

2026

# EMPLOYEE BENEFITS HANDBOOK



- ✓ Medical, Dental, & Vision
- ✓ FSAs & DCFSAs
- ✓ Includes important employee notices & information



**COUNTY of VENTURA**

County Executive Office  
Human Resources



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### On-Line Resources

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

# Important Sections to Check

## ✓ *Life Events Checklist*

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

## ✓ *Appendix A – Consumer Issues*

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

## ✓ *Appendix B – Employee Notices Information Link to:*

- ✓ **Medicare Part D – Creditable Coverage Notice**
- ✓ **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**
- ✓ **CalCOBRA Extension**
- ✓ **HIPAA Notice of Special Enrollment Rights**
- ✓ **Medicare and the Active Worker**
- ✓ **Premium Assistance Under Medicaid and Children's Health Insurance Program (CHIP)**
- ✓ **Women's Health and Cancer Rights Act**
- ✓ **Newborn and Mother Health Protection Act**
- ✓ **Lactation Accommodation Policy**
- ✓ **Availability of Summary Health Information (SBCs) Notice**
- ✓ **Availability of Privacy Practices**
- ✓ **California Specific Benefit Update – (SB 729) COV Blue Shield Plans for 2025-2026**
- ✓ **Primary Care Provider Patient Protection Notice**
- ✓ **Family and Medical Leave Act (FMLA)**
- ✓ **Pregnancy Disability Leave (PDL)**
- ✓ **California Family Rights Act (CFRA)**
- ✓ **Paid Family Leave (PFL)**
- ✓ **Uniformed Services Employment and Reemployment Rights Act (USERRA)**
- ✓ **Reproductive Loss Leave**
- ✓ **Victim of Domestic Violence & Survivor Leave Rights**
- ✓ **Workplace Discrimination and Harassment Prevention**

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

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

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

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

**KEEP THIS HANDBOOK FOR FUTURE REFERENCE**

# Online Enrollment Instructions

The County of Ventura utilizes VCHRP online enrollment (Ventura County Human Resources & Payroll) for all active and intermittent leave employees. Employees on a leave of absence other than intermittent will receive additional information about their open enrollment process.

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

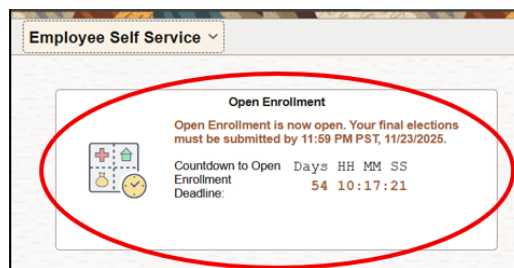
## SIGNING ON TO VCHRP

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

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

## ONLINE ENROLLMENT

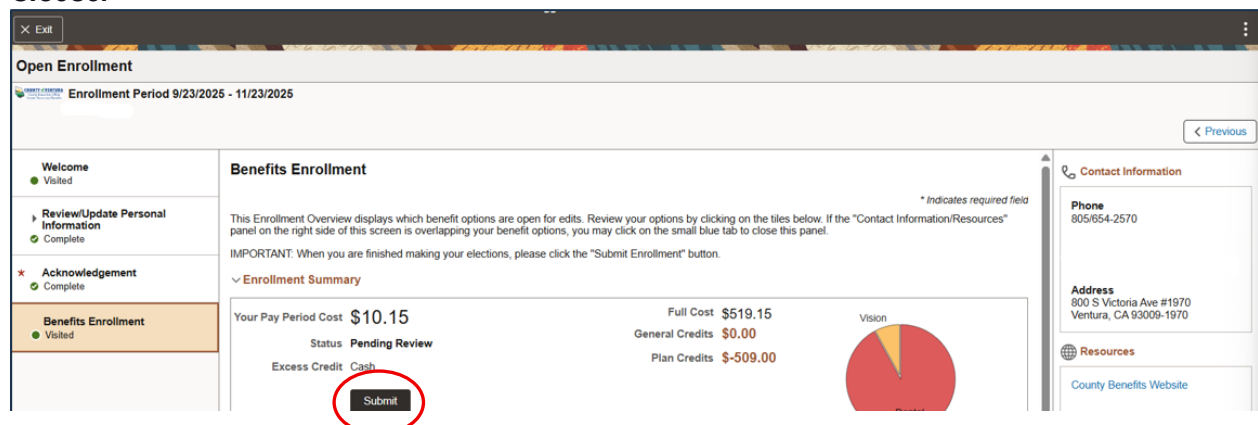
From the Employee Self Service home page, click on the Open Enrollment file:



The system will now guide you through the process. Read each screen for instructions. This link is a user guide with step-by-step instructions:

<https://vcportal.venturacounty.gov/CEO/benefits/docs/py2026/2026%20VCHRP%20Open%20Enrollment%20User%20Guide-Final.pdf>

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





# Life Events Checklist

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

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

Review this chapter for more information. If you need to make a mid-year change to your benefits, you may do so through VCHR Employee Self Service - Benefits - Life Events, or you may complete an Enrollment & Change Form and Mid-Year Change Request Form. You have up to 60 days to submit a mid-year change, including the event date (for example, birth or marriage). Additional information can be found on our websites: <http://myvcweb/index.php/benefits> (intranet), <https://hr.venturacounty.gov/benefits> (internet), or contact your Department's Human Resources/Benefits Representative. A *Beneficiary Designation Checklist* is available on the websites noted above. See the Flexible Benefits Program Information and Miscellaneous Benefits chapters for descriptions of the plans and programs that appear below.

## Life Events Checklist

Event	Actions
New Regular Employee <ul style="list-style-type: none"> <li>• New Hire</li> <li>• From Optimum Census Staffing (OCS)</li> <li>• From Extra-Help</li> <li>• From Per-Diem Pool</li> </ul>	<ul style="list-style-type: none"> <li>■ 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"> <li>✓ Flexible Benefits Program (submit <i>enrollment or waive participation</i> <b>within 31 days including the date of hire</b>).</li> <li>✓ Optional term life insurance (best to apply within 90 days of eligibility)</li> <li>✓ Short-Term Disability Plan (apply within 90 days of eligibility)</li> <li>✓ Deferred Compensation plans (you may be eligible for County 401(k) match)</li> <li>✓ Defined Benefit Pension Plans:                   <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> </li> </ul> </li> </ul>
Address Change  Name Change	<ul style="list-style-type: none"> <li>■ Enter your new address in VCHR (Employee Self Service &gt; Personal Details &gt; Addresses) or notify your department representative to update your address and your name in VCHR. Notification will go to your insurance and retirement plans and to the Auditor/Controller for your annual W-2 form.</li> <li>■ If you have funds on deposit in the Safe Harbor Retirement Plan but aren't currently contributing, notify the Plan at (805) 654-2921.</li> <li>■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.</li> </ul>
Salary Change	<ul style="list-style-type: none"> <li>■ You may want to change your 457 Plan or 401(k) Plan contribution amount(s). Call Fidelity at (800) 343-0860 or go online to <a href="http://netbenefits.com/ventura">http://netbenefits.com/ventura</a>.</li> <li>■ You may want to adjust your tax-withholding amount.</li> </ul>
Job Change	<ul style="list-style-type: none"> <li>■ 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"> <li>✓ 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.</li> <li>✓ Your 401(k) Plan County Match may have changed. Your new union may have a different minimum 401(k) contribution. Employer match information can be found on the plan brochure at: <a href="https://dc.venturacounty.gov/resource-page/">https://dc.venturacounty.gov/resource-page/</a>. To change your 457 or 401(k) Plan contribution amount, log on to Fidelity Net Benefits at <a href="http://netbenefits.com/ventura">http://netbenefits.com/ventura</a>.</li> <li>✓ You have gained or lost eligibility to Long-Term and/or Short-Term Disability Plans.</li> </ul> </li> </ul>

# Life Events Checklist *(continued)*

Event	Actions
<p>Marriage</p> <p>Registration of Domestic Partner</p> <p>New dependent child as a result of birth, legal adoption, or marriage</p>	<ul style="list-style-type: none"> <li>■ You have up to <b>60 days</b> to submit a mid-year change to add your new dependent(s) to your medical, dental, and vision plans. Otherwise, you will have to wait for the next open enrollment period.</li> <li>■ If you are currently enrolled in Optional Life Insurance, you have up to <b>31 days</b> to enroll a new dependent in a Dependent Life Insurance plan. If you have existing Dependent Life Insurance coverage on other dependents, you have 90 days to complete a Dependent Life Enrollment Change Request Form to add your new dependent without providing evidence of insurability.</li> <li>■ You may be eligible to add or change Flexible Benefit Program plans. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions.</li> <li>■ Is it time to apply for or increase life insurance coverage for yourself or your dependent(s)? For a description, see the Life Insurance Section of the Miscellaneous Benefits chapter or the Optional Life Brochure on our website.</li> <li>■ You may need to update your beneficiaries. See “Beneficiary Update” on page L-3.</li> </ul>
<p>Legal Separation or Divorce</p> <p>Child no longer meets eligibility criteria</p>	<ul style="list-style-type: none"> <li>■ You must formally cancel coverage for your dependent if they become ineligible. This will trigger an offer of continued coverage through COBRA, but only if the mid-year change request to drop the dependent is received within 60 days of the event. Be sure to include the dependent’s current mailing address, if different than the employee’s address. Although you have up to 60 days, you should notify Benefits to drop your ineligible dependents as soon as possible. You may be liable for claims paid after eligibility ends. <ul style="list-style-type: none"> <li>■ You do not need to formally cancel coverage for your overage dependent (age 26 and over). They will be automatically dropped, and coverage will be terminated. This will trigger an offer of continued coverage through COBRA.</li> <li>■ Consequences of the failure to request removal of dependents that no longer meet the eligibility requirements (other than dependents reaching age 26 noted above) for enrollment under health plans. Those dependents will be terminated as of the original date of ineligibility, and all expenses will be the responsibility of the employee/dependent(s). Furthermore, health plans have the right to collect any claims paid during any ineligible period, including the use of collections and adverse credit reporting.</li> </ul> </li> <li>■ You may want to drop or change your life insurance or dependent life insurance.</li> <li>■ You may need to update your beneficiaries. See “Beneficiary Update” on page L-3.</li> </ul>
<p>Loss of Other Health Insurance</p>	<ul style="list-style-type: none"> <li>■ If you opt-out of County-sponsored medical insurance coverage, you must notify County Benefits (contact your HR Dept. Rep) if you lose your other group health coverage. Employees are required to enroll in one of the County-sponsored medical plans with no lapse in coverage. Failure to notify the County and enroll in a medical plan will lead to retro default enrollment in an employee-only VCHCP HMO plan (VCPFA &amp; VCDSA will default into their lowest cost HMO plan), and possible repayment of ineligible Opt-Out cashback, and/or employee disciplinary actions. Dependents who show loss of outside coverage are enrolled in prospective coverage only based on the processing period received.</li> </ul>
<p>Change in Other Health Insurance</p>	<ul style="list-style-type: none"> <li>■ 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.</li> </ul>
<p>Standard Hours Decrease</p> <ul style="list-style-type: none"> <li>• From 60 hours or more to between 40 &amp; 59 hours per pay period</li> </ul>	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ 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.</li> </ul>
<p>Standard Hours Decrease</p> <ul style="list-style-type: none"> <li>• To fewer than 40 hours per pay period</li> </ul>	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ 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.</li> </ul>
<p>Standard Hours Increase</p> <ul style="list-style-type: none"> <li>• To between 40 &amp; 59 hours per pay period</li> </ul>	<ul style="list-style-type: none"> <li>■ You are now eligible for the Flexible Benefits Program. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions.</li> <li>■ Covered job titles have a County Long-Term Disability plan (LTD) if the Standard Hours is at least 60 hours per pay period, or at least 40 hours per pay period if covered under the Management Resolution or in UAPD.</li> <li>■ 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.</li> </ul>
<p>Standard Hours Increase</p> <ul style="list-style-type: none"> <li>• To 60 hours or more per pay period</li> </ul>	<ul style="list-style-type: none"> <li>■ Your Flexible Credit Allowance may increase. You may be eligible to add a health plan or change to a higher cost plan. See the Flexible Benefits Program Information chapter for eligibility, deadlines, and instructions.</li> <li>■ If you are in the Supplemental Retirement Plan (SRP) 457 and your hours increase to 64 or more per pay period, verify on your paystub contributions have stopped. You’ll be in the Ventura County Employees’ Retirement Association (VCERA) from now on. VCERA will mail you plan information.</li> </ul>

## Life Events Checklist *(continued)*

Event	Actions
Leave of Absence Request	<ul style="list-style-type: none"> <li>■ Ask your department or check online sources for an Absence Management Handbook; read it thoroughly.</li> <li>■ For you to maintain continuity of your health plan(s), optional life insurance(s) and Flexible Spending Account during your approved unpaid leave of absence. Your Agency's leave coordinator will provide initial information on the County's Direct Bill services through Optum Financial, our third-party administrator. You will receive direct correspondence from Optum Financial with more information on amounts due and payment schedules.</li> <li>■ If you have a 401(k) loan, you may need to continue making loan payments. Contact the Deferred Compensation Program at (805) 654-2620.</li> <li>■ If you have a Dependent Care Flexible Spending Account, unless your entire leave will be unpaid, you may complete an Enrollment &amp; Change Form now to reduce your annual pledge when your leave starts and complete another form upon your return, if you wish to increase your pledge. You may not file claims for services incurred while you are not working.</li> </ul>
Leaving County Employment or Retiring	<ul style="list-style-type: none"> <li>■ If you experience a qualified federal COBRA event resulting in a loss of health coverage, you will receive a COBRA Continuation Offer from our COBRA Administrator. Please contact Fidelity regarding 457 and 401(K) Plans at (800) 343-0860.</li> <li>■ If you are changing jobs, in most circumstances, you have time sensitive options to continue your current Group Life coverage and maintain this important protection for you and your family. See the MetLife Certificate of Insurance for more information.</li> <li>■ If you're retiring soon:               <ul style="list-style-type: none"> <li>✓ Ventura County Employees' Retirement Plan (VCERA) members - call (805) 339-4250</li> <li>✓ Safe Harbor Retirement Plan members - call (805) 654-2921</li> </ul> </li> </ul>
Death of a Dependent	<ul style="list-style-type: none"> <li>■ If the dependent is covered under County health insurance, notify County Benefits and the health plan(s).</li> <li>■ If the dependent is covered under County dependent life insurance through MetLife, notify County Benefits.</li> <li>■ You may need to update your beneficiaries. See "Beneficiary Update" on page L-3.</li> </ul>
Death of a Regular County Employee	<ul style="list-style-type: none"> <li>■ If the employee is enrolled in the County's Flexible Benefits Program, his/her department will pay a \$1,000 death benefit to his/her beneficiary (see "Beneficiary Update" on page L-3).</li> <li>■ If the employee has County health insurance, life insurance, or disability insurance (LTD or Short-Term Disability Plan), notify County Benefits at (805) 654-2570. The surviving spouse and/or dependent children may be eligible for continued health insurance coverage through COBRA.</li> <li>■ Notify the Ventura County Employees' Retirement Association (VCERA) at (805) 339-4250.</li> <li>■ If the employee was ever an extra-help or part-time employee, notify Safe Harbor Retirement Plan at (805) 654-2921.</li> <li>■ If the employee ever made contributions to 457 or 401(k) with the County, call Fidelity at (800) 343-0860.</li> </ul>
Beneficiary Update	<p>Beneficiaries are tracked separately by Plan or Plan Administrator. The preferred method to designate the below beneficiaries except Deferred Compensation, VCERA, and Safe Harbor plans is to access <b>VCHRP &gt; Employee Self-Service &gt; Benefit Detail</b> tile. The first step is to provide the Dependent/Beneficiary Info in that tab. The second step is to access the Designate Beneficiaries tab. Click on the drop-down box under Select Benefits for each plan. Read the information on each plan type and designate. If you are unsure of previous beneficiary plan designations, provide a new/updated election in this area. You can view and update this information at any time. <i>Note: DO NOT change any dependent relationship status that currently shows in the Dependent/Beneficiary Info area, for example "Child" to "Adult Child."</i> Changing a dependent relationship in this area will cause health plan enrollment issues. Contact your agency's HR Rep or <a href="mailto:Benefits.ServiceRep@venturacounty.gov">Benefits.ServiceRep@venturacounty.gov</a> if you need to make a dependent relationship change.</p> <ul style="list-style-type: none"> <li>■ You may access beneficiary change forms on the following websites:           <ul style="list-style-type: none"> <li>• Salary/Wages, Leave &amp; Compensatory Banks – <a href="http://vcportal.venturacounty.gov/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf">http://vcportal.venturacounty.gov/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf</a></li> <li>• Basic and/or Optional Life Insurance – <a href="http://vcportal.venturacounty.gov/CEO/benefits/docs/Basic&amp;Optional_Life_Beneficiary_Designation_Form.pdf">http://vcportal.venturacounty.gov/CEO/benefits/docs/Basic&amp;Optional_Life_Beneficiary_Designation_Form.pdf</a></li> <li>• Deferred Compensation (401k and 457 plans) – Log into Fidelity NetBenefits or call Fidelity at 800-343-0860. See instructions: <a href="http://vcportal.venturacounty.gov/CEO/benefits/def-comp/docs/Online_Beneficiary.pdf">http://vcportal.venturacounty.gov/CEO/benefits/def-comp/docs/Online_Beneficiary.pdf</a></li> <li>• Death Benefit (Flexible Benefits Program) – <a href="http://vcportal.venturacounty.gov/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf">http://vcportal.venturacounty.gov/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf</a></li> <li>• Wage Supplement Plan AD&amp;D – <a href="http://vcportal.venturacounty.gov/CEO/benefits/docs/WSP-Enrollment_Form-Brochure.pdf">http://vcportal.venturacounty.gov/CEO/benefits/docs/WSP-Enrollment_Form-Brochure.pdf</a></li> <li>• Ventura County Employees' Retirement Association – <a href="https://content.vcera.org/wp-content/uploads/2023/10/VCERA-Beneficiary-Designation-07.23.pdf">https://content.vcera.org/wp-content/uploads/2023/10/VCERA-Beneficiary-Designation-07.23.pdf</a></li> <li>• Safe Harbor Retirement Plan – <a href="https://dc.venturacounty.gov/safe-harbor/">https://dc.venturacounty.gov/safe-harbor/</a></li> <li>• Accidental Death Benefit per MOA/Management Resolution (a.k.a. Supplemental Life Insurance) – <a href="http://vcportal.venturacounty.gov/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf">http://vcportal.venturacounty.gov/CEO/HR/Personnel_Services/docs/VCHRP_Designation_of_Beneficiary_Forms.pdf</a></li> </ul> </li> </ul>



# Chapter 1

## Flexible Benefits Program Information

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

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

### ■ *How the Flexible Benefits Program Works*

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

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. Your flexible credit allowance is determined by your medical enrollment. If your overall healthcare elections (medical, dental, vision, flexible spending accounts and health savings accounts) equate to more than your Flexible Credit Allowance, you pay the rest through pre-tax salary reduction. This means you get a tax break—your share of the cost is deducted from your pay before federal and state income taxes and Social Security taxes are calculated, so you don't pay taxes on the money you spend on benefits.

Depending on the plan(s) you choose, you may get "Cash Back" added to your taxable pay because of Flexible Credits not spent. Your Flexible Credit Allowance is not taxed, except for the portion taken as "Cash Back" in your paycheck. "Cash Back" gives you additional income. If this is the case, you may wish to lower your current tax liability and invest in your own future by channeling those extra dollars into a tax-deferred savings program. The Deferred Compensation Program is one of the topics covered in chapter 6, Miscellaneous Benefits, later in this handbook.

### ■ *Am I eligible for the Flexible Benefits Program?*

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

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

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

## ■ *Your Flexible Benefits Choices*

You may choose among (unless you Waive Participation in the Flexible Benefits Program):

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

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

## ■ *How Do I Enroll in the Flexible Benefits Program?*

### 1. Learning About Your Plan Options

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

### 2. Making Flexible Benefits Program Selections

You must enroll in a medical plan to participate in the Program or, if you already have employer group medical insurance or Medicare, you may opt-out of County medical coverage. Information on Medical Plan Opt-Out is in Chapter 2, Medical Plan Options. If you opt-out now, you must enroll later if you lose your other coverage. See *“Can I Change My Mind about the Plans I’ve Chosen?”* later in this chapter.

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

You can also choose to waive all coverage. This means forfeiting your participation in the Flexible Benefits Program and your Flexible Credit Allowance. Waiving participation in the Flexible Benefits Program also means that you cannot enroll in any of the County’s Flexible Benefits Program health plans for any reason



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

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

**All forms are available at:**

<http://myvcweb/index.php/hr/benefits/home>  
or <http://www.venturacounty.gov/benefits>.

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

until a subsequent annual open enrollment period, even if you lose outside coverage.

### 3. Online Enrollment and Manual Enrollment

Go online (through VCHRP Employee Self Service, Benefits tile, and Life Events) and attach the documentation within the deadlines discussed under “*Employee Enrollments*” and/or “*Can I Change My Mind about the Plans I’ve Chosen?*” later in this chapter.

Before you decide whether to enroll a dependent, be sure to read “*When and How Can I Enroll Dependents?*” later in this chapter. For manual enrollment, all forms are available on our websites: <http://myvcweb/index.php/benefits> (intranet) and <http://www.venturacounty.gov/benefits> (internet).

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

## ■ Employee Enrollments

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

### 1. Eligible New Employees

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

For your protection, if you fail to make your plan elections within 31 days of becoming eligible, you will be automatically enrolled in the lowest-cost County-sponsored HMO medical plan or the lowest-cost Association-sponsored HMO medical plan at employee-only coverage for which you are eligible.

### 2. Consequences of Not Submitting Your Forms on Time

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

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

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

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

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

Follow the same steps as item 3 above.

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

See the “Mid-Year Changes” section under “Can I Change My Mind about the Plans I’ve Chosen?” in this chapter.

#### 6. When Coverage Begins

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

## ■ Dependent Enrollments

No dependent coverage is automatic, even for newborns (*coverage for eligible newborn children of current plan members ends at 30 days after birth if action is not taken to enroll them on your plans*). Whether you acquire a new dependent after your coverage has begun, or you wish to enroll an existing dependent, be sure to read this section for instructions and information on coverage effective dates.

### 1. Whom Can I Enroll as a Dependent?

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

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

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

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

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

- **New Employee:** When you first enroll, you must enroll all eligible dependents you wish to cover for the current Plan Year. Generally, employee and dependent coverage begin on the same coverage effective date (see “*When Coverage Begins*” under “*Employee Enrollments*”) unless an employee submits incomplete paperwork missing the necessary dependent proof, and it is not provided before the payroll processing deadline. If the missing dependent proof is received within the 31-day deadline, enrollment for the dependent(s) will be processed based on the payroll processing period received.
- **New Dependent:** If you want new dependents covered under your health plan(s) for the remainder of the Plan Year, you must enroll them within 60 days of eligibility; for example, marriage, registration of domestic partnership, birth of a child, adoption placement, or loss of the dependent’s other coverage. Newborns, adoptions, and placement for adoption received within 60 days of the event date will be enrolled to the event date (ex., birth/adoption). While you have a 60-day window to enroll a newborn, requests received after 31 days can result in unavoidable delays in the insurance company’s acknowledgment of the newborn’s coverage for necessary services. Examples of potential access to care issues include delayed appointment authorizations, referrals, and prescription payment denials. **We strongly urge employees to submit enrollment paperwork within 25 days of a newborn’s date of birth.** All other mid-year changes are prospective based on the payroll processing period during which the mid-year change is received.
- **Existing Dependent:** For all plans, existing dependents can only be enrolled during the annual Open Enrollment period or if a qualified mid-year event occurs. See “*Open Enrollment*” and “*Mid-Year Changes*” under “*Can I Change My Mind about the Plans I’ve Chosen?*”

When you acquire a new dependent, enroll them online (through VCHRP Employee Self Service, Benefits tile, and Life Events) or submit an Enrollment & Change Form, making sure to submit the proof of dependent documentation. Except for 31 days of coverage from the date of birth for a newborn child, coverage for dependents is never automatic. Coverage is also not retroactive. Restrictions may apply in some cases for some plans. See the medical, dental, and vision chapters for further information.

If an enrollment is submitted timely, coverage for new dependents begins on the event date for newborns (date of birth) or placement for adoption, and the first day of the following pay period (from the County Payroll Calendar) for which a change was input into our payroll system for a marriage or registration for domestic partnership.



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

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

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

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

*Examples:*

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

Cancel the dependent in VCHRP or turn in forms ***within 60 calendar days of the event*** (date eligibility ends). For divorces and termination of domestic partnerships it is strongly advised to notify us as soon as

you receive your dissolution date. Notifying us promptly upon becoming aware of ineligibility is crucial. Failure to do so could result in liability for claims incurred after the dependent's eligibility ended and may jeopardize their eligibility for continuation of coverage.

Loss of dependent eligibility does not necessarily mean the loss of County health coverage. The section later in this chapter titled "*When Does Coverage End?*" contains information on extension of coverage options that may be available if you notify the County in a timely manner of a loss of eligibility. *Federal COBRA laws and regulations do not apply to domestic partners or their dependent children.*

## ■ *Can I Change My Mind about the Plans I've Chosen?*

### 1. Open Enrollment

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

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

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

### 2. Mid-Year Changes

Due to IRS restrictions on Flexible Benefits Programs, the choices you make generally **cannot** be changed until the next annual Open Enrollment period. However, the IRS does permit you to file revised elections, or adjust Flexible Spending Account contributions, **within 60 days** of certain qualified mid-year events, such as changes in your family/employment status. See below for more information and review the Mid-Year Change Spreadsheet found on the Benefits Page for more detailed information and what documentation is required to request a mid-year change.

#### **Read your Open Enrollment materials very carefully!**

Open Enrollment procedures vary from year to year.

- ❖ Some years, if you do not designate your choices during Open Enrollment, your current selections or Flexible Benefits Program 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, including a current Flexible Benefits Program Waiver.

*The following applies to employees enrolled in the Flexible Benefits Program. The mid-year change in your plan selections must be because of, and consistent with, the reason for the change.* Consistency is met if the election change affects eligibility for coverage under the plan. The election change must be on account of and correspond with the event. In some cases, the IRS requires that the change be retroactive to the pay period in which you became eligible to make the change.

**\*\*\*Note: Employees on a Leave of Absence have the same responsibilities as active employees to submit mid-year changes within 60 days of life events and open enrollment changes during annual open enrollment periods. See the Absence Management Program Handbook (<https://hr.venturacounty.gov/benefits/absence-management-disability-plans>) and contact your**

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**Department’s LOA Coordinator for any additional questions you have regarding Benefit changes during a Leave of Absence.**

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

- Change in legal marital status, including marriage, registration of domestic partnership, death of spouse, divorce, legal separation, termination of a domestic partnership, and annulment; **with the consequence that there is a gain or loss of coverage due to the change in marital status.**
- Change in number of tax dependents, including birth, adoption, placement for adoption, or death of a dependent; **with the consequence that there is a gain or loss of coverage due to the change in tax dependents.**
- Change in employment status or work schedule, including the start or termination of employment by you, your spouse, or your dependent child; this could also include a strike or lockout, a commencement of or return from an unpaid leave of absence, and a change in worksite; any other changes in employment status that change eligibility of the employee, spouse, or tax dependent under the benefit plan, such as a change from part-time to full-time or full-time to part-time status, a change from salaried to hourly-paid, or hourly-paid to salaried employment, ***with the consequence that an individual becomes (or ceases to be) eligible under the plan***, constitutes a change in employment status under this section.

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

- Change in a child’s dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them. Events that cause an employee’s tax dependent to satisfy or cease to satisfy eligibility requirements for coverage are attainment of age, or any similar circumstance as provided in the health plan under which the employee receives coverage; the change allowed is restricted to adding or dropping coverage for the dependent affected.
- Change in the place of residence of the employee, spouse, or tax dependent that affects the employee’s eligibility for coverage (e.g., moving out of the HMO service area of the employee’s current plan, or change that affects the accessibility of network providers of the employee. (Some HMO plans provide dependents away from home network options, or allow continuation of dependents when living outside of a service area. If these are the case in your enrolled plan, a change in plans would not be available).
- Change in an individual’s eligibility for Medicaid or Medicare, such as an employee, spouse, or tax dependent becoming entitled to or losing coverage under Medicaid or Part A or Part B of Medicare.
- A judgment, decree, or court order resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for an employee’s child, or for a foster child, or any other change in status that entitles an employee, spouse, or tax dependent to change benefit elections pursuant to COBRA (Consolidated Omnibus Reconciliation Act), HIPAA (Health Insurance Portability and Accountability Act) or any other law.
- An event that is a special enrollment event under HIPAA, including acquisition of a new dependent (when an employee, spouse, or new tax dependent is entitled to enroll in a health plan under HIPAA’s

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

- Voluntary or involuntary termination of employment or reduction in hours of employment, death, divorce, or legal separation,
  - Termination of employer contributions toward the other coverage, OR
  - If the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.
- A significant increase or decrease in premium cost or coverage, the elimination of an existing plan, or the availability of a new group plan (applies to health plans and Dependent Care Flexible Spending Accounts; *does not permit a change to a Health Care Flexible Spending Account contribution/election*).
  - A change of spouse's or tax dependent's coverage, such as an election change made by an employee's spouse or tax dependent under his or her employer's cafeteria plan; when an employee makes a change that is consistent with the spouse's or tax dependent's election change, for example, if spouses have each elected single coverage under their respective employer's health plans, and subsequently adopt a child, one spouse could elect to drop coverage, if the other spouse changes his/her election to add family coverage. An election change that is made to conform to a change made by a spouse or tax dependent under his or her employer's open enrollment period may also be permitted.
  - For Dependent Care Flexible Spending Accounts, a status change that affects the employee's eligibility for tax-favored treatment for Dependent Care Flexible Spending Accounts, including a change in dependent care provider, a raise for the provider (except in the instance where the provider is related to the employee), a reduction in care-giver hours due to tax dependent's enrollment in school, or a change in the number of tax dependents, including a dependent's loss of eligibility under IRC Section 21 (b).

### Eligible to cancel a Flexible Spending Account mid-year?

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

- Any changes you make must be because of and consistent with the change in status, AND
- You must make the changes within 60 days of the date of the event (marriage, birth, etc.).

**Revised forms** must be received by CEO/Human Resources/Benefits **within 60 days** of the qualified change in status, or you may not be able to make the requested change until the next Open Enrollment period. Depending on the nature of the change, documentation may be required (such as a copy of a marriage or birth certificate, court documents, or a letter from a current or former employer). If there is a delay in obtaining the documentation, submit the form within 60 days and *attach a note of explanation*. Follow-up as soon as possible with the documentation.

### Qualified Medical Child Support Order (QMCSO)

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

# When Does Coverage End?

## 1. New Plan Year

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

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

## 2. Dependent Coverage

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

*If your dependent becomes ineligible*, you must complete a County of Ventura Enrollment & Change Form and cancel coverage for the dependent or submit a VCHRP Employee Self-Service Life Event **within a maximum of 60 days** of the date your dependent becomes ineligible. The dependent will be terminated from coverage as of their ineligibility date. The completed form/VCHRP Life Event must be submitted to CEO/Human Resources/Benefits within 60 days of the event. **You do not need to cancel coverage for your overage dependent.** They will be automatically dropped, and coverage will be terminated.

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

*Direct notification to the Plan is not sufficient.*

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

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

## 3. Termination of Employment

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

- The County’s COBRA Administrator will send you information on continuation of coverage options.<sup>1</sup>

## 4. Eligible for Retirement with a Pension?

If you are retiring and want information on County retiree health plan options, you may call (805) 477-1580 to request a Retiree Health Benefits Program handbook and rate sheet. The Retiree Health Benefits Program handbook and rate sheet are also available on the following websites:

- <http://myvcweb/index.php/hr/benefits/home> (under “Retiree Health Benefits”)

- <http://www.venturacounty.gov/benefits> (under “Open Enrollment - Health Plans Information”)

## 5. Leave of Absence

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

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




To continue coverage once your County contributions end, or if the County contribution is less than the cost of your premiums, you must make biweekly premium payments directly to the County’s Direct Bill services third-party administrator. Their contact information can be found on the back cover of this book. Employees who allow benefit plans to lapse during a leave of absence, are still responsible to submit mid-year changes within 60 days of a life event, and annual open enrollment changes during annual open enrollment periods.

After one year on an unpaid leave, if you have continued your health plan premiums payments, you may qualify for extended health coverage under COBRA continuation of coverage provisions.<sup>1</sup>

If you are considering a Leave of Absence, be sure to read the *Absence Management Program* section on Miscellaneous Benefits in Chapter 6 and Employee Notices in Appendix B. You should also review a copy of the County’s Absence Management Program Handbook (<https://hr.venturacounty.gov/benefits/absence-management-disability-plans>).

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

### On-Line Resources

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



## Chapter 2 Medical Plan Options

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

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

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

### ■ Types of Plans

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

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

At the time you enroll, you must choose a PCP for yourself and each eligible dependent from the plan’s panel. The panel includes general and family practitioners, internists, and pediatricians. If you do not choose a PCP, one will be assigned to you. You may choose a different PCP for each member of your family, and you can change providers during the year by contacting the plan directly. Please note, depending on the plan, there are limits to the mileage from the home address. See each plan below and contact the plan directly to confirm PCP eligibility if you have any concerns. If your PCP leaves the plan during the Plan Year, you must select a new PCP within the plan.

**Preferred Provider Organization (PPO)** - With a PPO plan, you do not need to select a PCP, or obtain a referral to see a specialist. Each time you need medical services, you choose whether to self-refer to a PPO provider and receive in-network benefits or a non-participating provider and receive out-of-network benefits. Please note that some services require pre-authorization, an example of this is a PET scan. Please refer to

your plan document or contact the plan directly if you have any questions about specific coverage and preauthorization requirements, if any, that may apply when seeking services.

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

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

## ■ *What Plans Are Available?*

The County offers four medical plans to choose from:

- Ventura County Health Care Plan (full HMO network)
- Blue Shield Trio HMO (ACO network)
- Blue Shield Access+ HMO (full HMO network)
- Blue Shield High-Deductible PPO (High Deductible Health Plan; HSA-compatible)

Regardless of which plan you select, once you enroll, the plan will mail ID cards and plan information directly to your home. It is critical to review your cards as soon as you receive them. If there are any errors in enrollment, contact the Benefits Service Rep immediately. For HMO plans, if you were enrolled in the correct plan, but with an incorrect PCP or Medical Group/IPA, contact the specific plan directly immediately to review your options.

### ❖ **Ventura County Health Care Plan (full HMO network)**

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

There is no annual deductible to meet, and services are generally covered in full after any required copayment when accessing the Plan's in-network primary care and specialty care physicians, hospitals, and facilities.

To see a list of VCHCP contracted providers, visit <https://vchcp.venturacounty.gov/>, and click on “Find a Provider.”

Additional Plan benefits include, but are not limited to:

- Members have access to several contracted urgent care facilities located throughout the County of Ventura.
- Female members may self-refer for OB/GYN services by selecting a listed Direct-Access OB/GYN in the Provider Directory.
- Members may self-refer for chiropractic and acupuncture services. (Reimbursement varies; for benefit details, see Comparison Chart in this chapter.)
- Members may self-refer for Mental Health and Substance Abuse Services to a contracted physician.

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

If you have an eligible dependent attending school or living in an area outside Ventura County, you must select a VCHCP PCP for that dependent, and the dependent must come to Ventura County for coverage of routine physical exams and medical services. Only emergency care services, urgent care services, behavioral health services, and prescriptions are covered outside of the Plan's service area. No mid-year changes will be approved due to a dependent who moves outside of the service area.

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

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

### ❖ **Blue Shield Trio ACO (HMO)**

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

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

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

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

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

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

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

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

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

### ❖ **Blue Shield Access+ HMO (full HMO network)**

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

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

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

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

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

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

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

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

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

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

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

This plan is a High Deductible Health Plan, and the deductibles are \$3,400 for employee-only coverage and \$6,000 for family coverage. Family coverage has an individual deductible within the family deductible. This means that the deductible will be met for an individual who meets the individual deductible prior to family meeting the family deductible within a calendar year. Please note that the deductible, which must be met before the plan benefits are payable, applies to **all** expenses (except preventative care).

***Self-Referral to Network Provider:***

You may seek care from any Blue Shield PPO provider. For most in-network services, you pay 20% after the deductible has been met.

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

***Self-Referral to Any Non-Network Provider:***

For most covered services received from a non-network provider, the plan pays 60% of an amount based on 110% of the Medicare published rates and you pay the remainder plus the annual deductible amount. You may also be responsible for filing your own claims. Most hospitals contract with Blue Shield; however, in order to be covered, hospital admissions and surgeries require prior authorization.

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

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

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

## ❖ Medical Plan Opt-Out

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

To opt-out, select “Opt-Out” on the *Enrollment and Change Form* or in your Open Enrollment event in Self Service on VCHRP during Open Enrollment, complete the County’s *Opt Out Certification Form*, attach proof that you have other employer-group medical coverage (for example, a copy of the front and back of your medical plan identification card or a letter from the insurer with information about your coverage), and submit/upload in Employer Self-Service > Benefit Details > Opt-Out Certification. This page is not available to you to submit to until the day after you make an Opt-Out election. You should also receive a reminder email. **If Opting Out of medical during open enrollment, make sure your other group coverage begins on or before the County plan year effective date; if not, your event would be a mid-year change rather than an open enrollment election. If this is the case, do not elect medical Opt-Out during open enrollment because you will be taken out of that option and returned to whatever medical plan and coverage level you had prior to your open enrollment election.**

If you opt-out of County-sponsored medical coverage, you are still eligible to participate in County-sponsored dental, vision, flexible spending accounts, the County Employee Assistance Program, the Wellness Program, the WorkLife Program, and Employee Health Services.

If you opt-out of County-sponsored medical coverage due to Medicare A/B coverage, Medicare will be the primary payer for Medicare-covered health services. Keep in mind that Medicare Parts A and B do not cover all medical services. For added protection, you may wish to enroll in a Medicare supplement plan. Since the law does not allow employers to offer Medicare-supplement plans to active employees, you will need to explore plans available through other sources. Please note that as an **active** employee who is Medicare A/B eligible, you can choose to remain on the County sponsored medical plan without enrolling in Medicare. This is up to the employee and their circumstances. If you need help understanding your options for coverage when reaching Medicare eligibility, you can contact Area Agency on Aging/HICAP at 805-477-7300 for information about supplemental plan options if you choose to Opt-Out of County-sponsored medical insurance.

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

## ❖ Waive Participation in the Flexible Benefits Program

There may be a reason, such as a religious principle, that you wish to decline medical coverage altogether. Unlike the Medical Plan Opt-Out option, you will not have to show proof that you have medical coverage elsewhere, but you **forfeit Flexible Benefits Program participation, and you will not receive a Flex Credit or Opt-Out Allowance.** If you choose this option, you will be unable to enroll in health plans mid-year for any reason, including loss of other health coverage. You could choose to enroll in the County’s Flexible Benefits Program during the next annual open enrollment period. If you choose no medical coverage (waive), you must sign a waiver agreement when you first become eligible for a medical plan or during Open

Enrollment. If you do not turn in a waiver, you will be automatically assigned coverage in the lowest cost employee-only HMO coverage, as described in the *Flexible Benefits Program Information* chapter.

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

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

This is how the coordination process generally works:

- First, file your claim with the primary plan. After your claim is processed, you will receive an Explanation of Benefits (EOB) from the primary plan.
- Then, file a claim with your secondary plan. Be sure to attach a copy of the EOB from your primary plan to your claim form. The secondary plan may reimburse you for a part of your claim that the primary plan did not cover.
- Be sure to keep a copy of each EOB in a safe place in case a question arises. You may find your EOBs are valuable to you when you complete your income tax returns or file claims under your Health Care Flexible Spending Account or your Health Savings Account.

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

- Most HMOs do not provide EOBs. If your primary plan is an HMO, check with your secondary plan to see if they’ll accept a provider’s itemized receipt for the copayment amount in lieu of an EOB. In some circumstances, VCHCP and BlueShield can provide an EOB upon request.
- If your secondary plan is an HMO-type plan and you received services from a provider who is not a provider for the secondary plan, your secondary plan probably will not cover those services, unless they were out-of-the-area emergency services.
- If the services you received will not be covered by your primary plan, you may still need to submit a claim to them in order to obtain an EOB or letter of denial to send to your secondary plan.
- If you or a covered dependent is age 65 or over, and you are still working, Medicare is always the secondary payer to any employer group health plan coverage you have, such as any of the plans offered through the County. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services; however, they usually will not pay above a group’s plan.

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

<b>How to determine which plan is primary (pays first) for each family member and which is secondary:</b>		
CLAIMS FOR	PRIMARY PLAN	SECONDARY PLAN
Yourself	Yours	Spouse’s/Domestic Partner’s
Spouse/Domestic Partner	Spouse’s/Domestic Partner’s	Yours
Children living with and covered by both parents	Plan of the parent whose birth date is earliest in the year, regardless of parent’s year of birth	Other parent’s plan

# Comparison of Medical Plan Benefits

These plan descriptions are general in nature and cannot modify or affect the Plans in any way. Consult the Plan’s Evidence of Coverage booklet for governing provisions. The following represents the patients/member’s responsibility.

	<b>Ventura County Health Care Plan</b> (Full HMO Network)	<b>Blue Shield Trio HMO</b> (Limited ACO Network)	<b>Blue Shield Access+ HMO</b> (Full HMO Network)	<b>Blue Shield High-Deductible PPO</b> (High Deductible Health Plan; HSA-compatible)
			<b>Participating Provider</b>	<b>Non-Participating Provider</b>
<b>Deductible</b> (Per Member/Per Family; per-Calendar Year)	None	None	None	Applies to all medical and pharmacy expenses except preventative care: \$3,400/\$6,000 <sup>4</sup>
<b>Maximum Out-of-Pocket Expense</b> (Per Member/Per Family; per-Calendar Year)	\$3,000/\$6,000	\$1,500/\$3,000	\$1,500/\$3,000	\$5,000/\$10,000 \$10,000/\$20,000
	Includes copayments made to providers for covered medical, pharmacy, and behavioral health services	Excludes premiums and health care expenses that this plan doesn't cover	Excludes premiums and health care expenses that this plan doesn't cover	Excludes premiums and non-covered expenses. In-network/out-of-network out-of-pocket maximums are exclusive of each other and include calendar-year deductible and prescription drug maximum allowed amounts.
<b>PHYSICIAN SERVICES</b>				
<b>Office visits</b> (consultations & in-office procedures)	\$20 copay/visit	\$15 copay per visit	\$35 copay per visit	40% coinsurance <sup>3</sup>
<b>Preventative Care</b>	no copay	no copay	no copay	40% coinsurance <sup>3</sup>
<b>Specialist</b>	\$35 copay/visit	\$15 copay (PCP referral) \$20 copay (Self-referral) Limited – Contact Insurance Carrier	\$35 copay (PCP referral) \$40 copay (Self-referral) Limited – Contact Insurance Carrier	40% coinsurance <sup>3</sup>
<b>HOSPITAL/FACILITY</b>				
<b>Inpatient Services and Supplies</b> <sup>5</sup>	\$100 per day copay (up to \$500 maximum)	\$100 per admit	\$500 per admit	40% coinsurance <sup>3,4</sup>
<b>Skilled Nursing Facility</b>	\$50 per day copay, \$500 maximum (up to 100 combined days for all stays)	100% coverage (limited to 100 days per calendar year)	100% coverage (limited to 100 days per calendar year)	40% coinsurance <sup>3,4</sup>
<b>Outpatient Surgery</b> <sup>5</sup>	10% up to \$250 copay	\$50 copay – per surgery	\$250 copay – per surgery	40% coinsurance <sup>3,4</sup>
<b>Emergency Room</b> (covers emergency services only)	\$100 copay (copay waived if directly admitted)	\$100 copay (copay waived if directly admitted)	\$100 copay (copay waived if directly admitted)	20% coinsurance <sup>3,4</sup> (deductible waived if directly admitted)

Footnote descriptions are on page 2 –13

	Ventura County Health Care Plan (Full HMO Network)		Blue Shield Trio HMO (Limited ACO Network)		Blue Shield Access+ HMO (Full HMO Network)		Blue Shield High-Deductible PPO (High Deductible Health Plan; HSA-compatible)	
	Participating Provider		Non-Participating Provider		Participating Provider		Non-Participating Provider	
<b>OTHER SERVICES</b>								
<b>Ambulance</b> <i>(When medically necessary)</i>	\$150 copay (air and ground)	\$100 copay- per transport (air and ground)	\$100 copay- per transport (air and ground)	\$100 copay- per transport (air and ground)	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>
<b>Urgent Care</b>	\$35 copay per visit (no PCP or Plan referral required)	\$15 copay per visit	\$15 copay per visit	\$35 copay per visit	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3</sup>	40% coinsurance <sup>3</sup>
<b>Teladoc</b>	\$20 copay	no copay	no copay	no copay	no copay	no copay	Not Covered	Not Covered
<b>Rehabilitation Therapy</b> <i>(includes physical, speech, occupational, and respiratory therapy)</i>	\$15 copay/visit	\$15 copay per visit	\$15 copay per visit	\$35 copay per visit	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3, 4</sup>	40% coinsurance <sup>3, 4</sup>
<b>Chiropractic/ Acupuncture</b>	Plan reimburses \$20/visit for any chiropractor/acupuncturist (limited to 15 combined chiropractor/ acupuncturist visits per Plan Year) <sup>6</sup>	\$15 copay per visit (chiropractic/acupuncture services limited to 30 visits per year-combined visit limit)	\$15 copay per visit (chiropractic/acupuncture services limited to 30 visits per year-combined visit limit)	\$15 copay per visit (chiropractic/acupuncture services limited to 30 visits per year-combined visit limit)	20% coinsurance <sup>2</sup> <i>Limits: Chiropractic Services – 30 visits/year- combined in/out of network Acupuncture – 20 visits/year combined in/out of network</i>	20% coinsurance <sup>2</sup> <i>Limits: Chiropractic Services – 30 visits/year- combined in/out of network Acupuncture – 20 visits/year combined in/out of network</i>	40% coinsurance <sup>3</sup> <i>Limits: Chiropractic Services – 30 visits/year- combined in/out of network Acupuncture – 20 visits/year combined in/out of network</i>	40% coinsurance <sup>3, 4</sup> <i>Limits: Chiropractic Services – 30 visits/year- combined in/out of network Acupuncture – 20 visits/year combined in/out of network</i>
<b>Imaging (MRI, CT, PET)</b>	\$100 per test	\$100 per test (\$100 per test for other radiological and nuclear imaging services <sup>5</sup> )	\$100 per test (\$100 per test for other radiological and nuclear imaging services <sup>5</sup> )	\$100 per test (\$100 per test for other radiological and nuclear imaging services <sup>5</sup> )	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3, 4</sup>	40% coinsurance <sup>3, 4</sup>
<b>Diagnostic/ X-Ray, Ultrasound (Outpatient)</b>	\$15 copay	no copay	no copay	no copay	20% coinsurance <sup>2</sup>	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3, 4</sup>	40% coinsurance <sup>3, 4</sup>

Footnote descriptions are on page 2-13

		Ventura County Health Care Plan (Full HMO Network)	Blue Shield Trio HMO (Limited ACO Network)	Blue Shield Access+ HMO (Full HMO Network)	Blue Shield High-Deductible PPO (High Deductible Health Plan; HSA-compatible)	
					Participating Provider	Non-Participating Provider
<b>Hospice</b>		no copay	no copay	no copay	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3</sup>
<b>Home Health Services</b>		\$20 copay/visit; 100 visits/calendar year (max does not apply to Behavioral Health treatment)	\$15/visit (limited to 100 visits per calendar year)	\$35/visit (limited to 100 visits per calendar year)	20% coinsurance <sup>2</sup>	Not Covered
<b>Durable Medical Equipment</b>		10% copay; 50% copay for replacement, when medically necessary	20% copay (rental or purchase; breast pump and supplies are covered under preventative care at no charge)	50% copay (rental or purchase; breast pump and supplies are covered under preventative care at no charge)	50% of Negotiated Allowance <sup>2</sup>	50% coverage <sup>3</sup>
<b>Annual Eye Refraction Exam</b>		Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>BEHAVIORAL HEALTH</b>						
<b>Mental Health &amp; Substance Abuse Services</b>		Self-referral to any "OptumHealth Behavioral Solutions (Life Strategies)" provider; PCP referral not required	Self-referral to any Blue Shield mental health service administrator (MHSA); PCP referral not required	Self-referral to any Blue Shield mental health service administrator (MHSA); PCP referral not required	Self-referral to any Blue Shield mental health service administrator (MHSA); PCP referral not required	
<b>Inpatient</b> <sup>1, 5, 7</sup>		\$100 per day copay (up to \$500 maximum)	\$100/admit (subject to utilization review)	\$500/admit	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3, 4</sup>
<b>Residential/Alternative Treatment</b> <sup>1, 5, 7</sup>		\$50 per day copay (\$500 maximum)	\$100/admit	\$500/admit	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3, 4</sup>
<b>Outpatient</b> <sup>1, 7</sup>		\$20/visit	\$15/visit	\$35/visit	20% coinsurance <sup>2</sup>	40% coinsurance <sup>3, 4</sup>

Footnote descriptions are on page 2-13

		Ventura County Health Care Plan (Full HMO Network)	Blue Shield Trio HMO (Limited ACO Network)	Blue Shield Access+ HMO (Full HMO Network)	Blue Shield High-Deductible PPO (High Deductible Health Plan; HSA-compatible)	
		<b>PRESCRIPTION BENEFITS</b>			Participating Provider	Non-Participating Provider
<b>Outpatient Prescriptions</b>	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.
<b>Plan's Local Pharmacy Network (Retail Pharmacy)</b>	100% for up to a 30-day supply after copay of: Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$45 Tier 4 (Specialty Drugs) Generic- 10% up to \$100/script/month Brand- 10% up to \$250/script/month 50% for covered infertility drugs	100% for 30-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$25 Tier 3- \$45 Tier 4 (excluding Specialty Drugs) 20% coinsurance, up to \$150 per fill Specialty Drugs - 20% coinsurance, up to \$150 per fill See Plan for Retail RX 90-day supply copays	100% for 30-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$25 Tier 3- \$45 Tier 4 (excluding Specialty Drugs) 20% coinsurance, up to \$150 per fill Specialty Drugs - 20% coinsurance, up to \$150 per fill See Plan for Retail RX 90-day supply copays	100% for 30-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$30 Tier 3- \$50 Tier 4 (excluding Specialty Drugs) \$30% coinsurance, up to \$200 per fill Specialty Drugs - 30% coinsurance, up to \$200 per fill See Plan for Retail RX 90-day supply	<b>Contracting Pharmacies:</b> 100% for 30-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$30 Tier 3- \$50 Tier 4 (excluding Specialty Drugs) \$30% coinsurance, up to \$200 per fill Specialty Drugs - 30% coinsurance, up to \$200 per fill See Plan for Retail RX 90-day supply	<b>Non-Contracting Pharmacies:</b> Tier 1 - \$10 + 25% Tier 2 - \$30 + 25% Tier 3 - \$50 + 25% Tier 4 (excluding Specialty Drugs) - 25% + 30% coinsurance, up to \$200 per fill Specialty Drugs Not Covered
<b>Plan's Mail-Service</b>	100% for up to a 90-day supply* after copay of: Tier 1- \$30 Tier 2- \$60 Tier 3- \$90 * 90-day supply of maintenance medication also available at participating Smart 90 retail locations. 50% for covered infertility drugs	100% for 90-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$50 Tier 3- \$90 Tier 4 (excluding Specialty Drugs) - 20% coinsurance, up to \$300 per fill Specialty Drugs (limited to a 30-day supply) - 20% coinsurance, up to \$150 per fill	100% for 90-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$50 Tier 3- \$90 Tier 4 (excluding Specialty Drugs) - 20% coinsurance, up to \$300 per fill Specialty Drugs (limited to a 30-day supply) - 20% coinsurance, up to \$150 per fill	100% for 90-day supply after copay <sup>1</sup> of: Tier 1- \$10 Tier 2- \$60 Tier 3- \$100 Tier 4 (excluding Specialty Drugs) - 30% coinsurance, up to \$400 per fill Specialty Drugs (limited to a 30-day supply)- 30% coinsurance, up to \$200 per fill	Not covered	

Footnote descriptions are on page 2-13

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

## ELIGIBLE DEPENDENTS

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

- \* Your current legal husband or wife.
- \* Your domestic partner, **if** you provide documentation that you and your partner have registered a Declaration of Domestic Partnership with the Secretary of State or a California county or municipality.
- \* Any natural child(ren), stepchild(ren), adopted child(ren), child(ren) of domestic partners, child(ren) placed with you for permanent adoption, or child(ren) for whom permanent legal custody has been granted up to age 26. Unless stated otherwise for that plan, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews, and non-relatives. Certain unmarried dependent children aged 26 and over if handicapped, incapable of self-support, continuously covered by a County-sponsored (same type i.e., medical, dental, or vision) plan since prior to age 26, and whose disability was certified by the health plan and began before age 26.

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

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

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

## Medical Plan Options Footnotes

- 1 If a member requests a brand name drug when a generic drug exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed amount for the generic drug and the brand name drug dispensed, but not more than 50% of BlueShield’s average cost of that type of prescription drug. The Preferred Generic Program does not apply when the physician has specified “dispense as written” (DAW) or when it has been determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply. Classified specialty drugs must be obtained through Blue Shield’s Specialty Pharmacy Program and are subject to the terms of this program.
- 2 These PPO Benefits are payable only after satisfaction of the annual deductible. Provider payments are based on negotiated fees.
- 3 These Out-of-Network Benefits are payable only after satisfaction of the annual deductible. Provider will pay a maximum daily amount based on the “Allowable Amount” as defined in the EOC. You are responsible for any charges above the Allowable Amount, as summarized in the “Summary of Benefits” and defined in the EOC.
- 4 “Allowable Amounts” are daily amounts per BlueShield of CA and as follows:
  - \$350 per day maximum for, Hospital/Facility- Outpatient Surgery, Other Services- Rehabilitation Therapy (outpatient department of a hospital), Imaging: MRI, CT, PET (outpatient department of a hospital), Diagnostic/X-Ray & Ultrasound (outpatient department of a hospital), Behavioral Health- Outpatient (Hospitalization Program).
  - \$1,000 per day maximum for, Hospital/Facility- Inpatient Services and Supplies, Skilled Nursing Facility (Hospital based), Behavioral Health- Inpatient, Residential/Alternative Treatment.
- 5 Prior authorizations may be required, except under emergency conditions. Prior authorization arrangements will be made by your plan provider or plan-authorized specialist. If prior authorization is not obtained for scheduled hospital admissions and surgeries, services will not be covered.
- 6 VCHCP: Chiropractic and Acupuncture claims must be submitted within 180 days from the date of service.
- 7 Serious Emotional Disturbances (SED) of children and Severe Mental Illnesses (SMI) diagnoses, as defined in California Assembly Bill 88, are covered at regular medical plan benefit levels subject to deductibles and copayments.
8. Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG will be charged a \$100 copayment.
9. Blue Shield Plans- Beginning in 2026 plan year prescriptions for weight loss will only be covered in cases of Class III obesity (BMI ≥ 40).

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



## Chapter 3 Dental Plan Option

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

- Regular dental checkups have been proven to reduce the need for later extensive dental procedures.
- Studies have also shown that there is a link between your oral health and your overall general health. Specifically, good oral health has been associated with decreased risk of coronary heart disease and lower incidence of premature delivery of low-birth-weight babies.

With this in mind, you may want to consider the dental plan offered through the County. If you decide not to participate in the dental plan, you may wish to consider a *Health Care* Flexible Spending Account (HCFA) to fund any expected dental expenses. See Chapter 5 of this handbook for more information about FSAs if applicable.

### ▪ *What Plan is Available?*

#### ❖ **MetLife Dental PPO**

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

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

MetLife does not mail out member identification cards. Eligibility and benefit information are available online, including the ability to print an ID card: <https://www.metlife.com/info/countyofventura/>. You may also call their customer service department at (800) 438-6388.

#### **Providers**

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

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

For a MetLife PDP Plus dentist provider directory, you can call MetLife at (800) 438-6388, or find a dentist online: [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits).

### **Covered Fees**

After an annual deductible, the MetLife Dental PPO plan pays a percentage of the negotiated fee, up to the plan maximum benefit per person per year. If you select a non-contracting provider, payment is made based on the provider's fee charged or the Reasonable & Customary (R&C) charge which is based on the lowest of 1) the dentist's actual charge, 2) the dentists' usual charge for the same or similar services or 3) the usual charge of most dentists in the same geographical area for the same or similar services as determine by MetLife. If the dentist charges a higher amount than the R&C amount, MetLife payment may cover a lower percentage of the dentist's actual fees. This may mean additional out-of-pocket expense for you. In addition, you are responsible for paying the entire bill, and MetLife will reimburse you directly.

### **Predetermination of Costs**

MetLife strongly recommends, whenever you are considering extensive or complex dental services in excess of \$300.00, that you have your dentist submit a predetermination in advance so that the costs and coverage are predetermined and explained to you before you begin the proposed treatment.

Per compliance with California Insurance Code Section 10603.04 and California Code Regulation Section 1300.63.4, you can access the County of Ventura's MetLife Dental Plan's Summary of Dental Benefits and Coverage ("SDBC") for the current plan year on the 2026 Health Plans Benefits page: <https://hr.venturacounty.gov/benefits/py2026> or navigate to the main COV Benefits page: <https://hr.venturacounty.gov/benefits> and click on the Health Plans Information page for the current plan year. You can request a copy of the plan's SDBC free of charge by contacting MetLife directly at 800-438-6388 or requesting a copy by contacting [Benefits.ServiceRep@venturacounty.gov](mailto:Benefits.ServiceRep@venturacounty.gov).

### **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**

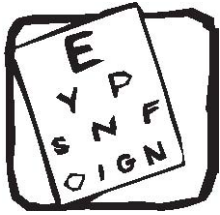
MetLife Dental PPO Plan Limitations and Exclusions are listed in the Summary of Benefits/Evidence of Coverage Booklet.

<b>MetLife Dental PPO Group Number 0154209</b>		
	<b>In DPO Network</b>	<b>Out of DPO Network</b>
<b>CALENDAR YEAR DEDUCTIBLE</b> Per Member/Per Family	\$15/\$45	\$25/\$75
<b>MAXIMUM BENEFIT</b> Each Calendar year (excluding MPD-TMJ and Orthodontics)	\$2,500 per person	\$1,500 per person
<b>SEPARATE LIFETIME MAXIMUM:</b> Orthodontic Benefits	\$1,500 per person	
<b>Benefits Coverage</b>	<b>In DPO Network</b>	<b>Out of DPO Network</b>
<b>DIAGNOSTIC/PREVENTIVE SERVICES</b>		
Oral exam, x-rays	Plan pays 100%  Deductible does not apply	Plan pays 100%  Deductible does not apply
Biopsy/Tissue Exam, Study Models		
Prophylaxis (cleaning)		
Topical fluoride treatment (up to age 14)		
<b>BASIC BENEFITS</b>		
<b>Oral Surgery:</b> Simple/Surgical Extractions; General Anesthesia; Frenulectomy; Pre/Post-Operative visits	Plan pays 80% (after you have met your deductible)	Plan pays 70% (after you have met your deductible)
<b>Impactions</b>		
<b>Space maintainers</b>		
<b>Fillings (amalgam and resin/composite)</b>		
<b>Emergency Palliative Treatment</b>		
<b>Endodontic – Tooth Pulp:</b>		
Pulp capping; Pulpotomy		
Recalcification/Apexification		
Root Canal (per canal)		
Apicoectomy Anterior & Bicuspid, first root Molar, first root Each additional root		
Retrograde filling, per root		
<b>Periodontic</b> (treatment of gums, bones, and supporting teeth)		
<b>ORTHODONTIC BENEFITS – ADULT OR CHILD (Malalignment of teeth or jaws)</b>		
<b>Full or partial banded case</b>	Plan pays 50%; up to \$1,500 lifetime maximum	Plan pays 50%; up to \$1,500 lifetime maximum

		<b>MetLife Dental PPO Group Number 0154209</b>	
<b>Benefits Coverage</b>	<b>In or Out of DPO Network</b>		
<b>CROWNS, JACKETS, AND CAST RESTORATIONS</b>			
<b>Crowns/bridges, per unit</b>			
Porcelain	Plan pays 50%  (See MetLife Dental PPO Plan Exclusions and Limitations)	Plan pays 40%  (See MetLife Dental PPO Plan Exclusions and Limitations)	
Porcelain with metal			
Full cast metal			
Stainless steel (temporary)			
Cast post and core in addition to crown; prefabricated post and core in addition to crown			
Pin retention in addition to restoration, per tooth			
Re-cementation: Inlay, Crown, Bridge			
<b>PROSTHETIC (DENTURE) BENEFITS</b>			
Complete or partial upper or lower denture	Plan pays 50%	Plan pays 40%	
Interim partial denture, upper or lower			
Teeth and clasps (per tooth/unit)			
Simple stress breaker (each)			
Adjust denture or partial; reline in office			
Adjust denture or partial; reline in lab			
Repairs to denture/partial (no teeth)			
Add teeth or clasps to partial (per unit/tooth)			
Replace/add denture clasp			
Extra denture			
<b>LIMITATIONS AND EXCLUSIONS</b> (listed in the plan's Summary of Benefits/Evidence of Coverage booklet)	Excludes most procedures started prior to joining the plan		

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

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



## Chapter 4 Vision Coverage Option

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

### ■ *What Plan is Available?*

The County offers a voluntary vision plan through EyeMed Vision.

#### ❖ **EyeMed Vision Plan**

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

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

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

### ■ *How to Use the Plan*

Covered employees follow these steps to receive their vision benefits:

1. The employee can make an appointment with the eye care specialist of his/her choice. Members will have less out of pocket expense if they utilize an EyeMed in-network provider and the provider will file the claim on behalf of the member, so the member does not need to take a claim form with them to their appointment. To find a Participating Provider, please visit [www.eyemed.com](http://www.eyemed.com), and register first or contact EyeMed directly at (866) 800-5457.
2. At the time of the vision appointment, please make sure you notify the provider you are an EyeMed member. The Participating Provider will contact EyeMed for benefit determination and eligibility verification and then submit the Claim Form for payment for Covered Services.
3. If Covered Services are received from a Non-Participating Provider, the eligible employee is responsible for paying the provider in full at the time services are rendered. The eligible employee or the provider must submit an itemized billing and a copy of his/her prescription with the Claim Form to EyeMed. Please go to [www.eyemed.com](http://www.eyemed.com) and download a claim form for reimbursement should you chose to go to an out-of-network provider. Reimbursement will be made to the eligible employee, up to the Schedule of Allowances shown for Non-Participating Providers.

There is a \$0 copayment for an annual exam with a PLUS Provider and a \$20 copayment for all other in-network providers, which is due at the time of service.

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

## EyeMed Summary of Benefits

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

## ■ *EyeMed Limitations & Exclusions*

### EyeMed – LIMITATIONS

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

### EyeMed – EXCLUSIONS

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

## ■ *Health Care Flexible Spending Account*

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

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



## Chapter 5 Flexible Spending Account & Health Savings Account Options

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

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

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

### What Does Non-Taxable Mean?

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



### IMPORTANT!

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

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

- **Your elections will terminate at the end of the Plan Year. You must make a new election during the annual Open Enrollment period (November 1 – 23) to enroll in an FSA in the new Plan Year.**

- There are 24 contribution periods during each Plan Year. Account contributions are only taken on your 1<sup>st</sup> and 2<sup>nd</sup> paychecks of each month, so you will not have a deduction on any 3<sup>rd</sup> paycheck in a month. If you are enrolling mid-year, divide your annual pledge amount by the number of contribution periods remaining in the year. See the coverage period chart below. Your contributions will appear on your paychecks under the “Before-Tax Deductions” section.
  - Be sure to make allowances for:
    - coverage and reimbursements provided by all medical, dental, and vision plans.
    - vacations, sick days, leaves of absence, or other times dependent care services will not be eligible for reimbursement.
- As required by the IRS, you forfeit to the County all funds remaining in your FSA after all claims for qualified expenses incurred during the Plan Year have been processed. Therefore, set aside only as much as you expect to incur during the Plan Year. Claims must be received by Chard Snyder by April 15 of the following year (or the next business day if April 15 falls on a weekend or County holiday). For example, all claims for Plan Year 2026 must be submitted by April 15, 2027.
- You can only file claims for expenses incurred (services received) in the same Plan Year that you made your contributions and only for periods for which contributions were made. For Dependent Care FSA participants, please keep in mind that expenses cannot be reimbursed to you during periods where you and/or your spouse are not working (i.e., leave of absence, vacation), regardless of whether you made a contribution for that period.

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

The contribution deducted from the:

- First paycheck of the month covers qualified expenses for dates of service that fall between the 1<sup>st</sup> and 15<sup>th</sup> of the month.
- Second paycheck of the month covers qualified expenses for dates of service that fall between the 16<sup>th</sup> and last day of the month.
- If your Health Care FSA has a negative balance when you terminate or retire, you will not be eligible to elect COBRA benefits for this account.
- **The Dependent Care and Health Care FSAs are separate. Under no circumstance can dollars be transferred between your Dependent Care and your Health Care FSAs.**
- The FSA Plan Year is the calendar and tax year (January 1 through December 31). For Health Care FSAs only, the County offers an IRS-approved 2½-month grace period that

begins on January 1 and ends on March 15, during which you may incur additional expenses to claim against your remaining FSA balance after the close of the Plan Year. However, this grace period is only available to employees who make a contribution into their account in the final contribution period of the Plan Year (for 2026, this is pay period 26-26).

### **Chard Snyder Benefit Card**

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

Employees that newly enroll (never enrolled or have not been enrolled since Chard Snyder has been the plan administrator) in the Flexible Spending Account Program during Open Enrollment, could expect to receive their Debit Card by January 22, 2026. Please watch your mail carefully and open the envelope to ensure the card is not thrown away.

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

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

### **Submitting a Claim**

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

### **Using the Mobile App**

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

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

#### **What Do “Date of Service” and “Expense Incurred” Mean?**

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

*Please keep in mind that medical expenses are incurred when the employee (or the employee's dependent) is provided with the medical care that gives rise to the medical expense, and not when the employee is formally billed, charged for, or pays for the medical care.*

### **Using the Website**

Save postage and time by filing your claim online.

- Scan your receipt and save it in one of the following formats: JPEG (.jpeg), GIF (.gif), or PDF (.pdf). Each file may not be larger than 2MB. ***Make sure the scan is clear and writing is legible.***
- Log in to [www.chard-snyder.com](http://www.chard-snyder.com).
  - Click the bright blue Login button in the upper-right corner of the page.
  - Go to *Employees* in the blue upper-left area and click *Access Your FSA, HRA, HSA Advantage, TRP Accounts*.
  - Enter your social security number (no dashes) or Username (if already created). Use Employee ID if directed to do so.

- Enter your password. The first time you log in, your password is the last four digits of your social security number.
- Choose File a Claim.
- Enter your claim information.
- Click Upload Receipt to attach your receipt to your claim. Be sure to upload the correct receipt file, as attaching the wrong file will delay your payment.
- Click Add Claim.
- Read Terms & Conditions, then click that you have done so.
- Click Submit Claim(s) or continue adding claims.

### **Sending a Paper Claim**

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

## **IMPORTANT Proof of Expenses Information!**

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



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

- Date(s) of service (must be incurred within the Plan Year),
- Patient name,
- Provider name,
- Description of service(s) provided,
- Itemized expense(s),
- Amount of un-reimbursed/un-reimbursable expenses.

If you are claiming an expense for an item normally considered personal rather than medical, such as a wig, you must submit a Letter of Medical Necessity from your doctor or other independent third party (physician, dentist, pharmacist, etc., as appropriate) verifying such expense was medically necessary and a statement from you that you would not have incurred the expense but for the medical necessity. This form can be obtained from Chard Snyder at [www.chard-snyder.com](http://www.chard-snyder.com) or by phone: (513) 459-9997 or (800) 982-7715 Monday – Friday, 8 am – 8 pm ET.

### **▪ Dependent Care Flexible Spending Account (DCFSA)**

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

- gainfully employed
- seeking gainful employment

- enrolled as a full-time student
- disabled

You can set up your account for any amount *up to the annual maximum*. The maximums are restricted to:

- Married couples filing a joint return, OR a single individual: \$7,500.00 per year (\$312.50 semi-monthly)
- Married couples filing separate returns \$3,750.00 per year (\$156.25 semi-monthly)

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

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

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

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

### **Eligible Dependents**

Eligible dependents include:

1. A dependent under the age of 13 for whom the participant is entitled to a deduction under Internal Revenue Service (IRS) Code Section 21, subsections (b)(1)(A) and (e)(5)(B); or
2. A spouse or dependent over age 13 who is physically or mentally unable to care for himself or herself; or
3. In the case of expenditures outside the home to enable the member or spouse to work:
  - a. A child described in number 1 above, or
  - b. A person described in number 2 above who spends at least eight hours each day in the member's household.

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

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

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

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

A “dependent care center” is defined by IRS Code Section 21(b)(2)(D) as any facility which (a) provides care for more than six individuals (other than individuals who reside there); and (b) receives a fee, payment, or

grant for providing services for any of the individuals' care (regardless of whether the facility is operated for profit).

Eligible Expenses do **NOT** include:

1. Any expenses incurred for payments to any individual who is a dependent of you or your spouse as described in Code Section 151(e), or who is your son, stepson, daughter, or stepdaughter under the age of 19 at the end of the calendar year in which the expense is paid or incurred; or
2. Tuition expenses at any age, if tuition can be separated from after-school care; once a dependent enters kindergarten, tuition expenses *must* be separated from childcare and after-school care.
3. Overnight camp expenses and any camp expenses arising from services or activities other than normal day care services.
4. Food expenses (unless inseparable from care expenses).
5. Incidental expenses (such as extra charges for supplies, special events, or activities, unless these expenses are inseparable from care expenses).
6. Dependent Care while you and/or your spouse are on leave of absence.

***IRS Tax Credit: The use of the Dependent Care Flexible Spending Account may eliminate the availability of an income tax credit for dependent care.*** The maximum amount you may claim for a tax credit for dependent care on your tax return must be reduced by the amount paid under the Dependent Care Flexible Spending Account. Consult your tax advisor for any questions related to your taxes and contributing to a Dependent Care Flexible Spending Account (FSA).

## ■ Health Care Flexible Spending Account (HCFSA)

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

You can set up your account for any amount *up to the annual maximum*. The maximum is restricted to \$3,300.00 per year (\$137.50 semi-monthly). *All unclaimed account balances are forfeited after the end of the Plan Year, so estimate your needs carefully.* Chard Snyder has an *Expense Estimate Worksheet* on their website to help choose an amount.

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

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

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

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

### Eligible Dependents

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

### Eligible Expenses

You may claim any eligible health care expenses incurred during the Plan Year, as long as the expenses are not reimbursed through another source and are not reimbursable by any medical, dental, or vision plans that

cover the eligible person. *Please keep in mind that medical expenses are incurred when the employee (or the employee's dependent) is provided with the medical care that gives rise to the medical expense, and not when the employee is formally billed, charged for, or pays for the medical care.*

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

### **Examples of Eligible and Ineligible Expenses:**

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

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

### **Is This Medical Expense Eligible for Reimbursement Under Your HCFSA?**

Often, participants have a medical expense that they want to submit for reimbursement but are not sure if it is eligible. You may visit Chard Snyder’s website for a sample list of both Eligible and Ineligible expenses. We also have formulated the questions listed below that you can ask yourself to help you determine if your expense is in fact eligible for reimbursement under your account.

1. Is the expense primarily for a medical purpose? Is it directly or proximately related to the diagnosis, cure, mitigation, or prevention of disease or illness? This is the primary way of determining if your expense is eligible for reimbursement.
2. *Diagnose* means using any procedure to find out whether someone has a disease or dysfunction. *Cure* means a medical treatment or drug used to restore health. For care to *mitigate*, it must make a medical condition less harsh or severe. *Prevent* requires that the care involve the immediate and proximate prevention of a disease, defect, or illness and that the disease, etc., be imminent. Examples of expenses for the purpose of “affecting any structure of the body” include operations or treatments affecting any portion of the body.
3. Why was the expense incurred? For dual purpose items (personal as well as medical reasons) we need adequate substantiation generally requiring a medical practitioner’s diagnosis of a medical condition.
4. You must be sick before you can get well – was there the present existence or imminent probability of a defect or ailment that caused you to incur these medical expenses?
5. Is the type of expense permitted (not excluded) under the plan document?
6. Apply the “*But-For*” Test to these expenses. This test basically asks whether an expense that would normally be thought of as a personal expense would have been incurred in the absence of the medical condition. If the answer is yes, then the expense is not reimbursable.
7. Does the expense have any cosmetic uses? Cosmetic expenses are not reimbursable expenses.
8. Finally, if you still cannot ascertain whether an expense is eligible for reimbursement, please contact Chard Snyder, our Flexible Spending Account Administrator, at (513) 459-9997 or (800) 982-7715 Monday – Friday, 8 am – 8 pm ET, Fax: (513) 459-9947 or (888) 245-8452, or email Chard Snyder at [askpenny@chard-snyder.com](mailto:askpenny@chard-snyder.com) and they will be glad to help you.

## ▪ *Limited-Purpose Flexible Spending Account (LPFSA)*

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

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

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

### **Eligible Expenses**

- Dental coinsurance & copays
- Dental deductibles
- Dental treatments
- Dental visits
- Orthodontia
- Eye exams & eyeglasses
- Optical coinsurance & copays
- Optical deductibles
- Optical surgeries (LASIK/RK)
- Contact lenses and more

### **Ineligible Expenses**

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

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

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

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

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

The last date of service to *incur* qualified expenses depends upon the last contribution made to your FSA. The Payroll Calendar on page 5-2 will help to determine the last date to incur qualified expenses. If you

separate from County service in 2026, you will still have until April 15, 2027, to submit your claims. We strongly encourage submitting your claims as soon as possible.

## ▪ *Health Savings Account (HSA)*

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

- HSA payroll deductions follow the same payroll deduction schedule and effective dates of coverage as the FSA accounts. There are 24 contribution periods during each Plan Year. Account contributions are only taken on your 1<sup>st</sup> and 2<sup>nd</sup> paychecks each month, so you will not have a deduction on any 3<sup>rd</sup> paycheck in a month. Please see the coverage period chart at the beginning of this chapter for applicable deductions and effective dates.
- There are maximum contributions allowable per pay period via payroll deduction as follows:
  - Employee Only Enrollment: \$183.33
  - Employee Only Enrollment; 55 years or older (account holder): \$224.99
  - Employee + 1 or more Enrollment: \$364.58
  - Employee + 1 or more Enrollment; 55 years or older (account holder): \$406.24
- Unlike FSA plans, you can make enrollment and election changes mid-year, if you wish.
- Unlike FSAs, HSAs are considered an individual's property. The balance in an HSA rolls over from year to year and you do not lose the funds in an HSA if you do not have claims that meet the balance in a plan year.
- You must not be covered by another medical insurance plan that is not a high-deductible health plan (dental, vision, life, and disability plans are okay).
- Once enrolled in an HSA through HealthEquity, you will receive a welcome packet with information regarding your account, how to use it, and contact information for HealthEquity if you have questions or need help at any time.
- It is an enrollee's responsibility to follow IRS guidelines for HSA plans.



## Chapter 6 Miscellaneous Benefits

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

### Programs described in this chapter:

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

Forms and information can be found on the Benefits websites:

- <http://myvcweb/index.php/hr/benefits/home> (intranet)
- <http://www.venturacounty.gov/benefits> (internet)

### ▪ *Employee Health Services*



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

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

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

EHS is conveniently located in the Lower Plaza of the Hall of Administration (HOA) at the Government Center. Open Monday through Friday (except holidays) 8:00am-5:00pm closed between 12pm-1pm (lunch break). Walk-Ins are not permitted. Services are provided by appointment only.

For more information or to schedule an appointment, please call (805) 654-3813 or email [EHS@venturacounty.gov](mailto:EHS@venturacounty.gov).

## Employee Assistance Program

The Employee Assistance Program (EAP) provides confidential and professional mental health assessment, brief treatment, and/or referral recommendations to employees and eligible family members. The EAP has licensed counselors on staff who are available to work with you for up to 5 visits at no cost. They have



extensive clinical experience in assessing, developing solution options, and offering resources for a wide range of issues. This includes, but is not limited to, having difficulty with a personal crisis or stressful experience, a marriage/family related problem, a substance-abuse related issue, or a troubling challenge at work. The EAP is also a confidential referral source to help you find providers that fit your needs if additional counseling or treatment is recommended or requested.

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

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

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

## ■ Wellness Program

The Employee Wellness Program is designed to help you live a healthier, higher-quality life while also controlling medical costs by identifying and reducing health risks before they become serious.



### Eligibility

- Regular County employees receiving a Flex Credit are eligible and encouraged to participate.
- Spouses of eligible employees may participate in certain programs.
- Employees not receiving a Flex Credit still have access to free online resources and health club discounts.

### Wellness Profile Screening & Health Coaching

Eligible employees and their spouses are invited to take part in an annual **Wellness Profile Screening**, which measures cholesterol, glucose, blood pressure, and other key health factors. You'll receive a detailed results report, and if risks are identified, you can meet with a personal **Health Coach** at no cost.

## Programs & Resources

The Wellness Program offers a wide variety of resources to support your well-being, including:

- Virtual courses on health and well-being topics
- Physical activity challenges on the Be Well platform
- Health club discounts and recreation events
- A free premium subscription to **Headspace** (meditation & mindfulness app)

## Cash Incentive Program – Wellthy Rewards

Through **Wellthy Rewards**, eligible employees can earn up to **\$300** by completing wellness activities between January and August. Cash awards are paid in November paychecks and are subject to taxes.

- Regular employees receiving a Flex Credit are eligible.
- If you are unable to complete activities due to a medical condition, reasonable accommodations or alternative standards may be available. Please contact the Wellness Program for details.

For more information on the County of Ventura’s Wellness Program:

- Visit: [wellness.venturacounty.gov](https://wellness.venturacounty.gov)
- Email: [wellness.program@venturacounty.gov](mailto:wellness.program@venturacounty.gov)
- Phone: 805-654-2628

## ■ *Lactation Accommodation*

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

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

- Visit: <https://hr.venturacounty.gov/benefits>
- Email: [worklife@venturacounty.gov](mailto:worklife@venturacounty.gov)

## ■ *Employee Commuter Benefits*

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

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

## ■ *Deferred Compensation Program*

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

to the Plan, the County will make a contribution to your account. This match is free money to you just for contributing a small percentage of your pay and the match maximizes your overall retirement savings! You may think you can't afford to participate in the Plans but, on the other hand, can you afford not to participate? Remember, you can start small – every little bit helps. It's never too late to start!

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

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

**401 (k) Eligibility:** You are eligible to participate in the 401(k) Shared Savings Plan if you are a regular employee with a work schedule of 40 hours or more biweekly. If you are a regular employee represented by UAPD, you are eligible to participate regardless of your work schedule.

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

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

### Deferred Compensation Contact Information

#### Fidelity Investments:

**Telephone:** (800) 343-0860

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

#### Deferred Compensation Program:

**Telephone:** (805) 654-2620

**E-mail:** [deferred.compensation@venturacounty.gov](mailto:deferred.compensation@venturacounty.gov)

**Internet** <https://dc.venturacounty.gov>

# Comparison of Deferred Compensation Plans

	Section 457 Plan	401(k) Shared Savings Plan
<b>Matching Contribution<sup>1</sup></b>	No matching County contribution	For most employees, the County provides a matching contribution when you participate in the Plan. The amount varies by group.
<b>Annual Contributions<sup>1</sup></b>	In addition to the regular IRS annual contribution limit, you may be able to make Special and age 50+ Catch-up contributions.	In addition to the regular IRS annual contribution limit, you may be able to make age 50 + Catch-up contributions.
<b>Loans Against Your Account Balance</b>	Not available	Loans of up to \$50,000 or 50% of your vested account balance are available after 12 months of participation.
<b>Fund Withdrawals While Employed</b> <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.
<b>Taxes and Penalties on Distributions</b>	<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.<sup>2</sup></p> <p>No penalties for distribution prior to age 59½.</p>	<p>Pre-tax Option – Distributions are taxed as regular income. A 10% penalty will also apply before age 59½, unless you leave service on or after age 55 and in other limited circumstances.</p> <p>After-Tax Roth option – Distributions are tax free if you meet the requirements of a Qualified Distribution.<sup>2</sup></p>
<b>Distribution Options at Termination or Retirement</b>	<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>

<sup>1</sup> See the current year’s *Deferred Compensation Program Plan Year Information* for the County match schedules and the IRS contribution limits.

<sup>2</sup> A Qualified Distribution is one that is taken at least five years after the first Roth 457 and/or 401(k) contribution and you have attained age 59 ½.

## ■ Retirement Plans

Almost all County employees participate in either the County's defined benefit plan (VCERA) or the SRP 457 deferred compensation plan. The defined benefit plan is a pension that is based on a formula provided by state law, not on the earnings generated by your contributions. The SRP 457 deferred compensation plan will include a percentage of your regular earnings and a percentage the County contributes. Your benefit total will grow in the SRP 457 plan as more contributions are made.

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

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

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

For further information, visit (<https://dc.venturacounty.gov/safe-harbor>), call (805) 654-2921, or e-mail [safe.harbor@venturacounty.gov](mailto:safe.harbor@venturacounty.gov).

## ■ Absence Management Program

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

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

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

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

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

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

### **Important!**

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

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

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

## ■ *Life & Disability Insurance Programs*

### ■ **Optional Life Insurance**

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

**If an employee enrolls within their first 90 days of eligibility**, they may elect guaranteed Optional Life Insurance coverage of \$10,000, one time, two times, or three times their base annual earnings, with no Statement of Health or additional underwriting required when the limit does not exceed \$500,000. Complete the Group Life Insurance Enrollment Form (found on the Benefits intranet and internet websites; see back cover of this book) and turn the form into your department's Benefits Representative for enrollment.

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

**If an employee enrolls after the first 90 days of eligibility**, you must complete the Group Enrollment Form for any level of coverage, and an electronic Supplemental Enrollment/Statement of Health form will be sent to the email submitted on the enrollment form. Your application is subject to underwriting approval by MetLife.

Employees must be in active employment status at the time they submit their enrollment application for employee optional life insurance. Enrollment requests cannot be initiated or approved while an employee is on a leave of absence. Any attempt to enroll during an unpaid leave period will be considered invalid. Coverage will only be processed and approved for employees who are actively working at the time of application and approval.

If you need to change your beneficiary, you may complete the **Basic/Optional Life Insurance Beneficiary Designation Form** found on the Benefits intranet and internet websites (links listed on the back cover of this handbook). You may also change your beneficiaries in VCHRP. Log into VCHRP > Employee Self-Service > Benefit Details Tile. Complete the Dependent/Beneficiary Info tile for everyone you plan to designate as a beneficiary. All personal information is required for dependents and beneficiaries, including a Social Security number/ITIN, which should be entered into the National ID field of the Dependent/Beneficiary tab. Do not duplicate, change, or override any dependent/beneficiary information currently reflected in VCHRP. If a change needs to be made to an existing record, contact your agency HR department or CEO/HR-Benefits. Next, from the Benefit Details tile, select the Designate Beneficiaries tile, click on the magnifying search glass, and select the beneficiary you wish to designate. Elections will need to be made and saved for all benefits that require a designated beneficiary (life insurance, wages/salary, death benefit, etc.).

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

#### ▪ **Optional Dependent Life Insurance**

When you enroll yourself in an Optional Life Insurance plan, you can also add life insurance for your dependents. Eligible dependents are your current spouse, registered domestic partner, and eligible children up to their 26th birthday, including stepchildren who are living with you. A small, biweekly premium covers all your eligible dependents regardless of the number you enroll. If at any time you no longer have qualified dependents, it is the employee's responsibility to request to cancel the Dependent Life Deduction by submitting a payroll deduction card.

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

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

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

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

*Option 1 - Low Option:* \$5,000 spouse; \$2,000 on each dependent

*Option 2 - High Option:* \$10,000 spouse; \$5,000 on each dependent

### ▪ **Basic Life Insurance**

Except where noted employees in the following groups who are scheduled for and working at least 40 hours per pay period are automatically covered by a \$50,000 group term life insurance/AD&D policy. Managers, Confidential Clerical, and Unrepresented Others covered under the Management Resolution, CJAAVC-represented employees, SEIU-represented employees, IUOE-represented employees, SPOAVC-represented employees, UAPD-represented employees (at least 1 hour per pay period), VCPPOA-represented Patrol Unit employees, VCPPOA-represented Probation Unit employees, VCERA-represented employees, and VEA-represented. If you need to change your beneficiary, you may complete the Basic/Optional Life Insurance Beneficiary Designation Form found on the Benefits intranet and internet websites (links listed on the back cover of this handbook).

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

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

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

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

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

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

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

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

For eligible employees covered under the Management Resolution UAPD, CJAAVC, and Professional Engineers represented by VEA this plan can extend your LTD coverage beyond that under the LTD Core

plan to your base income exceeding \$12,000 per month, up to 66.67% of \$22,500, with a maximum monthly benefit of up to \$15,000 for an approved disability claim.

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

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

Employees must be in active employment status at the time they submit their enrollment application for disability insurance. Enrollment requests cannot be initiated or approved while an employee is on a leave of absence. Any attempt to enroll during a leave period will be considered invalid. Coverage will only be processed and approved for employees who are actively working at the time of application and approval.

#### ▪ **Optional Wage Supplement Plan (WSP)**

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

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

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

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

Employees must be in active employment status at the time they submit their enrollment application for disability insurance. Enrollment requests cannot be initiated or approved while an employee is on a leave of absence. Any attempt to enroll during a leave period will be considered invalid. Coverage will only be processed and approved for employees who are actively working at the time of application and approval.

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

#### ▪ **State Disability Insurance (SDI)**

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

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

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

### ▪ **Paid Family Leave Benefits (PFL)**

California Senate Bill 1661 was enacted for employees who have a loss of wages when they need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, registered domestic partner, or to bond with a new child entering the family through birth, adoption, or foster care placement.

**For Information on the Paid Family Leave Program  
contact: (877) 238-4373**

Detailed information, including forms and publications and "Frequently Asked Questions" may also be obtained from the EDD website at:  
[www.edd.ca.gov](http://www.edd.ca.gov)

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

This legislation established the Paid Family Leave insurance program administered by the State Disability Insurance (SDI) program. See Appendix B for Employee Notices. Employees covered by the SDI program are also covered for Paid Family Leave insurance benefits. Mandatory employee contributions pay for the program.

## ▪ ***\$1,000 Employee Death Benefit***

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

## ▪ ***Employee Emergency Assistance Program***

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

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

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

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

If you would like to contribute or apply for assistance, please visit our website (links listed on the back cover of this handbook) for the appropriate forms.

## Transportation Benefit Reimbursement Program

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

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

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

The transportation program covers:

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

The transportation program does not cover:

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

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

1. There is no "use it or lose it" penalty. Unused balances can be rolled over from month to month or year to year within the same account, subject to plan maximums. Maximum reimbursement cannot exceed the IRS limit in any single month (please refer to the Internal Revenue Code §132(f)(1) for the monthly IRS limit).
2. There are 26 contribution periods during each plan year.

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

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

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

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

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

# Appendix A

## Consumer Issues

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

### ■ *Frequently Used Terms*

#### *Coordination of Benefits*

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

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

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

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

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

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

### ***Capitation***

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

### ***Fee-For-Service***

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

### ***Formulary Drugs***

See *Prescription Drug Coverage*.

### ***Generic Drugs***

See *Prescription Drug Coverage*.

### ***Group (Clinic) Practice***

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

### ***Individual Practice Association (IPA)***

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

### ***Preferred Provider Organization (PPO)***

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

### ***Primary Care Provider/Physician (PCP)***

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

Medical plan PCPs are usually family practice specialists, general practitioners, internists, or pediatricians.

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

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

*(Courtesy of Northwestern National Life)*

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

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

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

## **▪ *Patients' Rights***

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

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

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

***You can help protect your rights by doing the following:***

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

***How and where to get help:***

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

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

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

### ***Your Role in the Fight Against Health Care Cost Increases***

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

#### ***Be an Informed Consumer***

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

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

#### ***Use your Medical Plan Wisely***

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

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

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

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

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

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

#### ***Check Your Medical Bills Carefully***

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

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

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

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

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

*(Based on an article by Northwestern National Life)*

## ▪ **Prescription Drug Coverage**

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

### ***Generic Drugs/Brand Name Drugs***

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

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

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

### ***Drug Formulary***

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

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

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

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

### ***Mail Order Pharmacy Services***

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

### ***Copayment Structures***

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

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

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

### ***For Further Information***

Be sure to check the prescription drug coverage descriptions in the Medical Plan Charts in Chapter 2 of this handbook for details about the various plans' prescription drug coverage. Contact your current and/or prospective plan for specific questions about your individual prescriptions and how the plan will handle them if you have concerns.

# 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 remain compliant with applicable regulations. As part of this commitment, the County provides all required notices to eligible new employees at the time of hire. Additionally, annual employee notices are distributed each October and are accessible on our Benefits website under the corresponding plan year. To view the notices directly, you may use the QR code provided below or access them via the following link: [2026-Annual-Employee-Notices.pdf](#)

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

### **NOTICES TO COUNTY OF VENTURA EMPLOYEES**

- ❖ Medicare Part D – Creditable Coverage Notice
- ❖ Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)
- ❖ CalCOBRA Extension
- ❖ HIPAA Notice of Special Enrollment Rights
- ❖ Medicare and the Active Worker
- ❖ Premium Assistance Under Medicaid and Children’s Health Insurance Program (CHIP)
- ❖ Women’s Health and Cancer Rights Act
- ❖ Newborn and Mother Health Protection Act
- ❖ Lactation Accommodation Policy
- ❖ Availability of Summary Health Information (SBCs) Notice
- ❖ Availability of Privacy Practices
- ❖ California Specific Benefit Update – (SB 729) COV Blue Shield Plans for 2025-2026
- ❖ Primary Care Provider Patient Protection Notice
- ❖ Family and Medical Leave Act (FMLA)
- ❖ Pregnancy Disability Leave (PDL)
- ❖ California Family Rights Act (CFRA)
- ❖ Paid Family Leave (PFL)
- ❖ Uniformed Services Employment and Reemployment Rights Act (USERRA)
- ❖ Reproductive Loss Leave
- ❖ Victim of Domestic Violence & Survivor Leave Rights
- ❖ Workplace Discrimination and Harassment Prevention



*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.*

# Appendix C

## Summaries of Benefits and Coverage

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

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

### (Intranet)

<http://myvcweb/index.php/benefits>

### (Internet)

<https://hr.venturacounty.gov/benefits/py2026>

*Hard copies are available upon request:*

County of Ventura – CEO/HR Benefits

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

805.654.2570 (phone)

Benefits.ServiceRep@venturacounty.gov (email)

# Who Do I Contact?

## Ventura County Health Care Plan (HMO)

Website: <http://www.vchealthcareplan.org>, Member Services Email: [vchcp.memberservices@venturacounty.gov](mailto:vchcp.memberservices@venturacounty.gov)  
Customer Service (805) 981-5050 or (800) 600-8247  
24/7 Nurse Advice/Health Information (no copayment) (800) 334-9023  
Teladoc (24/7 doctor visit via telephone or web) (800) 835-2362  
Mail Order Pharmacy – Express Scripts (<https://www.express-scripts.com>) (800) 811-0293  
Behavioral Health – Optum Health Behavioral Solutions – Life Strategies (800) 851-7407

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

Group# W0067449, Website: [www.blueshieldca.com](http://www.blueshieldca.com), <https://www.blueshieldca.com/group/ventura/>  
TRIO ACO HMO Customer Service (855) 747-5800  
Access+ HMO and High-Deductible PPO Customer Service (855) 256-9404  
NurseHelp (available 24/7; no copayment) (877) 304-0504  
TelaDoc (24/7 doctor visit via telephone or web; typically, no copayment) (800) 835-2362  
Mail Order Pharmacy – Caremark (<https://www.blueshieldca.com/wellness/drugs/mail-service-prescriptions>) (866) 346-7200  
Blue Shield Mental Health Services (877) 263-9952

## MetLife Dental PPO Plan

Group# 0154209 (PDP Plus Plan), Website: <https://www.metlife.com/info/countyofventura/> or [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)  
Customer Service (Member Services office for Eligibility/Claims/Benefits/Pre-certifications) (800) 438-6388

## EyeMed – Vision Plan

Group# 1041070, Website: <https://eyemed.com/en-us>  
Customer Service (866) 800-5457

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

Website: <http://www.chard-snyder.com>, Customer Service Email: [askpenny@chard-snyder.com](mailto:askpenny@chard-snyder.com)  
Customer Service (800) 982-7715

## HealthEquity HSA (for BlueShield HDHP-PPO enrollees only)

Website: <http://www.healthequity.com>  
Customer Service (866) 346-5800

## County Retiree Health Benefits

Website: <https://hr.venturacounty.gov/benefits/retiree-health-benefits>; Email: [retiree.benefits@venturacounty.gov](mailto:retiree.benefits@venturacounty.gov) (805) 477-1580

## Optional Life Insurance/Basic Life Insurance – MetLife

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

## Long Term & Short Term Disability Insurance – MetLife

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

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

Website: <https://hr.venturacounty.gov/benefits/absence-management-disability-plans> (805) 654-2780

## Absence Management Program

Website: <https://hr.venturacounty.gov/benefits/absence-management-disability-plans>  
Absence Management Analyst Email: [LOA.Benefits@venturacounty.gov](mailto:LOA.Benefits@venturacounty.gov) (805) 677-8785

## Employee Assistance Program (EAP)

Website: <https://hr.venturacounty.gov/benefits/employee-assistance-program> (805) 654-4327

## Employee Emergency Assistance Program (EEAP)

Website: <https://hr.venturacounty.gov/benefits/employee-emergency-assistance-program> (805) 677-8785

## Wellness Program

Website: <https://wellness.venturacounty.gov/> (805) 654-2628

## Lactation Accommodation Information

Website: <https://hr.venturacounty.gov/benefits> Email: [WorkLife@venturacounty.gov](mailto:WorkLife@venturacounty.gov) (805) 654-3938

## Deferred Compensation Program (401k and 457 Plans)

401K and 457 Plans: <https://dc.venturacounty.gov/> Email: [Deferred.Compensation@venturacounty.gov](mailto:Deferred.Compensation@venturacounty.gov) (805) 654-2620  
Safe Harbor: <https://dc.venturacounty.gov/safe-harbor/> Email: [Safe.Harbor@venturacounty.gov](mailto:Safe.Harbor@venturacounty.gov) (805) 654-2921

## COBRA/Direct Bill Administrator – Optum Financial

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

## County of Ventura – CEO/HR/Benefits

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

PHONE (805) 654-2570 FAX (805) 654-2665  
Email: [Benefits.ServiceRep@venturacounty.gov](mailto:Benefits.ServiceRep@venturacounty.gov)

Internet: <https://hr.venturacounty.gov/benefits>  
Intranet: <http://myvcweb/index.php/hr/benefits/home>