COUNTY OF VENTURA

RETIREE HEALTH BENEFITS HANDBOOK

PLAN YEAR 2024

01/01/2024 – 12/31/2024

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COUNTY of VENTURA

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County of Ventura Retiree Health Benefits Coordinator:
Preferred contact is by Email to Retiree.Benefits@ventura.org or call (805) 477-1580

Chapter 1
About This Handbook

We realize how important it is that you get the most out of your benefits and it is our goal to provide you with the necessary resources. The County of Ventura is pleased to offer eligible retirees insurance plans to protect against unexpected events and the high cost of health care expenses. The information presented in this Handbook is aimed at helping you determine which plans will best meet your individual and family needs.

This Handbook summarizes the benefits available to you and provides important information about eligibility and how to enroll.

▪ Eligibility

You may be eligible for County-sponsored health coverage if you are a retired County employee or Surviving Spouse who receives a monthly pension check from the Ventura County Employees' Retirement Association (VCERA). Most plans require continuous coverage in a County-sponsored health plan without a lapse in coverage.

To be eligible to enroll, you must move directly into a Retiree County Sponsored Health plan, without a lapse in coverage, from enrollment in the County's Employer Group Health Plan(s) as an active employee or COBRA participant (offered by the County's third-party administrator through OPTUM).

Except under very limited circumstances, once your coverage has ended, you may not re-enroll unless a special enrollment occurs providing the option to re-enroll.

▪ Special Notice

These are voluntary plans that are subject to periodic rate changes and benefit modifications.

If you experience a change that affects your eligibility or coverage, you need to complete and submit a Retiree Health Plan Enrollment & Change Form to the County of Ventura CEO/HR/Benefits office (contact information is listed on the back cover of this handbook). Enrollment & Change Forms are required if:

- ✓ You wish to change to a lower cost medical plan (if eligible for the plan)
- ✓ You are moving (or have moved) out of your current plan's service area
- ✓ You or a dependent has recently turned age 65, or has otherwise become Medicare eligible
- ✓ Your dependent is no longer eligible
- ✓ You wish to cancel a health plan you are enrolled in

This Handbook is a Summary Only

This handbook is not a contract, but an outline of the coverage offered by the County-Sponsored medical, dental and vision plans that are offered to eligible retirees. The services to be provided shall be in accordance with agreements between the plan providers and the County of Ventura.

The Board of Supervisors of the County of Ventura reserves the right to amend, modify or terminate at any time the health plans in which it allows retirees to participate, including, but not limited to, the right to periodically adjust the rates of any or all plans made available to retirees. The amendment, modification, or termination of a health plan (or plans) shall not deprive any participating retiree of the right to payment for any covered expense which he or she incurred under the health plan prior to its amendment, modification or termination.

The Plans' Employer Group Agreement and/or Evidence of Coverage booklet should be consulted to determine the exact nature of the governing contractual provisions. The plan descriptions in this handbook are general in nature and cannot modify or affect the Plans in any way.

Chapter 2
Medical Plans: Non-Medicare Eligible

You may be eligible for Retiree County-sponsored medical coverage if you are a retired County employee or Surviving Spouse who receives a monthly pension check from the Ventura County Employees' Retirement Association (VCERA).

To be eligible to enroll, you must move directly into a Retiree Health Program medical plan, without a lapse in coverage, from enrollment in a medical plan as an active employee or COBRA participant.

Except under very limited circumstances, once your coverage has ended, you may not re-enroll unless a special enrollment period occurs providing the option to re-enroll as most plans require continuous coverage from our Employer Group Health Plan(s) to our Retiree County-sponsored health plan(s), without a lapse in coverage.

Unless stated otherwise for that plan, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews and non-relatives. Periodic documentation of eligibility may be required by your plan. No person can be covered as a retiree and as a dependent, or as a dependent of more than one retiree. Also, domestic partners and their dependents are not eligible for continuation of coverage (COBRA).

The retiree County-sponsored medical plans offered may vary in 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.

See page 2-11 for a listing of qualified dependents for each plan.

▪ Types of Plans

Health Maintenance Organization (HMO) **-** A 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. 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 a HMO, or they do not like the provider and referral restrictions of a 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 non-Medicare medical plans to choose from:

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

If the medical plan for which you enroll provides a new ID card upon enrollment, it's critical to review your cards as soon as you receive them. If your card reflects an incorrect PCP, contact the specific plan directly to change and/or review your PCP 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 services.

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

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

Additional Plan benefits include, but are not limited to:

- Members have access to several contracted urgent care facilities located throughout the County of Ventura.

- Female members may self-refer for OB/GYN services by selecting a listed Direct Access OB/GYN in the Provider Directory.

- Members may self-refer for chiropractic and acupuncture services. (Reimbursement varies; for benefit details, see Comparison Chart in this chapter).

- Members may self-refer for Mental Health and Substance Abuse Services to a contracted physician.

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

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

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

- Nurse Advice Line –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 – Allows you to talk to a licensed, board-certified doctor anytime, anywhere and at no cost. Go to Teladoc.com or call (800) 835-2362.

❖ BlueShield Trio HMO (ACO Network)

BlueShield's Trio HMO offers a broad range of benefits and low out-of-pocket expenses. It uses BlueShield'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. ***Currently in Ventura County, the physicians who are considered in-network for this plan are those who are contracted with SeaView IPA (Independent Physician Association). 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 desired PCP if they are 15 miles or more from your residence.***

With the Trio ACO HMO plan, you have access to a select network of medical groups and IPA's 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/independent practice association (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 BlueShield Trio HMO network:

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

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

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

Away From Home Care Program

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

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

- Shield Concierge – for 360º high-touch member support through one dedicated support team.
- BlueShield'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.

❖ **BlueShield 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 who is contracted with a medical group or IPA, who is responsible for the overall coordination of your care. 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 from your place of residence.

If your primary care physician participates in our Access+ Specialist SM program, you may go directly to a specialist within your physician's medical group or Independent Practice Association (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 BlueShield Access+ HMO network:

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

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

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

Away From Home Care Program

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

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

- BlueShield'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.

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

BlueShield'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 $3,000 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 BlueShield PPO provider. For most in-network services, you pay 20% after deductible has been met.

To find providers within California, go to blueshieldca.com/pponetwork
1. Select the provider type you are looking for.
2. Enter your location, then click Continue.

To find providers outside of California, go to provider.bcbs.com and enter XEA. Search for the type of provider you need.

Self-Referral to Any Non-Network Provider:

For most covered services received from a non-network provider, the plan pays 60% of an amount based on 110% of the Medicare published rates, and you pay the remainder, plus the annual deductible amount. You may be responsible for filing your own claims.

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

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

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

- BlueShield'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.

Comparison of Medical Plan Benefits

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

	Ventura County Health Care Plan (HMO)	**BlueShield Trio HMO** (Limited ACO Network)	**BlueShield Access+ HMO** (Full HMO Network)	**BlueShield High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
				Participating Provider	**Non-Participating Provider**
Deductible *(Per Member/Per Family; per Calendar Year)*	None	None	None	Applies to all medical and pharmacy expenses except preventative care: $3,000/$6,000 [4]	
Maximum Out-of-Pocket Expense *(Per Member/Per Family; per Calendar Year)*	Includes copayments made to providers for covered medical, pharmacy, and behavioral health services	Excludes premiums and health care expenses that this plan doesn't cover	Excludes premiums and health care expenses that this plan doesn't cover	Excludes premiums and non-covered expenses. In-network/out-of-network out-of-pocket maximums are exclusive of each other and include calendar-year deductible and prescription drug maximum allowed amounts.	
	$3,000/$6,000	$1,500/$3,000	$1,500/$3,000	$5,000/$10,000	$10,000/$20,000
PHYSICIAN SERVICES					
Office visits *(consultations & in-office procedures)*	$15 copay/visit	$15 copay per visit	$35 copay per visit	20% coinsurance [2]	40% coinsurance [3]
Preventative Care	no copay	no copay	no copay	no copay	40% coinsurance [3]
Specialist	$30 copay/visit	$15 copay (PCP referral) $20 copay (Self-referral) Limited – Contact Insurance Carrier	$35 copay (PCP referral) $40 copay (Self-referral) Limited – Contact Insurance Carrier	20% coinsurance[2]	40% coinsurance [3]
HOSPITAL/FACILITY					
Inpatient Services and Supplies [5]	$100 per day copay (up to $500 maximum)	$100 per admit	$500 per admit	20% coinsurance[2]	40% coinsurance [3, 4]
Skilled Nursing Facility	$50 per day copay, $500 maximum (up to 100 combined days for all stays)	100% coverage (limited to 100 days per calendar year)	100% coverage (limited to 100 days per calendar year)	20% coinsurance[2]	40% coinsurance [3, 4]
Outpatient Surgery [5]	10% up to $250 copay	$50 copay – per surgery	$250 copay – per surgery	20% coinsurance[2]	40% coinsurance [3, 4]
Emergency Room *(covers emergency services only)*	$100 copay (copay waived if directly admitted)	$100 copay (copay waived if directly admitted)	$100 copay (copay waived if directly admitted)	20% coinsurance[2]	20% coinsurance[3, 4] (deductible waived if directly admitted)

Footnote descriptions are on page 2-13

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

Footnote descriptions are on page 2-13

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

Footnote descriptions are on page 2-13

	Ventura County Health Care Plan (HMO)	**BlueShield Trio HMO** (Limited ACO Network)	**BlueShield Access+ HMO** (Full HMO Network)	**BlueShield High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
				Participating Provider	**Non-Participating Provider**
PRESCRIPTION BENEFITS					
Outpatient Prescriptions	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.	Can be written by any licensed physician. Generic substitution and formulary rules apply.
Plan's Local Pharmacy Network *(Retail Pharmacy)*	100% for up to a 30-day supply after copay of: Tier 1 - $9 Tier 2 - $30 Tier 3 - $45 Tier 4 (Specialty Drugs) Generic- 10% up to $100/script/month Brand- 10% up to $250/script/month 50% for covered infertility drugs	100% for 30-day supply after copay[1] of: Tier 1- $10 Tier 2- $25 Tier 3- $45 Tier 4 (excluding Specialty Drugs) 20% coinsurance, up to $150 per fill Specialty Drugs - 20% coinsurance, up to $150 per fill See Plan for Retail RX 90-day supply copays	100% for 30-day supply after copay[1] of: Tier 1- $10 Tier 2- $25 Tier 3- $45 Tier 4 (excluding Specialty Drugs) 20% coinsurance, up to $150 per fill Specialty Drugs - 20% coinsurance, up to $150 per fill See Plan for Retail RX 90-day supply copays	**Contracting Pharmacies:** 100% for 30-day supply after copay[1] of: Tier 1- $10 Tier 2- $30 Tier 3- $50 Tier 4 (excluding Specialty Drugs) $30% coinsurance, up to $200 per fill Specialty Drugs - 30% coinsurance, up to $200 per fill See Plan for Retail RX 90-day supply	**Non-Contracting Pharmacies:** Tier 1 - $10 + 25% Tier 2 - $30 + 25% Tier 3 - $50 + 25% Tier 4 (excluding Specialty Drugs) – 25% + 30% coinsurance, up to $200 per fill Specialty Drugs Not Covered
Plan's Mail-Service	100% for up to a 90-day supply* after copay of: Tier 1- $18 Tier 2- $60 Tier 3- $90 *90-day supply of maintenance medication also available at participating Smart 90 retail locations. 50% for covered infertility drugs	100% for 90-day supply after copay[1] of: Tier 1- $10 Tier 2- $50 Tier 3- $90 Tier 4 (excluding Specialty Drugs) - 20% coinsurance, up to $300 per fill Specialty Drugs (limited to a 30-day supply) - 20% coinsurance, up to $150 per fill	100% for 90-day supply after copay[1] of: Tier 1- $10 Tier 2- $50 Tier 3- $90 Tier 4 (excluding Specialty Drugs) - 20% coinsurance, up to $300 per fill Specialty Drugs (limited to a 30-day supply) - 20% coinsurance, up to $150 per fill	100% for 90-day supply after copay[1] of: Tier 1- $10 Tier 2- $60 Tier 3- $100 Tier 4 (excluding Specialty Drugs) - 30% coinsurance, up to $400 per fill Specialty Drugs (limited to a 30-day supply)- 30% coinsurance, up to $200 per fill	Not covered

Footnote descriptions are on page 2-13

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

ELIGIBLE DEPENDENTS

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

* Your current legal husband or wife.

* Your domestic partner, **if** you provide documentation that you and your partner have registered a Declaration of Domestic Partnership with the Secretary of State or a California county or municipality.

* Any natural child, stepchild, adopted children, children of domestic partners, child placed with you for permanent adoption, or child for whom permanent legal custody has been granted up to age 26. Unless stated otherwise for that plan, ineligible dependents include your ex-spouse, parents, grandparents, grandchildren, brothers, sisters, nieces, nephews and non-relatives. Certain unmarried dependent children age 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.

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

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

7 Serious Emotional Disturbances (SED) of children and Severe Mental Illnesses (SMI) diagnoses, as defined in California Assembly Bill 88, are covered at regular medical plan benefit levels subject to deductibles and copayments.

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

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

Chapter 3
Medical Plans: Medicare Eligible

TO BE ELIGIBLE TO PARTICIPATE IN ANY MEDICARE-ELIGIBLE PLAN, YOU MUST BE COVERED BY MEDICARE PARTS A AND B.

The County offers it's Medicare-eligible retirees and/or their Medicare-eligible dependents, medical plan coverage through the Alight Retiree Health Solutions. As a Medicare-eligible retiree or dependent, you have more options than ever before to get coverage that fits your health care needs, lifestyle, and budget. And with so many choices, you will find that Alight Retiree Health Solutions can help simplify the process and make it easier to decide what's right for you.

Alight's licensed Benefit Advisors have the expertise to help you understand your coverage options, compare benefits, and keep you on track to meet enrollment deadlines. With access to regional and national insurance companies in your area, Alight can help you select and enroll in a Medicare Advantage, Medicare Supplement, or Prescription Drug Plan.

For general questions, you may call Alight Retiree Health Solutions at (877) 216-3706 (TTY 711), Monday through Friday, 8:00 a.m. to 8:00 p.m. CT.

To view available plans and rates, please visit our County of Ventura Alight Solutions website: retiree.alight.com/COV.

Newly Retirees: If you are Medicare-eligible upon retirement, an information packet will be mailed to you from Alight Retiree Health Solutions, only after you have provided your set date of retirement to the County Retiree Health Benefits Coordinator, Patty Vandewater.
Preferred contact is by email to Retiree.Benefits@ventura.org.

Current Retirees: If you are a non-Medicare retiree or dependent enrolled in a non-Medicare Retiree County-sponsored medical plan, and will soon be aging into Medicare, an information packet will be mailed to you from Alight Retiree Health Solutions prior to becoming eligible for Medicare.

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 4
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.

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 Expense is either the customary and reasonable charge or the Maximum Allowable Fee Schedule for professional services, depending on your plan. Please see your Certificate of Insurance (Certificate) for details. You may also be asked to pay your portion of the bill at the time of service and submit claim forms for reimbursement.

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

Providers

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

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

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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 2022 Health Plans Benefits page: https://hr.ventura.org/benefits/py2022 or navigate to the main COV Benefits page: https://hr.ventura.org/benefits and click on the Health Plans Information page for the current plan year. You can request a copy of the plan's SDBC free of charge by contacting MetLife directly at 800-438-6388 or requesting a copy by contacting Benefits.ServiceRep@ventura.org.

Coordination of Benefits (Dual Coverage)

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

Limitations and Exclusions

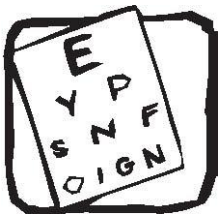
MetLife Dental PPO Plan Limitations and Exclusions are listed in the Summary of Benefits/Evidence of Coverage Booklet.

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

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

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

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



Chapter 5
Vision Coverage Options

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

▪ What Options are Available?

❖ **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 wearers and extra ways to save, including 40% off additional pairs of glasses and Special Offers.

▪ How to Use the Plan

Covered Members - follow these steps to receive vision benefits:

1. Make an appointment with the eye care specialist of his/her choice. Members will have less out of pocket 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, 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 member will be responsible for paying the provider in full at the time services are rendered. The member must submit an itemized billing and a copy of his/her prescription with the Claim Form to EyeMed. Please go to www.eyemed.com and download a claim form for reimbursement should you chose to go to an out of network provider. Reimbursement will be made to the member, up to the Schedule of Allowances shown for Non-Participating Providers.

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

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

EyeMed Summary of Benefits

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

▪ EyeMed Limitations & Exclusions

MEDICAL EYE SERVICES – LIMITATIONS

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

MEDICAL EYE SERVICES – EXCLUSIONS

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

Chapter 6
Frequently Asked Questions

1. Who is eligible to enroll in a County-sponsored Retiree Health Plan?

You may be eligible to enroll in a County-sponsored Health Plan if you are receiving a pension from Ventura County Employees' Retirement Association (VCERA). Some plans require continuous coverage in a County-sponsored health plan without a lapse in coverage.

2. When is my retiree health plan coverage effective?

Coverage for the non-Medicare medical, dental, and vision plans is effective the day after your active employee or COBRA coverage terminates.
Coverage under the Medicare-compatible medical plans must be effective on the first day of a month.

3. When am I eligible or required to change plans?

- If you are enrolled in a non-Medicare medical plan, you can change your coverage to a lower premium plan for which you are eligible effective the first of the month following enrollment transfer.

- If you are enrolled in a Medicare-compatible medical plan, you will be eligible to change plans during the Medicare Open Enrollment period each year.

- If you become ineligible for your current retiree non-Medicare medical plan (i.e. move out of your plan's service area, or if you or an enrolled dependent become Medicare-eligible), you must change to another plan for which you are eligible.

4. Can I add a dependent to my insurance?

Retired employees can add a new dependent within 31 days of marriage, registration and Declaration of Domestic Partnership with the Secretary of State or any California county or municipality, birth, placement for adoption, or permanent legal guardianship. If you are retiring and have an existing dependent that is not covered under your active employee/COBRA County plan, you cannot enroll them as a dependent under retiree health plan(s).

Surviving spouses cannot add new dependents.

You must complete and submit a Retiree Enrollment & Change Form within 31 days of the qualifying event to cover new dependents. This form can be found on our website:
https://hr.ventura.org/benefits/retiree-health-benefits

Please note:

- Coverage for most new dependents begins on the first day of the month after you complete and turn in the form, if it is received within 31 days of the qualifying event.
- Coverage for a child placed in your home pending adoption is effective on the date of placement.
- Coverage for a child for whom you are granted permanent legal custody is effective on the date permanent legal custody is effective.
- Coverage for your newborn is effective on the date of birth but is canceled 31 days from birth if a Retiree Enrollment & Change Form adding the new dependent has not been filed with the County by that time.

A premium adjustment may be required.

5. When and how are dependents canceled?

You can cancel coverage for a dependent at any time. You must cancel a dependent who is no longer eligible for coverage; for example, 1) an ex-spouse or 2) a child who reaches age 26. The former dependent may qualify for continued County coverage under COBRA if they experience a qualified event and you notify the County in writing within 60 days of the event that made them ineligible.

To cancel a dependent's coverage, notify the Retiree Health Benefits Coordinator in writing by completing and returning the Retiree Enrollment & Change Form as soon as possible. This form can be found on our website: https://hr.ventura.org/benefits/retiree-health-benefits

6. What if I no longer want insurance?

To cancel your retiree health plan, you must notify the Retiree Health Benefits Coordinator in writing by completing and returning a Retiree Enrollment & Change Form. The Form must be received by the 10th of any month for coverage to terminate the 1st of the following month. This form can be found on our website: https://hr.ventura.org/benefits/retiree-health-benefits

7. When planning your retirement: What happens to my Flexible Spending Account when I separate from County service (Retirement, Resignation or Termination)?

For questions regarding your Flexible Spending Account (FSA) when planning your Retirement; please see the Employee Benefit Plans Handbook (PY 2024) Chapter 5, under the heading titled "What happens to my Flexible Spending Account when I separate from County service (Retirement, Resignation, or Termination)?". The Employee Benefit Plans Handbook can be found via https://hr.ventura.org/benefits (scroll down to the end of the page).

Additional Questions? Send an email to the County's Retiree Health Benefits Coordinator at Retiree.Benefits@ventura.org.

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.

Appendix A
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 website:

https://hr.ventura.org/benefits

County of Ventura – CEO/HR Benefits

800 S. Victoria Avenue #1970, Ventura CA 93009

Retiree.Benefits@ventura.org

WHO DO I CONTACT?

Medical Plans for Non-Medicare Retirees and Dependents

- ***BlueShield Non-Medicare Medical Plans (Trio ACO HMO, Access+ HMO, and High-Deductible PPO)***

Group ID #W0067630
Website: www.blueshieldca.com

TRIO ACO HMO Customer Service	**(855) 747-5800**
Access+ HMO and High-Deductible PPO Customer Service	**(855) 256-9404**
NurseHelp 24/7 (no copayment)	**(877) 304-0504**
TelaDoc (24/7 doctor visit via telephone, web, or mobile app; 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**

- ***Ventura County Health Care Plan Non-Medicare Medical Plan***

Member Services E-Mail: vchcp.memberservices@ventura.org
Website: http://www.vchealthcareplan.org

Local Phone Number	**(805) 981-5050**
Toll-Free Number	**(800) 600-8247**
24/7 Nurse Advice/Health Information (no copayment)	**(800) 334-9023**
TelaDoc (24/7 doctor visit via telephone, web, or mobile app; no copayment)	**(800) 835-2362**
Mail Order Pharmacy - Express Scripts (www.express-scripts.com)	**(800) 233-8065**
Behavioral Health - Optum Health Behavioral Solutions – Life Strategies	**(800) 851-7407**

Medical Plans for Medicare-Eligible Retirees and Dependents

- ***Alight Retiree Health Solutions (for Medicare-eligible retirees and dependents only)***

Websites: https://myexchangeconnection.com/COV and https://retiree.alight.com/COV

Toll Free	**(877) 216-3706**
TTY	**(877) 216-3711**

Dental & Vision Plans

- ***MetLife Dental PPO Plan***

Group# 0154209
Website: http://www.metlife.com/mybenefits
Customer Service (Member Services office for Eligibility/Claims/Benefits/Pre-certifications) **(800) 438-6388**

- ***EyeMed - Vision Plan***

Website: https://eyemed.com/en-us
Group #: 1041072
Customer Service **(866) 800-5457**

County Retiree Benefits Website:
https://hr.ventura.org/benefits/retiree-health-benefits

Retiree Health Benefits Coordinator (Patty Vandewater)
Preferred Contact Method is by Email: Retiree.Benefits@ventura.org

CEO-HUMAN RESOURCES/BENEFTIS
800 S. VICTORIA AVENUE #1970
VENTURA, CA 93009-1970
(805) 477-1580