County of Ventura
Retiree Health Benefits Handbook
Plan Year 2017

01/01/2017 - 12/31/2017

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Questions?

Contact the County's Retiree Health Benefits Coordinator:
Phone: (805) 662-6791
Email: Patty.Vandewater@ventura.org

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 contains all the relevant information regarding Medical, Dental, and Vision Plans for both Non-Medicare Retirees and Medicare-Eligible Retirees. This Handbook summarizes the benefits available to you, and gives you 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). Some plans require continuous coverage in a County-sponsored health plan without a lapse in coverage.

▪ Special Notice

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

There are no Open Enrollment Periods for retirees. On rare occasion, the County may hold a Special Enrollment for existing participants.

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

▪ Eligibility

You may be eligible for 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). Some plans require continuous coverage in a County-sponsored health plan 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).

See page 2-9 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 some plans, you will be referred to a specialist within the PCP's medical group or Independent Practice Association (IPA). Should you choose to receive services without a referral or outside the plan's network of providers, you will not be entitled to coverage by the plan.

At the time you enroll, you must choose a PCP for yourself and each eligible dependent from the plan's panel. 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. If your PCP leaves the plan during the Plan Year, you must select a new PCP within the plan.

***Exclusive Provider Organization (EPO)* -** An EPO is like a HMO, in that you MUST use network providers (except in an emergency); however, with an EPO, you do **NOT** need to select a PCP, nor do you need a referral to see a specialist. If care is received from a non-participating provider, there is no benefit coverage. It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.

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.

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 you three medical plans to choose from:

- Ventura County Health Care Plan (HMO)
- Anthem EPO
- Anthem 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.

❖ Ventura County Health Care Plan (HMO)

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

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

Additional Plan benefits include, but are not limited to:

- Members have access to 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 an annual vision refraction exam, and for chiropractic and acupuncture services. (Reimbursement varies; for benefit details, see Comparison Chart in this chapter).

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

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

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

❖ Anthem EPO

Anthem's EPO offers a broad range of benefits and low out-of-pocket expenses. Members do not pay an annual deductible.

Unlike a HMO, you do not need to select a Primary Care Physician (PCP) to direct your care, nor do you need to obtain a referral to see a specialist. You do however need to seek services from providers who participate in the Prudent Buyer PPO network (except in an emergency). If care is received from a non-participating provider, there is no benefit coverage. It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network.

To see a list of the providers who participate in the Prudent Buyer PPO network, go to the Anthem website (www.anthem.com/ca), click on "Find a Doctor," click the "Continue" button in the "Search as a Guest" section, and select the "Blue Cross PPO (Prudent Buyer) – Large Group" plan when prompted to do so.

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

Anthem'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 Anthem Prudent Buyer 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. If you have family coverage, the $6,000 deductible will apply regardless of the number of family members who are receiving treatment. Please note that the deductible, which must be met before the plan benefits are payable, applies to **all** expenses (except preventative care).

Self-Referral to Network Provider:
You may seek care from any Anthem Prudent Buyer PPO provider. For basic physician services, you pay 20% after deductible. For most other services, you pay 20% of the negotiated rate, plus the annual deductible amount. Your PPO provider may file claims on your behalf.

Self-Referral to Any Non-Network Provider:
For most covered services received from a non-network provider, the plan pays 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 Anthem. 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). A HSA is an individually-owned savings account, similar to an IRA or 401(k) retirement plan, except that

funds are used to pay for health care costs. A HSA provides consumers with a tax-efficient method of saving and paying for qualified medical expenses. However, an account owner must not be enrolled in Medicare, claimed as a dependent on another's tax return, or enrolled in another health plan that is not a high deductible health plan.

Comparison of Medical Plan Benefits

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

	Ventura County Health Care Plan (HMO)	**Anthem EPO** (Prudent Buyer PPO Network)	**Anthem High-Deductible PPO** (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	**Non-Participating Provider**
Deductible *(Per Member/Per Family; per Calendar Year)*	None	None	Applies to all expenses except preventative care: $3,000/$6,000 [5]	
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 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	$5,000/$10,000	$10,000/$20,000
PHYSICIAN SERVICES				
Office visits *(consultations and in-office procedures)*	$10 copay/visit with a VCMC provider; $20 copay/visit at other contracted providers	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Preventative Care	100% coverage (no copay)	100% coverage (no copay)	100% coverage (no copay)	60% coverage [3]
Maternity Care	$10 copay/visit with a VCMC provider; $20 copay/visit at other contracted providers (initial visit only)	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Specialist	$20 copay/visit with VCMC specialist; $40 copay/visit at other contracted providers	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Well Woman Annual Exam *(exam, pap smear & associated tests)*	100% coverage (no copay) (may self-refer to any OB/GYN who participates in the Plan's Self-Referral Program for most OB/GYN services)	100% coverage (no copay)	100% coverage (no copay)	60% coverage [3]
Well child, including immunizations *(birth through age 18)*	100% coverage (no copay)	100% coverage (no copay)	100% coverage (no copay)	60% coverage [3]
Adult Immunizations	100% coverage (no copay) *(excluding occupational; ACIP-approved travel immunizations are covered)*	100% coverage *(excluding travel & occupational)*	100% coverage *(excluding travel & occupational)*	60% coverage [3]
Allergy Testing & Treatment *(includes injections/serum)*	100% coverage	$15 copay per visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]

Footnote descriptions are on page 2-12

	Ventura County Health Care Plan (HMO)	Anthem EPO (Prudent Buyer PPO Network)	Anthem High-Deductible PPO (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	Non-Participating Provider
HOSPITAL/FACILITY				
Inpatient Services and Supplies [6]	No copay at VCMC/SPH; $150 per day copay at contracted non-VCMC facilities (up to $600 maximum)	$100/admit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3] ($1,000/day limit)
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)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Outpatient Surgery [6]	No copay at VCMC/SPH; $250 copay at non-VCMC[9] contracted facilities, when preauthorized	$50 copay	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3] ($350/admit limit)
Emergency Room *(covers emergency services only)*	$150 copay (copay waived if directly admitted)	$100 copay (copay waived if directly admitted)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3] (deductible waived if directly admitted)
OTHER SERVICES				
Ambulance *(when medically necessary)*	$150 copay (air and ground)	$100 copay (air and ground)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage; 40% w/o referral [3] (air and ground)
Urgent Care	$50 copay (no PCP or Plan referral required)	$15/visit (copay waived if directly admitted)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Rehabilitation Therapy *(includes physical, speech, occupational, and respiratory therapy)*	$10 copay/visit at VCMC/SPH; $20 copay/visit at other contracted facilities	$15/visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Chiropractic/Acupuncture	Plan reimburses $20/visit to any chiropractor/acupuncturist (limited to 15 combined chiropractor/ acupuncturist visits per Plan Year) [7]	$15/visit (chiropractic services limited to 30 visits per year; acupuncture limited to 20 visits per year)	80% of Negotiated Allowance [2] (20% coinsurance) *Limits: Chiropractic Services – 30 visits/year Acupuncture – 20 visits/year*	60% of Negotiated Allowance [3] (40% coinsurance) *Limits: Chiropractic Services – 30 visits/year Acupuncture – 20 visits/year*
Imaging (MRI, CT, PET)	No copay at VCMC/SPH; $125 copay at other contracted facilities	$100/test	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Diagnostic/screening X-ray, Ultrasound, Laboratory *(Outpatient)*	100% coverage at VCMC/SPH and contracted facilities	100% coverage (no copay)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]

Footnote descriptions are on page 2-12

	Ventura County Health Care Plan (HMO)	Anthem EPO (Prudent Buyer PPO Network)	Anthem High-Deductible PPO (High Deductible Health Plan; HSA-compatible)	
			Participating Provider	Non-Participating Provider
Hospice	**Inpatient:** 100% coverage **Outpatient:** 100% coverage; prognosis of life expectancy of one year or less	100% coverage (no copay)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [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)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Durable Medical Equipment	100% coverage (no 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% of Negotiated Allowance [2]	50% coverage [3]
Annual Eye Refraction Exam	Plan reimburses cost of refraction exam, up to $50 per person per calendar year [7] (no PCP referral needed)	Not Covered	Not Covered	Not Covered
BEHAVIORAL HEALTH				
Mental Health & Substance Abuse Services	Self-referral to any "Life Strategies" provider; PCP referral not required			
Inpatient [1, 6, 8]	**Through VCHCP's "Life Strategies" Program only** 100% coverage (no copay)	$100/admit (subject to utilization review)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Residential/Alternative Treatment [1, 6, 8]	**Through VCHCP's "Life Strategies" Program only** 100% coverage (no copay)	100% coverage (no copay)	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]
Outpatient [1, 8]	**Through VCHCP's "Life Strategies" Program only** $10/visit	$15/visit	80% of Negotiated Allowance [2] (20% coinsurance)	60% coverage [3]

Footnote descriptions are on page 2-12

	Ventura County Health Care Plan (HMO)	Anthem EPO (Prudent Buyer PPO Network)	Anthem 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.
Plan's Local Pharmacy Network *(Retail Pharmacy)*	100% for 30-day supply after copay of: Tier 1 - $9 Tier 2 - $30 Tier 3 - $45 Tier 4* - 10% up to $250/script/month * Specialty Drugs 50% for covered infertility drugs	100% for 30-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $25 Approved Non-Formulary - $45 Specialty Drugs - 20% coinsurance, up to $150 per fill	**Contracting Pharmacies:** 100% for 30-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $30 Approved Non-Formulary - $50 Specialty Drugs - 30% coinsurance, up to $150 per fill	**Non-Contracting Pharmacies:** All Tiers - 40% coinsurance, plus costs in excess of maximum allowed amount (compound drugs & specialty pharmacy drugs are not covered; classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program)
Plan's Mail-Service	100% for 90-day supply after copay of: Tier 1- $18 Tier 2- $60 Tier 3- $90 50% for covered infertility drugs	100% for 90-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $50 Approved Non-Formulary - $90 Specialty Drugs – 20% coinsurance, up to $300 per fill	100% for 90-day supply after copay[1] of: Generic - $10 Brand-Name Formulary - $60 Approved Non-Formulary - $100 Specialty Drugs – 30% coinsurance, up to $300 per fill	Not covered

Footnote descriptions are on page 2-12

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 continuation of coverage (COBRA).

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

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

Medical Plan Options Footnotes

1 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 Anthem'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 Anthem'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 payments are based on **110% of the Medicare published rates**. Member pays the applicable co-insurance and is also responsible for amounts charged by the provider in excess of this co-insurance.

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

5 There is no per member deductible accumulation/accrual. It is a single comprehensive family deductible. If a member changes plan status from family to individual, any family deductible amount will be applied to the new individual deductible. In addition, if a member changes plan status from individual to family, any individual deductible amount will be applied to the new family deductible. No one in the family is eligible for benefits until the family coverage deductible is met.

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

7 VCHCP: Chiropractic, Acupuncture, and Eye Refraction claims must be submitted within 180 days from the date of service.

8 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.

9 There is no copayment to the member for services if the service is available and obtained at VCMC/SPH. If the service is not available at VCMC/SPH, for whatever reason, the member will need to obtain the service at another contracted facility and a copay will apply.

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

Chapter 3
Medical Plans –Medicare-Eligible Retirees

The County offers Medicare-eligible retirees and their dependents a choice of three medical plans:

- ✓ Ventura County Health Care Plan's Medicare Coordination of Benefits (COB) HMO
- ✓ Kaiser Permanente Senior Advantage HMO Plan
- ✓ Anthem Medicare Preferred PPO

To be eligible to participate in any of the Medicare-Eligible Retiree plans, you must be covered by Medicare Parts A and B.

❖ Ventura County Health Care Plan's Medicare Coordination of Benefits (COB) HMO

The Ventura County Health Care Plan's Medicare Coordination of Benefits (COB) HMO is an HMO plan that coordinates with your existing Medicare coverage. You retain your Medicare coverage and do not assign your Medicare to VCHCP. Your providers submit claims to Medicare first and VCHCP second. You are responsible for the copayments per the Plan Summary of Benefits.

As with any regular HMO, you choose a physician to act as your Primary Care Provider (PCP). This physician acts as the "coordinator" or "gatekeeper" for all your health care services. A prescription drug plan is also included.

At the time you enroll, you must choose a PCP for yourself and each eligible dependent from the plan's panel. You may choose a different PCP for each member of your family, and you can change providers during the year. If your PCP leaves the plan during the year, you must select a new PCP from within the medical plan.

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. You will generally be referred to a specialist within the PCP's Medical Group or Independent Practice Association (IPA).

Medicare does not require a referral to pay claims, however, 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 HMO plan for those expenses, except in an emergency situation.

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

❖ Kaiser Permanente Senior Advantage – Medicare Replacement Plan

Kaiser Permanente Senior Advantage HMO plan is a CMS Medicare-approved plan with Part D coverage. Medicare pays the plan a monthly fee to provide all covered services to members. When you select the Kaiser Permanente Senior Advantage plan, you are agreeing to use this plan for all services instead of billing Medicare. You pay your provider a copayment for some services.

All Kaiser Permanente Senior Advantage members have open access to all primary care services. 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.

With Kaiser Permanente Senior Advantage, you do not need to identify your PCP on the enrollment form for yourself and eligible dependent. You will receive a new member welcome kit which will provide you with a list of medical office locations. You and your eligible dependent(s) are free to select a PCP from Kaiser Permanente's doctors currently practicing in Camarillo, Oxnard, Simi Valley, Thousand Oaks and Ventura. For more information, contact Kaiser Permanente Member Service Call Center at 1-800-443-0815 (TTY 1-800-777-1370 for the hearing/speech impaired), seven days a week, from 8 a.m. to 8 p.m. Or visit them online at kp.org.

❖ Anthem Medicare Preferred PPO

The Anthem Medicare Preferred PPO plan is a Medicare Advantage plan. It provides Medicare-eligible individuals with an alternative to the traditional Medicare program. Through a contract with Medicare, the Anthem Medicare Preferred PPO plan provides the health care services covered by original Medicare. This plan includes prescription drug coverage with the medical plan so you do not need to purchase a separate Medicare Part D plan.

The Anthem Medicare Preferred PPO plan uses a network of health care providers, but gives you the freedom to see providers outside of the network. No referrals are required. Your medical plan pays the same benefit for in–network and out-of-network providers who accept Medicare. Using our network of doctors can help keep your medical cost lower. This plan provides reimbursement for all covered services regardless of whether they are received in or out of network and are a Medicare-covered benefit.

The Anthem Medicare Preferred (PPO) plan also offers wellness programs at no extra cost. These programs include access to discounts on weight loss programs, nutritional supplements and more. You'll also enjoy the flexibility of using just one card whenever you seek medical or prescription benefits.

▪ Medicare/Non-Medicare Combination Plan Options

If you or one or more of your eligible dependents is not yet Medicare eligible, you can enroll in a combination coverage plan with Anthem or with the Ventura County Health Care Plan.

Anthem allows for a combination of the Anthem Medicare Preferred PPO option for family members covered by Medicare and Anthem's EPO or High-Deductible PPO Plan coverage for family members who are not eligible for Medicare.

Ventura County Health Care Plan allows for a combination of the VCHCP Medicare COB HMO option for family members covered by Medicare and the VCHCP HMO plan for family members who are not eligible for Medicare.

For Information on the Medical Plans

Before choosing a plan, be sure to compare benefits, providers, copayments and out-of-pocket expenses, as well as premiums. Your Retiree Health Benefits Coordinator can provide you with a packet for the Kaiser Permanente Senior Advantage plan, the Ventura County Health Care Medicare COB HMO plan, or the Anthem Medicare Preferred PPO plan, along with options for non-Medicare eligible dependents.

The Provider/Carrier's packet is your primary source of information about the plan. If you still have questions about whether or not you live within a plan's service area or any other questions about the plan, call the plan directly. See the back cover of this handbook for a listing of plan contact numbers and websites.

Whichever medical plan you select, once you enroll, ID cards and plan benefit booklets will be mailed to your home.

Comparison of Medical Plans

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. Retiree and dependents must be enrolled in Medicare Parts A & B. All plans include Prescription Drug Coverage/Medicare Part D.

	Anthem Medicare Preferred PPO Medicare Advantage Plan so Medicare is not billed	**Kaiser Permanente Senior Advantage** Medicare Advantage Plan so Medicare is not billed	**VCHCP Medicare COB HMO** Medicare billed as Primary; VCHCP billed as secondary
Office visits	100% Coverage (no copay)	100% Coverage after $10 copay	$10 VCMC physician; $20 non-VCMC physician
Specialist	100% Coverage (no copay)	100% Coverage after $10 copay	$20 VCMC physician; $30 non-VCMC physician
Hospitalization	100% Coverage (no copay)	100% Coverage after $250 copay	No copay VCMC; $150 per day non-VCMC ($600 max)
Urgent Care	100% Coverage (no copay)	100% Coverage after $10 copay	$50 copay
Emergency Room	100% Coverage (no copay)	100% Coverage after $50 copay	$150 copay
Outpatient Surgery	100% Coverage (no copay)	100% Coverage after $10 copay	No copay VCMC; $250 non-VCMC
Pharmacy	$10 copay Generic $20 copay Brand Name $35 copay Non-Formulary	Formulary $10 copay Generic $10 copay Brand Name Non-Formulary Not Covered	$9 copay Generic $30 copay Brand Name $45 copay Non-Formulary Speciality Drugs – 10% up to $250/script/month
Mail Order Pharmacy	Express Scripts 800-233-8065 www.express-scripts.com 90-day supply: $20/$40/$70	Not Applicable	Express Scripts 800-233-8065 www.express-scripts.com 90-day supply: $18/$60/$90
Eye Refraction	Not Covered	100% Coverage after $10 copay	Plan reimburses member up to $50 per year
Eyeglasses	Not Covered	$150 eyewear allowance (once every 24 months)	Not Covered
Hearing Exam	Not Covered	100% Coverage after $10 copay	$10 copay
Hearing Aids	Not Covered	$500 allowance per Hearing Aid (once every 36 months)	Not Covered
Dental	Not Covered	Not Covered	Not Covered

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 in mind that:

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

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

❖ MetLife Dental PPO

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

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

Eligibility and benefit information are available on-line, including the ability to print an ID card: www.metlife.com/mybenefits. You may also call their customer service department at (800) 438-6388.

Providers

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

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

Covered Fees

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

Predetermination of Costs

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

Coordination of Benefits (Dual Coverage)

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

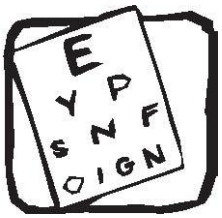
Limitations and Exclusions

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

	MetLife Dental PPO Group Number 0154209	
	In DPO Network	**Out of DPO Network**
CALENDAR YEAR DEDUCTIBLE Per Member/Per Family	$15/$45	$25/$75
MAXIMUM BENEFIT Each Calendar year (excluding MPD-TMJ and Orthodontics)	$2,000 per person	$1,000 per person
SEPARATE LIFETIME MAXIMUM: Orthodontic Benefits	$1,000 per person	
Benefits Coverage	**In DPO Network**	**Out of DPO Network**
DIAGNOSTIC/PREVENTIVE SERVICES		
Oral exam, x-rays	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)		
Emergency Palliative Treatment		
Space maintainers		
BASIC BENEFITS		
Oral Surgery: Simple Extraction; Local 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		
Restorative: (treatment of carious lesions resulting from dental decay)		
Amalgam		
Resin/Composite		
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 $1,000 lifetime maximum	Plan pays 40%; up to $1,000 lifetime maximum

Benefits Coverage	MetLife Dental PPO Group Number 0154209 In or Out of DPO Network	
CROWNS, JACKETS, CAST RESTORATIONS Treatment of carious lesions (resulting from dental decay) which cannot be filled		
Crowns/bridges, per unit	Plan pays 50% (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		
Recementation: 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)		
Stayplate		
Adjust denture or partial; reline in office		
Adjust denture or partial; reline in lab		
Repairs to denture/partial (no teeth)		
Add teeth or clasps to partial (per unit/tooth)		
Replace/add denture clasp		
Extra denture		
LIMITATIONS AND EXCLUSIONS (listed in the plan's Summary of Benefits/Evidence of Coverage booklet)	Excludes most procedures started prior to joining the plan	

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



Chapter 5
Vision Plan

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.

❖ **Medical Eye Services (MES) – Vision Plan**

MES offers the largest and most comprehensive network in California and nationally through its provider network, The Eye Care Network (ECN). In California alone, there are over 7,000 participating providers, with 29,000 providers nationally to choose from.

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

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

▪ How to Use the Plan

Covered retirees follow these steps to receive their vision benefits:

1. The retiree can make an appointment with the eye care specialist of his/her choice. Members will have less out of pocket if they utilize an MES Participating 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 go to the MES website at www.mesvision.com, or contact MES directly at (800) 877-6372 or (714) 619-4660.

2. At the time of the vision appointment, please make sure you notify the provider you are an MES member. The Participating Provider will contact MES for benefit determination and eligibility verification and then submit the Claim Form for payment for Covered Services.

3. If Covered Services are received from a Non-Participating Provider, the eligible retiree is responsible for paying the provider in full at the time services are rendered. The eligible retiree or the provider must submit an itemized billing and a copy of his/her prescription with the Claim Form to MES. Please go to www.mesvision.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 retiree, up to the Schedule of Allowances shown for Non-Participating Providers.

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

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

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

Medical Eye Services (MES) Summary of Benefits

Vision Service	Participating Provider Benefit *Amount Covered by the Plan*	Non-Participating Provider Benefit Amount *Reimbursed by the Plan*	Benefit Frequency (months)
Vision Examination	Covered in Full after $20 copay	$40 after $20 copay	12
Standard Lenses (less than 61mm)	Covered in Full	$30 Single $50 Bifocal $65 Trifocal $125 Lenticular	12
Frame	Up to $100 Retail	Up to $40 Retail	24
Contact Lenses – Non-Elective/ Medically Necessary[1]	Covered in Full with Authorization	Up to $250	12
Contact Lenses – Elective/Cosmetic[1]	Up to $105	$100	12

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

1 The contact lens allowance is in lieu of other eyewear. The allowance includes the contact lens evaluation, fitting costs, and materials. Any different between the allowance and the provider's charge is the patient's responsibility.

Medical Eye Services Limitations & Exclusions

MEDICAL EYE SERVICES – LIMITATIONS

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

MEDICAL EYE SERVICES – EXCLUSIONS

- Any 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.

Coverage Through Your Medical Plan

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

Anthem EPO

For the Anthem EPO plan, you pay a **$10 office visit copayment** for the annual eye examination with refraction.

Ventura County Health Care Plan (VCHCP)

VCHCP will reimburse you for the cost of your annual eye refraction exam, up to $50 for you and each covered dependent. You can go to any eye doctor you choose. To file a claim for reimbursement, you may obtain a claim form from VCHCP's website (http://www.vchealthcareplan.org). *Claims must be presented to VCHCP within 180 days from the date of the exam.*

VCHCP does not cover materials such as frames and lenses.

Vision-Related Discounts

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

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 Retiree 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 plans, dental and vision plans is effective the day after your active employee or COBRA coverage terminates.

Coverage under the Medicare medical plans must be effective on the first day of a month. If your active or federal COBRA coverage ends mid-month, special arrangements can be made to allow you to continue coverage in a non-Medicare medical plan through the end of a month to avoid a break in coverage.

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

- If you are enrolled in a retiree 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 become ineligible for your current retiree 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, if you wish to remain in one of the County-sponsored Retiree medical plans.

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 your 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: www.ventura.org/benefits/flexible-benefits (look under the Post-Retirement Health Insurance section for "Retiree Enrollment Form").

- 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: www.ventura.org/benefits/flexible-benefits (look under the Post-Retirement Health Insurance section for "Retiree Enrollment Form").

If you are canceling coverage for a dependent covered by Kaiser Senior Advantage, both the Retiree and the dependent must sign the Retiree Enrollment & Change Form.

6. What if I no longer want insurance?

To cancel your retiree health plan, notify the Retiree Health Benefits Coordinator in writing by completing a Retiree Enrollment & Change Form no later than the 15th of your last month of coverage, and coverage will end on the last day of the month. This form can be found on our website: www.ventura.org/benefits/flexible-benefits (look under the Post-Retirement Health Insurance section for "Retiree Enrollment Form").

Additional Questions? Call the County's Retiree Health Benefits Coordinator at (805) 662-6791 or email her at Patty.Vandewater@ventura.org.

Chapter 7
Summaries of Benefits and Coverage

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

Ventura County Health Care Plan (HMO)

Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** HMO

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

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

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov. 1 of 9

Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** HMO

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

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

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider VCMC	Your cost if you use an In-network Provider Non-VCMC	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay	$20 co-pay	Not Covered	None
	Specialist visit	$20 co-pay	$40 co-pay	Not Covered	None
	Other practitioner office visit	$10 co-pay	$20 co-pay	Not Covered	PT/OT/ST
	Preventive care/screening/immunization	No Charge	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray[TC1], blood work)	No Charge	$20 x-ray only	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	$125 co-pay	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.vchealthcareplan.org – My Benefit Plan	Generic drugs	(No Rx services available)	$9 co-pay $18 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Preferred brand drugs	(No Rx services available)	$30 co-pay $60 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Non-preferred brand drugs	(No Rx services available)	$45 co-pay $90 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Specialty drugs	(No Rx services available)	10% of cost up to $250 max per prescription, per month.	Not Covered	None

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

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** HMO

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	$250 co-pay	Not Covered	None
	Outpatient Services – Other	No Charge	10% of cost up to $250 maximum	Not Covered	None
	Physician/surgeon fees	No Charge	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$150 per visit	$150 per visit	$150 per visit	$0 co-pay if admitted to hospital.
	Emergency medical transportation	$150 co-pay	$150 co-pay	$150 co-pay	None
	Urgent care	$50 co-pay	$50 co-pay	$50 co-pay outside service area.*	*Urgently Needed Care is covered while outside the service area. When inside the service area, must use an In-Network facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	$150 per day/$600 maximum per stay	Not Covered	None
	Physician/surgeon fee	No Charge	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	(Behavioral Health Services Not Available)	$10 per visit	Not Covered	Administered by Optum Health Behavioral Solutions (OHBSC), "Life Strategies".
	Mental/Behavioral health inpatient services	(Behavioral Health Services Not Available)	$0	Not Covered	Administered by Optum Health Behavioral Solutions (OHBSC), "Life Strategies".
	Substance use disorder outpatient services	(Behavioral Health Services Not Available)	$10 per visit	Not Covered	Administered by Optum Health Behavioral Solutions (OHBSC), "Life Strategies".
	Substance use disorder inpatient services	(Behavioral Health Services Not Available)	$0	Not Covered	Administered by Optum Health Behavioral Solutions (OHBSC), "Life Strategies".

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

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** HMO

If you are pregnant	Prenatal and postnatal care	No Charge	$20 co-pay for initial pre-natal visit only	Not Covered	(First visit only; No co-pay thereafter.)
	Delivery and all inpatient services	No Charge	$150 co-pay per day/ $600 max per stay	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Not Available	$20 per visit	Not Covered	None
	Rehabilitation services	$50 per day/$500 max per stay	$50 per day/$500 max per stay	Not Covered	None
	Habilitation services	$10 co-pay	$20 co-pay	Not Covered	None
	Skilled nursing care	Not Available	$50 per day/$500 max per stay	Not Covered	None
	Durable medical equipment	No Available	10% co-pay	Not Covered	50% co-pay for replacement when medically necessary.
	Hospice service	No Charge	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	No Charge when part of routine physical (through age 17)	No Charge when part of routine physical (through age 17)	Not Covered	Over Age 17 – VCHCP reimburses up to $50 co-pay reimbursement for refraction, once every 12 months.
	Glasses	Not Covered	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	Not Covered	Dental Services are not covered.

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

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees & Dependents | **Plan Type:** HMO

Excluded Services & Other Covered Services:

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

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental care (Adults)
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Eye Exams
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs
- Eye Glasses

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Infertility Treatment

Your Rights to Continue Coverage:

"If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at (805) 981-5050 or (800) 600-8247. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565, or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B,

Questions: Call (805) 981-5050 or visit us at www.vchealthcareplan.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov. 6 of 9

Oxnard, CA 93036; (805) 981-5050 or (800) 600-8247; or visit them on line @ www.vchealthcareplan.org. Additionally, a consumer assistance program can help you file your appeal. Contact the Department of Managed Health Care (DMHC) at (877) 688-9891.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

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

Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees and Dependents | **Plan Type:** HMO

Coverage Examples

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

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

Sample care costs:

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

Patient pays:

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

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

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

Sample care costs:

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

Patient pays:

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

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

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Ventura County Health Care Plan: Group Coverage

Coverage Period: 1/1/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employees and Dependents | **Plan Type:** HMO

Coverage Examples

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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

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Anthem EPO

Anthem Blue Cross Life and Health Insurance Company
VENTURA COUNTY
EPO 15 (0/15/0)

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

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual + Family | **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/ca/aso or by calling (800) 727-2762.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 3 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes; **$100** per visit for Emergency room services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes; **$1,500** per member/**$3,000** family for PPO Providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, EPO. For a list of PPO providers, see www.anthem.com/ca or call **(800) 727-2762**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network,

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca. CA/L/A/PACE:CUSTOM15(0/15/0)-EPO/NA/NA/07-16
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (800) 727-2762 to request a copy.

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Important Questions	Answers	Why this Matters:
		preferred, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services.**

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

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not covered	--------none--------
	Specialist visit	$15 copay per visit	Not covered	--------none--------
	Other practitioner office visit	Chiropractor $15 copay per visit Acupuncture $15 copay per visit	Chiropractor Not covered Acupuncture Not covered	Chiropractor Coverage is limited to 30 visits per benefit period. Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services. Acupuncture Coverage is limited to 20 visits per benefit period.
	Preventive care/ screening/immunization	No cost share	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No cost share X-Ray – Office No cost share	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	$100 copay per test	Not covered	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/ca/pharmacyinformation/	Tier 1 - Typically Generic	$10 copay per prescription (retail only) and $10 copay per prescription (home delivery only)	$10 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug	30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
			maximum allowed amount	only at retail pharmacies). Covers up to a 90 day supply (home delivery program) (includes diabetic supplies).
	Tier 2 - Typically Preferred / Brand	$25 copay per prescription (retail only) and $50 copay per prescription (home delivery only)	$25 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies). Covers up to a 90 day supply (home delivery program) If a member requests a brand name drug when a generic drug version 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 our 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

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
				name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$45 copay per prescription (retail only) and $90 copay per prescription (home delivery only)	$45 copay per prescription (retail only) plus 50% of the remaining prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies). Covers up to a 90 day supply (home delivery program) If a member requests a brand name drug when a generic drug version 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 our 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

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
				determined that the brand name drug is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply. Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies (includes compound drugs).
	Tier 4 - Typically Specialty Drugs	20% coinsurance up to $150 per prescription (retail only) and 20% coinsurance up to $300 per prescription (home delivery only)	50% coinsurance	30-day supply for specialty pharmacy. Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30 day supply. Member pays retail pharmacy copay plus 50% for Out-of Network Providers.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay per admission	Not covered	--------none--------
	Physician/surgeon fees	No cost share	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	$100 copay per visit	Covered as In-Network	If admitted inpatient, ER copay is waived.
	Emergency medical transportation	$100 copay per trip	Covered as In-Network	--------none--------
	Urgent care	$15 copay per visit	Covered as In-Network	Copay waived if admitted inpatient and outpatient ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per admission	Not covered	--------none--------
	Physician/surgeon fee	No cost share	Not covered	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an PPO Provider	Your Cost if You Use an Non-PPO Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit $15 copay per visit Facility Charges No cost share	Office Visit Not covered Facility Charges Not covered	Office Visit --------none-------- Facility Charges --------none--------
	Mental/Behavioral health inpatient services	No cost share	Not covered	This is for facility professional services only. Refer to hospital stay for facility fees.
	Substance use disorder outpatient services	Office Visit $15 copay per visit Facility Charges No cost share	Office Visit Not covered Facility Charges Not covered	Office Visit --------none-------- Facility Charges --------none--------
	Substance use disorder inpatient services	No cost share	Not covered	This is for facility professional services only. Refer to hospital stay for facility fees.
If you are pregnant	Prenatal and postnatal care	$15 copay per visit	Not covered	--------none--------
	Delivery and all inpatient services	$100 copay per admission	Not covered	--------none--------
If you need help recovering or have other special health needs	Home health care	$15 copay per visit	Not covered	Coverage is limited to 100 visits per benefit period; one visit by a home health aide equals four hours or less.
	Rehabilitation services	$15 copay per visit	Not covered	--------none--------
	Habilitation services	$15 copay per visit	Not covered	--------none--------
	Skilled nursing care	No cost share	Not covered	Coverage is limited to 100 days limit per benefit period.
	Durable medical equipment	20% coinsurance	Not covered	--------none--------
	Hospice service	No cost share	Not covered	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery for morbid obesity only.
- Chiropractic care

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at (800) 727-2762. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Department of Labor, Employee Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)
1-213-897-8921
1-800-482-4TDD (4633)
http://www.insurance.ca.gov/

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm.Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,160
- **Patient pays** $380

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$230
Coinsurance	$0
Limits or exclusions	$150
Total	$380

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,520
- **Patient pays** $880

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$550
Coinsurance	$250
Limits or exclusions	$80
Total	$880

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca.

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UnitedHealthcare High Deductible Health Plan (PPO)

Anthem Blue Cross Life and Health Insurance Company
VENTURA COUNTY
High-Deductible PPO - Lumenos Health Savings Account (HSA) 3000 20/40 (LHSA291) Embedded

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

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Individual + Family | **Plan Type:** CDHP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/ca/aso or by calling (800) 727-2762.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual member / **$6,000** family for In-Network Providers. Does not apply to Preventive care. **$3,000** individual member/**$6,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers deductibles are combined.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$5,000** individual member/**$10,000** family for In-Network Providers. **$10,000** individual member/**$20,000** family for Out-of-Network Providers. In-Network Providers and Non-Network Providers Out of Pocket are separate and do not count towards each other.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca

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Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, Prudent Buyer PPO. For a list of In-Network providers, see www.anthem.com/ca or call **(800) 727-2762**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about **excluded services.**

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

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	--------none--------
	Specialist visit	20% coinsurance	40% coinsurance	--------none--------
	Other practitioner office visit	Chiropractor 20% coinsurance Acupuncture 20% coinsurance	Chiropractor 40% coinsurance Acupuncture 40% coinsurance	Chiropractor Coverage for In-Network Providers and Non-Network Providers combined is limited to 30 visits per benefit period. Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services. Acupuncture Coverage for In-Network Providers and Non-Network Providers combined is limited to 20 visits per benefit period.
	Preventive care/ screening/immunization	No cost share	40% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Coverage for Out-of-Network Providers is limited to $800 maximum per procedure.
	Tier 1 - Typically Generic	$10 copay per prescription	40% coinsurance (retail only) of the	Until the benefit period deductible is satisfied, the

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/ca/pharmacyinformation/		(retail only) and $10 copay per prescription (home delivery only)	prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	member pays the prescription drug covered expense, and not the copays. 30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies) Covers up to a 90 day supply (home delivery program) (includes diabetic supplies).
	Tier 2 - Typically Preferred / Brand	$30 copay per prescription (retail only) and $60 copay per prescription (home delivery only)	40% coinsurance (retail only) of the prescription drug maximum allowed amount and costs in excess of the prescription drug maximum allowed amount	Until the benefit period deductible is satisfied, the member pays the prescription drug covered expense, and not the copays. 30-day supply; 60-day supply for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies).

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				Covers up to a 90 day supply (home delivery program). If a member requests a brand name drug when a generic drug version 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 our 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 for In-Network Providers.
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$50 copay per prescription (retail only) and $100 copay per prescription (home delivery only)	40% coinsurance (retail only) of the prescription drug maximum allowed amount and costs in excess of the	Until the benefit period deductible is satisfied, the member pays the prescription drug covered expense, and not the copays. 30-day supply; 60-day supply

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
			prescription drug maximum allowed amount	for federally classified schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies). Covers up to a 90 day supply (home delivery program). If a member requests a brand name drug when a generic drug version 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 our 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

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				such case, the applicable copay for the dispensed drug will apply for In-Network Providers. Compound drugs are not covered through home delivery; only covered through certain retail participating pharmacies. (includes compound drugs).
	Tier 4 - Typically Specialty Drugs	30% coinsurance up to $150 per prescription (retail only) and 30% coinsurance up to $300 per prescription (home delivery only)	Not covered	Until the benefit period deductible is satisfied, the member pays the prescription drug covered expense, and not the coinsurance. 30-day supply for specialty pharmacy. Certain specialty pharmacy drugs may only be obtained through the specialty pharmacy program and are limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Coverage for Out-of-Network is limited to $350 maximum per admission.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	20% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	20% coinsurance	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Coverage for Out-of-Network is limited to $1,000

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
				maximum per day limit for non-emergency admission.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit 20% coinsurance Facility Charges 20% coinsurance	Office Visit 40% coinsurance Facility Charges 40% coinsurance	Office Visit --------none-------- Facility Charges --------none--------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	This is for facility professional services only. Refer to hospital stay for facility fees.
	Substance use disorder outpatient services	Office Visit 20% coinsurance Facility Charges 20% coinsurance	Office Visit 40% coinsurance Facility Charges 40% coinsurance	Office Visit --------none-------- Facility Charges --------none--------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	This is for facility professional services only. Refer to hospital stay for facility fees.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	--------none--------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Coverage for Out-of-Network is limited to $1,000 maximum per day limit for non-emergency admission.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage for In-Network and Non-Network Providers combined is limited to 100 visits per benefit period. One visit by a home health aide equals four hours or less.
	Rehabilitation services	20% coinsurance	40% coinsurance	--------none--------
	Habilitation services	20% coinsurance	40% coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 days limit per benefit period.
	Durable medical equipment	50% coinsurance	50% coinsurance	--------none--------
	Hospice service	20% coinsurance	40% coinsurance	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery for morbid obesity only.
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at (800) 727-2762. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

Department of Labor, Employee Benefits Security Administration
(866) 444-EBSA (3272)
www.dol.gov/ebsa/healthreform

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357)
1-213-897-8921
1-800-482-4TDD (4633)
http://www.insurance.ca.gov/

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Haí'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm.Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

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

Sample care costs:

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

Patient pays:

Deductibles	$3,000
Copays	$20
Coinsurance	$850
Limits or exclusions	$150
Total	$4,020

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,750
- **Patient pays** $3,650

Sample care costs:

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

Patient pays:

Deductibles	$3,000
Copays	$200
Coinsurance	$370
Limits or exclusions	$80
Total	$3,650

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Questions: Call (800) 727-2762 or visit us at www.anthem.com/ca

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WHO DO I CONTACT?

Anthem Blue Cross

Member Services for Medical and Prescription Eligibility/Claims/Benefits/Pre-certifications

Non-Medicare EPO & High-Deductible PPO (www.anthem.com/ca) – Policy# C18449 **(800) 727-2762**

Medicare Preferred PPO (www.anthem.com/ca) – Policy# Y0114 **(800) 797-6438**

Mail Order Pharmacy – Express Scripts (www.express-scripts.com) **(800) 233-8065**

Kaiser Permanente Senior Advantage Medicare Replacement Plan

Group Number: 228638-0

Toll Free: **(800) 443-0815**

TTY: **(800) 777-1370**

Website: www.kp.org

Ventura County Health Care Plan

Member Services office for Medical and Prescription Eligibility/Claims/ Benefits Questions/

Behavioral Health Program Administrator

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

Website: www.vchealthcareplan.org/

Local Phone Number: **(805) 981-5050**

Toll-Free Number: **(800) 600-8247**

Mail Order Pharmacy – Express Scripts (www.express-scripts.com) **(800) 233-8065**

MetLife Dental PPO Plan

Group# 0154209

Customer Service (Member Services office for Eligibility/Claims/Benefits/Pre-certifications) **(800) 438-6388**

Website: www.metlife.com/mybenefits

Medical Eye Services (MES) – Vision Plan

Customer Service: **(800) 877-6372**

Customer Services e-mail: customerservice@mesvision.com **or (714) 619-4660**

Website: www.mesvision.com

County Retiree Health Benefits Coordinator

Retiree Health Benefits Coordinator: **(805) 662-6791**

E-mail: Patty.Vandewater@ventura.org

Website: www.ventura.org/benefits/flexible-benefits

(go to the “Post-Retirement Health Insurance” section)