw your balance in a small, inactive account if you have not contributed for at least two years. An emergency withdrawal may be allowed for severe financial need if it is determined that your request meets Internal Revenue Code 457 guidelines.	A hardship withdrawal may be allowed for an immediate and heavy financial need if it is determined that your request meets Internal Revenue Code 401(k) guidelines.
Taxes and Penalties on Distributions	<p>Pre-Tax Option - Distributions are taxed as regular income when they are withdrawn from your account.</p> <p>After-Tax Roth Option – Distributions are tax free if you meet the requirements of a Qualified Distribution.²</p> <p>No penalties for distribution prior to age 59½.</p>	Distributions are taxed as regular income. A 10% penalty will also apply before age 59½, unless you leave service on or after age 55 and in other limited circumstances.
Distribution Options at Termination or Retirement	<p>You can remain in the Plan, set up systematic withdrawals, purchase an annuity, transfer to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, or take a lump sum distribution.</p> <p>You do not have a deadline to choose your payout date and option until you are subject to IRS minimum required distribution rules.</p>	<p>You can remain in the Plan, set up systematic withdrawals, transfer to an Individual Retirement Account (IRA) or to another employer's workplace savings plan, or take a lump sum distribution.</p> <p>You do not have a deadline to choose your payout date and option until you are subject to IRS minimum required distribution rules.</p>

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

² A Qualified Distribution is one that is taken at least five years after the first Roth 457 contribution and you have attained age 59 ½.

■ Retirement Pension Plans

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

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

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

■ Absence Management Program

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

Events that may qualify for a Leave of Absence include:

- Illness
- Injury
- Pregnancy/Maternity
- Military Service
- Industrial Leave
- Family Care Leave/Bonding
- Military Family Care Leave
- Adoption/Foster Care Placement
- Educational/Academic
- Organ and Bone Marrow Donation
- Personal

If you are thinking about taking a leave of absence, contact Court Human Resources for information. Review the information provided to you thoroughly for important information on these topics and more:

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

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

Important!

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

■ Life & Disability Insurance Programs

Optional Life Insurance

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

If you enroll within your first 90 days of eligibility, you may elect guaranteed optional life coverage of \$10,000 or one times your base annual earnings with no Evidence of Insurability required. Complete an Enrollment form along with a Beneficiary Designation form (found on the Benefits' intranet and internet websites; see back cover of this book) 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 enrollment form and an Evidence of Insurability form for any level of coverage.

If you wish to enroll in two or three times your base salary, you must complete an enrollment form

and an Evidence of Insurability form. Your application is subject to approval by Minnesota Life.

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 including the last pay period during which a premium contribution was taken from your pay. In many cases, you can continue your insurance under the Portability Option for up to two years after you leave County employment. Optional Life Insurance brochures are available from your department's Personnel Representative, or by accessing the Benefits' intranet or internet website (listed on the back cover of this book).

Dependent Life Insurance

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

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

If you enroll them with your initial enrollment, no dependent Evidence of Insurability forms are needed. Once you have dependent 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; \$2,000 on each dependent
High Option: \$10,000 spouse; \$5,000 on each dependent

The level of dependent coverage cannot exceed 50% of your employee coverage. For example, you are only 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. If you need to change your beneficiary, you may complete the Basic Life Insurance Enrollment Form found on the Benefits intranet and internet websites (listed on the back cover of this book).

■ Long-term Disability (LTD)

You are automatically enrolled in LTD if you are a Manager, Confidential Clerical, Unrepresented Other, CJAAVC-represented employee, CNA-represented employee, IUOE-represented employee, VEA-represented employee, or Sheriff's Service Technician. Nurses, Nursing Care Coordinators I-II, Clinical Coordinators, and Clinical Coordinators-Surgical Services who are covered by the Annual Leave program also participate. To be eligible for benefits, you must be scheduled for and working at least 60 hours a biweek, for all eligible employees not covered by the County of Ventura's Management Resolution.

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 earnings history. You are eligible to file an SDI claim once you have made SDI contributions for at least six months. If you were covered under SDI on your last job, your contributions carry over to the County.

SDI is not a County-provided benefit. If you have an SDI question, you may call the State Disability

Insurance Program at (800) 480-3287 or visit their website at www.edd.ca.gov.

■ Paid Family Leave Benefits Program (PFL)

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

Beginning July 1, 2014, California workers may be eligible to receive PFL benefits when taking time off of work to care for a seriously ill parent-in-law, grandparent, grandchild, or sibling. For more information, see Senate Bill 770.

**For Information on the
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

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.

■ \$1,000 Employee Death Benefit

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

■ Long-Term Care Plan

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

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

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

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

■ Ventura County Wellness Program

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

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

To view the Wellness Program resources, current schedule, or to register, visit the Wellness Program website at:

<http://www.ventura.org/benefits/wellness-program>

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

■ Work/Life Program

The County's Work/Life 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 continue to nurse their babies.

County employees are also eligible for discounts at numerous childcare centers throughout the County. The Work/Life Program also sponsors Balancing Work/Family seminars and Positive Parenting classes through the Wellness Program as well as an elder care support group.

For more information on elder care resources or childcare resources, contact the County's **Work/Life Program** at:

(805) 477-7234

or go to their website at:

<http://www.ventura.org/benefits/work/life-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, substantial portions of equipment, and professional, technical, and administrative staffs. Patients will generally be referred to a specialist within the group.

Individual Practice Association (IPA)

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

Preferred Provider Organization (PPO)

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

Primary Care Provider/Physician (PCP)

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

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

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

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

(Courtesy of Northwestern National Life)

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

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

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

■ Patients' Rights

As a health plan member, you have important rights such as the right to privacy, access to quality health care, and the right to participate fully in medical decisions affecting you and your family. You owe it to yourself to do at least as much homework and ask as many questions about your health care as you do

before you purchase an automobile or have work done on your house. If any aspect of a medical procedure is confusing to you, ask your doctor for a simple, clear, complete explanation.

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

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

You can help protect your rights by doing the following:

- Express your health care needs clearly.
- Build mutual trust and cooperation with your providers.
- Treat providers and plans with the same consideration and respect you expect to receive.
- Give relevant information to your health care provider about your health history and condition.
- Contact your providers promptly when health problems occur.

- Ask questions if you don't understand a medical condition or treatment.
- Be on time for appointments.
- Notify providers in advance if you can't keep your health care appointment.
- Adopt a healthy lifestyle and use preventive medicine, including appropriate screenings and immunizations.
- Familiarize yourself with your health benefits and any exclusions, deductibles, copayments, and treatment costs.
- Understand that cost controls, when reasonable, help keep good health care affordable.

How and where to get help:

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

Health plans are licensed under a California law known as the Knox-Keene Health Care Service Plan Act of 1975. The Act is administered by the California Department of Managed Health Care (DMHC). The DMHC has established a toll-free telephone number to receive and address complaints against health care services. The toll-free number is (888) HMO-2219, or (888) 466-2219. If you wish to file a complaint against your health plan with the DMHC, please do so only after you have contacted your health plan and used the plan's grievance process. However, you may immediately file a complaint with the DMHC in an emergency medical situation. You may also file a complaint with the DMHC if the health plan has not satisfactorily resolved your grievance within 60 days of filing.

Your Role in the Fight Against Health Care Cost Increases

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

Be an Informed Consumer

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

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

Use your Medical Plan Wisely

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

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

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

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

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

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

Check Your Medical Bills Carefully

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

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

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

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

(Based on an article by Northwestern National Life)

■ Prescription Drug Coverage

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

Generic Drugs/Brand Name Drugs

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

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

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

Drug Formulary

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

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

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

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

Mail Order Pharmacy Services

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

For Further Information

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

■ Why a Medical Plan Opt-Out Charge?

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

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

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

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

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

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

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

In the summer of 1999, the Medical Plan Opt-Out option was 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.

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, updated handbook or policies will be posted on the intranet reflecting any new or changing laws, regulations or benefits.

NOTICES TO COUNTY OF VENTURA EMPLOYEES

FMLA	Family and Medical Leave Act of 1993
PDL	Pregnancy Disability Leave – “Notice A” Your Rights and Obligations as a Pregnant Employee
CFRA/PDL	California Family Rights Act of 1993 – “Notice B” Family Care and Medical Leave and Pregnancy Disability Leave
DPA	Organ and Bone Marrow Donation Protection Act
PFL	Paid Family Leave Benefits Program
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
MEDICARE PART D	Important Notice about Your Prescription Drug Coverage and Medicare
HIPAA	Health Insurance Portability and Accountability Act of 1996
PPACA/HCERA	Patient Protection and Affordable Care Act/Health Care and Education Reconciliation Act

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES**Family and Medical Leave Act of 1993****Eligibility for FMLA**

You are eligible if you have worked for the County for at least one year and have worked at least 1,250 hours over the 12 months immediately preceding your leave. If you are eligible and the reason for the leave falls under the guidelines below, you may take up to 12 weeks (6 pay periods) of FMLA leave per calendar year. The 6 pay periods include any combination of paid and unpaid leave, including leave due to work-related illness or injury, except periods during which a safety member receives 4850 benefits. Under some circumstances, the leave may be extended beyond 6 pay periods, but FMLA provisions will not apply to the additional period.

FMLA Measuring Period

The FMLA entitles eligible employees up to 12 weeks of job-protected leave for the reasons described below during a predetermined 12-month period. Any leave of absence qualifying as FMLA, CFRA, or PDL will be counted as such. Entitlement to FMLA or CFRA will be counted on a “rolling” 12-month period (pursuant to 29 CFR Section 825.200 (b) (4)), measured backward from the date an employee uses any FMLA or CFRA leave.

Reasons for Taking a Leave

You may take a leave for the following reasons:

- For your own serious health condition that makes you unable to perform your job.
- For incapacity due to pregnancy, prenatal medical care or child birth; or
- To care for your child within the first 12 months after birth, or placement for adoption or foster care; or
- To care for your spouse, domestic partner, child or parent who has a serious health condition; or

Military Family Leave Entitlements

- Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies.
- FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period.

Substitution of Paid Leave for Unpaid Leave

- You may substitute paid leave for unpaid leave but the substitution will not extend the length of your FMLA leave.
- At your department’s discretion, and subject to the County’s integration leave policy and the collective bargaining agreement between the County and the bargaining unit which represents your job title, you may use leave bank hours in conjunction with disability benefits that result in the employee’s full biweekly base pay. The appropriate use of your leave bank hours must be because of and consistent with the type of leave granted.

Advance Notice and Medical Certification

If the leave is foreseeable, you must provide your supervisor with at least 30 days notice of the proposed leave. If it is unforeseeable, you need to notify your supervisor as soon as you learn of the need for the leave, but in any event no later than 5 working days from learning of the need for the leave. The County requires medical certification to support a request for leave or continuation of leave due to a serious health condition. Additional certifications may be required at intervals of 30 days during the leave. The County may also require you to provide a medical release statement from your health care provider.

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

Job and Benefits Protection

Most employees returning from leave will be restored to their original position or a position with equivalent pay, benefits, and other employment terms. This may not apply to certain highly compensated employees if necessary to avoid substantial and grievous economic injury to the County's operation.

You will not lose any employment benefits you had accrued (earned) before you went on leave, such as continuous service hours. If your job category is exempt under the Fair Labor Standards Act, your leave will not affect your exempt status.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to interfere with, restrain, or deny the exercise of any rights provided under FMLA; discharge or discriminate against any person for opposing any practice made unlawful by FMLA, and, discharge or discriminate against any person because of involvement in any proceeding under or related to FMLA.

Health Insurance Coverage

During your FMLA leave, the County will continue its regular contributions toward any County medical, dental, vision and Health Care Flexible Spending Account in which you are enrolled. If you normally pay a portion of the premiums through payroll deduction, you will need to pay that amount directly to the County to maintain that benefit while you are on an unpaid leave.

If your unpaid leave is extended beyond the maximum 6 pay periods of FMLA leave and you wish to maintain coverage for any remaining pay periods of approved leave, you are responsible for the premium, unless your union contract specifies an additional period of County contributions toward coverage.

Depending on the collective bargaining agreement between the County and the union that represents your job title, you may be required to repay the County for the premiums paid on your behalf if you don't return from your FMLA leave.

Intermittent or Reduced Leave

Most employees on leave of absence are completely off work for a specified period. Under some circumstances, with County approval or if medically necessary, you may use an alternative method:

- "Intermittent" leave means you take the leave in separate blocks of time, not continuously.
- "Reduced" leave means you reduce the hours in your regular work schedule.

FMLA Does Not:

- Affect any federal or State law prohibiting discrimination;
- Supersede any State or local law that provides greater family or medical leave rights;
- Diminish an employer's obligation to provide greater leave rights under a collective bargaining agreement or employment benefit plan, nor may the rights provided under FMLA be diminished by such agreement or plans; nor,
- Discourage employers from adopting policies more generous than required by FMLA.

FMLA Enforcement

The Secretary of Labor is authorized to investigate and attempt to resolve complaints of violations, and may bring an action against an employer in any federal or State court of law. FMLA's enforcement procedures parallel those of the federal Fair Labor Standards Act. The FMLA will be enforced by the department's Wage and Hour Division.

An eligible employee may bring civil action against an employer for violations. Employers who act in good faith and have reasonable grounds to believe their actions did not violate FMLA may have any damages reduced to actual damages at the discretion of the judge.

For information on eligibility for a leave and/or the impact of a leave on your seniority and benefits, refer to the applicable Memorandum of Agreement or Resolution between the County and the bargaining unit that represents your job title. If you are considering a leave of absence, your department's Personnel Representative can provide you with an *Absence Management Handbook* that explains your rights and responsibilities while on leave. FMLA, as well as applicable collective bargaining Memoranda of Agreement (MOAs), and Personnel Rules run concurrently. As a County employee, you may qualify for a leave of absence even if you are not eligible under these laws.

Information on FMLA is available from the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division. **You may contact the Department of Labor at 1-213-894-6375 or 1-866-487-9243, or visit their website at www.dol.gov/whd.**

NOTICE TO COUNTY OF VENTURA EMPLOYEES

California Family Rights Act of 1993

“Notice B”

Family Care and Medical Leave and Pregnancy Disability Leave

- Under the California Family Rights Act of 1993 (CFRA), if you have more than 12 months of service with your employer and have worked at least 1,250 hours in the 12-month period before the date you want to begin your leave, you may have a right to an unpaid family care or medical leave (CFRA leave). This leave may be up to 12 workweeks in a 12-month period for the birth, adoption, or foster care placement of your child or for your own serious health condition or that of your child, parent or spouse.
- Even if you are not eligible for CFRA leave, if disabled by pregnancy, childbirth or related medical conditions, you are entitled to take pregnancy disability leave (PDL) of up to four months, or the working days in one-third of a year or 17½ weeks, depending on your period(s) of actual disability. Time off needed for prenatal or postnatal care; doctor-ordered bed rest; gestational diabetes; pregnancy-induced hypertension; preeclampsia; childbirth; postpartum depression; loss or end of pregnancy; or recovery from childbirth or loss or end of pregnancy would all be covered by your PDL.
- Your employer also has an obligation to reasonably accommodate your medical needs (such as allowing more frequent breaks) and to transfer you to a less strenuous or hazardous position if it is medically advisable because of your pregnancy.
- If you are CFRA-eligible, you have certain rights to take BOTH PDL and a separate CFRA leave for reason of the birth of your child. Both leaves guarantee reinstatement to the same or a comparable position at the end of the leave, subject to any defense allowed under the law. If possible, you must provide at least 30 days advance notice for foreseeable events (such as the expected birth of a child or a planned medical treatment for yourself or a family member). For events that are unforeseeable, you must notify your employer, at least verbally, as soon as you learn of the need for the leave.
- Failure to comply with these notice rules is grounds for, and may result in, deferral of the requested leave until you comply with this notice policy.
- Your employer may require medical certification from your health care provider before allowing you a leave for:
 - your pregnancy;
 - your own serious health condition; or
 - to care for your child, parent, or spouse who has a serious health condition.
- See your employer for a copy of a medical certification form to give to your health care provider to complete.
- When medically necessary, leave may be taken on an intermittent or a reduced work schedule. If you are taking a leave for the birth, adoption or foster care placement of a child, the basic minimum duration of the leave is two weeks and you must conclude the leave within one year of the birth or placement for adoption or foster care.
- Taking a family care or pregnancy disability leave may impact certain of your benefits and your seniority date. Contact your employer for more information regarding your eligibility for a leave and/or the impact of the leave on your seniority and benefits.

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Pregnancy Disability Leave

“Notice A”

Your Rights and Obligations as a Pregnant Employee

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

- California law protects employees against discrimination or harassment because of an employee’s pregnancy, childbirth or any related medical condition (referred to below as “because of pregnancy”). California also law prohibits employers from denying or interfering with an employee’s pregnancy-related employment rights.
- Your employer has an obligation to:
 - reasonably accommodate your medical needs related to pregnancy, childbirth or related conditions (such as temporarily modifying your work duties, providing you with a stool or chair, or allowing more frequent breaks);
 - transfer you to a less strenuous or hazardous position (where one is available) or duties if medically needed because of your pregnancy;
 - provide you with pregnancy disability leave (PDL) of up to four months (the working days you normally would work in one-third of a year or 17 ½ weeks) and return you to your same job when you are no longer disabled by your pregnancy or, in certain instances, to a comparable job. Taking PDL, however, does not protect you from non-leave related employment actions, such as a layoff; and
 - provide a reasonable amount of break time and use of a room or other location in close proximity to the employee’s work area to express breast milk in private as set forth in Labor Code section 1030, et seq.
- For pregnancy disability leave:
 - PDL is not for an automatic period of time, but for the period of time that you are disabled by pregnancy. Your health care provider determines how much time you will need.
 - Once your employer has been informed that you need to take PDL, your employer must guarantee in writing that you can return to work in your same position if you request a written guarantee. Your employer may require you to submit written medical certification from your health care provider substantiating the need for your leave.
 - PDL may include, but is not limited to, additional or more frequent breaks, time for prenatal or postnatal medical appointments, doctor-ordered bed rest, “severe morning sickness,” gestational diabetes, pregnancy-induced hypertension, preeclampsia, recovery from childbirth or loss or end of pregnancy, and/or post-partum depression.
 - PDL does not need to be taken all at once but can be taken on an as-needed basis as required by your health care provider, including intermittent leave or a reduced work schedule, all of which counts against your four month entitlement to leave.
 - Your leave will be paid or unpaid depending on your employer’s policy for other medical leaves. You may also be eligible for state disability insurance or Paid Family Leave (PFL), administered by the California Employment Development Department.
 - At your discretion, you can use any vacation or other paid time off during your PDL.
 - Your employer may require or you may choose to use any available sick leave during your PDL.
 - Your employer is required to continue your group health coverage during your PDL at the level and under the conditions that coverage would have been provided if you had continued in employment continuously for the duration of your leave.
 - Taking PDL may impact certain of your benefits and your seniority date; please contact your employer for details.

Notice obligations as an Employee:

- Give your employer reasonable notice: To receive reasonable accommodation, obtain a transfer, or take PDL, you must give your employer sufficient notice for your employer to make appropriate plans – 30 days advance notice if the need for the reasonable accommodation, transfer or PDL is foreseeable, otherwise as soon as practicable if the need is an emergency or unforeseeable.
- Provide a Written Medical Certification from Your Health Care Provider. Except in a medical emergency where there is no time to obtain it, your employer may require you to supply a written medical certification from your health care provider of the medical need for your reasonable accommodation, transfer or PDL. If the need is an emergency or unforeseeable, you must provide this certification within the time frame your employer requests, unless it is not practicable for you to do so under the circumstances despite your diligent, good faith efforts. Your employer must provide at least 15 calendar days for you to submit the certification. See your employer for a copy of a medical certification form to give to your health care provider to complete.
- PLEASE NOTE that if you fail to give your employer reasonable advance notice, or if your employer requires it, written medical certification of your medical need, your employer may be justified in delaying your reasonable accommodation transfer, or PDL.

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Organ and Bone Marrow Donation Protection Act

California Senate Bill 1304 was enacted to grant a leave of absence to an employee who is an organ or bone marrow donor. Leave provided for pursuant to this section may be taken in one or more periods, but in no event shall exceed the amount of leave prescribed.

Employees who are donating an organ to another person may take a leave of absence not exceeding 30 days (and which may be taken in one or more periods) in any one-year. Employees who are donating their bone marrow to another person may take a leave of absence not exceeding 5 days (and which may be taken in one or more periods) in any one year. This one year period is measured from the date the employee's leave begins.

An employee shall provide written verification to his or her employer that he or she is an organ or bone marrow donor and that there is a medical necessity for the donation of the organ or bone marrow.

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Paid Family Leave benefits for California workers

There may be times in the life of a working person when they need to care for a loved one. Whether it's a working parent bonding with a newborn or an employee caring for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner California's Paid Family Leave (PFL) was created for these times (**Note:** Registered domestic partners must meet requirements and register with the California Secretary of State to be eligible for benefits).



A program benefitting you and your family

California leads the nation as the first state to make it easier for employees to balance the demands of the workplace and family care needs at home. PFL benefits are based on the claimant's (care provider's) past quarterly earnings. For more information regarding maximum benefit amounts paid, read the *Disability Insurance (DI) and Paid Family Leave (PFL) Weekly Benefit Amounts in Dollar Increments* form, DE 2589, at www.edd.ca.gov/disability.

Paid Family Leave for California employees

PFL benefits do not provide job protection or return rights. Job protection **may** be provided **if** your employer is subject to the federal Family Medical Leave Act and the California Family Rights Act. Notify your employer of the reason for taking leave in a manner consistent with your company's leave policy.

To qualify for PFL benefits, you must meet the following requirements:

- Be covered by State Disability Insurance (SDI) (or a voluntary plan in lieu of SDI) and have earned at least \$300 in your base period from which deductions were withheld
- Supply medical information supporting your claim that the care recipient has a serious health condition and requires your care
- Submit your claim no earlier than nine days, but no later than 49 days, after the first day your family care leave began
- Provide documentation to support a claim for bonding with a new biological, adopted, or foster child
- Use up to two weeks of any earned but unused vacation leave or paid time off, if required by your employer, prior to the initial receipt of benefits
- Serve a seven-day unpaid waiting period before benefits begin for each different care recipient within the 12-month period.

You may not be eligible for benefits if:

- You are receiving Disability Insurance, Unemployment Insurance, or Workers' Compensation benefits
- You are not working or looking for work at the time you begin your family care leave
- You are not suffering a loss of wages
- The need for care is not supported by the certificate of a treating physician/practitioner
- You are in custody due to conviction of a crime

You are entitled to:

- Know the reason and basis for decisions affecting your benefits
- Appeal decisions about your eligibility for benefits. (Appeals must be sent to PFL in writing.)



- A hearing of your appeal before an Administrative Law Judge. Decisions may be further appealed to the California Unemployment Insurance Appeals Board and the courts
- Privacy-Information about your claim will be kept confidential except for the purposes allowed by law.

Apply for benefits

Apply for PFL benefits online at www.edd.ca.gov/disability. Employers and physicians/practitioners can submit claim information through SDI Online. You may also file a paper form. To request a claim form visit www.edd.ca.gov/disability.

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

Contact Paid Family Leave

For questions about PFL benefits, please visit www.edd.ca.gov/disability.

Phone number: 1-877-238-4373

- Press 1 for English.
- Press 2 for Spanish.
- Press 3 for Cantonese.
- Press 4 for Vietnamese.
- Press 5 for Armenian.
- Press 6 for Tagalog.
- Press 7 for Punjabi.

TTY: 1-800-445-1312 (This number does not accept voice calls). For more information, visit www.edd.ca.gov/disability. Claim forms should be mailed to PFL at: P.O. Box 997017, Sacramento, CA 95799-7017

NOTICE TO COUNTY OF VENTURA EMPLOYEES

The Newborns' and Mothers' Health Protection Act

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

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

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES

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

WHCRA Enrollment Notice

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

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

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

WHCRA Annual Notice

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

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

UnitedHealthcare HMOs	(800) 624-8822		
UnitedHealthcare HDHP (PPO)	(866) 633-2446		
Ventura County Health Care Plan	(805) 981-5050	or	(800) 600-8247

NOTICE TO COUNTY OF VENTURA EMPLOYEES**Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**

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

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

These events qualify for coverage:

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

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

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

2. If one of the following events occurs, your spouse's and other dependents' coverage may be continued for up to 36 months:
 - Your death,
 - Your divorce or legal separation,
 - A dependent child exceeds the maximum age for coverage,
 - You become entitled to Medicare benefits and lose your eligibility for continuation of benefits

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

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

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

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

1. The County stops providing group health benefits to its employees.
2. Required premiums are not paid when due.

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES

CalCOBRA Extension

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

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

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

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

NOTICE TO COUNTY OF VENTURA EMPLOYEES

Mental Health Parity Act (MHPA)

Overview

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

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

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

Coverage under MHPA

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

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

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. The County of Ventura has determined that your prescription drug coverage with the County of Ventura-sponsored medical plans, (i.e., Ventura County Health Care Plan and UnitedHealthcare HMO and HDHP PPO Plans) are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

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

1. Beginning January 1, 2006, new Medicare prescription drug coverage became available to everyone with Medicare.
2. The County of Ventura has determined that the prescription drug coverage offered by the Ventura County Health Care Plan, and the UnitedHealthcare HMO and HDHP PPO Plans are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
3. Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

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

People with Medicare may enroll in a Medicare prescription drug plan from October 15 through December 7, 2014, for 2015. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

If you do decide to enroll in a Medicare prescription drug plan and drop your County-sponsored medical plan and its respective prescription drug coverage, be aware that you may not be able to get this coverage back.

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

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

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

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

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

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

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

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

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

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare, which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to illustrate that you are not required to pay a higher premium amount.

Retiree Health Benefits Coordinator:

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

Distributed in October 2014
County of Ventura

NOTICE TO COUNTY OF VENTURA EMPLOYEES**Health Insurance Portability & Accountability Act of 1996 (HIPAA)**

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

Centers for Medicare & Medicaid Services (CMS)

Telephone: 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:

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

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

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

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

US Department of Labor website:

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

Portability Provision

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

Pre-existing Conditions Exclusion Provision

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

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

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

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

Creditable Coverage

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

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

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

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

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.

Appendix C

Summaries of Benefits and Coverage

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

Ventura County Health Care Plan (HMO)

Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees & Dependents | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.vchealthcareplan.org or by calling 1-800-600-8247 or 805-981-5050.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart on page 2 for the cost of services this plan covers.
Are there other deductibles for specific services?	No.	You don’t have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$3,000 per person / \$6,000 per family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care services that this plan doesn’t cover.	Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.vchealthcareplan.org member section, or call (805) 981-5050 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term “in-network”, preferred, or “participating” for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes, written referral	This plan will pay some or all of the costs to see a specialist for covered services. Please see the Direct Specialty Referral policy for more information
Are there services this plan doesn’t cover?	Yes.	Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees & Dependents | **Plan Type:** HMO



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

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees & Dependents | Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		In-network Provider VCMC	In-network Provider Non-VCMC	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	\$20 co-pay	Not Covered	None
	Specialist visit	No Charge	\$30 co-pay	Not Covered	None
	Other practitioner office visit	\$10 co-pay	\$20 co-pay	Not Covered	PT/OT/ST
	Preventive care/screening/immunization	No Charge	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	\$125 co-pay	Not Covered	None
If you need drugs to treat your illness or condition	Generic drugs	(No Rx services available)	\$9 co-pay \$20 co-pay	Not Covered	30-day supply - retail; 90-day supply - mail order
	Preferred brand drugs	(No Rx services available)	\$30 co-pay \$60 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Non-preferred brand drugs	(No Rx services available)	\$45 co-pay \$90 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Specialty drugs	(No Rx services available)	25% of cost per RX, up to \$150; \$300 max per month if multiple prescriptions.	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	\$250 copay	Not Covered	None
	Physician/surgeon fees	No Charge	No Charge	Not Covered	---None---
	Emergency room services	\$75 per visit	\$75 per visit	\$75 per visit	\$0 co-pay if admitted to hospital.

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees & Dependents | Plan Type: HMO

If you need immediate medical attention	Emergency medical transportation	\$50 co-pay	\$50 co-pay	\$50 co-pay	---None---
	Urgent care	\$50 co-pay	\$50 co-pay	\$50 co-pay outside service area.*	*Urgently Needed Care is covered while outside the service area. When inside the service area, must use an In-Network facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	\$150 per day/\$600 maximum per stay	Not Covered	None
	Physician/surgeon fee	No Charge	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	(Behavioral Health Services Not Available)	\$20 per visit	Not Covered	Administered by Optum Health Behavioral Solutions (OHBS), “Life Strategies”.
	Mental/Behavioral health inpatient services	(Behavioral Health Services Not Available)	\$150 per day/\$600 maximum	Not Covered	Administered by Optum Health Behavioral Solutions (OHBS), “Life Strategies”.
	Substance use disorder outpatient services	(Behavioral Health Services Not Available)	\$20 per visit	Not Covered	Administered by Optum Health Behavioral Solutions (OHBS), “Life Strategies”.
	Substance use disorder inpatient services	(Behavioral Health Services Not Available)	\$150 per day/\$600 maximum	Not Covered	Administered by Optum Health Behavioral Solutions (OHBS), “Life Strategies”.
If you are pregnant	Prenatal and postnatal care	No charge	\$20 co-pay for initial pre-natal visit only	Not Covered	(First visit only; No co-pay thereafter.)
	Delivery and all inpatient services		\$150 co-pay per day/ \$600 max per stay	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$15 per visit	\$15 per visit	Not Covered	None
	Rehabilitation services	\$50 per day/\$500 max per stay	\$50 per day/\$500 max per stay	Not Covered	None
	Habilitation services	\$10 co-pay	\$20 co-pay	Not Covered	None

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees & Dependents | Plan Type: HMO

	Skilled nursing care	\$50 per day/\$500 max per stay	\$50 per day/\$500 max per stay	Not Covered	None
	Durable medical equipment	No Charge	No Charge	Not Covered	50% co-pay for replacement when medically necessary.
	Hospice service	No Charge	No charge	Not Covered	None
If your child needs dental or eye care	Eye exam	No Charge when part of routine physical (through age 17)	No Charge when part of routine physical (through age 17)	Not Covered	Over Age 17 – VCHCP reimburses up to \$50 co-pay reimbursement for refraction, once every 12 months.
	Glasses	Not Covered	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	Not Covered	Dental Services are not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Chiropractic care Cosmetic surgery Dental Care (Adults) Dental Care (Children) 	<ul style="list-style-type: none"> Hearing aids Long-term care Non-emergency care when traveling outside the U.S. Eye Exams 	<ul style="list-style-type: none"> Private-duty nursing Routine eye care (Adult) Routine foot care Weight loss programs Eye Glasses
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> Bariatric Surgery Infertility Treatment 		

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees & Dependents | Plan Type: HMO

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at (805) 981-5050 or (800) 600-8247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565, or www.cciio.cms.gov.”

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93016; (805) 981-5050 or (800) 600-8247; or visit them on line @ www.vchealthcareplan.org. Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Managed Health Care (DMHC) at (877) 688-9891.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees and Dependents | Plan Type: HMO

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,220
- Patient pays \$ 320

Sample care costs:

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

Patient pays:

Deductibles	\$0
Co-pays	\$320
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$ 320

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

- Amount owed to providers: \$5,400
- Plan pays \$4,320
- Patient pays \$1,080

Sample care costs:

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

Patient pays:

Deductibles	\$0
Co-pays	\$500
Co-insurance (Prescriptions)	\$500
Limits or exclusions	\$80
Total	\$ 1,080

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Ventura County Health Care Plan: Group Coverage

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employees and Dependents | Plan Type: HMO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

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UnitedHealthcare HMO Plan – Network 1



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM3XV

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.welcometouhc.com/uhcwest or by calling 1-800-624-8822.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: \$0 Individual/ \$0 Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Participating: \$2,000 Individual / \$6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care services that this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes, see www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating providers.	If you use a participating doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating provider for some services. Plans use the term in-network, preferred , or participating to refer to providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.

HMO No Deductible



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO



- **Co-payments (copays)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by participating providers. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays or co-ins may apply.
	Specialist visit	\$20 copay per visit	Not Covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copays or co-ins may apply.
	Other practitioner office visit	Not Covered	Not Covered	No Coverage for manipulative (chiropractic) services.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	\$100 copay per procedure	Not Covered	None



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com/uhcwest	Formulary Generic– Your Lowest-Cost Option	3 - tier: Retail: \$15 copay Mail-Order: \$30 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Formulary Generic Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Formulary Brand– Your Midrange-Cost Option	3 - tier: Retail: \$30 copay Mail-Order: \$60 copay	Not Covered	
	Non-Formulary – Your Highest-Cost Option	3 - tier: Retail: \$50 copay Mail-Order: \$100 copay	Not Covered	
	Specialty Drugs – Additional High-Cost Options	Not Applicable	Not Covered	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	\$500 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	\$100 copay per visit	\$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	\$100 copay per trip	\$100 copay per trip	None
	Urgent care	\$20 copay per visit	\$20 copay per visit	Copay waived if admitted. If you receive services in addition to urgent care, additional copays or co-ins may apply.
If you have a hospital stay	Facility fee (example: hospital room)	\$500 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$20 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	\$500 copay per admit	Not Covered	None
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	\$20 copay per admit	Not Covered	Additional copays or co-ins may apply depending on services rendered. Routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	\$500 copay per admit	Not Covered	Additional copays or co-ins may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	\$20 copay per visit	Not Covered	Limited to 100 visits per calendar year.
	Rehabilitation services	\$20 copay per visit	Not Covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 consecutive calendar days from the first treatment per disability.
	Durable medical equipment	No Charge	Not Covered	Limited to \$5,000 Benefit Maximum per Calendar year.
	Hospice service	\$500 copay per admit	Not Covered	If Inpatient admission, subject to inpatient copays.
If your child needs dental or eye care	Eye exam	\$20 copay per visit	Not Covered	1 exam every 12 months.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-ups.



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Excluded Services & Other Covered Services

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

<ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic Surgery • Dental Care (Adult/Child) 	<ul style="list-style-type: none"> • Infertility Treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs
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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<ul style="list-style-type: none"> • Bariatric Surgery – may be covered with limitations 	<ul style="list-style-type: none"> • Hearing Aids – may be covered with limitations 	<ul style="list-style-type: none"> • Routine eye care (Adult) – may be covered with limitations
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HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015
Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee/Family **Plan Type:** HMO

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-800-624-8822. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323x61565 or visit <http://www.cciio.cms.gov>

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or Department of Managed Health Care at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>

Additionally, a consumer assistance program may help you file your **appeal**. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-624-8822.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-8822。

NAVAJO (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-624-8822.

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



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

About these Coverage Examples:

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

	This is not a cost estimator.
<p>Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.</p> <p>See the next page for important information about these examples.</p>	

Having a baby (normal delivery)

<input type="checkbox"/> Amount owed to providers:	\$7,540
<input type="checkbox"/> Plan pays	\$6,840
<input type="checkbox"/> Patient pays	\$700
Sample care costs:	
Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$0
Co-pays	\$500
Co-insurance	\$0
Limits or exclusions	\$200
Total	\$700

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

<input type="checkbox"/> Amount owed to providers:	\$5,400
<input type="checkbox"/> Plan pays	\$4,220
<input type="checkbox"/> Patient pays	\$1,180
Sample care costs:	
Prescriptions	\$2,900
Medical Equipment & Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$0
Co-pays	\$1,100
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,180



HMO Network 1 - CA SignatureValue Flex Tier 1 VPM/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-participating providers. If the patient had received care from out-of-participating providers, costs would have been higher. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>* No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>* No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.</p>	

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call the telephone numbers above to request a copy.

UnitedHealthcare HMO Plan – Network 2**HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV****Coverage Period: 12/21/2014 – 12/19/2015**

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

Coverage for: Employee/Family**Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.welcometouhc.com/uhcwest or by calling 1-800-624-8822.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: \$0 Individual/ \$0 Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Participating: \$2,000 Individual / \$6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care services that this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes, see www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating providers.	If you use a participating doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating provider for some services. Plans use the term in-network, preferred , or participating to refer to providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.
HMO No Deductible



HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO



- **Co-payments (copays)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by participating providers. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays or co-ins may apply.
	Specialist visit	\$20 copay per visit	Not Covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copays or co-ins may apply.
	Other practitioner office visit	Not Covered	Not Covered	No Coverage for manipulative (chiropractic) services.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	\$100 copay per procedure	Not Covered	None



HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com/uhcwest	Formulary Generic– Your Lowest-Cost Option	3 - tier: Retail: \$15 copay Mail-Order: \$30 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Formulary Generic Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Formulary Brand– Your Midrange-Cost Option	3 - tier: Retail: \$30 copay Mail-Order: \$60 copay	Not Covered	
	Non-Formulary – Your Highest-Cost Option	3 - tier: Retail: \$50 copay Mail-Order: \$100 copay	Not Covered	
	Specialty Drugs – Additional High-Cost Options	Not Applicable	Not Covered	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	\$500 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	\$100 copay per visit	\$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	\$100 copay per trip	\$100 copay per trip	None
	Urgent care	\$20 copay per visit	\$20 copay per visit	Copay waived if admitted. If you receive services in addition to urgent care, additional copays or co-ins may apply.
If you have a hospital stay	Facility fee (example: hospital room)	\$500 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None



HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$20 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	\$500 copay per admit	Not Covered	None
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	\$20 copay per admit	Not Covered	Additional copays or co-ins may apply depending on services rendered. Routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	\$500 copay per admit	Not Covered	Additional copays or co-ins may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	\$20 copay per visit	Not Covered	Limited to 100 visits per calendar year.
	Rehabilitation services	\$20 copay per visit	Not Covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 consecutive calendar days from the first treatment per disability.
	Durable medical equipment	No Charge	Not Covered	Limited to \$5,000 Benefit Maximum per Calendar year.
	Hospice service	\$500 copay per admit	Not Covered	If Inpatient admission, subject to inpatient copays.
If your child needs dental or eye care	Eye exam	\$20 copay per visit	Not Covered	1 exam every 12 months.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-ups.



HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Excluded Services & Other Covered Services

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

<ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic Surgery • Dental Care (Adult/Child) 	<ul style="list-style-type: none"> • Infertility Treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs
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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<ul style="list-style-type: none"> • Bariatric Surgery – may be covered with limitations 	<ul style="list-style-type: none"> • Hearing Aids – may be covered with limitations 	<ul style="list-style-type: none"> • Routine eye care (Adult) – may be covered with limitations
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HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV Coverage Period: 12/21/2014 – 12/19/2015
Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee/Family **Plan Type:** HMO

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-800-624-8822. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323x61565 or visit <http://www.cciio.cms.gov>

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or Department of Managed Health Care at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>

Additionally, a consumer assistance program may help you file your **appeal**. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-624-8822.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-624-8822。

NAVAJO (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-624-8822.

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



HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

About these Coverage Examples:

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

	This is not a cost estimator.
<p>Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.</p> <p>See the next page for important information about these examples.</p>	

Having a baby (normal delivery)

- Amount owed to providers:** \$7,540
- Plan pays** \$6,840
- Patient pays** \$700

Sample care costs:

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

Patient pays:

Deductibles	\$0
Co-pays	\$500
Co-insurance	\$0
Limits or exclusions	\$200
Total	\$700

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

- Amount owed to providers:** \$5,400
- Plan pays** \$4,220
- Patient pays** \$1,180

Sample care costs:

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

Patient pays:

Deductibles	\$0
Co-pays	\$1,100
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,180



HMO Network 2 - CA SignatureValue Flex Tier 2 VZE/3XV Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-participating providers. If the patient had received care from out-of-participating providers, costs would have been higher. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>* No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>* No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.</p>	

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call the telephone numbers above to request a copy.

UnitedHealthcare HMO Plan – Network 3



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.welcometouhc.com/uhcwest or by calling 1-800-624-8822.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: \$0 Individual/ \$0 Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Participating: \$2,000 Individual / \$6,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium and health care services that this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes, see www.welcometouhc.com/uhcwest or call 1-800-624-8822 for a list of participating providers.	If you use a participating doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating provider for some services. Plans use the term in-network, preferred , or participating to refer to providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.
HMO No Deductible



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

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 - Co-payments (copays)** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
 - Co-insurance (co-ins)** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
 - The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
 - This plan only covers services if rendered by participating providers. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays or co-ins may apply.
	Specialist visit	\$20 copay per visit	Not Covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copays or co-ins may apply.
	Other practitioner office visit	Not Covered	Not Covered	No Coverage for manipulative (chiropractic) services.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	\$100 copay per procedure	Not Covered	None



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.welcometouhc.com/uhcwest	Formulary Generic– Your Lowest-Cost Option	3 - tier: Retail: \$15 copay Mail-Order: \$30 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Formulary Generic Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Formulary Brand– Your Midrange-Cost Option	3 - tier: Retail: \$30 copay Mail-Order: \$60 copay	Not Covered	
	Non-Formulary – Your Highest-Cost Option	3 - tier: Retail: \$50 copay Mail-Order: \$100 copay	Not Covered	
	Specialty Drugs – Additional High-Cost Options	Not Applicable	Not Covered	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	\$500 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	\$100 copay per visit	\$100 copay per visit	Copay waived if admitted.
	Emergency medical transportation	\$100 copay per trip	\$100 copay per trip	None
	Urgent care	\$20 copay per visit	\$20 copay per visit	Copay waived if admitted. If you receive services in addition to urgent care, additional copays or co-ins may apply.
If you have a hospital stay	Facility fee (example: hospital room)	\$500 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$20 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	\$500 copay per admit	Not Covered	None
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	\$20 copay per admit	Not Covered	Additional copays or co-ins may apply depending on services rendered. Routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	\$500 copay per admit	Not Covered	Additional copays or co-ins may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	\$20 copay per visit	Not Covered	Limited to 100 visits per calendar year.
	Rehabilitation services	\$20 copay per visit	Not Covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	No Charge	Not Covered	Limited to 100 consecutive calendar days from the first treatment per disability.
	Durable medical equipment	No Charge	Not Covered	Limited to \$5,000 Benefit Maximum per Calendar year.
	Hospice service	\$500 copay per admit	Not Covered	If Inpatient admission, subject to inpatient copays.
If your child needs dental or eye care	Eye exam	\$20 copay per visit	Not Covered	1 exam every 12 months.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-ups.



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Excluded Services & Other Covered Services

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

<ul style="list-style-type: none"> • Acupuncture • Chiropractic care • Cosmetic Surgery • Dental Care (Adult/Child) 	<ul style="list-style-type: none"> • Infertility Treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs
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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<ul style="list-style-type: none"> • Bariatric Surgery – may be covered with limitations 	<ul style="list-style-type: none"> • Hearing Aids – may be covered with limitations 	<ul style="list-style-type: none"> • Routine eye care (Adult) – may be covered with limitations
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HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

Summary of Benefits and Coverage: What This Plan Covers & What it Costs
Coverage for: Employee/Family**Plan Type:** HMO

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-800-624-8822. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323x61565 or visit <http://www.cciio.cms.gov>

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or Department of Managed Health Care at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>

Additionally, a consumer assistance program may help you file your **appeal**. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

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NAVAJO (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-624-8822.

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



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

About these Coverage Examples:

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

	This is not a cost estimator.
<p>Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.</p> <p>See the next page for important information about these examples.</p>	

Having a baby
(normal delivery)

- Amount owed to providers:** \$7,540
- Plan pays** \$6,840
- Patient pays** \$700

Sample care costs:

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

Patient pays:

Deductibles	\$0
Co-pays	\$500
Co-insurance	\$0
Limits or exclusions	\$200
Total	\$700

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

- Amount owed to providers:** \$5,400
- Plan pays** \$4,220
- Patient pays** \$1,180

Sample care costs:

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

Patient pays:

Deductibles	\$0
Co-pays	\$1,100
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,180



HMO Network 3 - CA SignatureValue Flex Tier 3

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee/Family

Plan Type: HMO

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-participating providers. If the patient had received care from out-of-participating providers, costs would have been higher. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.</p>	

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call the telephone numbers above to request a copy.

UnitedHealthcare High Deductible Health Plan (PPO)



HDHP (PPO) - HSA Choice Plus Plan BJO / 0H9

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee & Family

Plan Type: PS1

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-866-873-3903.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,000 *Individual / \$6,000 Family Non-Network: \$3,000 *Individual / \$6,000 Family Per calendar year. Deductibles cross apply. services listed below as "No Charge" do not apply to the deductible. *Doesn't apply if policy covers 2+ people. Prescription drug costs are subject to the Annual Deductible.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No. There are no other deductibles .	You don't have to meet deductibles for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: \$5,000 *Individual / \$10,000 Family Non-Network: \$5,000 *Individual / \$10,000 Family. Out-of-pocket limits cross apply *Doesn't apply if policy covers 2+ people.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care services that this plan doesn't cover, and penalties for failure to obtain Pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The Common Medical Events chart describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers . If you use a non-network provider your cost may be more. For a list of network providers , see www.myuhc.com or call 1-866-873-3903 for a list of network providers .	If you use a network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred , or participating for providers in their network . See the Common Medical Events chart for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist .	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services .

Questions: Call 1-866-873-3903 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.

1 of 8

You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**

It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.



HDHP (PPO) - HSA Choice Plus Plan BJO / 0H9

Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee & Family

Plan Type: PS1

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

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network for Genetic Testing – BRCA or benefit reduces to 50% of eligible expenses.
	Specialist visit	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network for Genetic Testing – BRCA or benefit reduces to 50% of eligible expenses.
	Other practitioner office visit	30% co-ins after ded. for Manipulative (Chiropractic) services	50% co-ins for Manipulative (Chiropractic) services after ded.	Limited to 24 visits of Manipulative (Chiropractic) services per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	30% co-ins after ded.	50% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	30% co-ins after ded.	50% co-ins after ded.	None
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Retail: \$15 copay after ded. Mail-Order: \$30 copay after ded.	Retail: \$15 copay, then 50% co-ins, after ded. Mail-Order: Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply



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Coverage Period: 12/21/2014 – 12/19/2015

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

Coverage for: Employee & Family

Plan Type: PS1

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
More information about prescription drug coverage is available at www.myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: \$30 copay after ded. Mail-Order: \$60 copay after ded.	Retail: \$30 copay, then 50% co-ins, after ded. Mail-Order: Not Covered	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-authorization requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Prescription drug costs are subject to the annual deductible.
	Tier 3 – Your Highest-Cost Option	Retail: \$50 copay after ded. Mail-Order: \$100 copay after ded.	Retail: \$50 copay, then 50% co-ins, after ded. Mail-Order: Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	30% co-ins after ded.	50% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	30% co-ins after ded.	Same as Network	Notification is required if confined in a non-Network Hospital.
	Emergency medical transportation	30% co-ins after ded.	Same as Network	None
	Urgent care	30% co-ins after ded.	50% co-ins after ded.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	30% co-ins after ded.	50% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.



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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Mental / Behavioral health inpatient services	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
If you become pregnant	Prenatal and postnatal care	30% co-ins after ded.	50% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered. Your cost in this category includes Physician Delivery Charges. Network routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	30% co-ins after ded.	50% co-ins after ded.	Your cost for inpatient services only. Delivery see above. Inpatient Pre-authorization may apply non-network or benefit reduces to 50% of eligible expenses.
If you need help recovering or have other special health needs	Home health care	30% co-ins after ded.	50% co-ins after ded.	Home health care services are unlimited per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	30% co-ins after ded.	50% co-ins after ded.	Depending on the type of therapy, there may be a limit of 20-36 visits per calendar year.
	Habilitative services	30% co-ins after ded.	50% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	30% co-ins after ded.	50% co-ins after ded.	Skilled nursing care/Inpatient Rehabilitation services are unlimited per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.



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Plan Type: PS1

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-Network Provider	
	Durable medical equipment	30% co-ins after ded.	50% co-ins after ded.	Pre-authorization is required non-network for DME over \$1,000 or no coverage. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	30% co-ins after ded.	50% co-ins after ded.	Inpatient Pre-authorization is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	30% co-ins after ded.	Not Covered	Limited to 1 exam every 2 years. No coverage non-network.
	Glasses	Not Covered	Not Covered	No coverage for Glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-up.

Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult/Child) Glasses (Adult/Child) Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss Programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
<ul style="list-style-type: none"> Chiropractic care – limitations may apply 	<ul style="list-style-type: none"> Habilitative services – limitations may apply 	<ul style="list-style-type: none"> Hearing aids – limitations may apply Infertility treatment – limitations may apply 	<ul style="list-style-type: none"> Routine eye care (Adult/Child) – limitations may apply



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Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit <http://www.cciio.cms.gov>.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or California Department of Insurance at 1-800-927-4357 or visit <http://www.insurance.ca.gov/>.

Additionally, a consumer assistance program may help you file your appeal. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or visit <http://www.healthhelp.ca.gov>. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-866-873-3903.
 如果需要中文的帮助, 请拨打这个号码 1-866-873-3903.
 Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-873-3903.
 Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-873-3903.



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

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

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

Sample care costs:

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

Total **\$7,540**

Patient pays:

Deductibles	\$1,100
Co-pays	\$20
Co-insurance	\$1,300
Limits or exclusions	\$200

Total **\$4,520**

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

- Amount owed to providers:** \$5,400
- Plan Pays** \$3,320
- Patient Pays** \$2,080

Sample care costs:

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

Total **\$5,400**

Patient pays:

Deductibles	\$1,100
Co-pays	\$900
Co-insurance	\$0
Limits or exclusions	\$80

Total **\$2,080**



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Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.</p>	

Questions: Call 1-866-873-3903 or visit us at www.myuhc.com. If you aren't clear about any of the terms used in this form, see the Glossary.

You can view the Glossary at www.dol.gov/ebsa/healthreform or call the phone number above to request a copy. **This is only a summary.**

It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

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, and be prepared to specify which plan you are calling about.

Ventura County Health Care Plan

Member Services E-Mail: vchcp.memberservices@ventura.org

Website: <http://www.vchealthcareplan.org/>

Local Phone Number:

(805) 981-5050

Toll-Free Number:

(800) 600-8247

Mail Order Pharmacy – Express Scripts (www.express-scripts.com)

(800) 233-8065

UnitedHealthcare Plans

Policy# 755788

HMOs - Website: <http://www.uhcwest.com>

(800) 624-8822

PPO - Website: <http://www.myuhc.com>

(866) 633-2446

Mail Order Pharmacy – Optum Rx (www.optumrx.com)

(800) 788-7871

MetLife Dental PPO Plan

Group# 0154209 (PDP Plus Plan)

Customer Service (Member Services office for Eligibility/Claims/Benefits/Pre-certifications)

(800) 438-6388

Website: www.metlife.com/mybenefits

Medical Eye Services (MES) – Vision Plan

Customer Service:

(800) 877-6372

Customer Service e-mail: customerservice@mesvision.com

or (714) 619-4660

Website: <http://www.mesvision.com>

Flexible Spending Accounts (Health Care and Dependent Care)

Email: claims@takecareclaims.com

(877) 782-8889

Website: <https://www.myflexonline.com/Login/Welcome.aspx>

HealthEquity HSA (for UHC HDHP-PPO enrollees only)

Website: <http://www.healthequity.com>

(866) 346-5800

Optional Life Insurance/Basic Life Insurance – Minnesota Life

(Group Policy# 33988-G) – Customer Service

(800) 843-8358

Long Term Disability Insurance – MetLife

(Group Policy#0154209) – Group Disability Claims

(800) 858-6506

Absence Management Program

Court Human Resources – Hill Road

(805) 289-8625

Court Human Resources – HOJ

(805) 289-8656

Website: http://courtweb/hr_loa.html

Employee Assistance Program (EAP)

Lincoln's Inn, 950 County Square Drive, Suite 200, Ventura, CA 93003

(805) 654-4327

Website: <http://www.ventura.org/benefits/eap>

Wellness Program

Website: <http://www.ventura.org/benefits/wellness-program>

(805) 654-2628

Work/Life Program

Website: <http://www.ventura.org/benefits/work/life-program>

(805) 477-7234

CalPERS Long Term Care Insurance (Account# 5917734) - Information and Claims

(800) 982-1775

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

Ventura Superior Court
Human Resources

http://courtweb/hr_emp_benefits.html (court intranet)

Court.Benefits@ventura.courts.ca.gov (email)

805.289-8618 (phone)

805.339-2945 (fax)

County of Ventura
CEO/HR/Benefits

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

805.654.2570 (phone)

805.654.2665 (fax)

Benefits.ServiceRep@ventura.org (email)

<http://vcweb/ceo/HR/Benefits> (intranet)

www.ventura.org/benefits (internet)