2026 Employee Benefits Guide

Benefits Effective January 1, 2026

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This brochure summarizes the benefit plans that are available to eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Benefits Department. Information provided in this brochure is not a guarantee of benefits.

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Welcome

Ventura Superior Court recognizes that benefits are an important part of your total compensation, your well-being and your covered dependents. Each year we work with our providers to carefully review our benefits program, search for new ways to maintain the quality of our plans and meet your benefit needs and your family in a cost-effective manner. This brochure is a guide to the options available for the duration of the plan year. The actual plan documents shall prevail in case of any conflict in descriptions.

Selecting your benefits can be confusing. As a healthcare consumer, it's very important that you educate yourself about the various health plans being offered. In doing this, you should consider the costs, benefits, ease of obtaining healthcare, and how well the plan matches the needs of you and your family.

If you have further questions about the information contained in this brochure or about any of the benefit options, please don't hesitate to call the Benefits Department.

Eligibility

Employees

All regular benefits-eligible employees who work at least 20 or more hours per week are eligible for benefits on the first of the month following your date of hire. Your eligible dependents are also eligible at that time.

As a newly hired employee, you will be provided enrollment materials by Human Resources to assist you in the timely election of your benefit plans. If you elect not to enroll at the time of hire, your next opportunity to enroll, along with your eligible dependents will be at the Court's annual Open Enrollment period, or mid-year, if you experience a qualifying life event.

Eligible Dependents

Eligible dependents include your spouse, registered domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children and children obtained through court- appointed legal guardianship, as well as children of state-registered domestic partners.

Enrollment

When to Enroll

During open enrollment period, you can make changes to your benefit plans, select new benefit plans and add or delete eligible dependents. The annual Open Enrollment period is typically in the fall each year for plan year coverage effective January 1st.

As a new hire — If you choose to enroll in our benefits package, you will have the opportunity to do so within your first 60 days of employment.

How do I make changes during the year?

Changes to your benefits can only be made during open enrollment or if you experience a qualified life event. The Court's benefit plan year begins each January 1st and ends December 31st. Benefit plans and rates are established each plan year.

Choose your coverage carefully, as your plan elections are irrevocable until the Court's next annual Open Enrollment period, unless you have a qualifying event. Qualifying events include marriage, divorce, childbirth, death, adoption and more. *Click Here* to find out what you need to do when you experience mid-year qualifying life events that would permit enrollment changes during the plan year.

When Coverage Ends

Your Court provided group health insurance coverage terminates the last day of the month in which you separate from Court's employment. If you leave employment with the Court, or you or any of your covered dependents are no longer eligible to participate in the Court's health plans, continuation of coverage under the law called Consolidated Omnibus Budget Reconciliation Act, or COBRA, is available. Reach out to the Human Resources Department for more information.

Quick Tip

The Ventura Superior Court offers benefits-eligible employees a comprehensive benefits program including a variety of quality health plans and coverage options to promote your good health, peace of mind and financial security through CalPERS for benefits-eligible employees.

You are encouraged to use this guide as a reference throughout the year. If you have questions, contact the Human Resources Department.

Choosing a health coverage option is an important decision. To help you make an informed selection, the insurance carriers make available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format.

The SBCs are available on the Court's Benefits website. A paper copy is also available at no cost by calling Human Resources.

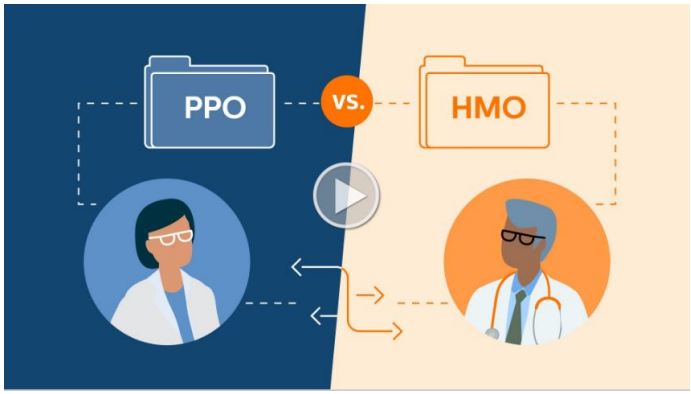
CalPERS Medical & Pharmacy

Ventura Superior Court will continue to offer medical options through CalPERS to benefited eligible employees. It is great to have options, but you want to choose the one that's right for you. Choosing the right health plan is probably one of the most important decisions you can make for you and your family. It is our objective to provide an employee benefits program with high quality making it easy for you and your dependents to access the medical care you need.

Here are some guidelines to consider when choosing a plan.

HMO	PPO
Members must select a Primary Care Physician (PCP) from the carrier network. PCP will refer to specialists within the same medical group or physician group. PCP will also take care of prior authorizations when needed. Hospitalization will be at the facility where the physician has admitting rights. Benefits are not available out-of-network unless it is an emergency. Services typically require a small dollar co-payment and there are no claims to file unless it is an emergency claim.	Members do not need to select a Primary Care Physician (PCP) and may self-refer to a specialist. The most financial savings in costs are from PPO providers. Members can use Non-PPO providers but keep in mind members will incur more out-of-pocket costs. Members are responsible for making sure prior authorizations are obtained. Costs are in the form of a co-insurance percentage after satisfying a deductible. Claims submission is required for services provided by a Non-PPO provider.

Still not sure how HMO and PPO plans work?
Click the image to learn more about **HMO v. PPO.**



Important Update:

Effective 2026: CVS Caremark (CVS) will be the new pharmacy for the following plans:

Anthem Blue Cross Traditional HMO
Anthem Blue Cross Select HMO
PERS Gold PPO
PERS Platinum PPO
Sharp HMO
United Health Care Alliance HMO
United Health Care Harmony HMO

For more information, please visit www.calpers.ca.gov/CVS.

CalPERS Medical

Live/ Work Criteria When Selecting a Medical Plan

You may enroll in a plan using either your residential or work zip code. Upon retirement, and are no longer working for any employer, and would like to stay enrolled in a CalPERS plan, you must select a health plan using your residential zip code.

When selecting a health plan using your work zip code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the plan's service area, even if they do not reside in that area.

Do CalPERS Medical Plans Meet the Affordable Care Act Standards?

All CalPERS medical plans offered by the Ventura Superior Court provide Minimum Essential Coverage and meet the Minimum Value Standards.

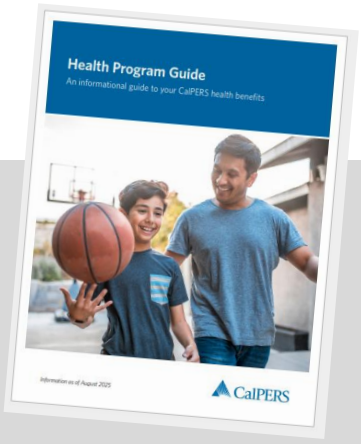
Click the following for health care terminology: https://www.healthcare.gov/sbc-glossary/. When the link opens, click on the "x" to bypass adding your state and email address. This is a valuable resource to reference as you review your benefit options.

Where Can I Find CalPERS Information Customized for Me?

Employees should always login to MyCalPERS.gov for the most current CalPERS information including rate and benefit information.

2026 CalPERS Health Plan Changes

There will be pharmacy changes to certain HMO and PPO plans. Please visit CalPERS website for more information: CalPERS Changes



Make your best benefits decisions

In deciding on a medical plan option, consider the following:

- Are your current doctors in the plan network?
- How often do you plan to use your medical benefits during the year? Do you require extensive medical care or have a longstanding relationship with an out-of-network provider?
- What are the out-of-pocket costs associated with each plan? Is there a deductible before the plan pays benefits?

MetLife Dental Benefits

The Court offers a dental PPO plan through MetLife Insurance.

MetLife Dental PPO

The MetLife Dental PPO plan allows you to receive care from any dentist each time you seek care; however, you will receive the highest level of benefits at the lowest out-of-pocket cost when you select an in-network dentist.

If you choose an out-of-network dentist who is not contracted with MetLife network, you will have to pay the cost difference if your dentist charges are more than Delta's approved fees. This cost is called balance billing and will vary by provider and may be substantial.

To locate a network provider, go to **www.metlife.com** and select ***Find a Provider***. Be sure to select your correct network.

Any questions?
DPPO members – (800) 275-4638

Find a network dentist near you! Click Here and select "Find a Dentist".

MetLife	MetLife Dental Insurance Company Dental PPO All Active Employees (30+ hrs/wk)		Met Life Dental Insurance Company Dental PPO Retired Employees	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	$15	$25	$15	$25
Family	$45	$75	$45	$75
Waived for Preventive Care?				
Lifetime Maximum Per Person / Family	$2,500 Per Person	$1,500 Per Person	$2,500 Per Person	$1,500 Per Person
Preventive	100%	100%	100%	100%
Basic	80%	70%	80%	70%
Major	50%	40%	50%	40%
Benefit Percentage	50%	50%	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	50%	50%	50%	50%
Dependent Child(ren)	50%	50%	50%	50%
Orthodontia Lifetime Maximum - Ortho applies to Adult and Child Dependent Age until the day he or she turns 26.	$1,500 per person	$1,500 per person	$1,500 per person	$1,500 per person
Benefit Waiting Periods	none	none	none	none

Vision

The Ventura Superior Court provides vision coverage through EyeMed. You can seek care from an EyeMed in-network provider or an out-of- network provider, however, your costs will be lower if you visit an in-network provider. If you visit an in-network provider, you will be responsible for a copayment at the time of your service. If you receive services from an out-of-network doctor, you will pay all costs at the time of service and submit a claim for reimbursement.

	EyeMed Vision In-Network Benefits
Copay	
Routine Exams (Annual)	$20 copay $0 copay at PLUS Provider
Vision Materials	
Materials Copay	$20 copay
Lenses	Benefit varies by type of lens. Covered every 12 months
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	Contacts – Conventional $0 copay; 15% off balance over $110 allowance Contacts – Disposable $0 copay; 100% of balance over $110 allowance Contacts – Medically Necessary $0 copay; paid-in-full
Frames	Frame at **PLUS Provider** $0 copay; 20% off balance over $150 allowance Frame $0 copay; 20% off balance over $100 allowance

Group Basic Life Insurance from Standard Insurance Company

Basic Life and AD&D

Unrepresented employees covered by the Management Resolution are automatically covered by a $50,000 group term life insurance/AD&D policy effective the 1st of the month following hire date. If you need to change your beneficiary, you may complete the Basic/Optional Life Insurance Beneficiary Designation Form found on the Human Resources intranet site, sign, scan and email it to: Court.Benefits@ventura.courts.ca.gov

Long Term Disability

The court also offers long term disability coverage to benefits eligible unrepresented employees at no cost.

If eligible, you will receive a benefit of 67% of your monthly earnings up to $8,000 per month. This benefit is available to you are long as you cannot perform your own or any occupation for up to 24 months. Should you continue to meet the insurance carrier's definition of disability after that time, the benefit will be paid to you up to age 65 or to the Social Security Normal Retirement Age (SSNRA).

Optional Life Insurance and AD&D from Standard Insurance Company

Optional Life and AD&D

Each benefit eligible employee may purchase optional group term life insurance/AD&D policy effective the 1st of the month following hire date.

Visit the Court's Benefits page on the HR's Intranet for more details on optional life insurance and AD&D coverage.

If you are enrolled in optional life insurance and need to change your beneficiary, you may complete the Basic/Optional Life Insurance Beneficiary Designation Form found on the Human Resources intranet site, sign, scan and email it to: Court.Benefits@ventura.courts.ca.gov

AFLAC Voluntary Benefits

AFLAC is an enhanced benefit, designed to help with life's unexpected occurrences. These plans are all employee funded and utilize a simple payroll deduction at significant cost savings. Please refer to the AFLAC section of the Benefits webpage of the Human Resources intranet site for more details.

Short-Term Disability (STD)

Provides you with a source of income if you're disabled due to a covered accident or illness – it can even help with maternity leave.

Accident

Accidents happen. When a covered accident happens, our accident insurance policy pays cash benefits (unless assigned) to help with the unexpected medical and everyday expenses that can begin to add up almost immediately.

Hospitalization

Hospital stays are expensive. An Aflac Hospital Confinement Indemnity Insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

Critical Illness

Helps cover expenses from initial diagnosis of a covered cancer, through treatment and follow-up visits.

Employee Assistance Program (EAP)

Life is not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life.

It's free... The Ventura Superior Court covers the cost of initial assessment, additional problem-solving sessions and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.

It's confidential... Your EAP with Aetna RFL is a counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

This benefit provides:

- 6 in person counseling visits
- Telephonic counseling
- Childcare consultation
- Elder care consultation
- Financial consultation
- Legal consultation
- Grief counseling

800-342-8111
Available 24/7/365

Resources *for* Living

Flexible Spending Accounts (FSA)

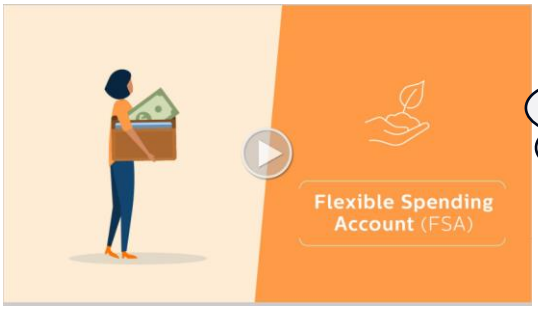
Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. FSA contributions are exempt from federal taxes and Social Security taxes (FICA).

The FSA Plan Year is January 1st through December 31st each calendar year. You can participate in a Health Care FSA and/or the Dependent Care FSA, but **you MUST re-enroll in the FSA each plan year if you wish to participate. Prior year elections will not carry over.**

Plan	Health Care FSA	Dependent Care FSA
Eligibility	For employees enrolled in a non-HSA medical plan	For all benefit eligible employees
Contributions	Contribute up to $3,400 (or IRS limit) per year, pretax to pay for services not covered by your medical, dental or vision plan. You cannot use your Health Care FSA to pay for Dependent Care expenses.	Contribute up to $7,500 per year, pretax, or $3,750 if married and filing separate tax returns to pay for day care expenses that are necessary for you and your spouse to work or attend school full-time.
Who is Covered	Covers eligible expenses for you, your spouse, and tax dependents, even if not covered on your medical plan	Eligible dependents include children under age 13 or any dependent claimed on federal income taxes who is incapable of self-care.
Covered Expenses	Eligible expenses include medical, dental or vision copays, coinsurance, deductibles, eyeglasses, and many over-the-counter medications.	Eligible expenses include day care and after-school programs for dependents up to age 13 or day care for a tax-claimed dependent of any age.
Deadlines	Participants have until March 15, 2027 to incur expenses during the plan year and until April 15, 2027 to submit for expenses incurred during the plan year. **Any unused funds after March 15, 2027, will be forfeited under the IRS "use-it-or-lose-it" rules.**	

How does the FSA work?

- You elect to participate in either or both the Health or Dependent Care FSA
- Through payroll deduction, you begin setting pre-tax dollars aside based on your annual election. Equal amounts are deducted each payroll period throughout the year.
  - **You have immediate access to the full annual elected amount in your Health FSA. You will only be able to access available funds in your Dependent Care FSA, not "future" funds**.
  - You **cannot** transfer funds between your Health FSA and Dependent Care FSA.
- You incur a **qualified Health or Dependent Care expense**. You may either:
  - Use your **FSA Debit Card** for the purchase or pay out-of-pocket and submit a claim for reimbursement.
- **Save your receipts!** You may be required to produce them during a plan year audit as required by the IRS.



Click the image to learn more about **HFSA & DCFSA.**

Additional Employee Benefits

COASTAL HOUSING PARTNERSHIP

Housing Support/Guidance

Coastal Housing Partnership is a nonprofit organization dedicated to helping local employers attract and retain valued employees by offering their workforce a wide range of housing benefits. Benefits include: Home Buying, Home Buying Education, Rental Assistance, Rental Search Site, and Mortgage Refinancing!

Carrier Contacts

Use the information below to reach out to carriers and resources below for things like;

- Benefit Coverage
- Reordering ID Cards
- Policy Questions
- Information about claims
- Access to Care issues
- Coordination of benefits
- Finding a provider
- Escalation, appeals, and resolutions

Benefits Plan	Carrier	Phone Number	Website
CalPERS	Various Health Plans	1-888-225-7377	California Public Employees' Retirement System - CalPERS
Dental PPO	MetLife Insurance Company	1-800-942-0854	https://www.metlife.com/support-and-manage/contact-us/contacts-for-individual/
Vision	EyeMed	1-844-225-3107	https://www.eyemed.com/en-us/contactus
Basic Life and AD&D	The Standard Insurance Company	800-628-8600	https://www.standard.com/contact-us
Voluntary Life and AD&D	The Standard Insurance Company	800-628-8600	https://www.standard.com/contact-us
Long Term Disability	The Standard Insurance Company	800-368-2859	https://www.standard.com/contact-us
Employee Assistance Program	Aetna Resources for Living	800-342-8111	Resourcesforliving.com Username: VenturaCourt Password: EAP
Housing Support/Guidance	Coastal Housing Partnership	805-969-1025	www.coastalhousing.org

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

NEWBORNS ACT DISCLOSURE − FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Your HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the carriers will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the administrator listed at the end of this summary.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from carriers or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the administrator listed at the end of this summary.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Court Human Resources
800 S. Victoria Avenue
Ventura, CA 93006
805-289-8618
CourtHumanResources@ventura.courts.ca.gov

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 09/15/2025
- Court Human Resources, CourtHumanResources@ventura.courts.ca.gov, (805) 289-8618

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice from Ventura Superior Court About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ventura Superior Court and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ventura Superior Court (the City) has determined that the prescription drug coverage offered by the medical carrier is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the City's plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose the City's plan creditable coverage.
- You may stay in the City's plan and also enroll in a Medicare prescription drug plan. The City's plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the City's plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the City's plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ventura Superior Court and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ventura Superior Court changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	09/15/2025
Name/Entity of Sender:	Ventura Superior Court
Contact Position/Office:	Court Human Resources, CourtHumanResources@ventura.courts.ca.gov
Address:	800 S. Victoria Avenue, Ventura, CA 93006
Phone Number:	(805) 289-8618

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Ventura Superior Court
Contact--Position/Office:	Court Human Resources, CourtHumanResources@ventura.courts.ca.gov
Address:	800 S. Victoria Avenue, Ventura, CA 930066
Phone Number:	805-289-8618

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Ventura Superior Court		4. Employer Identification Number (EIN) 52-2219097
5. Employer address 800 S. Victoria Avenue		6. Employer phone number 805-289-8618
7. City Ventura	8. State CA	9. ZIP code 93006
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address CourtHumanResources@ventura.courts.ca.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Regular employees working an average of 20 hours per week
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouse, registered domestic partner, children to age 26 (unless physical or mentally disabled), including natural legally adopted children under legal guardianship, children placed for the purpose of adoption, step-children, and domestic partner's children
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Provided by USI Insurance Services