

ORANGE COUNTY EMPLOYEES ASSOCIATION

# **OCEA** HEALTH & WELFARE TRUST

## BENEFITS ENROLLMENT GUIDE

DENTAL | VISION | DISABILITY | LIFE INSURANCE  
ACCIDENTAL DEATH & DISMEMBERMENT | ACCIDENT INSURANCE  
CRITICAL ILLNESS | HOSPITAL INDEMNITY

- *BENEFITS FOR EMPLOYEES IN OCEA-REPRESENTED UNITS*
- *ADDITIONAL BENEFITS FOR OCEA MEMBERS ONLY*

# 2026

# ABOUT THIS ENROLLMENT GUIDE

The information presented in this Benefits Enrollment Guide will help you make decisions about which plans are best for you. It is not a complete description of all plans. In case of any discrepancies between the information in this Benefits Enrollment Guide and the plan documents and contracts, the plan documents and contracts will prevail. For more details, refer to your plan booklets or contact OCEA at (714) 835-3355.

This Benefits Enrollment Guide presents information on benefits that are administered by the Orange County Employees Association (OCEA) Health & Welfare Trust. OCEA Health & Welfare Benefits are available to employees in bargaining units represented by OCEA at no cost, without regard to whether the employees are members of OCEA. They represent benefits that were negotiated by OCEA for all regular employees in those units. OCEA Supplemental Benefits are available only to OCEA members, and are paid by way of payroll deductions.

## INSTRUCTIONS

### 2026 OCEA HEALTH & WELFARE BENEFITS | PAGE 12

If you are a covered employee, when you complete the **2026 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM**, you will be enrolled in the **HEALTH & WELFARE DENTAL, VISION, BASIC DISABILITY, and LIFE INSURANCE** plans at **NO COST**. Complete the H&W Benefits Form if:

- You are a new employee or transfer into a bargaining unit represented by OCEA, or change from part-time or extra help to full-time employment status. (The form must be received by OCEA or postmarked within 45 days of your hire date, transfer, or full-time employment status change, or you will automatically be enrolled in Option 3.)
- You experience a family status change due to marriage, divorce, birth, adoption, death, or loss of coverage. (The form, together with supporting documentation, must be received by OCEA or postmarked within 31 days of your family status change date.)
- You want to change your dental option plan and dependents during Open Enrollment. (The form must be received by OCEA or postmarked during Open Enrollment.)

### 2026 OCEA SUPPLEMENTAL BENEFITS | PAGE 25

#### FOR PURCHASE BY OCEA MEMBERS ONLY:

Complete the **2026 SUPPLEMENTAL BENEFITS ENROLLMENT FORM(S)** if you want additional coverage for **DENTAL, DISABILITY, LIFE INSURANCE, VOLUNTARY AD&D, ACCIDENT INSURANCE, CRITICAL ILLNESS**, and/or **HOSPITAL INDEMNITY INSURANCES**, or obtain **VISION** coverage for your dependent(s). The cost of each supplemental plan can be found beginning on page 60 of this Benefits Enrollment Guide.

Complete the Supplemental Benefits Enrollment Form(s) within the first 31 days of your OCEA membership or, if applicable, upon a family status change (with supporting documentation), or during Open Enrollment.

**DON'T MISS YOUR DEADLINES!**

# WELCOME TO THE OCEA BENEFIT PLANS—2026!

THIS ENROLLMENT GUIDE IS INTENDED TO HELP YOU MAKE VERY IMPORTANT BENEFIT DECISIONS THAT AFFECT YOU AND YOUR FAMILY.

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THIS COLOR-CODED ENROLLMENT GUIDE COVERS TWO CATEGORIES OF BENEFITS AVAILABLE BASED ON YOUR BARGAINING UNIT:

### HEALTH & WELFARE BENEFITS

Basic level benefits provided at no cost to ALL EMPLOYEES in regular or limited-term positions in OCEA-represented bargaining units at the County, Superior Court, Fire Authority, and Law Library, regardless of whether or not you are an OCEA member.

### SUPPLEMENTAL BENEFITS

Benefits available for purchase by OCEA MEMBERS ONLY beyond those provided under the Health & Welfare Benefits Plans.

GENERAL INFORMATION

## HEALTH & WELFARE BENEFITS PLAN

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Choose the **OPTION** that best suits your needs.

### INITIAL ENROLLMENT NOTES:

**45 DAY  
DEADLINE**  
FROM  
HIRE DATE

Provided at no cost to ALL EMPLOYEES in regular or limited-term positions in OCEA-represented bargaining units at the County, Superior Court, Fire Authority, and Law Library.

H&W BENEFITS PLAN

## SUPPLEMENTAL BENEFITS PLANS

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OCEA members may buy a variety of supplemental plans offering benefits beyond those provided in the Health & Welfare Benefits Plan.

### INITIAL ENROLLMENT NOTES:

**31 DAY  
DEADLINE**  
FROM  
MEMBERSHIP  
DATE

ONLY  
OCEA MEMBERS  
may purchase  
supplemental plans

SUPPLEMENTAL BENEFITS PLANS

## ENROLLMENT FORMS

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COMPLETED FORMS MAY BE SUBMITTED BY MAIL OR HAND DELIVERED TO:

**ORANGE COUNTY EMPLOYEES ASSOCIATION  
830 N. ROSS ST., SANTA ANA, CA 92701**

EMAILED TO: **BENEFITS@OCEA.ORG**

OR SUBMITTED ONLINE AT  
**OCEA.ORG/BENEFITS**

ENROLLMENT FORMS

## WELCOME!

The Orange County Employees Association has a long tradition of member success.

When working men and women stand together to improve their working conditions, pay, benefits, and other workplace issues, they have a stronger voice. We call that the “OCEA Difference”—an important distinction between how workers are treated when they stand shoulder-to-shoulder versus how they are treated when they stand alone.

OCEA members belong to one of the strongest independent labor organizations in the country. OCEA represents employees at the County of Orange, Superior Court, and Cities and Districts in Orange County. Every day, workplace leaders, called Stewards, are there to strengthen workplace protections and advance the interests of their co-workers and their families.

From that strength and unity, OCEA members have been able to ensure that every worker has a secure retirement and other important benefits.

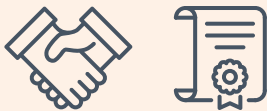
One way OCEA members help each other and their families is by offering a variety of excellent dental, vision, term life, disability, voluntary accidental death & dismemberment, accident insurance, critical illness, and hospital indemnity plans, which are paid for through payroll deductions. These benefits are administered by the OCEA Health & Welfare Trust. The Trust is governed by a Board of Trustees who are all OCEA members. In other words, the Trust is governed by OCEA members for OCEA members.

Please carefully review this Benefits Enrollment Guide. It includes valuable information regarding benefits for all regular and limited-term employees in bargaining units represented by OCEA—some at NO COST to you. It also contains details on many programs only available to OCEA members.

If you have not already, please stand with workers across Orange County by joining OCEA today!

## OCEA | OUR PROUD HERITAGE

- In 1937, County employees founded OCEA for the primary purpose of securing group insurance benefits.
- During the 1940s and 1950s, OCEA worked constantly to improve pay and working conditions.



- In 1960, OCEA hired a general manager and became incorporated under California law. The contributions of the leaders of that era are the bedrock of OCEA’s present strength and independence.

- OCEA now has a full-time professional staff of skilled labor relations experts, benefits administrators, organizers, communications specialists, and dedicated office services support.





- OCEA is always moving forward. It has gone from occupying one room in an old house to building and owning its own headquarters since 1974—from offering its members representation and a single term life insurance policy to providing a wide range of benefits and programs.

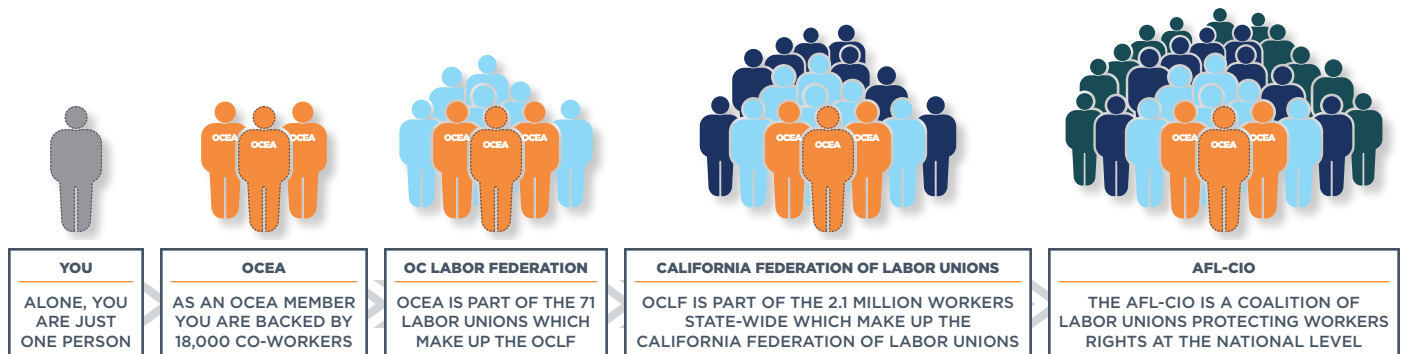
## JOIN OCEA—ONE OF THE MOST RESPECTED EMPLOYEE ORGANIZATIONS IN CA!

OCEA is a member-driven organization led by an elected Board of Directors and strengthened by member leaders. We are an independent union of members backed by a professional staff who watch out for the interests of working families.

OCEA members can help improve their pay and working conditions by voting on contracts and OCEA elections and by participating during negotiations. Members can become leaders and represent co-workers by joining a labor management committee, unit executive committee, or by applying to be an OCEA Steward or a Director on the OCEA Board.

	FULL MEMBER	NON-MEMBER
<b>HAVE A VOICE</b>	<b>ELIGIBLE TO VOTE IN OCEA ELECTIONS</b> CONTRACTS, ELECTIONS, WAGES, WORKING CONDITIONS, AND MORE.	<b>NOT ELIGIBLE</b>
<b>HEALTH RELATED BENEFITS</b>	<b>ACCESS TO ADDITIONAL BENEFITS</b>	<b>LIMITED BASIC COVERAGE</b>
<b>VISION</b>	Dependent coverage available	No dependent coverage available
<b>DENTAL</b>	Supplemental coverage available for yourself and your dependents	EMPLOYEE: Basic PPO or Basic DHMO WITH DEPENDENTS: Basic DHMO only
<b>LIFE</b>	Supplemental Life Insurance available for you and your dependents	Basic coverage only
<b>DISABILITY</b>	Supplemental Disability Insurance available	Basic coverage only
<b>AD&amp;D</b>	Supplemental Voluntary Accidental Death & Dismemberment available	Not available
<b>ACCIDENT</b>	Accident Insurance available	Not available
<b>CRITICAL ILLNESS</b>	Critical Illness insurance available	Not available
<b>HOSPITAL INDEMNITY</b>	Hospital Indemnity insurance available	Not available
<b>TICKETS &amp; DISCOUNTS</b>	<b>UNLIMITED ACCESS TO OCEA'S TICKETS &amp; DISCOUNT PROGRAM</b>  PLUS MANY MORE	<b>NO ACCESS</b>
<b>OCEA SCHOLARSHIP</b>	 <b>DEPENDENTS OF OCEA MEMBERS ARE ELIGIBLE TO APPLY FOR THE ANNUAL OCEA SCHOLARSHIP</b>	<b>NOT ELIGIBLE</b>
<b>MEMBERS ONLY EVENTS</b>	<b>ENHANCE YOUR PERSONAL AND PROFESSIONAL LIVES WITH ACCESS TO MEMBERS ONLY TRAININGS AND SEMINARS</b>	<b>NOT ELIGIBLE</b>

AT OCEA, WE BELIEVE THAT WHEN WORKERS STAND TOGETHER, WE CAN ACHIEVE GREAT THINGS



**HAVEN'T JOINED YET? SEE PAGE 67 TO LEARN HOW TO BECOME A MEMBER TODAY!**



# ELIGIBILITY & INITIAL ENROLLMENT

## WHO IS ELIGIBLE?

**IF YOU ARE A REGULAR OR LIMITED-TERM, FULL- OR PART-TIME EMPLOYEE IN ONE OF THE FOLLOWING OCEA-REPRESENTED BARGAINING UNITS:**

- COUNTY COMMUNITY SERVICES UNIT
- COUNTY GENERAL UNIT
- COUNTY HEALTHCARE PROFESSIONAL UNIT
- COUNTY OFFICE SERVICES UNIT
- COUNTY PUBLIC LAW LIBRARY UNIT
- COUNTY SHERIFF'S SPECIAL OFFICER UNIT
- COUNTY SUPERVISORY MANAGEMENT UNIT
- FIRE AUTHORITY GENERAL UNIT
- FIRE AUTHORITY SUPERVISORY MANAGEMENT UNIT
- SUPERIOR COURT CLERK UNIT
- SUPERIOR COURT GENERAL UNIT
- SUPERIOR COURT SUPERVISOR UNIT

**... AND YOU ...**

**... ARE AN  
OCEA MEMBER ...**

... YOU ARE ELIGIBLE FOR:

**HEALTH & WELFARE  
BENEFITS PLAN**  
NO COST TO YOU

**ALL SUPPLEMENTAL  
BENEFITS PLANS**  
FOR PURCHASE

**... ARE NOT AN  
OCEA MEMBER:**

... YOU ARE ONLY ELIGIBLE FOR:

**HEALTH & WELFARE  
BENEFITS PLAN**  
NO COST TO YOU

**IF YOU ARE EMPLOYED IN ONE OF THE FOLLOWING:**

- A BARGAINING UNIT NOT REPRESENTED BY OCEA
- AN OCEA REPRESENTED CITY OR DISTRICT
- AS AN EXTRA-HELP EMPLOYEE

**... AND YOU ...**

**... ARE AN  
OCEA MEMBER ...**

... YOU MAY BE ELIGIBLE FOR:

**SUPPLEMENTAL  
BENEFITS PLANS**  
FOR PURCHASE

**... ARE NOT AN  
OCEA MEMBER:**

... YOU ARE NOT ELIGIBLE FOR  
ANY BENEFITS THROUGH OCEA

**RETIREES—REFER TO RETIREE BENEFITS SECTION ON PAGE 9**

## INITIAL ENROLLMENT—HOW TO ENROLL

**45** DAYS

**FROM YOUR HIRE DATE TO  
ENROLL IN YOUR FREE BASIC  
HEALTH & WELFARE BENEFITS**

**DON'T MISS YOUR DEADLINE!**

You must complete and return the **HEALTH & WELFARE BENEFITS ENROLLMENT FORM** within **45 days** from your hire date, transfer into an OCEA-represented unit, or change from part-time to full-time employment status. If you fail to return your **HEALTH & WELFARE BENEFITS ENROLLMENT FORM**, you will automatically be enrolled in Option 3. Learn more starting on page 12.

**31** DAYS

**FROM YOUR OCEA MEMBERSHIP  
DATE TO PURCHASE UPGRADED  
SUPPLEMENTAL BENEFITS**

**DON'T MISS YOUR DEADLINE!**

You may sign up as an OCEA member anytime by submitting an **OCEA MEMBERSHIP APPLICATION**. See page 67.

You have **31 days** from your membership date to enroll in any of the supplemental benefits using the **OCEA HEALTH & WELFARE TRUST SUPPLEMENTAL BENEFITS ENROLLMENT FORM(S)**. Learn more starting on page 25.

**FOR INFORMATION REGARDING MAKING CHANGES AFTER INITIAL ENROLLMENT, PLEASE SEE PAGE 8.**

# BENEFITS OVERVIEW

## — HEALTH & WELFARE BENEFITS PLAN —

LEARN MORE STARTING ON PAGE 12

For regular or limited-term, full- or part-time employees in OCEA-represented bargaining units with the County, Court, Fire Authority, and Law Library. (See page 4)

The Health & Welfare Benefits Plan consists of four basic types of coverage (at **no cost to you**):

**DENTAL | VISION  
BASIC DISABILITY | LIFE/AD&D**

The exact nature of your coverage depends on which of the three options you choose.

*IN MOST SITUATIONS:*

**OPTION  
1**

For full-time employees without dependents

**OPTION  
2**

For full-time employees with eligible dependents

**OPTION  
3**

This option is for full-time employees who do not select Option 1 or Option 2.

Part-time employees will automatically be enrolled in Option 3.

*Some helpful guidelines are found starting on page 12, which includes information on deadline dates. **Do not miss this deadline!***

## — SUPPLEMENTAL BENEFITS PLANS —

LEARN MORE STARTING ON PAGE 25

### OCEA MEMBERS ONLY

For the County, Court, Fire Authority, Law Library, and other eligible cities or districts represented by OCEA.

The supplemental plans, which members may choose to purchase, are as follows:

**SUPPLEMENTAL DENTAL**

**VISION**

**SUPPLEMENTAL DISABILITY**

**SUPPLEMENTAL LIFE INSURANCE**

**SUPPLEMENTAL VOLUNTARY  
ACCIDENTAL DEATH & DISMEMBERMENT**

**ACCIDENT INSURANCE**

**CRITICAL ILLNESS INSURANCE**

**HOSPITAL INDEMNITY INSURANCE**

*Some helpful guidelines are found starting on page 25, which includes information on deadline dates. **Do not miss this deadline!***

Open enrollment periods for the above plans are typically scheduled during the month of September.

*CONTACT OCEA FOR CURRENT INFORMATION REGARDING OPEN ENROLLMENT.*

SEND ALL  
MATERIALS TO:

**ORANGE COUNTY EMPLOYEES ASSOCIATION**  
830 N. ROSS ST., SANTA ANA, CA 92701

EMAIL TO **BENEFITS@OCEA.ORG**  
OR SUBMIT ONLINE AT **OCEA.ORG/BENEFITS**

# IMPORTANT DATES & DEADLINES

## HEALTH & WELFARE BENEFITS PLAN

### HEALTH & WELFARE BENEFITS PLAN

Your application must be received within the first 45 days of your hire date. See page 8 for additional eligibility information and enrollment opportunities.

### WHEN COVERAGE ENDS FOR HEALTH & WELFARE BENEFITS PLAN

- Termination of employment,
- Change in bargaining unit, or
- The plan ends.

### EFFECTIVE DATE OF HEALTH & WELFARE BENEFITS COVERAGE

In most cases, benefits for new employees become effective on the first of the month following 60 calendar days of continuous active employment.

## SUPPLEMENTAL BENEFITS PLANS

### SUPPLEMENTAL DELTA DENTAL PPO PLAN A+

Your application must be received within the first 31 days of OCEA membership or upon a family status change, or during open enrollment.

### SUPPLEMENTAL DELTACARE USA CAM49 (DHMO)

Your application must be received within the first 31 days of OCEA membership or upon a family status change, or during open enrollment.

### VISION PLAN (VSP)

Your application must be received within the first 31 days of OCEA membership or upon a family status change, or during open enrollment.

### SUPPLEMENTAL DISABILITY

Your application must be received within the first 31 days of OCEA membership, or during open enrollment (otherwise Evidence of Insurability (EOI) is required). If you were previously denied coverage, EOI is required before coverage can be approved by The Standard.

### SUPPLEMENTAL LIFE INSURANCE

Your application must be received within 31 days of your OCEA membership date. You may apply for life insurance for up to two times your Base Annual Salary (BAS) or \$120,000, whichever is less, without evidence of insurability. In all other situations, Evidence of Insurability is required.



## **SUPPLEMENTAL LIFE (FOR DEPENDENTS)**

Your application must be received within 31 days of your OCEA membership date (otherwise Evidence of Insurability is required). Enrollment of the employee in supplemental life is a prerequisite to the enrollment of dependents.

If you are currently enrolled in the Supplemental Life Insurance and have no dependent life coverage, then any dependent(s) coverage requests must be approved by The Standard, our carrier. Evidence of Insurability is required if you apply outside of the initial eligibility period, unless enrollment is due to family status change.

Family status change includes: marriage, divorce, birth, adoption, death, or loss of coverage.

You have 31 days within which to submit your enrollment form with changes, plus supporting documentation (marriage certificate, birth certificate, etc.), if you have a family status change.

## **SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT**

An OCEA member may enroll in the Accidental Death & Dismemberment plan at any time during the year.

## **ACCIDENT INSURANCE**

Your application must be received within the first 31 days of OCEA membership or during open enrollment.

## **CRITICAL ILLNESS INSURANCE**

Your application must be received within the first 31 days of OCEA membership or during open enrollment.

## **HOSPITAL INDEMNITY INSURANCE**

Your application must be received within the first 31 days of OCEA membership or during open enrollment.

## **WHEN COVERAGE OR PAYMENT BEGINS FOR SUPPLEMENTAL PLANS**

For all of the supplemental plans, OCEA will determine your effective date, the date your benefits become payable, and the period covered by the benefits based on many factors such as:

- your OCEA membership date
- the date your evidence of insurability is approved
- the date you enroll in the plan
- the payday your payroll deductions are to begin
- whether or not you are on a leave of absence

Among other things, you must be an “active” employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an “active” employee.)

The following sections provide further general information on effective dates for some of the supplemental plans offered to OCEA members. Remember, these are simplified rules. In the event of any conflict between the following and plan documents, the plan documents will prevail.

For details, contact OCEA at (714) 835-3355 or by email at [benefits@oceca.org](mailto:benefits@oceca.org).

## **WHEN COVERAGE ENDS FOR SUPPLEMENTAL PLANS**

- Termination of employment,
- Cancellation of OCEA membership,
- Non-payment of benefit contributions, or
- The plan ends.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until signed written notification is received at OCEA’s Headquarters.

# CHANGING ENROLLMENT SELECTIONS

## OPEN ENROLLMENT & OTHER CIRCUMSTANCES

After initial enrollment, you may make changes to your selections.

<b>DURING OPEN ENROLLMENT</b>	Each year open enrollment is typically in September.
<b>WHEN YOU CHANGE EMPLOYMENT STATUS:</b> <ul style="list-style-type: none"><li>• From part-time to full-time</li><li>• From full-time to part-time</li><li>• From extra help to regular</li></ul>	You have <b>45 days</b> from the qualifying event date to submit your <b>HEALTH &amp; WELFARE BENEFITS ENROLLMENT FORM</b>
<b>UPON A FAMILY STATUS CHANGE</b> (Marriage, divorce, birth, adoption, death, or loss of coverage).	You have <b>31 days</b> from the qualifying event date to submit all applicable <b>BENEFITS ENROLLMENT FORMS</b> with changes, plus supporting documentation (marriage certificate, birth certificate, etc.), if you have a family status change. <b>HEALTH &amp; WELFARE BENEFITS ENROLLMENT FORM</b> <b>AND/OR SUPPLEMENTAL BENEFITS ENROLLMENT FORM(S)</b>

## INSURANCE CARRIER CONTACT INFO

TYPE OF BENEFIT	BENEFIT CARRIER/ ADMINISTRATOR	WEBSITE ADDRESS	PHONE NUMBER
Dental (PPO)	Delta Dental	deltadentalins.com	(888) 335-8227
Dental (DHMO)	DeltaCare USA	deltadentalins.com	(800) 422-4234
Vision	Vision Service Plan (VSP)	vsp.com	(800) 877-7195
Basic Disability Supplemental Disability	The Standard Insurance Company	standard.com	(800) 368-1135
Basic Life Supplemental Life Supplemental Voluntary AD&D	The Standard Insurance Company	standard.com	(800) 628-8600
Accident Insurance Critical Illness Hospital Indemnity	The Standard Insurance Company	standard.com	(800) 634-1743

# RETIREE BENEFITS

## ELIGIBILITY

You may be eligible to enroll in the benefits described below if:

ONE		TWO		THREE		FOUR
You were an active member of OCEA for at least one year immediately preceding your retirement date;	&	Your application to purchase certain coverages is received by OCEA within 31 days of your retirement date;	&	You are a current member of the Retired Employees Association of Orange County (REAOC);	&	You will be receiving a retirement check from the Orange County Employees Retirement System (OCERS).

## DENTAL

If you were covered by either the DHMO or PPO dental plan as an active OCEA member, you are eligible to purchase DeltaCare USA CAM49 DHMO within 31 days of your retirement date.

You are required to continue your coverage after your Retirement Date by electing COBRA when offered until your coverage becomes effective through OCERS payroll deductions.

This plan offers you a comprehensive program of dental care with no annual benefit limit. Most preventive services, such as cleanings and examinations, are covered in full. Other procedures require copayments at the time the dentist performs the service.

You are only covered for services received from your designated California DHMO DeltaCare USA provider.

## LIFE INSURANCE

If you were covered by Supplemental Life Insurance through OCEA as an active OCEA member, you are eligible to purchase Retiree Life Insurance within 31 days of your retirement date, depending on the age at which you retire. For example:

- \$10,000 if you are under the age of 65
- \$6,500 if you are at least 65, but under 70
- \$2,000 if you are 70 or over

If you are covered by the Retiree Life Insurance Plan, an additional Burial Benefit of \$2,000 will be paid to your beneficiary upon your death.

## VISION

If you were covered by the Vision Service Plan as an active OCEA member, you are eligible to purchase the plan within 31 days of your retirement date.

This plan offers you a comprehensive program of vision care.

You are required to continue your coverage after your Retirement Date by electing COBRA when offered, until your coverage becomes effective through OCERS payroll deductions.

## MORE INFORMATION

Contact OCEA at (714) 835-3355 or by email at [benefits@oceca.org](mailto:benefits@oceca.org) for more information about retiree benefits.

# TERMS YOU NEED TO KNOW

## "ACTIVE" EMPLOYEE

Among other things, you must be an "active" employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an "active" employee.)

If your application is received and you are not an Active Employee when the plan should take effect, OCEA will hold your application until you Return to Work, but for no longer than six (6) months. If you Return to Work after the six-month holding period, your application is considered void, and you must wait until the next open period to apply for the coverage(s).

Your ability to make certain changes to your benefit elections and the effective date of those changes, while on a leave of absence status, varies depending on which benefits you have, and whether or not you have elected to "buy-up" those coverages. Please refer to the specific benefit sections in this Enrollment Guide.

## BENEFICIARY

Person(s) designated by a participant to receive benefits provided by the plan if the participant should pass away.

## BIWEEKLY

As used throughout this guide, this term means "one time per two-week period" (that is, once every two weeks, or usually 26 times per year).

## TWICE-MONTHLY

As used throughout this guide, this term means "two times per month" (that is, twice per month, or 24 times per year).

## CITIES AND DISTRICTS

Municipalities, districts, agencies, and political subdivisions within the County of Orange.

## COPAYMENT

Refers to the vision plan and DHMO plan and is the dollar amount you pay each time a specified service is provided.

## DEDUCTIBLE

Refers to the dental plan offerings and is the annual dollar amount you must pay for certain classes of eligible dental services before benefits are payable by the insurance company.

## ELIGIBLE DEPENDENT

- Your legal spouse
- Your registered domestic partner
- Your children can be covered under your dental, vision, and dependent supplemental life plan until age 26.
  - Child must **not** be eligible for any other Employer dental and/or vision plan
  - Child does **not** need to be a full-time student
  - Child can be married or unmarried
  - Spouses and children of dependent children are **not** eligible for coverage
  - Any child of the employee regardless of dependency status under IRS rules

FOR DENTAL AND VISION: "Children" includes stepchildren and adopted children, provided they are chiefly dependent upon you for support and maintenance. Foster children are excluded.

FOR DEPENDENT SUPPLEMENTAL LIFE PLAN: "Children" includes stepchildren and adopted children, provided they live in the home of a covered employee as long as dependent life is in effect.

## EVIDENCE OF INSURABILITY

Any written statement of proof of a person's overall health status required by the insurance carrier prior to acceptance for insurance.

## FAMILY STATUS CHANGE

Allows changes to dependent coverage due to: marriage, divorce, birth, adoption, death, or loss of coverage.

## FULL-TIME EMPLOYEE

An employee employed in one or more regular or limited-term positions whose normally-assigned work hours equal those of a full work-week (40 hours or more per week) or work-period.

## HEALTH & WELFARE ELIGIBLE OCEA-REPRESENTED BARGAINING UNITS

- County Community Services Unit
- County General Unit
- County Healthcare Professional Unit
- County Office Services Unit
- County Public Law Library Unit
- County Sheriff's Special Officer Unit
- County Supervisory Management Unit
- Fire Authority General Unit
- Fire Authority Supervisory Management Unit
- Superior Court Clerk Unit
- Superior Court General Unit
- Superior Court Supervisor Unit

## OPEN ENROLLMENT

A period of time each year when you may change your benefit elections without a family status change.

## PART-TIME EMPLOYEE

An employee employed in one or more regular or limited-term positions whose normally-assigned work hours do not equal those of a full-time employee (less than 40 hours per week, but not less than 40 hours in a pay period).

## PLAN YEAR

January 1 through December 31.

## PREDETERMINATION

A predetermination is a free service that Delta Dental provides to its subscribers. It can help you and your dentist make better choices about your dental care. A predetermination is particularly useful for more costly procedures such as crowns, wisdom teeth extractions, bridges, dentures, or periodontal surgery. When your dentist predetermines treatment with Delta Dental, you will receive an estimate before treatment begins of your share of the cost and how much Delta Dental will pay.

## RETIREE

You may be eligible to enroll in the Retiree benefits if:

1. You were an active member of OCEA for at least one year immediately preceding your retirement date; and,
2. Your application to purchase certain coverages is received by OCEA within 31 days of your retirement date; and,
3. You are a current member of the Retired Employees Association of Orange County (REAOC); and,
4. You will be receiving a retirement check from the Orange County Employees Retirement System (OCERS).

## SUPPLEMENTAL BENEFITS

OCEA members may buy a variety of supplemental plans offering benefits beyond those provided in the Health & Welfare Benefits Plan.

## USUAL, CUSTOMARY AND REASONABLE CHARGE (UCR)

Fees that are regularly charged and are in the range of fees customarily charged for the same service or supply in the geographic area concerned.

## WAITING PERIOD

Refers to the number of days you must be disabled before a benefit becomes payable under your disability plan(s).

# OCEA-ADMINISTERED HEALTH & WELFARE BENEFITS PLAN

... FOR EMPLOYEES IN HEALTH & WELFARE ELIGIBLE OCEA-REPRESENTED BARGAINING UNITS

THESE BENEFITS WERE NEGOTIATED BY OCEA AND ARE PROVIDED AT **NO COST TO ALL EMPLOYEES** IN REGULAR OR LIMITED-TERM POSITIONS IN HEALTH & WELFARE ELIGIBLE OCEA-REPRESENTED BARGAINING UNITS, **REGARDLESS OF WHETHER OR NOT YOU ARE AN OCEA MEMBER.**

## HEALTH & WELFARE ELIGIBLE OCEA-REPRESENTED BARGAINING UNITS

County Community Services | County General | County Healthcare Professional | County Office Services  
County Public Law Library | County Sheriff's Special Officer | County Supervisory Management | Fire Authority General  
Fire Authority Supervisory Management | Superior Court Clerk | Superior Court General | Superior Court Supervisor

IF YOU ARE AN EMPLOYEE IN A BARGAINING UNIT OCEA REPRESENTS, YOU MAY NOT CHOOSE TO OPT OUT OF THE HEALTH & WELFARE BENEFIT PLANS PROVIDED TO YOU AT "NO COST."

### OPTION 1

PAGE 14

DENTAL / VISION / DISABILITY / LIFE/AD&D

#### FULL-TIME EMPLOYEE WITHOUT DEPENDENTS

CHOICE OF PPO OR DHMO DENTAL PLAN

### OPTION 2

PAGE 15

DENTAL / VISION / DISABILITY / LIFE/AD&D

#### FULL-TIME EMPLOYEE WITH DEPENDENTS

MAY ADD DEPENDENTS TO YOUR DENTAL PLAN (DHMO) ONLY

### OPTION 3

PAGE 16

DENTAL / DISABILITY / LIFE/AD&D

#### PART-TIME EMPLOYEE

DO NOT CHOOSE OPTION 3 IF YOU ARE A FULL-TIME EMPLOYEE

COMPLETE THE HEALTH & WELFARE BENEFITS ENROLLMENT FORM LOCATED ON PAGE 65 AND RETURN IT TO OCEA AT 830 N. ROSS ST., SANTA ANA, CA 92701. YOU MAY ALSO GO TO [OCEA.ORG/BENEFITS](https://oceaa.org/benefits) AND DOWNLOAD THE FORM OR COMPLETE IT ONLINE. ALL COMPLETED FORMS CAN BE EMAILED TO [BENEFITS@OCEA.ORG](mailto:BENEFITS@OCEA.ORG).



45-DAY TIME LIMIT

If you are a new employee, you must **complete and return the Health & Welfare Benefits Enrollment Form within 45 days of your hire date, transfer into an OCEA-represented unit, or change from part-time to full-time employment status.** (If you do not do this, you will automatically be enrolled in Option 3.) You may change your elections during “open enrollment” periods. Also, within 31 days of a qualifying event (such as divorce, marriage, birth of a child, or change of employment status) you may be eligible to make mid-year changes by submitting the enrollment form along with the supporting documents. For further information, call OCEA at (714) 835-3355.

WHICH OF THE THREE OPTIONS SHOULD I CHOOSE?

If you are a part-time employee, you will automatically be enrolled in Option 3.

If you are a full-time employee, you have a choice. The option that is right for you will depend on your individual circumstances. For simplified guidelines about the choice you should make, see below.

OVERVIEW OF THE THREE OPTIONS

OPTION 1	OPTION 2	OPTION 3
<div><p><b>SIMPLIFIED GUIDELINES</b></p><p>If you are a</p><p><b>FULL-TIME EMPLOYEE WITHOUT DEPENDENTS</b></p><p>or you have dependents but do not wish to include them for benefit coverage</p><p><b>YOU SHOULD CHOOSE OPTION 1</b></p></div> <div><p><b>EMPLOYEE ONLY</b></p><ul style="list-style-type: none"><li>Delta Dental PPO Plan A <b>OR</b> DeltaCare USA CAM50 (DHMO)</li><li>Vision Plan (VSP)</li><li>Basic Disability Plan</li><li>Life/AD&amp;D Insurance Plans</li></ul><p><i>FOR BENEFIT AMOUNTS, SEE PAGE 14</i></p></div>	<div><p><b>SIMPLIFIED GUIDELINES</b></p><p>If you are a</p><p><b>FULL-TIME EMPLOYEE WITH DEPENDENTS</b></p><p>in most situations</p><p><b>YOU SHOULD CHOOSE OPTION 2</b></p><p>Your family may be covered with you on the DeltaCare USA CAM50 (DHMO) dental plan. Your dependents <i>do not</i> receive vision coverage. You will need to elect supplemental vision to cover dependents.</p></div> <div><p><b>EMPLOYEE + DEPENDENTS</b></p><ul style="list-style-type: none"><li>DeltaCare USA CAM50 (DHMO)</li></ul><p><b>EMPLOYEE ONLY</b></p><ul style="list-style-type: none"><li>Vision Plan (VSP)</li><li>Basic Disability Plan</li><li>Life/AD&amp;D Insurance Plans</li></ul><p><i>FOR BENEFIT AMOUNTS, SEE PAGE 15</i></p></div>	<div><p><b>SIMPLIFIED GUIDELINES</b></p><p>If you are a</p><p><b>FULL-TIME EMPLOYEE DO NOT CHOOSE OPTION 3</b></p><p>Since OPTION 3 is a “default” package (with benefits of less value overall), you should take the initiative to choose either OPTION 1 or OPTION 2 if you are a full-time employee or had an employment status change.</p><p><b>PART-TIME EMPLOYEES choose OPTION 3</b></p></div> <div><p><b>EMPLOYEE ONLY</b></p><ul style="list-style-type: none"><li>Delta Dental PPO Plan A</li><li>Basic Disability Plan</li><li>Life/AD&amp;D Insurance Plans</li></ul><p><i>FOR BENEFIT AMOUNTS, SEE PAGE 16</i></p></div>

H&W BENEFITS PLAN

PLAN DESCRIPTIONS ARE AVAILABLE FOR ALL BENEFIT PLANS

Plan benefits are limited by plan provisions. To obtain a more detailed plan description with information on limitations and exclusions, please contact OCEA at (714) 835-3355 or visit us online at ocea.org.

## OPTION 1 — PLAN HIGHLIGHTS

With this option, you can choose one of two dental plans at no cost to you: Delta Dental PPO Plan A or DeltaCare USA CAM50 (DHMO). The plan you select must be indicated on the Health & Welfare Benefits Enrollment Form.

EMPLOYEE ONLY	DELTA DENTAL PPO PLAN A		OR	DELTACARE USA CAM50 (DHMO)
	YOU MAY USE YOUR OWN DENTIST, BUT YOU MUST USE A PPO DENTIST TO RECEIVE THE HIGHEST LEVEL OF BENEFITS			YOU MUST USE A PARTICIPATING DENTIST
	SERVICES FROM A PPO PROVIDER	SERVICES FROM A NON-PPO PROVIDER		
DENTAL SERVICES				
Deductible	\$50 per person (waived for preventive and diagnostic services)	\$75 per person (deductible applies to all services)	No Deductible	
Preventive/ Diagnostic Services	Payable at 100%	Payable at 50%	No Copayment	
Basic Services	Payable at 80%	Payable at 50%	Copayment	
Major Services	Payable at 50% after you have been on this plan for six (6) months.	Payable at 50% after you have been on this plan for six (6) months.	Copayment	
Maximum Payable	\$1,000 per calendar year	\$750 per calendar year	No Maximum	
ORTHODONTIC SERVICES				
Deductible	None	None	No Deductible	
Percentage Payable	50% of covered charges after you have been on this plan for six (6) months.	50% of covered charges after you have been on this plan for six (6) months.	Copayment	
Maximum Payable	\$750 Lifetime	\$750 Lifetime	Copayment	

EMPLOYEE ONLY	VISION PLAN (VSP)			
BENEFITS:	Exam:	Once each calendar year	COPAYMENT:	Exam \$5
	Lenses:	Once each calendar year		Materials \$20
	Frames:	Once every other calendar year		
	SERVICES FROM A VSP DOCTOR		SERVICES FROM AN OUT-OF-NETWORK PROVIDER	
Exam	Covered in full		up to \$45	
Single Vision Lenses	Covered in full		up to \$30	
Bifocal Lenses	Covered in full		up to \$50	
Progressive Lenses	Covered in full after \$55 copay		up to \$50	
Trifocal Lenses	Covered in full		up to \$65	
Anti-Reflective Coating	Covered in full after \$40 copay		Not a covered benefit	
Frame	A wide selection of frames are covered up to \$175		up to \$70	
Contact Lenses (in lieu of glasses)	Exam: Covered in full after a maximum copay of \$60 Contact Lenses: Up to \$175		up to \$105	

EMPLOYEE ONLY	BASIC DISABILITY			
BENEFITS:	MONTHLY BENEFIT PAYABLE			BENEFIT PERIOD: 24 months max.
	0-20 DAYS	21-90 DAYS	91+ DAYS	
	Waiting Period	60% to \$1,080 max.	60% to \$900 max.	

All disability benefits are coordinated with all other sources of income (including holiday pay, sick leave, annual leave, workers' compensation, retirement, and other disability benefits) and are subject to certain other benefit limitations.

EMPLOYEE ONLY	LIFE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
The benefit is \$25,000 of Life/Accidental Death & Dismemberment Insurance.	

## OPTION 2 — PLAN HIGHLIGHTS

With this option, you receive family coverage under the DeltaCare USA CAM50 (DHMO) dental plan at no cost to you. You must include the names of your dependents on the Health & Welfare Benefits Enrollment Form in order to enroll.

EMPLOYEE AND ELIGIBLE DEPENDENTS	DELTACARE USA CAM50 (DHMO)	
	YOU MUST USE A PARTICIPATING DENTIST	
DENTAL SERVICES		
Deductible		No Deductible
Preventive/ Diagnostic Services		No Copayment
Basic Services		Copayment
Major Services		Copayment
Maximum Payable		No Maximum
ORTHODONTIC SERVICES		
Deductible		No Deductible
Percentage Payable		Copayment
Maximum Payable		Copayment

EMPLOYEE ONLY	VISION PLAN (VSP)				
BENEFITS:	Exam:	Once each calendar year	COPAYMENT:	Exam	\$5
	Lenses:	Once each calendar year		Materials	\$20
	Frames:	Once every other calendar year			
	SERVICES FROM A VSP DOCTOR		SERVICES FROM AN OUT-OF-NETWORK PROVIDER		
Exam	Covered in full		up to \$45		
Single Vision Lenses	Covered in full		up to \$30		
Bifocal Lenses	Covered in full		up to \$50		
Progressive Lenses	Covered in full after \$55 copay		up to \$50		
Trifocal Lenses	Covered in full		up to \$65		
Anti-Reflective Coating	Covered in full after \$40 copay		Not a covered benefit		
Frame	A wide selection of frames are covered up to \$175		up to \$70		
Contact Lenses (in lieu of glasses)	Exam: Covered in full after a maximum copay of \$60 Contact Lenses: Up to \$175		up to \$105		

EMPLOYEE ONLY	BASIC DISABILITY			
BENEFITS:	MONTHLY BENEFIT PAYABLE			BENEFIT PERIOD: 24 months max.
	0-20 DAYS	21-90 DAYS	91+ DAYS	
	Waiting Period	60% to \$1,080 max.	60% to \$900 max.	

All disability benefits are coordinated with all other sources of income (including holiday pay, sick leave, annual leave, workers' compensation, retirement, and other disability benefits) and are subject to certain other benefit limitations.

EMPLOYEE ONLY	LIFE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
The benefit is \$25,000 of Life/Accidental Death & Dismemberment Insurance.	

## OPTION 3 — PLAN HIGHLIGHTS

There is no employee cost for Option 3.

This option is for full-time employees who do not select an option AND all part-time employees.

EMPLOYEE ONLY	DELTA DENTAL PPO PLAN A	
	YOU MUST SELECT A DELTA PPO PROVIDER FOR THE HIGHEST BENEFIT LEVEL	
	PPO PROVIDER	NON-PPO PROVIDER
DENTAL SERVICES		
Deductible	\$75 per person (waived for preventive and diagnostic services)	\$75 per person (deductible applies to all services)
Preventive/ Diagnostic Services	Payable at 80%	Payable at 50%
Basic Services	Payable at 80%	Payable at 50%
Major Services	<b>Payable at 50% after you have been on this plan for six (6) months.</b>	<b>Payable at 50% after you have been on this plan for six (6) months.</b>
Maximum Payable	\$375 per calendar year	\$375 per calendar year
ORTHODONTIC SERVICES		
Deductible	None	None
Percentage Payable	<b>50% of covered charges after you have been on this plan for six (6) months.</b>	<b>50% of covered charges after you have been on this plan for six (6) months.</b>
Maximum Payable	\$375 Lifetime	\$375 Lifetime

EMPLOYEE ONLY	BASIC DISABILITY			
	MONTHLY BENEFIT PAYABLE			BENEFIT PERIOD: 24 months max.
BENEFITS:	0-20 DAYS	21-90 DAYS	91+ DAYS	
	Waiting Period	60% to \$1,080 max.	60% to \$900 max.	

All disability benefits are coordinated with all other sources of income (including holiday pay, sick leave, annual leave, workers' compensation, retirement, and other disability benefits) and are subject to certain other benefit limitations.

EMPLOYEE ONLY	LIFE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
The benefit is \$25,000 of Life/Accidental Death & Dismemberment Insurance.	

— ABOUT YOUR HEALTH & WELFARE PLAN —

# DELTA DENTAL PPO PLAN A

Delta Dental PPO Plan A gives members the flexibility to choose their own dentists and to self-refer for specialty care services. To receive the highest level of benefits with the lowest out-of-pocket expense, you should consider visiting a Delta PPO dentist. PPO dentists agree to provide treatment to PPO patients at discounted fees prenegotiated by Delta. In addition, the percentages paid by Delta will be significantly higher when you visit a Delta PPO provider dentist.

Dentists who are not part of Delta Dental have not agreed to discounted fees. These dentists will be paid the usual, customary, and reasonable fees for services. Since these fees can be higher than Delta's discounted fees, you will spend more money with a dentist who is not participating with Delta Dental. You may also be required to file your own claims with Delta.

## WHO IS ELIGIBLE?

Employees only. Among other things, you must be an "active" employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an "active" employee.)

## FINDING A DELTA PPO DENTIST

You can access Delta directly by going to [deltadentalins.com](https://deltadentalins.com). Click on the link that specifies the Delta Dental PPO option. Additionally, you can call your dental office to ask if your dentist accepts Delta Dental PPO and if the dentist is a Delta Dental PPO in-network provider. You can also ask for assistance from Delta Dental Customer Service at (888) 335-8227.

## PREDETERMINATION OF BENEFITS

If you are considering having extensive or expensive dental work, you may obtain a predetermination review before the service begins. Predeterminations are free and usually take about three weeks to process. You may obtain a predetermination/claim form from your dentist, or your dentist can submit on your behalf to:

Delta Dental | P.O. Box 997330 Sacramento, CA 95899-7330 | (888) 335-8227 | [deltadentalins.com](https://deltadentalins.com)

## CLAIMS AND CUSTOMER SERVICE

Delta Dental customer service can provide assistance on benefit questions, eligibility, changing dentists, or explaining claim procedures. You may contact Delta Dental at:

Delta Dental | P.O. Box 997330 Sacramento, CA 95899-7330 | (888) 335-8227 | [deltadentalins.com](https://deltadentalins.com)

## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oce.org/dental-ppo-a-eoc](https://oce.org/dental-ppo-a-eoc).

# DELTACARE USA CAM50 (DHMO)

The DeltaCare USA DHMO offers you a comprehensive program of dental care with no annual benefit limit. Most preventive services like cleanings and examinations are covered in full. Other procedures will require copayments at the time the dentist performs the service.

This is a “managed” dental care program in which you must select a dentist from an extensive network to be your personal provider. This dentist will perform, arrange, or refer all of your dental care needs. You must receive services from your DeltaCare USA dentist for contract benefits to apply. There is no coverage for care received from a dentist other than your DeltaCare USA dentist.

## WHO IS ELIGIBLE?

Employees and eligible dependents. Among other things, you must be an “active” employee (actually at work) on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an “active” employee.) **Dependents are generally your legal spouse or registered domestic partner, and children.** *Your children can be covered under your dental and vision plans until they reach age 26:*

- Child must **not** be eligible for any other Employer dental and/or vision plan.
- Child does **not** need to be a full-time student.
- Child can be married or unmarried.
- Spouses and children of dependent children are **not** eligible for coverage.
- Any child of the employee regardless of dependency status under IRS rules.

## FINDING A DELTACARE USA DHMO DENTIST

The DeltaCare USA Dental Network is a large, carefully selected list of dentists who meet the DeltaCare USA credentialing requirements and have agreed to a contractual relationship with DeltaCare USA.

Once you are enrolled in DeltaCare USA, you may choose or change dentists. To find an in-network dentist, visit the Delta Dental website at [deltadentalins.com](http://deltadentalins.com) or call the DeltaCare USA customer service line at (800) 422-4234. Changes are usually effective the first of the month following your request. DeltaCare USA will advise you of the new effective date.

## CUSTOMER SERVICE

DeltaCare USA provides its members with customer service at (800) 422-4234. Customer service can provide assistance on benefit questions, eligibility, changing dentists, or explaining claim procedures. You may also visit the DeltaCare USA website at [deltadentalins.com](http://deltadentalins.com) to view provider lists, obtain benefit information, and view your current assigned provider.

## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceo.org/dental-cam50-eoc](http://oceo.org/dental-cam50-eoc).



## SAMPLES OF DELTACARE CAM50 COPAYS

DESCRIPTION	ENROLLEE PAYS
Oral evaluation	No Cost
Intraoral—radiographic image	No Cost
Bitewings	No Cost
Panoramic radiographic image	No Cost
Prophylaxis cleaning per 6 month period	No Cost
Topical application of fluoride per 6 month period	No Cost
Periodontal scaling and root planing— limited to 4 quadrants during any 12 consecutive months	\$15
Root canal	\$45-135
Extraction, coronal remnants—primary tooth	\$3-8
Removal of impacted tooth	\$40-80
Amalgam	No Cost
Resin-based composite—anterior	No Cost
Resin-based composite crown—posterior	\$55-85
Crown	\$90
Comprehensive orthodontic treatment	\$1,600-1,800

SEE FULL LIST OF COPAYS AT [OCEA.ORG/CAM50](https://oceaprovider.org/CAM50)

## — ABOUT YOUR HEALTH & WELFARE PLAN —

# VISION PLAN (VSP)

Vision Service Plan (VSP) is the nation's largest eye-care doctor network with thousands of participating doctors. If you choose to receive services from a VSP provider, benefit coverage is more comprehensive and your out-of-pocket expenses may be less.

If you choose to receive services from an out-of-network provider, VSP will reimburse you up to the amount allowed under the plan's out-of-network provider reimbursement rate. Services obtained through out-of-network providers are subject to the same copayments and limitations as services obtained through VSP doctors.

Be aware your out-of-network provider reimbursement rate does not guarantee full payment, and VSP cannot guarantee patient satisfaction when services are received from an out-of-network provider.

### WHO IS ELIGIBLE?

You must be a full-time employee and not enrolled in Option 3. Among other things, you must be an "active" employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an "active" employee.)

### FINDING A VSP PROVIDER

It's easy to find a VSP provider. Log on to the VSP website at [vsp.com](http://vsp.com) and use the doctor directory to look for a provider in the Choice Network. Or, you can call the VSP Member Services phone number at (800) 877-7195.

### FILING A CLAIM

If you choose to use an out-of-network provider, claims must be filed with VSP within six months from the date of service. Please keep a copy for your records and send the originals to:

VSP Member Claims | P.O. Box 495933 Cincinnati, OH 45249

Full details may be found on VSP's website at [vsp.com/faqs/claims-reimbursement](http://vsp.com/faqs/claims-reimbursement).

### EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oce.org/vsp-eoc](http://oce.org/vsp-eoc).

## — ABOUT YOUR HEALTH & WELFARE PLAN —

# BASIC DISABILITY PLAN

OCEA provides a Basic Disability Plan at no additional cost to all employees in regular or limited-term positions in OCEA-represented bargaining units in the County of Orange, the Fire Authority, the Superior Court, and the Law Library, regardless of whether or not you are an OCEA member. This plan is designed to help replace your income if you become disabled. The Basic Disability Plan pays up to \$1,080 per month from the 21<sup>st</sup> calendar day through the 90<sup>th</sup> calendar day of your disability and up to \$900 per month from the 91<sup>st</sup> calendar day, for a maximum of 24 months. The Basic Disability Plan benefit amounts coordinate with all other sources of income (including holiday pay, sick leave, annual leave, workers' compensation, retirement, and other disability benefits) received for the period of your disability.

### PRE-EXISTING CONDITION

You may not be able to collect benefits beyond 90 days if your injury or illness is due to a pre-existing condition. A pre-existing condition is one in which a reasonably prudent person would have consulted a physician, received medical treatment, services or advice, undergone diagnostic procedures, including self-administered procedures, or taken medication in the 90-day period prior to your effective date. Please note that the pre-existing condition limitation only applies to disabilities that continue beyond 90 days.

For the **Basic Disability Plan**, disabilities that are not a result of a pre-existing condition are covered per the terms of the contract. Coverage for a pre-existing condition is not provided beyond 90 days if the disability begins during the first 12 months of your coverage. If the disability begins after you have been covered on the plan for more than 12 months, there is no pre-existing limitation.

### WHO IS ELIGIBLE?

Among other things, you must be an "active" employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an "active" employee.)

If you are on a leave of absence, the following rules apply depending on how long you have been on leave:

- **Leave of absence up to one year:** The Basic Disability plan will remain in force for the first three months following the beginning of your leave of absence. When you return to active employment, if eligible, you will be reinstated for the Basic Disability plan you had prior to taking your leave of absence.
- **Leave of absence greater than one year:** After one year, your Basic Disability plan will be canceled until you return to active employment. When you return to active employment you are automatically enrolled in the Basic Disability plan. Benefits become effective the first of the month following 60 calendar days of continuous active employment.

### DEFINITION OF DISABILITY

You will be considered disabled if, as a result of an illness, non-work related injury, or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation.

## WAITING PERIOD

No benefits are payable during the first 20 calendar-day waiting period.

## BENEFIT PERIOD OR DURATION

Benefits may be payable up to 24 months. In some cases, the maximum length of time benefits may be payable will depend on your age when you become disabled.

AGE WHEN DISABILITY BEGINS	MAXIMUM BENEFIT PERIOD
63	1 yr., 9 mos.
64	1 yr., 6 mos.
65	1 yr., 3 mos.
66 or over	1 yr.

## HOW TO FILE A CLAIM

To obtain a disability claim form, you may contact OCEA at (714) 835-3355 or download the form at [oceasouthwest.com/disabilityclaimform](https://oceasouthwest.com/disabilityclaimform).

## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceasouthwest.com/hw-disability-eoc](https://oceasouthwest.com/hw-disability-eoc).

— ABOUT YOUR HEALTH & WELFARE PLAN —

## LIFE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN

The Basic Life/Accidental Death & Dismemberment Insurance Plan is available to full-time and part-time employees. The plan pays a benefit of \$25,000 to the designated beneficiary upon the death of the employee. The policy has no cash value.

### WHO IS ELIGIBLE?

Among other things, you must be an "active" employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an "active" employee.)

If you are on a leave of absence, the following rules apply depending on how long you have been on leave:

- **Leave of absence up to one year:** The Health & Welfare Life/Accidental Death and Dismemberment Insurance coverage will remain in force for the first three months following the beginning of your leave of absence. When you return to active employment, if eligible, you will be reinstated for the Health & Welfare Life/Accidental Death and Dismemberment plan you had prior to taking your leave of absence.
- **Leave of absence greater than one year:** After one year, your Health & Welfare Life/Accidental Death and Dismemberment Insurance coverage will be canceled until you return to active employment. When you return to active employment, you are automatically enrolled in the Health & Welfare Life/Accidental Death and Dismemberment Insurance plan. Benefits will become effective the first of the month following 60 calendar days of continuous active employment.

### MATCHING ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

If the death of the employee is the result of an accident, this plan pays an additional \$25,000 benefit to the designated beneficiary.

### HOW TO FILE A CLAIM

Contact OCEA at (714) 835-3355 for claim forms.

### "LIVING BENEFIT" OPTION

The living benefit gives you the opportunity, while living and under age 60, to receive 75% of your life insurance coverage should you be diagnosed with a terminal illness with a life expectancy of twelve months or less. The minimum amount that can be requested is \$5,000 or 10% of your insurance, whichever is greater.

Upon your death, your designated beneficiary will receive any remaining benefit.

— LIFE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN CONTINUED ON NEXT PAGE —

## TRAVEL ASSISTANCE

All members participating in Basic Life program from The Standard are automatically enrolled in an Assist America travel assistance program. Travel assistance is intended to help members and their families while they are traveling to find medical & legal services, replace lost credit cards and passports, as well as other helpful assistance when traveling more than 100 miles from home, or in a foreign country, and for less than 180 days. For more information and a complete description of services available with travel assistance, please refer to [standard.com/eforms/21251.pdf](http://standard.com/eforms/21251.pdf).

## CONVERSION POLICY

You may convert your Basic Life Insurance to an individual whole life policy without evidence of insurability if:

- 1) Your insurance ends or is reduced due to a qualifying event, and
- 2) You apply in writing and pay the first premium within 31 days after your employment terminates.

The maximum you are eligible to convert is the amount of your life insurance before coverage ended.

## PORTABILITY

If your life insurance ends because your employment terminates, you may be eligible to continue group life insurance without evidence of insurability. To be eligible, you must satisfy the following requirements:

- 1) On the date your employment terminates, you must be able to perform the material duties of your occupation.
- 2) On the date your employment terminates, you are under the age of 65.
- 3) On the date your employment terminates, you must have been covered under this plan for at least 12 months.
- 4) You must apply in writing within 31 days after your employment terminates.

The maximum amount you are eligible to buy is the amount of life insurance you had before coverage ended.

## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceo.org/hw-life-eoc](http://oceo.org/hw-life-eoc).



# OCEA-ADMINISTERED **SUPPLEMENTAL BENEFITS PLANS**

THESE BENEFITS WERE NEGOTIATED BY OCEA AND ARE ONLY AVAILABLE [FOR PURCHASE BY OCEA MEMBERS](#).

**YOU HAVE 31 DAYS FROM YOUR MEMBERSHIP DATE FOR INITIAL ENROLLMENT**

## **SUPPLEMENTAL DENTAL INSURANCE**

PAGE 26

**UPGRADED DENTAL COVERAGE (PPO & DHMO)  
AVAILABLE FOR YOU AND YOUR FAMILY**

ENROLLMENT FORM ON PAGE 69

## **VISION INSURANCE**

PAGE 31

**ADD VISION COVERAGE FOR YOUR FAMILY OR PURCHASE  
FOR YOURSELF IF NOT ENROLLED IN OPTION 1 OR OPTION 2**

ENROLLMENT FORM ON PAGE 71

## **SUPPLEMENTAL DISABILITY INSURANCE**

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**FIND THE ENROLLMENT APPLICATIONS STARTING ON PAGE 69 AND SUBMIT TO OCEA AT  
830 N. ROSS ST., SANTA ANA, CA 92701 OR APPLY ONLINE AT [OCEA.ORG/BENEFITS](https://oceaa.org/benefits)  
COMPLETED FORMS CAN ALSO BE EMAILED TO [BENEFITS@OCEA.ORG](mailto:benefits@oceaa.org)**

# SUPPLEMENTAL DENTAL PLAN OPTION HIGHLIGHTS

Members and eligible dependents have a choice between two “buy-up” dental plans: Delta Dental PPO Plan A+ and DeltaCare USA CAM49 (DHMO). The plan you select must be indicated on the Supplemental Dental Enrollment Form.

EMPLOYEE AND ELIGIBLE DEPENDENTS	DELTA DENTAL PPO PLAN A+		OR	DELTACARE USA CAM49 (DHMO)
	YOU MAY USE YOUR OWN DENTIST, BUT YOU MUST USE A PPO DENTIST TO RECEIVE THE HIGHEST LEVEL OF BENEFITS			YOU MUST USE A PARTICIPATING DENTIST
	PPO PROVIDER	NON-PPO PROVIDER		
DENTAL SERVICES				
Deductible	\$25 per person \$75 per family (waived for preventive and diagnostic services)	\$50 per person \$150 per family (deductible applies to all services)		No Deductible
Preventive/ Diagnostic Services	Payable at 100%	Payable at 70%		No Copayment
Basic Services	Payable at 90%	Payable at 70%		Copayment
Major Services	<b>Payable at 60% after you have been on this plan for six (6) months.</b>	<b>Payable at 50% after you have been on this plan for six (6) months.</b>		Copayment
Maximum Payable	\$1,750 per calendar year	\$1,000 per calendar year		No Maximum
ORTHODONTIC SERVICES				
Deductible	None	None		No Deductible
Percentage Payable	<b>50% of covered charges after you have been on this plan for six (6) months.</b>	<b>50% of covered charges after you have been on this plan for six (6) months.</b>		Copayment
Maximum Payable	\$2,000 Lifetime per person	\$2,000 Lifetime per person		Copayment
IMPLANTS				
Deductible	\$25 per person/\$75 per family	\$50 per person/\$150 per family		Not Covered
Percentage Payable	<b>Payable at 60% after you have been on this plan for six (6) months.</b>	<b>Payable at 50% after you have been on this plan for six (6) months.</b>		
Maximum Payable	\$2,000 per calendar year per person	\$2,000 per calendar year per person		

## WHEN TO ENROLL

You may enroll within your first 31 days of OCEA membership, during the annual open enrollment period, or upon a family status change.

## HOW TO ENROLL

Complete the Supplemental Dental Enrollment Form, located on page 69, and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](http://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

## COST OF COVERAGE

Your premiums for supplemental dental coverage are paid through biweekly payroll deductions.

DELTA DENTAL PPO PLAN A+					
	Biweekly				Monthly
	Option 1	Option 2	Option 3	Non-H&W Enrollee	Retiree
Member only	\$13.27	\$13.27	\$18.15	\$28.00	Not available
Member + 1 Dependent	\$35.29	\$35.29	\$40.17	\$50.02	Not available
Member + 2 or More Dependents	\$66.93	\$66.93	\$71.82	\$81.66	Not available

DENTAL DHMO-DELTACARE USA CAM49					
	Biweekly				Monthly
	Option 1	Option 2	Option 3	Non-H&W Enrollee	Retiree
Member only	\$3.30	\$3.30	\$10.09	\$10.09	\$21.86
Member + 1 Dependent	\$4.60	\$4.60	\$19.14	\$19.14	\$41.46
Member + 2 or More Dependents	\$12.30	\$12.30	\$28.19	\$28.19	\$61.07

## WHEN COVERAGE BEGINS

The effective date of coverage will be determined by OCEA.

## ELIGIBILITY

Almost all OCEA members are eligible for enrollment in this coverage. If you have any questions regarding eligibility, contact OCEA at (714) 835-3355.

Among other things, you must be an “active” employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an “active” employee.)

Dependents are generally your legal spouse or registered domestic partner, and children.

Your children can be covered under your dental and vision plans until they reach age 26:

- Child must **not** be eligible for any other Employer dental and/or vision plan.
- Child does **not** need to be a full-time student.
- Child can be married or unmarried.
- Spouses and children of dependent children are **not** eligible for coverage.
- Any child of the employee regardless of dependency status under IRS rules.

## FAMILY STATUS CHANGE

You have 31 days from a qualifying event to submit your benefits enrollment form with changes plus supporting documents (marriage certificate, birth certificate, etc.) if you have a family status change.

## — ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS —

# DELTA DENTAL PPO PLAN A+

Delta Dental PPO Plan A+ is an upgrade to Health & Welfare PPO Plan A options. Plan A+ is the only PPO plan that may be purchased for the member and the member's family.

This plan allows members the flexibility to choose their own dentist, and to self-refer for specialty care services. To receive the highest level of benefits with the lowest out of pocket expense, you should consider visiting a Delta PPO dentist. PPO dentists agree to provide treatment to PPO patients at discounted fees prenegotiated by Delta. In addition, the percentages paid by Delta will be significantly higher when you visit a Delta PPO provider dentist.

Dentists who are not part of Delta Dental have not agreed to discounted fees. These dentists will be paid the usual, customary, and reasonable fees for services. Since these fees can be higher than Delta's discounted fees, you will spend more money with a dentist who is not participating with Delta Dental. You may also be required to file your own claims with Delta.

### HOW THE PLAN WORKS

Simply make an appointment to see the dental provider of your choice. Then have your dental office submit a claim form for the services rendered.

If you are considering having extensive or expensive dental work, you may obtain a predetermination review before the service begins. Predeterminations are free and usually take about three weeks to process. You may obtain a predetermination/claim form from your dentist, or your dentist can submit on your behalf to:

Delta Dental | P.O. Box 997330, Sacramento, CA 95899-7330 | (888) 335-8227 | [deltadentalins.com](https://deltadentalins.com)

### CLAIMS AND CUSTOMER SERVICE

Delta Dental customer service can provide assistance on benefit questions, eligibility, changing dentists, and explaining claim procedures. You may contact Delta Dental at:

Delta Dental | P.O. Box 997330, Sacramento, CA 95899-7330 | (888) 335-8227 | [deltadentalins.com](https://deltadentalins.com)

### FINDING A DELTA PPO DENTIST

You can access Delta directly by going to [deltadentalins.com](https://deltadentalins.com). Click on the link that specifies the Delta Dental PPO Option. Additionally, you can call your dental office to ask if your dentist accepts Delta Dental PPO and if the dentist is a Delta Dental PPO in-network provider. You can also ask for assistance from Delta Dental Customer Service at (888) 335-8227.

### EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceca.org/dental-a-plus-eoc](https://oceca.org/dental-a-plus-eoc).

FOR  
PURCHASE  
BY OCEA  
MEMBERS

## — ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS —

# DELTACARE USA CAM49 (DHMO)

DeltaCare USA CAM49 is the upgrade to the Health & Welfare DeltaCare USA CAM50 DHMO option. If you are an OCEA member or an eligible retiree, you may purchase DeltaCare USA CAM49 for you and your family.

### HOW THE PLAN WORKS

If you select this plan, you must choose a dentist from a list of participating dentists who agree to charge you based on a schedule of copayments for services performed. You may change dentists at any time by contacting DeltaCare USA directly at (800) 422-4234.

This plan is designed for coverage in California only. You are only covered for services received from your designated California DeltaCare USA provider.

### HOW TO FILE A CLAIM

There are no claim forms. The dentist handles any paperwork.

### FINDING A DELTACARE USA DENTIST

The DeltaCare USA Dental Network is a large, carefully selected list of dentists who meet the DeltaCare USA credentialing requirements and have agreed to a contractual relationship with DeltaCare USA.

Once you are enrolled in DeltaCare USA, you may choose or change dentists. To find an in-network dentist, visit the Delta Dental website at [deltadentalins.com](https://deltadentalins.com) or call the DeltaCare USA customer service line at (800) 422-4234. Changes are usually effective the first of the month following your request. DeltaCare USA will advise you of the new effective date.

### CUSTOMER SERVICE

DeltaCare USA provides its members with customer service at (800) 422-4234. Customer service can provide assistance on benefit questions, eligibility, changing dentists, or explaining claim procedures.

You may also visit the Delta Dental website at [deltadentalins.com](https://deltadentalins.com) to view provider lists, obtain benefit information and view your current assigned provider.

### EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oce.org/dental-cam49-eoc](https://oce.org/dental-cam49-eoc).

— DELTACARE USA CAM49 (DHMO) CONTINUED ON NEXT PAGE —

## SAMPLES OF DELTACARE CAM49 COPAYS

DESCRIPTION	ENROLLEE PAYS
Oral evaluation	No Cost
Intraoral—radiographic image	No Cost
Bitewings	No Cost
Panoramic radiographic image	No Cost
Prophylaxis cleaning per 6 month period	No Cost
Topical application of fluoride per 6 month period	No Cost
Periodontal scaling and root planing— limited to 4 quadrants during any 12 consecutive months	No Cost
Root canal	\$20-60
Extraction, coronal remnants—primary tooth	No Cost
Removal of impacted tooth	Up to \$40
Amalgam	No Cost
Resin-based composite—anterior	No Cost
Resin-based composite crown—posterior	\$45-75
Crown	\$50
Comprehensive orthodontic treatment	\$1,600-1,800

SEE FULL LIST OF COPAYS AT [OCEA.ORG/CAM49](https://oceacommunity.org/cam49)

## VISION PLAN (VSP)

The Vision Plan (VSP) is a plan that allows full-time OCEA members enrolled in Option 1 or Option 2 to obtain the same vision benefits they enjoy for their dependents. Part-time employees may obtain the plan for themselves and their dependents, if applicable. The VSP Choice Network provides an extensive nationwide network of doctors who provide care and materials. This plan supports vision maintenance by providing regular eye examinations and benefits for other vision care expenses including glasses or contact lenses.

EMPLOYEE AND ELIGIBLE DEPENDENTS	VISION PLAN (VSP)			
<b>BENEFITS:</b>	<b>Exam:</b>	Once each calendar year	<b>COPAYMENT:</b>	Exam \$5
	<b>Lenses:</b>	Once each calendar year		Materials \$20
	<b>Frames:</b>	Once every other calendar year		
	SERVICES FROM A VSP DOCTOR		SERVICES FROM AN OUT-OF-NETWORK PROVIDER	
Exam	Covered in full		up to \$45	
Single Vision Lenses	Covered in full		up to \$30	
Bifocal Lenses	Covered in full		up to \$50	
Progressive Lenses	Covered in full after \$55 copay		up to \$50	
Trifocal Lenses	Covered in full		up to \$65	
Anti-Reflective Coating	Covered in full after \$40 copay		Not a covered benefit	
Frame	A wide selection of frames are covered up to \$175		up to \$70	
Contact Lenses (in lieu of glasses)	Exam: Covered in full after a maximum copay of \$60 Contact Lenses: Up to \$175		up to \$105	

FOR DEPENDENTS UP TO AGE 19	SUPPLEMENTAL VSP KIDSCARE PLAN SUMMARY	
Plan Frequency	<ul style="list-style-type: none"> <li>Exam: Twice in calendar year</li> <li>Frame (child): Once every calendar year</li> </ul>	<ul style="list-style-type: none"> <li>Lens: Once each calendar year</li> <li>Contact lenses: Once each calendar year</li> </ul>
Exam Services	<ul style="list-style-type: none"> <li>Two covered-in-full, less any applicable copay, comprehensive eye exams that test for eye health and vision issues that can begin during childhood, like nearsightedness, amblyopia (lazy eye), and strabismus.</li> </ul>	
Lenses or Contact Lenses (in lieu of glasses)	<ul style="list-style-type: none"> <li>Lenses covered-in-full, less any applicable copay, including child-friendly, impact-resistant polycarbonate lenses</li> <li>Additional lenses covered-in-full when needed (minimum of .50 diopter change required)</li> </ul>	

### WHEN TO ENROLL

You may enroll within your first 31 days of OCEA membership, during the annual open enrollment period, or upon a family status change.



## HOW TO ENROLL

Complete the Vision Enrollment Form, located on page 71, and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](http://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

## COST OF COVERAGE

Your premiums for supplemental vision coverage are paid through regular twice-monthly payroll deductions.

VISION PLAN (VSP)					
	Twice-Monthly				Monthly
	Option 1	Option 2	Option 3	Non-H&W Enrollee	Retiree
Member only	No Charge	No Charge	\$2.55	\$4.61	\$9.23
Member + 1 Dependent	\$2.07	\$2.07	\$4.62	\$6.68	\$13.37
Member + 2 or More Dependents	\$7.36	\$7.36	\$9.92	\$11.98	\$23.96

## WHEN COVERAGE BEGINS

The effective date of coverage will be determined by OCEA.

## ELIGIBILITY

Almost all OCEA members are eligible for enrollment in this coverage. If you have any questions regarding eligibility, contact VSP at (800) 877-7195.

Among other things, you must be an “active” employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an “active” employee.)

Dependents are generally your legal spouse or registered domestic partner, and children.

Your children can be covered under your dental and vision plans until they reach age 26:

- Child must **not** be eligible for any other Employer dental and/or vision plan.
- Child does **not** need to be a full-time student.
- Child can be married or unmarried.
- Spouses and children of dependent children are **not** eligible for coverage.
- Any child of the employee regardless of dependency status under IRS rules.

## FAMILY STATUS CHANGE

You have 31 days from a qualifying event to submit your benefits enrollment form with changes plus supporting documents (marriage certificate, birth certificate, etc.) if you have a family status change.

## HOW THE PLAN WORKS

### Step One:

When you are ready to obtain vision care services, call your VSP participating doctor. If you need to locate a VSP participating doctor, call Vision Service Plan at (800) 877-7195 or visit the VSP website at [vsp.com](http://vsp.com).

### Step Two:

When making an appointment, identify yourself as a VSP member. The participating doctor will also need the last four digits of your Social Security Number to verify benefits. The participating doctor will contact VSP to verify your eligibility and obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you.

### Step Three:

At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. If so, the participating doctor will coordinate the prescription with a VSP-approved contract laboratory. The participating doctor will itemize any non-covered charges and have you sign a form to document that you received services. VSP will pay the participating doctor directly for covered services and materials. You are responsible for paying the doctor a \$5 copayment for the eye examination and a \$20 copayment for lenses and/or frames. You are responsible for any additional costs resulting from cosmetic options, or non-covered services, and materials you have selected. Selecting a participating doctor from VSP's network assures direct payment to the doctor and guarantees quality services and materials.

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## FINDING A VSP PROVIDER

It's easy to find a VSP provider. You may log on to the VSP website at [vsp.com](http://vsp.com) and use the doctor directory to look for a provider in the Choice Network. Or you can call the VSP Member Services phone number at (800) 877-7195.

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## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceo.org/vsp-eoc](http://oceo.org/vsp-eoc).

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## — ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS —

# SUPPLEMENTAL DISABILITY PLANS

The Supplemental Disability Plan is a voluntary plan **available to OCEA members only**. The plan is designed to provide additional benefits in the event of a disability. Benefit amounts will be coordinated with all other sources of income (including holiday pay, sick leave, annual leave, workers' compensation, retirement, and other disability benefits) received for the disability period and are subject to certain other benefit limitations. The Supplemental Disability Plan is not available to extra-help employees or dependents.

**Supplemental Disability Plan—Level One** includes the benefits described for the Basic Disability Plan with an increased maximum benefits schedule beginning the 91<sup>st</sup> calendar day of disability (or when benefits begin, if later), and an increased maximum benefit period.

**Supplemental Disability Plan—Level Two** includes the benefits for the Basic Disability Plan and Supplemental Disability Plan—Level One with an increased maximum benefits schedule beginning the 21<sup>st</sup> calendar day of disability and continuing through the 90<sup>th</sup> calendar day of disability (or when benefits begin, if later).

### WHEN TO ENROLL

You may enroll within your first 31 days of OCEA membership or during the annual open enrollment period. You may also enroll by completing an Evidence of Insurance form anytime throughout the year. Refer to page 35.

### HOW TO ENROLL

Complete the Supplemental Disability Enrollment Form, located on page 73, and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](http://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

### LEAVE OF ABSENCE

If you are on a leave of absence, the following rules apply depending on how long you have been on leave:

- **Leave of absence up to one year:** The Supplemental Disability Insurance coverage will remain in force for the first three months following the beginning of your leave of absence. When you return to active employment, if eligible, your coverage, which was in force on the date you went on a leave of absence, and your deductions (if any) will automatically be reinstated. Deductions will begin the first payday you return to active status.
- **Leave of absence greater than one year:** After one year, your Supplemental Disability Insurance coverage will be canceled until you return to active employment. When you return to active employment, you will be eligible to enroll in the Supplemental Disability Insurance Plan. Provided enrollment is made timely, buy-up coverage options include guarantee issue levels. Late enrollment requires Evidence of Insurability for both levels.

## LATE ENROLLMENT

There are two ways to enroll in the Supplemental Disability Plan if you miss your **initial enrollment** opportunity:

- **During OCEA Health & Welfare Trust's Annual Enrollment Period.** The Annual Open Enrollment period allows you to elect to enroll in either Level One or Level Two benefits without providing Evidence of Insurability (EOI). However, you will be subject to a waiting period for pre-existing conditions\* for disabilities **lasting more than 90 days**. For further explanation, please see page 37.
- **Outside of OCEA Health & Welfare Trust's Annual Enrollment Period.** If you choose to enroll outside of the OCEA Open Enrollment Period you must successfully complete EOI before your coverage is effective. Once effective, you will still be subject to a waiting period for pre-existing conditions **lasting more than 90 days** as described above and on page 37.

Members who have previously applied for Supplemental Disability Insurance but were denied coverage will need to provide Evidence of Insurability (EOI) for the Supplemental Disability Plan.

*\*A pre-existing condition means if you are disabled by an illness, condition, or injury for which you have been treated during the three month period immediately preceding your enrollment, that disability is not covered until you have been enrolled for 12 months on the Level One or Level Two disability plan.*

## EVIDENCE OF INSURABILITY (EOI) REQUIREMENTS

You will be required to fulfill Evidence of Insurability (EOI) requirements if you do any of the following:

- Apply for the plan after your first 31 days as an OCEA member and/or outside of an open enrollment period (including a request to increase the amount of your coverage from Level One to Level Two); or
- Members who have previously applied for Supplemental Disability Insurance but were denied coverage will need to provide EOI.

## WHEN COVERAGE BEGINS

For the Supplemental Disability Plan, the effective date of coverage will depend whether or not you were required to complete an Evidence of Insurability (EOI) form. You are required to complete an EOI before coverage can be approved when you apply more than 31 days after your initial eligibility date. When you are NOT required to complete the EOI, then your effective date will be determined by OCEA and will usually be the first of the month following the date you submit your completed enrollment forms to OCEA. When you are required to complete an EOI, (anytime you apply more than 31 days after your initial enrollment period), then your effective date of coverage is the date your EOI was approved by The Standard, even though premium deductions will not begin, usually, until the first day of the month following your approval. For more specific information, contact OCEA at (714) 835-3355.

## HOW TO FILE A CLAIM

To obtain a disability claim form, you may contact OCEA or download the form at [oceca.org/disabilityclaimform](http://oceca.org/disabilityclaimform).

## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceca.org/sup-disability-eoc](http://oceca.org/sup-disability-eoc).

## BENEFIT WAITING PERIODS & MONTHLY BENEFITS

If you are in an OCEA Bargaining Group which includes a H&W Contribution and apply during your Initial Enrollment Period

	Monthly Benefit Payable				Benefit Period	Cost
	0-20 days	21-90 days	91+ days			
<b>Basic Disability Benefits</b>	Waiting Period	60% to \$1,080 max.	60% to \$900 max.		24 months max.	No cost for H&W Units
<b>Supplemental Disability Plan - Level One</b>	Waiting Period	60% to \$1,080 max.	60% to \$5,000 max.		Payable to age 62 max.	Approx. 1.038% of salary; max. \$86.50 monthly
<b>Supplemental Disability Plan - Level Two</b>	Waiting Period	60% to \$5,000 max.	60% to \$5,000 max.		Payable to age 62 max.	Approx. 1.325% of salary; max. \$110.42 monthly

If enrollment is after your Initial Enrollment Period (i.e. Late Enrollment)

	Monthly Benefit Payable				Benefit Period	Cost
	0-20 days	21-60 days	61-90 days	91+ days		
<b>Supplemental Disability Plan - Level One</b>	Waiting Period	60% to \$1,080 max.	60% to \$1,080 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.038% of salary; max. \$86.50 monthly
<b>Supplemental Disability Plan - Level Two</b> (If disability occurs <b>during</b> the first 12 months of coverage under Level Two)	Waiting Period	60% to \$1,080 max.	60% to \$5,000 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.325% of salary; max. \$110.42 monthly
<b>Supplemental Disability Plan - Level Two</b> (If disability occurs <b>after</b> the first 12 months of coverage under Level Two)	Waiting Period	60% to \$5,000 max.	60% to \$5,000 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.325% of salary; max. \$110.42 monthly

Non H&W Members

	Monthly Benefit Payable				Benefit Period	Cost
	0-20 days	21-60 days	61-90 days	91+ days		
<b>Supplemental Disability Plan - Level One</b> (If disability occurs <b>during</b> the first 12 months of coverage under Level One)	Waiting Period	Waiting Period	60% to \$1,080 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.038% of salary; max. \$86.50 monthly
<b>Supplemental Disability Plan - Level One</b> (If disability occurs <b>after</b> the first 12 months of coverage under Level One)	Waiting Period	60% to \$1,080 max.	60% to \$1,080 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.038% of salary; max. \$86.50 monthly
<b>Supplemental Disability Plan - Level Two</b> (If disability occurs <b>during</b> the first 12 months of coverage under Level Two)	Waiting Period	Waiting Period	60% to \$5,000 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.325% of salary; max. \$110.42 monthly
<b>Supplemental Disability Plan - Level Two</b> (If disability occurs <b>after</b> the first 12 months of coverage under Level Two)	Waiting Period	60% to \$5,000 max.	60% to \$5,000 max.	60% to \$5,000 max.	Payable to age 62 max.	Approx. 1.325% of salary; max. \$110.42 monthly

All disability benefits are coordinated with all other sources of income (including holiday pay, sick leave, annual leave, workers' compensation, retirement, and other disability benefits) and are subject to certain other benefit limitations.

See page 37 for Maximum Benefit Period

PRE-EXISTING CONDITION

You may not be able to collect benefits beyond 90 days if your injury or illness is because of a pre-existing condition. A pre-existing condition is one in which a reasonably prudent person would have consulted a physician, received medical treatment, services or advice, undergone diagnostic procedures, including self-administered procedures, or taken medications in the 90-day period prior to your effective date. Please note that the pre-existing condition limitation only applies to disabilities that continue beyond 90 days.

For the **Supplemental Disability Plans** (Level One and Level Two) the pre-existing limitation is the same as the Basic Disability Plan unless you apply and are approved for this coverage after your initial eligibility date. In this case, the increase in benefits beyond the Basic Disability will be subject to the pre-existing condition limitation. Of course, disabilities which are not as a result of a pre-existing condition are covered per the terms of the contract for the Supplemental Disability Plans.

ABOUT YOUR DISABILITY PAYMENTS

All benefits you receive will be coordinated with other sources of income, which will reduce the amount you receive during your disability. Other sources of income include, but are not limited to, annual leave, holiday pay, sick time, workers’ compensation, Social Security benefits, work earnings while disabled, benefits received under other disability plans, and benefits received under any OCERS retirement plan.

COST OF COVERAGE

The amount you pay through payroll deductions for your Supplemental Disability Plan depends on your earnings and the plan you select. For OCEA members in OCEA Health & Welfare units, the rates are the percentages contained in the tables on the previous pages. If you are eligible for the Supplemental Disability Plan, but are not in an OCEA Health & Welfare unit, there is an additional \$4 twice-monthly service charge to cover the cost of Basic Disability benefits in addition to the percentages contained in the Cost of Coverage table.

Please refer to the relevant table on page 38 of this Benefits Enrollment Guide for details regarding your twice-monthly premiums.

While you are disabled, your disability plan will continue without payment of premiums as long as the LTD benefits are payable, **provided you are not receiving any payments from your employer**. However, if you are receiving payments from your employer, you must pay premiums in order for benefits to continue.

MAXIMUM BENEFIT PERIOD

The maximum length of time you are eligible for benefits depends on your age when you become disabled.

AGE WHEN DISABILITY BEGINS	MAXIMUM BENEFIT PERIOD
58 or younger	To age 62 or 3 yrs., 6 mos. if longer
59	3 yrs., 6 mos.
60	3 yrs.
61	2 yrs., 6 mos.
62	2 yrs.
63	1 yr., 9 mos.
64	1 yr., 6 mos.
65	1 yr., 3 mos.
66 or over	1 yr.

— SUPPLEMENTAL DISABILITY PLANS CONTINUED ON NEXT PAGE —

## TABLE FOR CALCULATING YOUR SUPPLEMENTAL DISABILITY COSTS

Use this table to calculate your twice-monthly cost for Level One or Level Two Supplemental Disability coverage. Non-H&W members add an additional \$4 twice-monthly service charge to cover the cost of Basic Disability benefits.

SUPPLEMENTAL DISABILITY (STANDARD INSURANCE COMPANY)					
MONTHLY SALARY	LEVEL ONE TWICE-MONTHLY COST	LEVEL TWO TWICE-MONTHLY COST	MONTHLY SALARY	LEVEL ONE TWICE-MONTHLY COST	LEVEL TWO TWICE-MONTHLY COST
\$2,000	\$10.38	\$13.25	\$5,300	\$27.51	\$35.11
\$2,100	\$10.90	\$13.91	\$5,400	\$28.03	\$35.78
\$2,200	\$11.42	\$14.58	\$5,500	\$28.55	\$36.44
\$2,300	\$11.94	\$15.24	\$5,600	\$29.06	\$37.10
\$2,400	\$12.46	\$15.90	\$5,700	\$29.58	\$37.76
\$2,500	\$12.98	\$16.56	\$5,800	\$30.10	\$38.43
\$2,600	\$13.49	\$17.23	\$5,900	\$30.62	\$39.09
\$2,700	\$14.01	\$17.89	\$6,000	\$31.14	\$39.75
\$2,800	\$14.53	\$18.55	\$6,100	\$31.66	\$40.41
\$2,900	\$15.05	\$19.21	\$6,200	\$32.18	\$41.08
\$3,000	\$15.57	\$19.88	\$6,300	\$32.70	\$41.74
\$3,100	\$16.09	\$20.54	\$6,400	\$33.22	\$42.40
\$3,200	\$16.61	\$21.20	\$6,500	\$33.74	\$43.06
\$3,300	\$17.13	\$21.86	\$6,600	\$34.25	\$43.73
\$3,400	\$17.65	\$22.53	\$6,700	\$34.77	\$44.39
\$3,500	\$18.17	\$23.19	\$6,800	\$35.29	\$45.05
\$3,600	\$18.68	\$23.85	\$6,900	\$35.81	\$45.71
\$3,700	\$19.20	\$24.51	\$7,000	\$36.33	\$46.38
\$3,800	\$19.72	\$25.18	\$7,100	\$36.85	\$47.04
\$3,900	\$20.24	\$25.84	\$7,200	\$37.37	\$47.70
\$4,000	\$20.76	\$26.50	\$7,300	\$37.89	\$48.36
\$4,100	\$21.28	\$27.16	\$7,400	\$38.41	\$49.03
\$4,200	\$21.80	\$27.83	\$7,500	\$38.93	\$49.69
\$4,300	\$22.32	\$28.49	\$7,600	\$39.44	\$50.35
\$4,400	\$22.84	\$29.15	\$7,700	\$39.96	\$51.01
\$4,500	\$23.36	\$29.81	\$7,800	\$40.48	\$51.68
\$4,600	\$23.87	\$30.48	\$7,900	\$41.00	\$52.34
\$4,700	\$24.39	\$31.14	\$8,000	\$41.52	\$53.00
\$4,800	\$24.91	\$31.80	\$8,100	\$42.04	\$53.66
\$4,900	\$25.43	\$32.46	\$8,200	\$42.56	\$54.33
\$5,000	\$25.95	\$33.13	\$8,300	\$43.08	\$54.99
\$5,100	\$26.47	\$33.79	\$8,333	\$43.25	\$55.21
\$5,200	\$26.99	\$34.45			

Deduction amounts per pay period are affected by many factors. The deductions per pay period illustrated in the calculations above are approximations only. All benefits are based upon a \$100,000 maximum annual salary. Please contact OCEA at (714) 835-3355 for additional information.



## — ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS —

# SUPPLEMENTAL LIFE INSURANCE

Supplemental Life Insurance is an optional benefit that can provide additional life insurance coverage to you and your dependents. Supplemental Life Insurance, **available only to OCEA members**, has great benefits and low rates. This plan is not available to extra-help employees.

This plan includes a Life Insurance benefit and an Accidental Death & Dismemberment (AD&D) benefit. As an OCEA member, you may apply for a level of coverage up to five times your base annual salary (BAS), subject to maximum benefits shown on the Schedule of Benefits. Also provided at no additional cost are a \$10,000 burial benefit and a 12-month living benefit. The policy has no cash value.

An OCEA member may enroll in the Supplemental Life Insurance Plan within the first 31 days of membership **(for up to two times BAS up to \$120,000 coverage)** with no health evidence of insurability required. Also, OCEA members may enroll at any time throughout the year, subject to approval of evidence of insurability by Standard Insurance. Benefits begin to decrease at age 65 as shown on the Reduction Schedule (Refer to page 42).

### DEPENDENT SUPPLEMENTAL LIFE INSURANCE

In addition to insuring your own life, you may also insure the lives of your spouse and your children. The maximum benefit will be a percentage of the amount you elect for yourself as shown on the Schedule of Benefits (Refer to page 42).

If you are currently enrolled in the Supplemental Life Insurance Plan and have no dependent life coverage, any dependent(s) coverage requests must be approved by The Standard. Evidence of Insurability is required if you apply outside of the initial eligibility period, unless due to family status change. Evidence of Insurability for dependents is required if they had been previously eligible but did not apply for coverage. New dependents have 31 days for their initial eligibility.

Family status change includes: Marriage, divorce, birth, adoption, death, or loss of coverage.

You have **31 days** within which to submit your enrollment form with changes, plus supporting documentation (marriage certificate, birth certificate, etc.), if you have a family status change.

Your unmarried child from live birth until they reach age 26 may be eligible to be covered under the Supplemental Dependent Life Plan if the member is enrolled in the Supplemental Life Group Policy.

It is the sole responsibility of the employee to notify OCEA in writing when a dependent ceases to be eligible for coverage. Payroll deductions will continue until signed written notification is received at OCEA Headquarters.

### ELIGIBILITY AND BEGINNING OF COVERAGE

For all of OCEA Health & Welfare Trust's supplemental benefits plans, the effective date of coverage will be determined by OCEA. Where appropriate, OCEA will notify you of your effective date. Also, limitations on eligibility (as well as other limitations) may apply. For more specific information on eligibility, coverage dates, and other matters, see the General Information section of this guide.

Among other things, you must be an "active" employee on the date you enroll in the plan and on the date coverage would otherwise become effective. (If you are on a leave of absence, you are not an "active" employee.)

— SUPPLEMENTAL LIFE INSURANCE CONTINUED ON NEXT PAGE —

## WHEN TO ENROLL

You may enroll within your first 31 days of OCEA membership or you may also enroll by completing an Evidence of Insurability form any time throughout the year.

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## HOW TO ENROLL

Complete the Supplemental Life Enrollment Form, located on page 75, and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](http://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

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## EVIDENCE OF INSURABILITY (EOI) REQUIREMENTS

You (and your dependents, if applicable) will be required to fulfill Evidence of Insurability (EOI) requirements if you do any of the following:

- Apply for the plan after your first 31 days as an OCEA member; or
  - Request to increase the amount of your coverage after the initial 31 days of your OCEA membership; or
  - Select an amount greater than two times your base annual salary.
  - Members who have previously applied for Supplemental Life Insurance but were denied coverage will need to provide EOI for the Supplemental Life Insurance.
- 

## LEAVE OF ABSENCE

If you are on a leave of absence, the following rules apply depending on how long you have been on leave:

- **Leave of absence up to one year:** The Supplemental Life Insurance coverage will remain in force for the first three months following the beginning of your leave of absence. When you return to active employment, if eligible, your coverage, which was in force on the date you went on a leave of absence, and your deductions (if any) will automatically be reinstated. Deductions will begin the first payday you return to active status.
  - **Leave of absence greater than one year:** After one year, your Supplemental Life Insurance coverage will be canceled until you return to active employment. When you return to active employment, you will be eligible to enroll in the Supplemental Life Insurance Plan. Provided enrollment is made timely, buy-up coverage amounts include guarantee issue levels. Late enrollment requires Evidence of Insurability for both levels.
- 

## INSURANCE DURING DISABILITY

Coverage may be continued without further payment, provided (a) you are under age 60, and (b) you satisfy the disability criteria. Proof must be provided within 12 months following the end of your active employment.

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## BASE ANNUAL SALARY

Your base annual salary (BAS) is the annual equivalent (rounded up to the next even thousand-dollar amount) of your base weekly, biweekly, semi-monthly, or monthly salary for your normal work schedule. This excludes overtime, bonuses, or any other special form of compensation.

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## BURIAL BENEFIT

An additional burial benefit in the amount of \$10,000 is available at no extra cost to OCEA members who enroll in the Supplemental Life Insurance Plan. The benefit is payable to the beneficiary in the event of your death.

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## DESIGNATING A BENEFICIARY

It is important that you designate a beneficiary of your Supplemental Life Insurance at the time of enrollment. You may name one or more persons or entities as your beneficiary. In the event you name more than one person or entity as a beneficiary, they will share the benefit equally unless you indicate otherwise. You may change your beneficiary at any time by notifying OCEA of the change in writing.

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## WHEN COVERAGE BEGINS

For the Supplemental Life Plan, the effective date of coverage will depend whether or not you were required to complete an Evidence of Insurability (EOI) form. You are required to complete an EOI before coverage is effective when you apply more than 31 days after your initial eligibility date. When you are NOT required to complete the EOI then your effective date will be determined by OCEA and will usually be the first of the month following the date you submit your completed enrollment forms to OCEA. When you are required to complete an EOI, (anytime you apply more than 31 days after your initial enrollment period), then your effective date of coverage is the date your EOI was approved by The Standard even though premium deductions will not begin, usually, until the first day of the month following your approval. For more specific information, contact OCEA at (714) 835-3355.

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## “LIVING BENEFIT” OPTION

The living benefit gives you the opportunity, while living and under age 60, to receive 75% of your life insurance coverage should you be diagnosed with a terminal illness with a life expectancy of twelve months or less. The minimum amount that can be requested is \$5,000 or 10% of your insurance, whichever is greater.

Upon your death, your beneficiary will receive any remaining benefit.

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## TRAVEL ASSISTANCE

All members participating in the Supplemental Life program from The Standard are automatically enrolled in an Assist America travel assistance program. Travel assistance is intended to help members and their families while they are traveling to find medical & legal services, replace lost credit cards and passports, as well as other helpful assistance when traveling more than 100 miles from home, or in a foreign country, and for less than 180 days. For more information and a complete description of services available with travel assistance, please refer to [standard.com/eforms/21251.pdf](http://standard.com/eforms/21251.pdf).

## SCHEDULE OF BENEFITS

The following chart summarizes the five available coverage options.

	COVERAGE OPTIONS		
	MEMBER BENEFIT	SPOUSE BENEFIT	CHILD BENEFIT
PLAN 1	One times BAS* not to exceed \$60,000	50% of Member amount to \$30,000	10% of Member amount to \$6,000
PLAN 2	Two times BAS* not to exceed \$120,000	50% of Member amount to \$60,000	10% of Member amount to \$12,000
PLAN 3	Three times BAS* not to exceed \$180,000	50% of Member amount to \$90,000	10% of Member amount to \$18,000
PLAN 4	Four times BAS* not to exceed \$240,000	50% of Member amount to \$120,000	10% of Member amount to \$20,000
PLAN 5	Five times BAS* not to exceed \$300,000	50% of Member amount to \$150,000	10% of Member amount to \$20,000

\* BAS=base annual salary. For a definition of “base annual salary,” see page 41.

**Example: If your base annual salary is \$64,000, and you choose “Plan 1” above, your coverage amount is \$60,000.**

## REDUCTION SCHEDULE

If you are an active employee and age 65 or more, your benefit will be reduced. See the chart below for the percentage of death benefit payable to your beneficiary.

AGE	% OF BENEFIT PAYABLE
65 and over, but under 70	65%
70 and over, but under 75	45%
75 and over	30%

## HOW TO FILE A CLAIM

Contact OCEA at (714) 835-3355 to request claim forms.

## CONVERSION OF SUPPLEMENTAL LIFE INSURANCE

### EMPLOYEE

You are entitled to convert your Supplemental Life Insurance to an individual policy when your employment ends or your job classification changes to a class not eligible to participate in this plan.

### DEPENDENT

Your dependents are also eligible to convert to an individual policy when you lose your coverage due to your employment ending or a change of class not eligible to participate in this plan. In addition, your dependents may also convert to an individual policy if you die, if your dependent child gets married, or if he or she reaches the maximum age limit to participate in this plan.

You are eligible to convert up to the amount of coverage you had before you lost coverage, but you must apply for conversion within 31 days of the loss of your coverage. For additional information, contact Standard Insurance directly at (800) 378-4668, extension 6785.

## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceca.org/sup-life-eoc](http://oceca.org/sup-life-eoc).

CALCULATING YOUR SUPPLEMENTAL LIFE INSURANCE COSTS

Your premiums for supplemental life coverage are paid through regular twice-monthly payroll deductions. The chart below shows your twice-monthly cost per \$1,000 of coverage. Calculation examples are below.

SUPPLEMENTAL LIFE (STANDARD INSURANCE COMPANY)		
AGE	MEMBER ONLY	MEMBER + DEPENDENTS
A   Less than 30	\$0.050	\$0.070
B   30-34	\$0.060	\$0.080
C   35-39	\$0.070	\$0.095
D   40-44	\$0.100	\$0.135
E   45-49	\$0.140	\$0.185
F   50-54	\$0.220	\$0.285
G   55-59	\$0.340	\$0.435
H   60-64	\$0.520	\$0.655
I   65-69	\$0.760	\$0.970
J   70-74	\$1.240	\$1.570
K   75 AND UP	\$2.240	\$2.825

EXAMPLES: SUPPLEMENTAL LIFE INSURANCE RATE CALCULATION

A 27-year-old member who has a base annual salary (BAS) of \$36,000 elects coverage at two times his/her BAS:

Salary	\$36,000 x 2 = \$72,000	
Salary factor	72	(\$72,000 divided by \$1,000)
Twice monthly rate	x .05	(rate per \$1,000 for members under age 30)
<b>Payroll deduction</b>	<b>\$3.60</b>	member only life coverage

The member decides to cover dependents:

Member salary factor	72	(\$72,000 divided by \$1,000)
Twice monthly rate	x .02	(rate per \$1,000 is based on member's age)
<b>Additional payroll deduction</b>	<b>\$1.44</b>	dependent life coverage

The member is covered for \$72,000, the spouse for \$36,000, children from birth until they reach age 26 for \$7,200.

A 39-year-old member who has a base annual salary (BAS) of \$62,000 elects coverage at two times his/her BAS:

Salary	\$60,000 x 2 = \$120,000 [BAS max at \$60,000]	
Salary factor	120	(\$120,000 divided by \$1,000)
Twice monthly rate	x .07	(rate per \$1,000 for 35 to 39 year olds)
<b>Payroll deduction</b>	<b>\$8.40</b>	member only life coverage

The member decides to cover dependents:

Member salary factor	120	(\$120,000 divided by \$1,000)
Twice monthly rate	x .025	(rate per \$1,000 is based on member's age)
<b>Additional payroll deduction</b>	<b>\$3.00</b>	dependent life coverage

The member is covered for \$120,000, the spouse for \$60,000, children from birth until they reach age 26 for \$12,000.

**Note:** For details on determining base annual salary, see page 41 of this Enrollment Guide.

FOR  
PURCHASE  
BY OCEA  
MEMBERS

— ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS —

## SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Supplemental Voluntary Accidental Death & Dismemberment coverage may be purchased in addition to what is included in the Supplemental Life Insurance Plan. Coverage amounts are either \$50,000, \$75,000, or \$100,000, based on your gross biweekly salary as shown in the Cost of Coverage chart below. Coverage is not available to extra-help employees.

An OCEA member may enroll in the Accidental Death & Dismemberment plan at any time during the year.

For all of the supplemental benefits plans, the effective date of coverage will be determined by OCEA. Where appropriate, OCEA will notify you of your effective date. Also, limitations on eligibility (as well as other limitations) may apply.

### WHEN TO ENROLL

Members may enroll anytime throughout the year.

### HOW TO ENROLL

Complete the Supplemental Voluntary Accidental Death & Dismemberment Benefits Enrollment Form located on page 77 and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](https://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

### LEAVE OF ABSENCE

If you are on a leave of absence, the following rules apply depending on how long you have been on leave:

- **Leave of absence up to one year:** The Voluntary Accidental Death & Dismemberment Insurance plan will remain in force for the first three months following the beginning of your leave of absence. When you return to active employment, if eligible, your coverage, which was in force on the date you went on a leave of absence, and your deductions will automatically be reinstated. Deductions will begin the first payday you return to active status.
- **Leave of absence greater than one year:** After one year, your Voluntary Accidental Death & Dismemberment Insurance coverage will be canceled until you return to active employment. When you return to active employment, you will be eligible to enroll in the Voluntary Accidental Death & Dismemberment Insurance Plan at any time.

### EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceca.org/sup-add-eoc](https://oceca.org/sup-add-eoc).

### COST OF COVERAGE FOR VOLUNTARY AD&D INSURANCE

Your premiums for Supplemental Voluntary Accidental Death & Dismemberment Insurance coverage are paid through regular twice-monthly payroll deductions.

BIWEEKLY SALARY:	LESS THAN \$1,500	\$1,500 TO \$1,999.99	\$2,000 AND OVER
Benefit Coverage:	\$50,000	\$75,000	\$100,000
Twice-Monthly Deduction:	\$1.63	\$2.44	\$3.25

FOR  
PURCHASE  
BY OCEA  
MEMBERS

— ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS —

# ACCIDENT INSURANCE

KEEP YOUR FINANCES ON TRACK WHEN AN ACCIDENT HAPPENS

Accident Insurance can help keep your finances on track when an accident happens. It pays a benefit directly to you, not to medical providers. Another perk—your group insurance rate won't increase as you get older.

## ELIGIBILITY REQUIREMENTS

To be eligible for this coverage, you must be 18 years old or older, actively working in the United States, a citizen or resident of the United States, and one of the following:

An active employee in a regular or limited term position who is regularly scheduled to work at least 20 hours each week, and for whom Orange County Employees Association receives a health and welfare contribution from Orange County or another affiliated Employer, and who are a dues-paying member of Orange County Employees Association.

Temporary and seasonal employees, full-time members of the armed forces, leased employees, and independent contractors are not eligible.

## DEPENDENT ACCIDENT INSURANCE

You can choose to cover your spouse, 18 years old or older, a person to whom you are legally married, or your domestic partner as recognized by law or by your employer's registered domestic partnership policy, if applicable. You can also cover your children from birth until they reach age 26. Your children cannot be insured by more than one employee. Your spouse or children must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and as a dependent.

## WHEN TO ENROLL

You may enroll within your first 31 days of OCEA membership or during the annual open enrollment period.

## HOW TO ENROLL

Complete the Accident Insurance Benefits Enrollment Form located on page 79 and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](https://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

## WHEN COVERAGE BEGINS

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact OCEA at [benefits@oceca.org](mailto:benefits@oceca.org), or call (714) 835-3355 for more information regarding the requirements that must be satisfied for your insurance to become effective.

— GROUP ACCIDENT INSURANCE CONTINUED ON NEXT PAGE —



## LEAVE OF ABSENCE

The Accident Insurance coverage will remain in force for the first 60 days following the first day your leave of absence begins as long as your premiums are paid. If you return to active employment within the first 60 days your deductions will continue.

If you are on a leave of absence for more than 60 days, the coverage becomes eligible for Portability (Refer to page 49).

## HOW ACCIDENT INSURANCE WORKS

### 1 YOU HAVE AN ACCIDENT

Your health insurance covers some costs, after you meet your deductible, but you still may have copays and a lot of out-of-pocket expenses.

### 2 WE SEND YOU A CHECK

The Standard will send a check directly to you—not to your medical providers—upon approval of your claim. You decide how you spend the money.

### 3 YOU FOCUS ON GETTING BETTER

With The Standard helping you handle the unexpected expenses, you get to pay attention to what matters most—your health.

### — HERE'S WHAT ACCIDENT INSURANCE DOES —

- **Pays you directly**, so you can choose how to spend the money.
- **Pays you for what happens**, regardless of your other coverage.
- **May go with you** if you leave your employer.
- **Provides coverage without answering any medical questions.**
- Gives you the option to **cover your spouse and children.**
- **Pays an additional 25 percent benefit** if your child, 18 or under, is injured playing organized sports.
- **You pay the same premium** for as long as you have your coverage.
- Provides the convenience of having your **premium payments deducted directly from your paycheck.**

## AN EXAMPLE OF BENEFITS PAID FOR A COVERED ACCIDENT

You are injured during your city league soccer game. An ER visit and scans reveal a concussion, broken leg, and a torn ACL and meniscus—requiring a 2 day hospital stay and surgery.

Here's what your plan would cover for this example:

BENEFITS PAID TO YOU	BENEFIT AMOUNTS
Emergency Room Visit	\$150
X-Ray	\$50
Concussion	\$150
Leg Fracture (Surgical)	\$2,400
Knee Cartilage Repair	\$750
Hospital Admission	\$1,000
2 Days Hospital Confinement	\$400
Medical Appliance	\$100
Physician Follow-Up Appointment	\$50
2 Physical Therapy Appointments	\$100
<b>TOTAL:</b>	<b>\$5,150</b>

ACCIDENT INSURANCE INCLUDES 70+ BENEFITS FOR COVERED INJURIES AND TREATMENT

This is only a partial listing of benefits offered. The specific benefit amounts you would receive vary. Please consult with your plan administrator for more details.

<b>INJURY</b> <ul style="list-style-type: none"><li>• Burns</li><li>• Dislocations</li><li>• Eye Injuries</li><li>• Concussion</li><li>• Loss of hearing</li><li>• Lacerations</li><li>• Fractures</li><li>• Coma</li><li>• Paralysis</li></ul>	<b>EMERGENCY</b> <ul style="list-style-type: none"><li>• Emergency Dental</li><li>• Urgent Care</li><li>• Ambulance</li><li>• Emergency Room</li><li>• X-ray</li><li>• Major Diagnostic Exam</li></ul>	<b>SURGERY</b> <ul style="list-style-type: none"><li>• Abdominal/Thoracic Surgery</li><li>• Outpatient Surgical Facility</li><li>• Skin Grafts</li><li>• Knee Cartilage/Ligament/Tendon Repair</li><li>• Ruptured Disk</li><li>• Rotator Cuff</li></ul>
<b>HOSPITALIZATION</b> <ul style="list-style-type: none"><li>• Hospital Admission</li><li>• Hospital Confinement</li><li>• CCU Confinement</li><li>• CCU Admission</li></ul>	<b>FOLLOW-UP CARE</b> <ul style="list-style-type: none"><li>• Chiropractor</li><li>• Medical Appliance</li><li>• Hearing Device</li><li>• Physical Therapy</li><li>• Physician Care</li><li>• Prosthesis</li><li>• Rehab Facility</li></ul>	<b>VALUE ADDED BENEFITS</b> <ul style="list-style-type: none"><li>• Transportation</li><li>• Lodging</li><li>• Youth Organized Sports Benefit</li></ul>

ADDITIONAL BENEFITS

- **24-hour coverage**—Includes coverage for accidents that occur on and off the job.
- **Accidental Death & Dismemberment**—Includes a benefit for an accidental death or covered dismemberment for you and your dependents.
- **Line of Duty Benefit**—Provides an additional benefit for public safety officers who suffer an accidental death or covered dismemberment, or impairment while on the job.
- **Health Maintenance Screening Benefit**—Pays a \$200 benefit once per calendar year when you or your dependents go to the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19), or a mammogram.
- **Automobile Accident Benefit**—Provides an additional \$500 benefit for injuries you or your dependents sustain while traveling in an automobile involved in a covered accident.

## COST OF COVERAGE

The amount you pay through payroll deductions for Accident Insurance Plan depends on if you are electing coverage for yourself only or if you are electing the plan to include your dependents and/or spouse. Your premiums are paid through regular biweekly payroll deductions.

ACCIDENT INSURANCE (THE STANDARD)	
	BIWEEKLY
MEMBER ONLY	\$3.71
MEMBER AND SPOUSE	\$6.18
MEMBER AND CHILD(REN)	\$6.80
MEMBER, SPOUSE, AND YOUR CHILD(REN)	\$10.78

## EXCLUSIONS

Benefits are not payable if an accident is proximately caused by any of the following:

- War or any act of war.
- Suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit a felony or being engaged in an illegal occupation.
- Any accident sustained or contracted in consequence of your or your dependent being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician.
- Sickness existing at the time of the accident, including any medical or surgical treatment, or diagnostic procedure from a sickness.
- Travel or flight in or on any aircraft, except as a fare-paying passenger on a commercial aircraft.
- Engaging in mountain climbing, caving, heli-skiing, boxing, full contact martial arts, bungee jumping, base jumping, parachuting, skydiving, hang gliding, sail gliding, parasailing, parakiting, kitesurfing, kiteboarding, or scuba diving.
- Practicing for, or participating in, any semiprofessional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Routine eye exams and dental procedures other than a crown or extraction for a tooth or teeth as a result of a covered accident.
- Riding in or driving any automobile in a race, stunt show, or speed test.
- Cosmetic surgery or other procedure to improve appearance, unless it is necessary to correct a deformity or restore bodily function after a covered accident.
- Any accident which occurs while you or your dependents are incarcerated in a jail, penal, or correctional institution.

## HOW TO FILE A CLAIM

Visit [standard.com](http://standard.com) or find the link on OCEA's website.

## PORTABILITY

This coverage is portable. That means that you may be able to continue your coverage through direct bill if your employment ends, the group policy terminates, or your insurance ends because you no longer meet the eligibility requirements.

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## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oceasolutions.com/ai-eoc](https://oceasolutions.com/ai-eoc). The information presented in this summary does not modify the group policy, certificate, or the insurance coverage in any way.

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## IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

**Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before you buy this insurance:**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

FOR  
PURCHASE  
BY OCEA  
MEMBERS

## — ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS — **CRITICAL ILLNESS INSURANCE**

*PLAN FOR THE COSTS OF A SERIOUS ILLNESS SO YOU CAN FOCUS ON GETTING WELL*

Critical Illness Insurance helps you manage expenses during a serious illness, such as a heart attack, stroke, or cancer. It pays a lump-sum benefit directly to you upon diagnosis with a covered illness. You can use the money to pay bills while you or a family member recover.

### **ELIGIBILITY REQUIREMENTS**

To be eligible for this coverage the plan must be in effect before your 65<sup>th</sup> birthday and you must be 18 years old or older, actively working in the United States, a citizen or resident of the United States, and one of the following:

An active employee in a regular or limited term position who is regularly scheduled to work at least 20 hours each week, and for whom Orange County Employees Association receives a health and welfare contribution from Orange County or another affiliated Employer, and who are a dues-paying member of Orange County Employees Association.

Temporary and seasonal employees, full-time members of the armed forces, leased employees, and independent contractors are not eligible.

### **DEPENDENTS CRITICAL ILLNESS**

You can choose to cover your spouse, 18 years old or older, a person to whom you are legally married, or your domestic partner as recognized by law or by your employer's registered domestic partnership policy, if applicable. You can also cover your children from birth until they reach age 26. Your children cannot be insured by more than one employee. Your spouse or children must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and as a dependent.

### **WHEN TO ENROLL**

You may enroll within your first 31 days of your OCEA membership date or during the annual open enrollment period.

### **HOW TO ENROLL**

Complete the Critical Illness Insurance Benefits Enrollment Form located on page 81 and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](https://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

### **WHEN COVERAGE BEGINS**

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact OCEA at [benefits@oceca.org](mailto:benefits@oceca.org), or call (714) 835-3355 for more information regarding the requirements that must be satisfied for your insurance to become effective.

LEAVE OF ABSENCE

The Critical Illness Insurance coverage will remain in force for the first 60 days following the first day your leave of absence begins as long as your premiums are paid. If you return to active employment within the first 60 days your deductions will continue.

If you are on a leave of absence for more than 60 days, the coverage becomes eligible for Portability (Refer to page 53).

HOW CRITICAL ILLNESS INSURANCE WORKS

1

YOU GET A CRITICAL ILLNESS DIAGNOSIS

Your health insurance covers many of your treatment costs, but you still have a lot of expenses that your finances aren't ready for.

2

THE STANDARD IS HERE FOR YOU

The Standard helps shield your finances by paying benefits directly to you. You get to decide how you spend that money.

3

FOCUS ON GETTING BETTER

With The Standard helping cover your out-of-pocket or everyday expenses, you get to concentrate on what's most important to you—getting better.

— HERE'S WHAT CRITICAL ILLNESS INSURANCE DOES —

- Pays you directly, so you can choose how to spend the money.
- May go with you if you leave your employer.
- Provides coverage without answering any medical questions.
- Covers children at 50 percent of your benefit amount, at no additional cost.
- Gives you the option to cover your spouse.

AN EXAMPLE OF BENEFITS PAID FOR A COVERED CRITICAL ILLNESS

**Cancer:** Shayna beat cancer, but faced many costs she didn't expect. There were her medical plan's copays for doctor visits, and what she owed for chemotherapy after meeting her deductible. She also bought hair prosthetics, paid for travel to specialists, and had alternative treatments. The benefits from Shayna's Critical Illness Insurance helped cover the expenses. Her plan also gave her access to Health Advocate™. Through this service, Shayna received the support of a personal guide who helped her make sense of her diagnosis and treatment options.

Here's an example of what this benefit could cover:

EXAMPLE OF OUT-OF-POCKET EXPENSES	
Medical plan	\$1,400
Lost wages	\$5,000
Alternate treatments and diets not covered by medical plan	\$4,500
TOTAL OUT-OF-POCKET EXPENSES:	\$10,900

EXAMPLE OF BENEFITS	
Critical Illness Benefit Option	\$10,000
Total Out-Of-Pocket Expenses	\$10,900
Remaining Out-Of-Pocket Expenses	\$900
REMAINING BENEFIT FOR OTHER EXPENSES:	\$0

— GROUP CRITICAL ILLNESS INSURANCE PLAN CONTINUED ON NEXT PAGE —

## WITH CRITICAL ILLNESS INSURANCE, YOU CAN:

- **Protect your loved ones.** Cover your spouse up to \$15,000, as long as it's not more than 50 percent of your benefit amount. Your children are automatically covered at 50 percent of the amount elected for yourself for the same critical illnesses that you are. Children are also covered for 21 additional childhood diseases, including cystic fibrosis, Down syndrome, muscular dystrophy, spina bifida, and cerebral palsy.
- **Receive a benefit for taking care of your health.** You and your covered loved ones receive a Health Maintenance Screening benefit of \$100 once per calendar year when visiting the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19), or a mammogram—that typically cost you nothing under your medical insurance.
- **Receive additional benefits.** If you are diagnosed with a covered illness again after a treatment-free period of 6 months, you will receive 100 percent of the original benefit amount. If you are diagnosed with a different and subsequent covered illness after the diagnosis of the first critical illness, you will receive an additional Critical Illness insurance benefit.
- **Access a Health Advocate™.** Additional services available through Health Advocate™, include access to specialists for a second opinion upon approval of a covered claim.
- **Update your coverage as needed.** As your life circumstances change, increase or decrease your coverage, in accordance with your employer's plan.

### COVERED CONDITIONS

Receive 100 percent of your coverage amount for:

- Heart Attack
- Severe Stroke
- Invasive Cancer
- End Stage Renal (Kidney) Failure
- Major Organ Failure
- Coma
- Paralysis of Two or More Limbs
- Loss of Sight
- Occupational Hepatitis
- ALS (Lou Gehrig's Disease)
- Advanced Alzheimer's Disease
- Advanced Multiple Sclerosis
- Advanced Parkinson's Disease
- Benign Brain Tumor
- Bone Marrow Transplant
- Loss of Hearing
- Loss of Speech

Receive 25 percent of your coverage amount for:

- Severe Coronary Artery Disease with Recommendation for Bypass
- Non-Invasive Cancer

\*Health Advocacy services are provided through an arrangement with Health Advocate™, a leading health advocacy and assistance company. Health Advocate™ is not affiliated with The Standard or any insurance or third-party provider, and does not replace health insurance coverage, provide medical care, or recommend treatment.

## COST OF COVERAGE

The amount you pay through payroll deductions for the Critical Illness Insurance Plan depends on the coverage level you choose and if you are electing to cover your spouse. Dependent children are automatically covered for 50% of your benefit amount. Your premiums are paid through regular biweekly payroll deductions.

### CRITICAL ILLNESS INSURANCE (THE STANDARD)

COVERAGE AMOUNTS	AGE BASED BIWEEKLY					
	18-29	30-39	40-49	50-59	60-69	70+
<b>MEMBER: \$10,000</b>	\$1.30	\$1.80	\$3.50	\$6.80	\$12.30	\$31.10
<b>MEMBER: \$10,000   SPOUSE: \$5,000</b>	\$1.95	\$2.70	\$5.25	\$10.20	\$18.45	\$46.65
<b>MEMBER: \$20,000</b>	\$2.60	\$3.60	\$7.00	\$13.60	\$24.60	\$62.20
<b>MEMBER: \$20,000   SPOUSE: \$5,000</b>	\$3.25	\$4.50	\$8.75	\$17.00	\$30.75	\$77.75
<b>MEMBER: \$20,000   SPOUSE: \$10,000</b>	\$3.90	\$5.40	\$10.50	\$20.40	\$36.90	\$93.30
<b>MEMBER: \$30,000</b>	\$3.90	\$5.40	\$10.50	\$20.40	\$36.90	\$93.30
<b>MEMBER: \$30,000   SPOUSE: \$5,000</b>	\$4.55	\$6.30	\$12.25	\$23.80	\$43.05	\$108.85
<b>MEMBER: \$30,000   SPOUSE: \$10,000</b>	\$5.20	\$7.20	\$14.00	\$27.20	\$49.20	\$124.40
<b>MEMBER: \$30,000   SPOUSE: \$15,000</b>	\$5.85	\$8.10	\$15.75	\$30.60	\$55.35	\$139.95



## EXCLUSIONS

Benefits are not payable if a critical illness is proximately caused by any of the following:

- War or any act of war
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit a felony.
- Intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician.
- Cosmetic surgery. Cosmetic surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve your or your dependent's appearance. This exclusion will not apply to a Critical Illness caused or contributed to by reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
  - To improve function;
  - To create a normal appearance to the extent possible. Reconstructive surgery includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

Note: This exclusion will not apply to a Critical Illness caused or contributed to by your or your dependent's donation of an organ or tissue.

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## HOW TO FILE A CLAIM

Visit [standard.com](http://standard.com) or find the link on OCEA's website.

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## PORTABILITY

This coverage is portable. That means that you may be able to continue your coverage through direct bill if your employment ends, the group policy terminates, or your insurance ends because you no longer meet the eligibility requirements.

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## EVIDENCE OF COVERAGE AND DISCLOSURES

The Evidence of Coverage and Disclosure Form is available online at [oce.org/ci-eoc](http://oce.org/ci-eoc). The information presented in this summary does not modify the group policy, certificate, or the insurance coverage in any way.

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## **IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed dollar amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before you buy this insurance:**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

FOR  
PURCHASE  
BY OCEA  
MEMBERS

## — ABOUT YOUR SUPPLEMENTAL BENEFIT OPTIONS — **HOSPITAL INDEMNITY INSURANCE**

*KEEP YOUR FINANCES ON TRACK WHEN YOU'RE IN THE HOSPITAL*

Hospital Indemnity Insurance can help you take care of the out-of-pocket costs of a stay in the hospital. It pays you a flat benefit regardless of any medical coverage you have.

### **ELIGIBILITY REQUIREMENTS**

To be eligible for this coverage the plan must be in effect before your 65<sup>th</sup> birthday and you must be 18 years old or older, actively working in the United States, a citizen or resident of the United States, and one of the following:

An active employee in a regular or limited term position who is regularly scheduled to work at least 20 hours each week, and for whom Orange County Employees Association receives a health and welfare contribution from Orange County or another affiliated Employer, and who are a dues-paying member of Orange County Employees Association.

Temporary and seasonal employees, full-time members of the armed forces, leased employees, and independent contractors are not eligible.

### **DEPENDENTS HOSPITAL INDEMNITY**

You can choose to cover: your spouse, 18 years old or older; a person to whom you are legally married; or your domestic partner as recognized by law or by your employer's registered domestic partnership policy, if applicable. You can also cover your children from birth until they reach age 26. Your child cannot be insured by more than one employee. Your spouse or children must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and as a dependent.

### **WHEN TO ENROLL**

You may enroll within your first 31 days of your OCEA membership date or during the annual open enrollment period.

### **HOW TO ENROLL**

Complete the Hospital Indemnity Insurance Benefits Enrollment Form located on page 83 and return it to OCEA at 830 N. Ross St. Santa Ana, CA 92701. You may also go to [oceca.org/benefits](https://oceca.org/benefits) and download the form or complete online. All completed forms can be emailed to [benefits@oceca.org](mailto:benefits@oceca.org).

### **WHEN COVERAGE BEGINS**

You must satisfy the eligibility requirements listed above, serve an eligibility waiting period, agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact OCEA at [benefits@oceca.org](mailto:benefits@oceca.org), or call (714) 835-3355 for more information regarding the requirements that must be satisfied for your insurance to become effective.

— GROUP HOSPITAL INDEMNITY INSURANCE PLAN CONTINUED ON NEXT PAGE —

LEAVE OF ABSENCE

The Hospital Indemnity Insurance coverage will remain in force for the first 60 days following the first day your leave of absence begins as long as your premiums are paid. If you return to active employment within the first 60 days your deductions will continue.

If you are on a leave of absence for more than 60 days, the coverage becomes eligible for Portability (Refer to page 58)

WAIVER OF PREMIUM

Your insurance will continue without payment of premiums if you are confined in a hospital for more than 30 days in a row. Standard will waive payment of premium for your insurance from the 31<sup>st</sup> day of your confinement until the last day of the month you are in the hospital.

HOW HOSPITAL INDEMNITY INSURANCE WORKS

1

**YOU'RE ADMITTED TO THE HOSPITAL**

Your health insurance covers many costs of your stay and treatment. You still have a lot of expenses, including deductibles, copays, and other costs you couldn't predict.

2

**WE SEND YOU A CHECK**

The Standard will send a check directly to you—not to your medical providers—upon approval of your claim. You decide how you spend the money.

3

**YOU FOCUS ON RECOVERING**

With The Standard helping you handle the costs of your hospital stay, you get to concentrate on what matters most—your health.

— HERE'S WHAT HOSPITAL INDEMNITY INSURANCE DOES —

- **Pays you directly**, so you can choose how to spend the money.
- **May go with you** if you leave your employer.
- **Provides coverage** without answering any medical questions.
- Gives you the option to **cover your spouse and children**.
- **Protects your HSA Account**.
- Provides the convenience of having your **premium payments deducted directly from your paycheck**.

AN EXAMPLE OF BENEFITS PAID FOR A HOSPITAL VISIT

**Ruptured Ulcer:** Kim is out of town on a business trip when she experiences abdominal pain and a racing heartbeat. Diagnosis: ruptured gastric ulcer. She is rushed to the hospital, admitted, and taken into surgery. She ends up being hospitalized for 15 days, 15 of which are in a critical care unit. Kim's spouse leaves their two kids with their daycare provider and flies to be at her side. The family now faces additional costs for medical bills, travel, and childcare amounting to \$6,500.

Here's an example of what this benefit could cover:

BENEFITS PAID TO YOU	BENEFIT AMOUNTS
Hospital admission	\$2,000
Hospital confinement (15 days)	\$2,250
Critical care unit confinement (15 days)	\$2,250
TOTAL PAID TO YOU:	\$6,500

BENEFIT PAYOUTS

Here’s an example of how Hospital Indemnity Benefit Plan pays.

BENEFITS PAID TO YOU	BENEFIT AMOUNTS
Hospital admission	\$2,000 (Maximum 1 per calendar year)
Daily hospital confinement <sup>1</sup>	\$150 per day (Maximum 15 days per stay)
Daily critical care unit confinement <sup>1, 2</sup>	\$150 per day (Maximum 15 days per stay)

<sup>1</sup> Defined as a stay for at least 20 consecutive hours in a hospital setting.  
<sup>2</sup> Payable in addition to the Hospital Admission and Daily Hospital Confinement benefit you may be eligible to receive.

ADDITIONAL BENEFITS

- **Health Maintenance Screening Benefit**—Pays a \$50 benefit once per calendar year when you or your dependents go to the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19), or a mammogram.
- **Protect your HSA Account**—Hospital Indemnity Insurance provides financial protection while you are building your HSA assets. Contact your employer to determine if this Hospital Indemnity plan impacts the taxability of your contributions to an HSA. It is a protection that’s also convenient: Your premium payments will be deducted directly from your paycheck.

COST OF COVERAGE

The amount you pay through payroll deductions for the Hospital Indemnity Insurance Plan depends on if you are electing coverage for yourself only or if you are electing the plan to include your dependents and/or spouse. Your premiums are paid through regular biweekly payroll deductions.

HOSPITAL INDEMNITY INSURANCE (THE STANDARD)	
	BIWEEKLY
MEMBER ONLY	\$7.38
MEMBER AND SPOUSE	\$12.60
MEMBER AND CHILD(REN)	\$10.28
MEMBER, SPOUSE, AND YOUR CHILD(REN)	\$18.41

## EXCLUSIONS

Benefits are not payable if an injury or sickness is proximately caused or contributed to by any of the following:

- War or any act of war
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane
- Committing or attempting to commit a felony or being engaged in an illegal occupation
- Intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician. This exclusion does not apply to a sickness.
- Travel or flight in or on any aircraft, except as a fare-paying passenger on a commercial aircraft
- Cosmetic surgery. Cosmetic surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve your or your dependent's appearance. Cosmetic surgery does not include reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
  - a. To improve function;
  - b. To create a normal appearance to the extent possible.
  - c. To restore or achieve symmetry
- Any injury or sickness which occurs while you or your dependent is incarcerated in a jail, penal, or correctional institution
- Dental care or dental procedures, unless treatment is the result of an injury
- Routine newborn nursing or well-baby care
- Hospital confinement of a newborn child following the child's birth unless the confinement is as a result of an injury or sickness
- Riding in or driving any automobile in a race, stunt show, or speed test

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## HOW TO FILE A CLAIM

Visit [standard.com](http://standard.com) or find the link on OCEA's website.

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## PORTABILITY

This coverage is portable. That means that you may be able to continue your coverage through direct bill if your employment ends, the group policy terminates, or your insurance ends because you no longer meet the eligibility requirements.

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## EVIDENCE OF COVERAGE AND DISCLOSURES

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## **IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some healthcare services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed dollar amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled to under Medicare or other insurance.**

**Before you buy this insurance:**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the Guide to Health Insurance for People with Medicare, available from Standard Insurance Company.
- For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

# SUPPLEMENTAL BENEFIT PLAN COSTS

JANUARY 1-DECEMBER 31, 2026

## SUPPLEMENTAL DENTAL PLANS

Your premiums for supplemental dental coverage are paid through biweekly payroll deductions.

### DELTA DENTAL PPO PLAN A+

	Biweekly				Monthly
	Option 1	Option 2	Option 3	Non-H&W Enrollee	Retiree
Member Only	\$13.27	\$13.27	\$18.15	\$28.00	Not available
Member + 1 Dependent	\$35.29	\$35.29	\$40.17	\$50.02	Not available
Member + 2 or More Dependents	\$66.93	\$66.93	\$71.82	\$81.66	Not available

### DENTAL DHMO-DELTACARE USA CAM49

	Biweekly				Monthly
	Option 1	Option 2	Option 3	Non-H&W Enrollee	Retiree
Member Only	\$3.30	\$3.30	\$10.09	\$10.09	\$21.86
Member + 1 Dependent	\$4.60	\$4.60	\$19.14	\$19.14	\$41.46
Member + 2 or More Dependents	\$12.30	\$12.30	\$28.19	\$28.19	\$61.07

## VISION

Your premiums for vision coverage are paid through twice-monthly payroll deductions.

### VISION PLAN (VSP)

	Twice-Monthly				Monthly
	Option 1	Option 2	Option 3	Non-H&W Enrollee	Retiree
Member Only	No Charge	No Charge	\$2.55	\$4.61	\$9.23
Member + 1 Dependent	\$2.07	\$2.07	\$4.62	\$6.68	\$13.37
Member + 2 or More Dependents	\$7.36	\$7.36	\$9.92	\$11.98	\$23.96

*"Biweekly" = 26 times per year | "Twice-Monthly" = 24 times per year | "Monthly" = 12 times per year.  
Remember, the above costs only apply if you are selecting some form of supplemental benefits.*



## SUPPLEMENTAL DISABILITY

Use this table to calculate your twice-monthly cost for Level One or Level Two Supplemental Disability coverage. Non-H&W members add an additional \$4 twice-monthly service charge to cover the cost of Basic Disability benefits.

SUPPLEMENTAL DISABILITY (STANDARD INSURANCE COMPANY)					
MONTHLY SALARY	LEVEL ONE TWICE-MONTHLY COST	LEVEL TWO TWICE-MONTHLY COST	MONTHLY SALARY	LEVEL ONE TWICE-MONTHLY COST	LEVEL TWO TWICE-MONTHLY COST
\$2,000	\$10.38	\$13.25	\$5,300	\$27.51	\$35.11
\$2,100	\$10.90	\$13.91	\$5,400	\$28.03	\$35.78
\$2,200	\$11.42	\$14.58	\$5,500	\$28.55	\$36.44
\$2,300	\$11.94	\$15.24	\$5,600	\$29.06	\$37.10
\$2,400	\$12.46	\$15.90	\$5,700	\$29.58	\$37.76
\$2,500	\$12.98	\$16.56	\$5,800	\$30.10	\$38.43
\$2,600	\$13.49	\$17.23	\$5,900	\$30.62	\$39.09
\$2,700	\$14.01	\$17.89	\$6,000	\$31.14	\$39.75
\$2,800	\$14.53	\$18.55	\$6,100	\$31.66	\$40.41
\$2,900	\$15.05	\$19.21	\$6,200	\$32.18	\$41.08
\$3,000	\$15.57	\$19.88	\$6,300	\$32.70	\$41.74
\$3,100	\$16.09	\$20.54	\$6,400	\$33.22	\$42.40
\$3,200	\$16.61	\$21.20	\$6,500	\$33.74	\$43.06
\$3,300	\$17.13	\$21.86	\$6,600	\$34.25	\$43.73
\$3,400	\$17.65	\$22.53	\$6,700	\$34.77	\$44.39
\$3,500	\$18.17	\$23.19	\$6,800	\$35.29	\$45.05
\$3,600	\$18.68	\$23.85	\$6,900	\$35.81	\$45.71
\$3,700	\$19.20	\$24.51	\$7,000	\$36.33	\$46.38
\$3,800	\$19.72	\$25.18	\$7,100	\$36.85	\$47.04
\$3,900	\$20.24	\$25.84	\$7,200	\$37.37	\$47.70
\$4,000	\$20.76	\$26.50	\$7,300	\$37.89	\$48.36
\$4,100	\$21.28	\$27.16	\$7,400	\$38.41	\$49.03
\$4,200	\$21.80	\$27.83	\$7,500	\$38.93	\$49.69
\$4,300	\$22.32	\$28.49	\$7,600	\$39.44	\$50.35
\$4,400	\$22.84	\$29.15	\$7,700	\$39.96	\$51.01
\$4,500	\$23.36	\$29.81	\$7,800	\$40.48	\$51.68
\$4,600	\$23.87	\$30.48	\$7,900	\$41.00	\$52.34
\$4,700	\$24.39	\$31.14	\$8,000	\$41.52	\$53.00
\$4,800	\$24.91	\$31.80	\$8,100	\$42.04	\$53.66
\$4,900	\$25.43	\$32.46	\$8,200	\$42.56	\$54.33
\$5,000	\$25.95	\$33.13	\$8,300	\$43.08	\$54.99
\$5,100	\$26.47	\$33.79	\$8,333	\$43.25	\$55.21
\$5,200	\$26.99	\$34.45			

Deduction amounts per pay period are affected by many factors. The deductions per pay period illustrated in the calculations above are approximations only. All benefits are based upon a \$100,000 maximum annual salary. Please contact OCEA at (714) 835-3355 for additional information.

— SUPPLEMENTAL COSTS CONTINUED ON NEXT PAGE —

## SUPPLEMENTAL LIFE

Your premiums for Supplemental Life coverage are paid through twice-monthly payroll deductions. The chart below shows your twice-monthly cost per \$1,000 of coverage. See page 43 for calculation examples.

SUPPLEMENTAL LIFE (STANDARD INSURANCE COMPANY)			
AGE		MEMBER ONLY	MEMBER + DEPENDENTS
A	Less than 30	\$0.050	\$0.070
B	30-34	\$0.060	\$0.080
C	35-39	\$0.070	\$0.095
D	40-44	\$0.100	\$0.135
E	45-49	\$0.140	\$0.185
F	50-54	\$0.220	\$0.285
G	55-59	\$0.340	\$0.435
H	60-64	\$0.520	\$0.655
I	65-69	\$0.760	\$0.970
J	70-74	\$1.240	\$1.570
K	75 AND UP	\$2.240	\$2.825

## SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT

Your premiums for Supplemental Voluntary Accidental Death & Dismemberment Insurance coverage are paid through twice-monthly payroll deductions.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT			
BIWEEKLY EARNINGS:	LESS THAN \$1,500	\$1,500 TO \$1,999.99	\$2,000 AND OVER
BENEFIT COVERAGE:	\$50,000	\$75,000	\$100,000
TWICE-MONTHLY DEDUCTION:	\$1.63	\$2.44	\$3.25

## ACCIDENT INSURANCE

Your premiums for Accident Insurance are paid through biweekly payroll deductions.

ACCIDENT INSURANCE (THE STANDARD)	
	BIWEEKLY
MEMBER ONLY	\$3.71
MEMBER AND SPOUSE	\$6.18
MEMBER AND CHILD(REN)	\$6.80
MEMBER, SPOUSE, AND YOUR CHILD(REN)	\$10.78

## CRITICAL ILLNESS INSURANCE

Your premiums for Critical Illness Insurance are paid through biweekly payroll deductions.

CRITICAL ILLNESS INSURANCE (THE STANDARD)						
	AGE BASED BIWEEKLY					
COVERAGE AMOUNTS	18-29	30-39	40-49	50-59	60-69	70+
MEMBER: \$10,000	\$1.30	\$1.80	\$3.50	\$6.80	\$12.30	\$31.10
MEMBER: \$10,000   SPOUSE: \$5,000	\$1.95	\$2.70	\$5.25	\$10.20	\$18.45	\$46.65
MEMBER: \$20,000	\$2.60	\$3.60	\$7.00	\$13.60	\$24.60	\$62.20
MEMBER: \$20,000   SPOUSE: \$5,000	\$3.25	\$4.50	\$8.75	\$17.00	\$30.75	\$77.75
MEMBER: \$20,000   SPOUSE: \$10,000	\$3.90	\$5.40	\$10.50	\$20.40	\$36.90	\$93.30
MEMBER: \$30,000	\$3.90	\$5.40	\$10.50	\$20.40	\$36.90	\$93.30
MEMBER: \$30,000   SPOUSE: \$5,000	\$4.55	\$6.30	\$12.25	\$23.80	\$43.05	\$108.85
MEMBER: \$30,000   SPOUSE: \$10,000	\$5.20	\$7.20	\$14.00	\$27.20	\$49.20	\$124.40
MEMBER: \$30,000   SPOUSE: \$15,000	\$5.85	\$8.10	\$15.75	\$30.60	\$55.35	\$139.95

## HOSPITAL INDEMNITY INSURANCE

Your premiums for Hospital Indemnity Insurance are paid through biweekly payroll deductions.

HOSPITAL INDEMNITY INSURANCE (THE STANDARD)	
	BIWEEKLY
MEMBER ONLY	\$7.38
MEMBER AND SPOUSE	\$12.60
MEMBER AND CHILD(REN)	\$10.28
MEMBER, SPOUSE, AND YOUR CHILD(REN)	\$18.41

## RETIREE SUPPLEMENTAL LIFE

Your premiums for Retiree Supplemental Life are paid through monthly payroll deductions.

RETIREE SUPPLEMENTAL LIFE (STANDARD INSURANCE COMPANY)		
AGE	COVERAGE	MONTHLY PREMIUMS
F   50-54	\$10,000	\$6.24
G   55-59	\$10,000	\$9.53
H   60-64	\$10,000	\$13.26
I   65-69	\$6,500	\$13.26
J   70-74	\$2,000	\$6.31
K   75 AND UP	\$2,000	\$11.65

# BENEFITS ENROLLMENT FORMS

RETURN TO OCEA WITHIN YOUR ELIGIBILITY PERIOD | **DON'T MISS YOUR DEADLINE!**

ALL FORMS ARE ALSO AVAILABLE ONLINE AT [OCEA.ORG/BENEFITS](https://oceaz.org/benefits)

## 2026 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM

### FREE BASIC BENEFITS

DENTAL | VISION | DISABILITY | LIFE/AD&D

## OCEA MEMBERSHIP APPLICATION FORM IS EMPLOYER SPECIFIC

### JOIN TODAY!

HAVE A VOICE! | ACCESS TO MEMBER ONLY PROGRAMS

## 2026 OCEA HEALTH & WELFARE SUPPLEMENTAL BENEFITS ENROLLMENT FORMS

### UPGRADED COVERAGE

AVAILABLE FOR PURCHASE BY OCEA MEMBERS

## INSTRUCTIONS

## 2026 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM

If you are a covered employee, when you complete the **2026 OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM**, you will be enrolled in the **HEALTH & WELFARE DENTAL, VISION, BASIC DISABILITY**, and **LIFE/AD&D** benefit plans at **NO COST**. Complete the H&W Benefits Form if:

- You are a new employee or transfer in a bargaining unit represented by OCEA or change from part-time or extra help to full-time employment status. (The form must be received by OCEA or postmarked within 45 days of your hire date, transfer, or full-time employment status change, or you will automatically be enrolled in Option 3.)
- You experience a family status change due to marriage, divorce, birth, adoption, death, or loss of coverage. (The form, together with supporting documentation, must be received by OCEA or postmarked within 31 days of your family status change date.)
- You want to change your dental option plan and/or dependents during Open Enrollment. (The form must be received by OCEA or postmarked during Open Enrollment.)

### HEALTH & WELFARE ELIGIBLE OCEA-REPRESENTED BARGAINING UNITS

County Community Services | County General | County Healthcare Professional | County Office Services  
County Sheriff's Special Officer | County Supervisory Management | County Public Law Library | Fire Authority General  
Fire Authority Supervisory Management | Superior Court Clerk | Superior Court General | Superior Court Supervisor

## FREE BASIC BENEFITS

DENTAL | VISION | DISABILITY | LIFE/AD&D

CHOOSE:

OPTION 1

OPTION 2

OPTION 3

LEARN ABOUT THE DIFFERENCES ON PAGE 12

**IF YOU HAVE ANY QUESTIONS, CONTACT OCEA AT (714) 835-3355 OR [BENEFITS@OCEA.ORG](mailto:BENEFITS@OCEA.ORG)**

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN **45 DAYS** FROM HIRE DATE, TRANSFER INTO AN OCEA-REPRESENTED UNIT, PART-TIME TO FULL-TIME EMPLOYMENT STATUS CHANGE | DURING OPEN ENROLLMENT | OR **31 DAYS** UPON A FAMILY STATUS CHANGE.

These benefits are provided at **NO COST** to OCEA-represented employees in County Units, Superior Court, Law Library, and Fire Authority.

### EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP	
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CITY	STATE	ZIP	HOME EMAIL
HOME PHONE	CELL PHONE	WORK PHONE	

### REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT   
 ☐ OPEN ENROLLMENT   
 ☐ FAMILY STATUS CHANGE

### CHOOSE AN OPTION PACKAGE

OPTION 1   PPO OR DHMO	OPTION 2   DHMO ONLY	OPTION 3   PPO ONLY
<input type="checkbox"/> <b>EMPLOYEE ONLY</b>	<input type="checkbox"/> <b>EMPLOYEE WITH DEPENDENTS</b>	<input type="checkbox"/> <b>PART-TIME EMPLOYEE</b>
VISION SERVICE PLAN is included for full-time employees only in Option 1 or Option 2.		BASIC LIFE and BASIC DISABILITY are included for employees in Option 1, Option 2, or Option 3.

### DENTAL PLAN

<input type="checkbox"/> <b>DELTA DENTAL PPO PLAN A</b>   EMPLOYEE ONLY—NO DEPENDENTS  To locate a DeltaCare USA dentist, visit the online DeltaCare USA directory at <a href="https://deltadentalins.com">deltadentalins.com</a> . You may also request the most current listing of DeltaCare USA dentists by calling toll-free at (800) 422-4234.	<input type="checkbox"/> <b>DELTACARE USA CAM50 (DHMO)</b>  DENTAL OFFICE # (DHMO ONLY)
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### COMPLETE THIS SECTION IF YOU WANT TO ENROLL YOUR DEPENDENTS UNDER THE DELTACARE USA CAM50 (DHMO) DENTAL PLAN

RELATIONSHIP	NAME ( LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	

— OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM CONTINUED ON NEXT PAGE —

CAREFULLY TEAR ALONG PERFORATION

**LIFE INSURANCE BENEFICIARY DESIGNATION**  
**\$25,000 POLICY PROVIDED AT NO COST BY THE HEALTH & WELFARE TRUST**


BENEFICIARY DESIGNATIONS  
 CANCEL ANY PREVIOUS DESIGNATIONS

PRIMARY—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- -			
		/ /	- -			

CONTINGENT—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- -			
		/ /	- -			

*DHMO NOTICE: IF YOU ARE ENROLLING IN A DHMO, BY SIGNING THIS DOCUMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE THE BINDING ARBITRATION SECTION OF YOUR EVIDENCE OF COVERAGE.*

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



EMPLOYEE SIGNATURE

DATE

CAREFULLY TEAR ALONG PERFORATION

# OCEA MEMBERSHIP APPLICATION

OCEA HAS UNIQUE MEMBERSHIP APPLICATIONS BASED ON YOUR EMPLOYER





**FIND THE LOOSE MEMBERSHIP APPLICATION INCLUDED WITH YOUR ENROLLMENT GUIDE**

— OR —

**FIND YOUR MEMBERSHIP APPLICATION AT [OCEA.ORG/JOIN](http://OCEA.ORG/JOIN) TO PRINT OR SUBMIT ONLINE**

## WHY SHOULD YOU BECOME A MEMBER?

	FULL MEMBER	NON-MEMBER
<b>HAVE A VOICE</b>	<b>ELIGIBLE TO VOTE IN OCEA ELECTIONS</b> CONTRACTS, ELECTIONS, WAGES, WORKING CONDITIONS, AND MORE	<b>NOT ELIGIBLE</b>
<b>HEALTH RELATED BENEFITS</b>	<b>ACCESS TO ADDITIONAL BENEFITS</b>	<b>LIMITED BASIC COVERAGE</b>
<b>VISION</b>	Dependent coverage available	No dependent coverage available
<b>DENTAL</b>	Supplemental coverage available for yourself and your dependents	EMPLOYEE: Basic PPO or Basic DHMO WITH DEPENDENTS: Basic DHMO only
<b>LIFE</b>	Supplemental Life Insurance available for you and your dependents	Basic coverage only
<b>DISABILITY</b>	Supplemental Disability Insurance available	Basic coverage only
<b>AD&amp;D</b>	Supplemental Voluntary Accidental Death & Dismemberment available	Not available
<b>ACCIDENT</b>	Accident Insurance available	Not available
<b>CRITICAL ILLNESS</b>	Critical Illness Insurance available	Not available
<b>HOSPITAL INDEMNITY</b>	Hospital Indemnity Insurance available	Not available
<b>TICKETS &amp; DISCOUNTS</b>	<b>UNLIMITED ACCESS TO OCEA'S TICKETS &amp; DISCOUNT PROGRAM</b>  PLUS MANY MORE	<b>NO ACCESS</b>
<b>OCEA SCHOLARSHIP</b>	 <b>DEPENDENTS OF OCEA MEMBERS ARE ELIGIBLE TO APPLY FOR THE ANNUAL OCEA SCHOLARSHIP</b>	<b>NOT ELIGIBLE</b>
<b>MEMBERS ONLY EVENTS</b>	<b>ENHANCE YOUR PERSONAL AND PROFESSIONAL LIVES WITH ACCESS TO MEMBERS ONLY TRAININGS AND SEMINARS</b>	<b>NOT ELIGIBLE</b>

**DON'T WAIT—STAND WITH YOUR CO-WORKERS AND SIGN UP TO BECOME AN OCEA MEMBER TODAY!**

## INSTRUCTIONS

### 2026 OCEA HEALTH & WELFARE TRUST SUPPLEMENTAL BENEFITS ENROLLMENT FORMS

OCEA Health & Welfare Trust's supplemental dental, disability, and life insurance plans are upgrades to the Health & Welfare benefit plans. These upgrades are available **FOR PURCHASE BY OCEA MEMBERS ONLY**.

Complete the **SUPPLEMENTAL BENEFITS ENROLLMENT FORM(S)** if you want to upgrade your **DENTAL, DISABILITY, or LIFE INSURANCE** coverage, enroll in the **ACCIDENT INSURANCE, CRITICAL ILLNESS, HOSPITAL INDEMNITY**, and/or **SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCES**, or obtain **VISION** coverage for your dependent(s). The cost of each supplemental plan can be found beginning on page 60 of this Benefits Enrollment Guide.

During the first 31 days of your membership in OCEA or upon a family status change, and also during Open Enrollment, as an OCEA member you may:

- Enroll in either the supplemental Delta Dental PPO Plan A+ dental plan or the DeltaCare USA CAM49 DHMO;
- Enroll in the Supplemental Disability Plan;
- Enroll in the Supplemental Voluntary Accidental Death & Dismemberment Plan (enrollment in Supplemental Voluntary AD&D is available anytime throughout the year.)
- Obtain VSP vision coverage for your dependent(s) or for yourself, if you are a part-time employee, or you are in a bargaining unit not represented by OCEA.
- Purchase Supplemental Life Insurance coverage up to two times the amount of your base annual salary (up to \$120,000) without any health evidence of insurability;

**NOTE: IF ENROLLED DURING FIRST 31 DAYS OF OCEA MEMBERSHIP ONLY; NOT PART OF OPEN ENROLLMENT.**

- Enroll in the Accident Insurance;
- Enroll in the Critical Illness Insurance;
- Enroll in the Hospital Indemnity Insurance.

**FOR PURCHASE BY OCEA MEMBERS ONLY**

### UPGRADED COVERAGE & ADDITIONAL BENEFITS

DENTAL | VISION | DISABILITY | LIFE INSURANCE | VOLUNTARY AD&D | ACCIDENT INSURANCE | CRITICAL ILLNESS | HOSPITAL INDEMNITY

**LEARN ABOUT THE AVAILABLE OPTIONS ON PAGE 25**

**IF YOU HAVE ANY QUESTIONS, CONTACT OCEA AT (714) 835-3355 OR [BENEFITS@OCEA.ORG](mailto:BENEFITS@OCEA.ORG)**



**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS FROM OCEA MEMBERSHIP OR UPON A FAMILY STATUS CHANGE | OR DURING OPEN ENROLLMENT**

*These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!*

**IF YOU ARE A NEW HIRE, OR RECENTLY TRANSFERRED INTO AN OCEA-REPRESENTED UNIT, YOU SHOULD ALSO SUBMIT THE OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM**

### EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER	
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP		
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
CITY	STATE	ZIP	HOME EMAIL	
HOME PHONE	CELL PHONE		WORK PHONE	

### REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT   
 ☐ OPEN ENROLLMENT   
 ☐ FAMILY STATUS CHANGE   
 ☐ RETIREE

### DENTAL PLAN

<input type="checkbox"/> <b>DELTA DENTAL PPO PLAN A+</b>   NOT AVAILABLE TO RETIREES	<input type="checkbox"/> <b>DELTACARE USA CAM49 (DHMO)</b>	
To locate a DeltaCare USA dentist, visit the online DeltaCare USA directory at <a href="https://deltadentalins.com">deltadentalins.com</a> . You may also request the most current listing of DeltaCare USA dentists by calling toll-free at (800) 422-4234.	DENTAL OFFICE # (DHMO ONLY)	

### DEPENDENT ENROLLMENT FOR SUPPLEMENTAL DENTAL PLAN

RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DENTAL OFFICE # (DHMO ONLY)
		- -	/ /	
		- -	/ /	
		- -	/ /	
		- -	/ /	

### AUTHORIZATION, SIGNATURE AND DISCLOSURE

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

If I enroll in a dental plan, I understand that provided I remain employed I must maintain the coverage throughout the plan year. (I can still make changes during open enrollment periods, and under other circumstances outlined in plan documents.)

**DHMO NOTICE: IF YOU ARE ENROLLING IN A DHMO, BY SIGNING THIS DOCUMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE THE BINDING ARBITRATION SECTION OF YOUR EVIDENCE OF COVERAGE.**

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



EMPLOYEE SIGNATURE

DATE



**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS FROM OCEA MEMBERSHIP OR UPON A FAMILY STATUS CHANGE | OR DURING OPEN ENROLLMENT**

*These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!*

**IF YOU ARE A NEW HIRE, OR RECENTLY TRANSFERRED INTO AN OCEA-REPRESENTED UNIT, YOU SHOULD ALSO SUBMIT THE OCEA HEALTH & WELFARE BENEFITS ENROLLMENT FORM**

### EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER	
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP		
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
CITY	STATE	ZIP	HOME EMAIL	
HOME PHONE	CELL PHONE		WORK PHONE	

### REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT   
 ☐ OPEN ENROLLMENT   
 ☐ FAMILY STATUS CHANGE   
 ☐ RETIREE

### VISION PLAN

VSP COVERAGE IS AUTOMATIC FOR **EMPLOYEES ONLY** IN HEALTH & WELFARE OPTION 1 OR OPTION 2.

☐ **I WISH TO ENROLL IN THE VSP PLAN WITHOUT DEPENDENTS**

*I am not enrolled in Health & Welfare Option 1 or Option 2 (or I am not in a Health & Welfare unit).*

☐ **I WISH TO ENROLL IN THE VSP PLAN WITH DEPENDENTS**

*(Permissible regardless of unit.)*

### DEPENDENT ENROLLMENT FOR VISION PLAN

RELATIONSHIP	NAME (LAST, FIRST, MI)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
		- -	/ /
		- -	/ /
		- -	/ /
		- -	/ /

### AUTHORIZATION, SIGNATURE AND DISCLOSURE

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

If I enroll in a vision plan, I understand that provided I remain employed I must maintain the coverage throughout the plan year. (I can still make changes during open enrollment periods, and under other circumstances outlined in plan documents.)

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



EMPLOYEE SIGNATURE

DATE

CAREFULLY TEAR ALONG PERFORATION



# DISABILITY

2026

OCEA H&W TRUST  
SUPPLEMENTAL BENEFITS  
ENROLLMENT FORM

**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS FROM OCEA MEMBERSHIP | DURING OPEN ENROLLMENT | OR WITH EVIDENCE OF INSURABILITY APPROVAL**

*These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!*

## EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER	
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP		
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
CITY	STATE	ZIP	HOME EMAIL	
HOME PHONE	CELL PHONE		WORK PHONE	

## REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT ☐ OPEN ENROLLMENT

## SUPPLEMENTAL DISABILITY PLAN | COVERAGE MAY REQUIRE EVIDENCE OF INSURABILITY | NOT AVAILABLE TO RETIREES

<b>I WISH TO ENROLL IN THE SUPPLEMENTAL DISABILITY PLAN.</b> <input type="checkbox"/> LEVEL ONE OR <input type="checkbox"/> LEVEL TWO	GROSS BIWEEKLY SALARY
MEDICAL HISTORY STATEMENT <input type="checkbox"/> I would like OCEA to mail the required Medical History Statement to my home. <input type="checkbox"/> I will find the required Medical History Statement online at <a href="https://oceahandbook.com/benefits">oceahandbook.com/benefits</a> and submit to OCEA. <b>NOTE: You will need to enter OCEA's policy #608843</b>	

## AUTHORIZATION, SIGNATURE AND DISCLOSURE

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



EMPLOYEE SIGNATURE

DATE

CAREFULLY TEAR ALONG PERFORATION



# LIFE INSURANCE

2026

OCEA H&W TRUST  
SUPPLEMENTAL BENEFITS  
ENROLLMENT FORM

**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS FROM OCEA MEMBERSHIP OR UPON A FAMILY STATUS CHANGE | OR WITH EVIDENCE OF INSURABILITY APPROVAL**

*These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!*

## EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER		
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP			
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		
CITY	STATE	ZIP	HOME EMAIL		
HOME PHONE	CELL PHONE		WORK PHONE		

## REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT   
 ☐ FAMILY STATUS CHANGE   
 ☐ RETIREE

## SUPPLEMENTAL LIFE INSURANCE | COVERAGE MAY REQUIRE EVIDENCE OF INSURABILITY

### I WISH TO ENROLL IN THE SUPPLEMENTAL LIFE INSURANCE PLAN.

#### I NOW HAVE:

- ☐ 1 x base annual salary
- ☐ 2 x base annual salary
- ☐ 3 x base annual salary
- ☐ 4 x base annual salary
- ☐ 5 x base annual salary
- ☐ Dependent life insurance
- ☐ Not currently enrolled

#### I AM APPLYING FOR:

- ☐ 1 x base annual salary
- ☐ 2 x base annual salary
- ☐ 3 x base annual salary
- ☐ 4 x base annual salary
- ☐ 5 x base annual salary
- ☐ Dependent life insurance\*
- ☐ Retiree life insurance

GROSS BIWEEKLY SALARY

*\*It is the sole responsibility of the employee to notify OCEA in writing when a dependent ceases to be eligible for coverage. Payroll deductions will continue until written notification is received at OCEA's Headquarters.*

### MEDICAL HISTORY STATEMENT

- ☐ I would like OCEA to mail the required Medical History Statement to my home.
- ☐ I will find the required Medical History Statement online at [oceaa.org/benefits](https://oceaa.org/benefits) and submit to OCEA.

**NOTE: You will need to enter OCEA's policy #608843**

## BENEFICIARY DESIGNATION—FOR THIS BENEFIT ONLY

BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS FOR SUPPLEMENTAL LIFE INSURANCE

PRIMARY—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- -			
		/ /	- -			

CONTINGENT—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- -			
		/ /	- -			

— SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM CONTINUED ON NEXT PAGE —

CAREFULLY TEAR ALONG PERFORATION

## AUTHORIZATION, SIGNATURE AND DISCLOSURE

---

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



---

**EMPLOYEE SIGNATURE**

**DATE**

CAREFULLY TEAR ALONG PERFORATION



# VOLUNTARY AD&D

2026

OCEA H&W TRUST  
SUPPLEMENTAL BENEFITS  
ENROLLMENT FORM

AN OCEA MEMBER MAY ENROLL IN THE SUPPLEMENTAL VOLUNTARY  
ACCIDENTAL DEATH & DISMEMBERMENT PLAN AT ANY TIME DURING THE YEAR.

These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!

## EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER	
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP		
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
CITY	STATE	ZIP	HOME EMAIL	
HOME PHONE	CELL PHONE		WORK PHONE	

## SUPPLEMENTAL VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) | NOT AVAILABLE TO RETIREES

<input type="checkbox"/> I WISH TO ENROLL IN THE SUPPLEMENTAL VOLUNTARY AD&D PLAN.	GROSS BIWEEKLY SALARY
--	-----------------------

## BENEFICIARY DESIGNATION—FOR THIS BENEFIT ONLY

BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS FOR VOLUNTARY AD&D

PRIMARY—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- - -			
		/ /	- - -			

CONTINGENT—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- - -			
		/ /	- - -			

## AUTHORIZATION, SIGNATURE AND DISCLOSURE

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



EMPLOYEE SIGNATURE

DATE

CAREFULLY TEAR ALONG PERFORATION



# ACCIDENT INSURANCE

2026

OCEA H&W TRUST  
SUPPLEMENTAL BENEFITS  
ENROLLMENT FORM

MUST BE **COMPLETED AND RETURNED** TO OCEA WITHIN THE FIRST  
**31 DAYS** FROM OCEA MEMBERSHIP | OR DURING OPEN ENROLLMENT

These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!

## EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER	
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP		
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
CITY	STATE	ZIP	HOME EMAIL	
HOME PHONE	CELL PHONE		WORK PHONE	
SPOUSE FULL NAME (LAST, FIRST, MI)			SPOUSE DATE OF BIRTH / /	

## REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT ☐ OPEN ENROLLMENT

## ACCIDENT INSURANCE

- ☐ I WISH TO ENROLL IN THE ACCIDENT INSURANCE PLAN.
- ☐ YOU ONLY
- ☐ YOU AND YOUR SPOUSE
- ☐ YOU AND YOUR CHILD(REN) (NO SPOUSE)
- ☐ YOU, YOUR SPOUSE, AND YOUR CHILD(REN)

*It is the sole responsibility of the employee to notify OCEA in writing when a dependent ceases to be eligible for coverage. Payroll deductions will continue until written notification is received at OCEA's Headquarters.*

## BENEFICIARY DESIGNATION—FOR THIS BENEFIT ONLY

BENEFICIARY DESIGNATIONS CANCEL ANY PREVIOUS DESIGNATIONS FOR ACCIDENT INSURANCE

PRIMARY—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- - -			
		/ /	- - -			

CONTINGENT—LAST, FIRST, MI	ADDRESS	DATE OF BIRTH	SSN	RELATIONSHIP	TELEPHONE	% OF BENEFIT
		/ /	- - -			
		/ /	- - -			

— ACCIDENT INSURANCE ENROLLMENT FORM CONTINUED ON NEXT PAGE —

CAREFULLY TEAR ALONG PERFORATION

These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

#### AUTHORIZATION, SIGNATURE AND DISCLOSURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

*I have read and reviewed the foregoing information and acknowledge that the selection(s) correctly reflect my enrollment choice(s). I represent that all statements herein are true and complete to the best of my knowledge and belief. I understand and acknowledge that any person who knowingly and with intent to defraud an insurance company files a statement of claim containing any materially false information or conceals information for such purpose commits a crime.*



\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

CAREFULLY TEAR ALONG PERFORATION

# CRITICAL ILLNESS

2026

OCEA H&W TRUST  
SUPPLEMENTAL BENEFITS  
ENROLLMENT FORM

**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS FROM OCEA MEMBERSHIP | OR DURING OPEN ENROLLMENT**

These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!

## EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP	
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CITY	STATE	ZIP	HOME EMAIL
HOME PHONE	CELL PHONE	WORK PHONE	
SPOUSE FULL NAME (LAST, FIRST, MI)			SPOUSE DATE OF BIRTH / /

## REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT ☐ OPEN ENROLLMENT

## CRITICAL ILLNESS INSURANCE

☐ I WISH TO ENROLL IN THE CRITICAL ILLNESS INSURANCE PLAN.

☐ YOU ONLY

☐ YOU AND YOUR SPOUSE

\* ELIGIBLE CHILD(REN) ARE AUTOMATICALLY COVERED AT 50% OF YOUR COVERAGE AMOUNT.

### MEMBER\*

YOU MUST CHOOSE ONE OF  
THE FOLLOWING OPTIONS

- ☐ \$10,000  
☐ \$20,000  
☐ \$30,000

SPOUSE COVERAGE CANNOT EXCEED  
50% OF MEMBERS COVERED AMOUNT

### SPOUSE

YOU MUST CHOOSE ONE OF  
THE FOLLOWING OPTIONS

- ☐ \$5,000  
☐ \$10,000  
☐ \$15,000  
☐ DECLINE CRITICAL ILLNESS  
COVERAGE FOR YOUR SPOUSE

*It is the sole responsibility of the employee to notify OCEA in writing when a dependent ceases to be eligible for coverage. Payroll deductions will continue until written notification is received at OCEA's Headquarters.*

A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No", you are not eligible for Critical Illness Insurance.)

☐ YES ☐ NO

B. Are you age 65 or older? (The plan must be in effect before your 65<sup>th</sup> birthday or you are not eligible for Critical Illness Insurance.)

☐ YES ☐ NO

— CRITICAL ILLNESS INSURANCE ENROLLMENT FORM CONTINUED ON NEXT PAGE —

CAREFULLY TEAR ALONG PERFORATION

These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

#### AUTHORIZATION, SIGNATURE AND DISCLOSURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

I hereby authorize payroll deduction of the premiums associated with the above benefits from my paycheck. I agree that I am solely responsible for such premium payments whether premiums are payroll-deducted or paid otherwise. I agree that any unpaid premiums, including those unpaid through administrative error or non-issuance of a paycheck, will be reimbursed to the OCEA Health & Welfare Trust upon demand.

In most cases, to cancel supplemental benefit plan coverage, it is the sole responsibility of the employee to notify OCEA in writing. Payroll deductions will continue until written notification is received at OCEA's Headquarters.

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\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

CAREFULLY TEAR ALONG PERFORATION

# HOSPITAL INDEMNITY

2026

OCEA H&W TRUST  
SUPPLEMENTAL BENEFITS  
ENROLLMENT FORM

**MUST BE COMPLETED AND RETURNED TO OCEA WITHIN THE FIRST 31 DAYS FROM OCEA MEMBERSHIP | OR DURING OPEN ENROLLMENT**

*These benefits are available to **OCEA MEMBERS ONLY (AT ADDITIONAL PREMIUMS)**. Join OCEA now to take advantage of these benefits!*

## EMPLOYEE INFORMATION

NAME (LAST, FIRST, MI)			EMPLOYEE ID NUMBER
SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	<input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> DOMESTIC PARTNERSHIP	
HOME ADDRESS			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CITY	STATE	ZIP	HOME EMAIL
HOME PHONE	CELL PHONE	WORK PHONE	
SPOUSE FULL NAME (LAST, FIRST, MI)			SPOUSE DATE OF BIRTH / /

## REASON I AM SUBMITTING THIS FORM

☐ INITIAL ENROLLMENT ☐ OPEN ENROLLMENT

## HOSPITAL INDEMNITY INSURANCE

☐ I WISH TO ENROLL IN THE HOSPITAL INDEMNITY INSURANCE PLAN.

- ☐ YOU ONLY
- ☐ YOU AND YOUR SPOUSE
- ☐ YOU AND YOUR CHILD(REN) (NO SPOUSE)
- ☐ YOU, YOUR SPOUSE, AND YOUR CHILD(REN)

*It is the sole responsibility of the employee to notify OCEA in writing when a dependent ceases to be eligible for coverage. Payroll deductions will continue until written notification is received at OCEA's Headquarters.*

A. Do you have major medical or other minimum essential insurance that provides medical, hospital, and surgical coverage? (If the answer is "No," you are not eligible for Hospital Indemnity Insurance.)

☐ YES ☐ NO

B. Are you age 65 or older? (The plan must be in effect before your 65<sup>th</sup> birthday or you are not eligible for Hospital Indemnity.)

☐ YES ☐ NO

IS YOUR SPOUSE GAINFULLY EMPLOYED OR CAPABLE OF PERFORMING THE MATERIAL DUTIES OF AN OCCUPATION? ☐ YES ☐ NO

— HOSPITAL INDEMNITY INSURANCE ENROLLMENT FORM CONTINUED ON NEXT PAGE —

CAREFULLY TEAR ALONG PERFORATION

These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

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\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

CAREFULLY TEAR ALONG PERFORATION



SUBMIT FORMS TO OCEA OR APPLY ONLINE AT [OCEA.ORG/BENEFITS](https://oceaa.org/benefits)

RETURN  
ENVELOPE

## ***WHERE ARE THE FORMS I NEED?***

YOU WILL FIND THE FORMS YOU NEED  
IN THE BACK OF THIS ENROLLMENT GUIDE  
OR ONLINE AT [OCEA.ORG/BENEFITS](https://oceaa.org/benefits)

### **HEALTH & WELFARE BENEFITS ENROLLMENT FORM**

— PAGE 65 —

### **OCEA MEMBERSHIP APPLICATION**

— EMPLOYER SPECIFIC: SEE PAGE 67 —

### **SUPPLEMENTAL DENTAL ENROLLMENT FORM**

— PAGE 69 —

### **SUPPLEMENTAL VISION ENROLLMENT FORM**

— PAGE 71 —

### **SUPPLEMENTAL DISABILITY INSURANCE ENROLLMENT FORM**

— PAGE 73 —

### **SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM**

— PAGE 75 —

### **SUPPLEMENTAL VOLUNTARY AD&D INSURANCE ENROLLMENT FORM**

— PAGE 77 —

### **ACCIDENT INSURANCE ENROLLMENT FORM**

— PAGE 79 —

### **CRITICAL ILLNESS INSURANCE ENROLLMENT FORM**

— PAGE 81 —

### **HOSPITAL INDEMNITY INSURANCE ENROLLMENT FORM**

— PAGE 83 —

RETURN TO OCEA WITHIN  
YOUR ELIGIBILITY PERIOD

**DON'T MISS YOUR DEADLINES!**

**2026**

**OCEA** HEALTH &  
WELFARE TRUST

**ORANGE COUNTY EMPLOYEES ASSOCIATION HEALTH & WELFARE TRUST**

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