

# 2008 Benefits Annual Enrollment Using eBenefits



Your Guide to Online Enrollment



# Your County of Riverside Benefits

## WE'RE IN THIS TOGETHER

While the County of Riverside pays a large portion of the cost, you pay your part too. The more you know about using your plans, the more you'll get out of your investment.

The County of Riverside recognizes excellence and performance by providing comprehensive and competitive benefit programs for its employees. We are dedicated to offering you and your family a variety of benefits that help meet your needs and balance your career with your personal life.

One theme of all the programs is flexibility. We understand that everyone's needs are unique, so the programs are designed to provide you with the opportunity to select the benefits that are right for you – whether you're married or single, close to retirement or just beginning your career.

CONTACT INFORMATION		
Plan	Telephone	Website
<b>Medical</b>		
Blue Shield of California (HMO & PPO)	(800) 642-6155	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>
Exclusive Care (EPO)	(800) 962-1133	<a href="http://www.exclusivecare.com">www.exclusivecare.com</a>
Kaiser (HMO)	(800) 464-4000	<a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>
PERSCare (PPO)	(877) 737-7776	<a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a>
PERS Choice (PPO)	(877) 737-7776	<a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a>
PORAC	(800) 937-6722	<a href="http://www.porac.org">www.porac.org</a>
<b>Wellness Program</b>		
Riverside County Human Resources Wellness Program	(951) 778-3976	<a href="http://www.rc-hr.com/wellness">www.rc-hr.com/wellness</a>
<b>Dental</b>		
Concordia TCA Plans (HMO)	(866) 357-3304	<a href="http://www.ucci.com">www.ucci.com</a>
Concordia Preferred (PPO)	(800) 332-0366	<a href="http://www.ucci.com">www.ucci.com</a>
Freedom Dental	(888) 540-9488	<a href="http://benefits.rc-hr.com">http://benefits.rc-hr.com</a>
Local Advantage (EPO)	(888) 540-9488	<a href="http://benefits.rc-hr.com">http://benefits.rc-hr.com</a>
<b>Vision</b>		
Vision Service Plan (VSP)	(800) 877-7195	<a href="http://www.vsp.com">www.vsp.com</a>
Medical Eye Services	(800) 877-6372	<a href="http://www.mesvision.com">www.mesvision.com</a>
<b>Employee Assistance Program</b>		
Employee Assistance Program	(951) 778-3970	<a href="http://www.rc-hr.com/eap/">www.rc-hr.com/eap/</a>
<b>Other Benefits and County Resources</b>		
eBenefits Online Enrollment System Entry	Call the Benefits Information Line for assistance at (951) 955-4981	<a href="http://www.workforceexchange.net">www.workforceexchange.net</a> or <a href="http://intranet.co.riverside.ca.us">http://intranet.co.riverside.ca.us</a>
Riverside County Human Resources Benefits Information Line	(951) 955-4981	<a href="http://benefits.rc-hr.com">http://benefits.rc-hr.com</a> or <a href="http://intranet.co.riverside.ca.us">http://intranet.co.riverside.ca.us</a>
FSA Claims Administrator (Flex Coordinator)	(951) 955-5873	<a href="http://benefits.rc-hr.com">http://benefits.rc-hr.com</a> or <a href="http://intranet.co.riverside.ca.us">http://intranet.co.riverside.ca.us</a>
CalPERS	(888) 225-7377	<a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a>



Alternative formats available upon request. Contact the Benefits Information Line at (951) 955-4981 as soon as possible. It may take up to two weeks to fulfill your request.

This guide gives you an overview of your benefits including eligibility, plan options, rates, how to enroll and other important information. More detailed information is available in the official plan documents.

## Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notice on page 37 for details.

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### Annual Enrollment for Current Employees

## Annual Enrollment for Current Employees

Getting the most value from your benefits depends on how well you understand your plans and how you use them. Benefits are important; they provide support to you when you need it the most. They're also a personal choice; your life circumstances change from year to year and your financial and protection needs may change as well.

Take action during Annual Enrollment to review your family's changing needs, evaluate your existing coverage and decide whether to continue with your current choices or make a change. Use the many resources available to make well-informed decisions about your benefits for the coming year. Being proactive now will ensure that you and your family have the coverage you need throughout the year ahead.

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 Annual Enrollment for Current Employees
 

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## What's new for 2008?

- The emergency room copayment under the Blue Shield Access+ HMO will increase from \$35 to \$50.
- Your contributions to the health plans will increase slightly. See pages 23-25 for details.
- Your life insurance coverage will remain the same, but the Jefferson Pilot insurance company is now known as Lincoln Financial Group.

## Important Dates

- **Deductions from your pay warrant.** All benefit changes will be effective January 1, 2008. Your pay warrant will reflect the new rates as follows:
  - **Medical, dental and vision rate changes** are effective pay period 25 of 2007: first deduction from the December 5, 2007 pay warrant.
  - **FSA and Supplemental Life** insurance deductions begin pay period 1 of 2008: first deduction from the January 2, 2008 pay warrant.

**RIVERSIDE COUNTY  
ANNUAL ENROLLMENT:  
OCTOBER 1 –  
OCTOBER 26, 2007**  
This includes enrollment  
in County plans: medical,  
dental, vision, Flexible  
Spending Accounts (Health  
Care and Dependent Care),  
and supplemental life  
insurance.

**CalPERS ANNUAL  
ENROLLMENT:  
SEPTEMBER 17 –  
OCTOBER 12, 2007**  
This year, employees who  
are eligible for CalPERS  
medical plans (DDAA,  
LEMU and RSA Public  
Safety Unit employees)  
will enroll for all health  
care plans (medical, dental,  
vision and Flexible  
Spending Accounts) during  
the CalPERS Annual  
Enrollment period. The  
election period for  
supplemental life will  
remain October 1 through  
October 26, 2007.

## What else should you know before you enroll?

- **If you wish to waive County-sponsored medical insurance**, please review the rules on page 7 to verify your eligibility and requirements.
- **Flexible Spending Accounts (FSAs)** let you set aside pre-tax earnings to pay for eligible health care or dependent care expenses. Money goes in tax-free and comes out tax-free. If you would like to participate in an FSA in 2008, Annual Enrollment is your opportunity to sign up. Remember, if you're currently enrolled in an FSA, you have until March 15, 2008 to incur expenses and use any funds remaining in your account. For more information on FSAs, turn to page 18.

	<b>Before you make any decisions, take a moment to review this helpful "To Do" List.</b>
<input type="checkbox"/>	Read the material in this enrollment guide
<input type="checkbox"/>	Share the material with your family members and discuss your family needs
<input type="checkbox"/>	Review the personalized enrollment statement, including your current elections, you received with this guide
<input type="checkbox"/>	Attend a Benefits Fair and meet with Benefits staff and representatives from the health insurance companies to get answers to your questions.
<input type="checkbox"/>	Decide if you're going to make any changes for 2008, or keep the coverage you have in place.
<input type="checkbox"/>	If you decide to make enrollment changes, follow the Online Enrollment instructions on page 3 of this guide.

## Annual Enrollment for Current Employees

**DO YOU NEED TO DO ANYTHING?**

The answer is “no” unless you want to:

- Change your plan elections;
- Add or delete coverage for an eligible dependent;
- Enroll or continue your participation in an FSA; OR
- Waive County medical insurance (you must also provide information about your other group coverage)

## How to Enroll

- **Online enrollment.** Plan changes, dependent additions or deletions, plan waivers and proof of insurance require an online enrollment using the County’s eBenefits enrollment process.
  - **Your online ID and password** are listed on the Personalized Annual Enrollment Statement that was mailed to you with this guide. You can access the online enrollment system on any computer with Web/Internet access at [www.workforceexchange.net](http://www.workforceexchange.net) or from a County computer at <http://intranet.co.riverside.ca.us>.
  - **Assistance and computer access** will be available at each of the Benefits Fairs (see page 4). Computers are also available during business hours at the County Administrative Center in Riverside at 4080 Lemon Street, First Floor, in the Human Resources reception area, and in Moreno Valley at the County Professional Center (CPC) in Human Resources at 14375 Nason Street, Suite 212. You can also contact your Department Representative to ask about access to department computers for enrollment or visit your local library.
- **Dependent documentation.** If you are enrolling a spouse, a domestic partner, or child(ren) for whom you have legal custody *for the first time*, you will need to provide supporting documentation by October 26, 2007. Your online enrollment for the dependent cannot be processed without the supporting documentation. See the “General Eligibility” section on page 26 for documentation requirements.
- **Enrolling domestic partners.** If you want to enroll or dis-enroll a domestic partner, or a domestic partner’s child, you must complete a *Benefit Election Form*, available at <http://benefits.rc-hr.com> or from your Department Representative. These changes *cannot* be made online using eBenefits.
- **Supplemental life insurance enrollment.** As a county employee you are provided a limited life insurance benefit. If you wish to purchase additional supplemental life insurance or make changes to your existing supplemental life insurance, you will need to complete and submit the life insurance enrollment forms. See page 21 for more specific enrollment information.

**IMPORTANT INFORMATION FOR EMPLOYEES ELIGIBLE FOR CalPERS MEDICAL PLANS****Only for employees in the following bargaining units: DDAA, LEMU and RSA Public Safety**

The CalPERS Annual Enrollment period is September 17, 2007 through October 12, 2007. If you are eligible for CalPERS-sponsored health plans, you should have received your *Health Plan Statement* from CalPERS in August. Your statement contained information on your current coverage and the steps you need to take if you want to make changes. If you want to change medical plans, you must complete a two-step process.

1. You must complete a CalPERS enrollment form (HBD12); AND
2. You must make your medical election online through eBenefits to ensure your payroll deduction is correct.

The County will use the eBenefits enrollment to process your payroll deductions. If there is a discrepancy between your online election and your CalPERS enrollment form, the County will use the CalPERS enrollment form to determine your coverage and adjust your premiums accordingly.

**New for 2008**

This year, you will make all of your health care benefit elections—medical, dental, vision and Flexible Spending Accounts—during the CalPERS Annual Enrollment period, September 17 through October 12. The enrollment period for the supplemental life insurance plans will remain October 1 through October 26, 2007.

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**Annual Enrollment for Current Employees**


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## Your Options During Annual Enrollment

- Select, change or cancel medical, dental or vision plan coverage
- Enroll or re-enroll in the FSAs (Health Care and/or Dependent Care)
- Waive medical coverage, if you are eligible (see page 7), and provide proof of other insurance coverage
- Select, change or cancel supplemental life insurance coverage
- Add or drop coverage for dependents and/or spouse/domestic partner

## Join Us at a Benefits Fair

Below is a list of enrollment Benefit Fairs. The following services will be available to you at these fairs:

- Human Resources will have computers and staff available to help you with your online enrollment.
- Representatives from all of the County plans will be available to answer your questions.
- Additional information, such as provider directories, will be available to help you make your 2008 benefit elections.

2008 BENEFITS FAIR SCHEDULE			
City	Date	Time	Location
Banning	10/11/2007	11:00 a.m. – 2:00 p.m.	Department of Public Social Services 63 S. 4th Street
Blythe	10/18/2007	10:00 a.m. – 2:00 p.m.	Blythe County Administrative Center 260 North Broadway Lunch Room of Main Facility
Hemet	10/04/2007	10:00 a.m. – 2:00 p.m.	Department of Public Social Services 541 N. San Jacinto, Conference Room 203
Indio	10/17/2007	11:00 a.m. – 3:00 p.m.	Workforce Development Center 44-199 Monroe Street, Room 402
Moreno Valley	10/10/2007	9:00 a.m. – 3:00 p.m.	Riverside County Regional Medical Center (RCRMC) 26520 Cactus Avenue, Patio
Cathedral City	10/16/2007	10:00 a.m. – 2:00 p.m.	Desert Court Facility 26-625 Perez Road, Suite 9B
Perris	10/25/2007	10:00 a.m. – 2:00 p.m.	Coroner's Office 800 S. Redlands, Large Conference Room
Riverside, CAC Downtown	10/03/2007	9:00 a.m. – 3:00 p.m.	County Administrative Center 4080 Lemon Street, 1st Floor, Front Lobby
Riverside, County Circle	10/24/2007	9:00 a.m. – 2:00 p.m.	Community Health Center 4065 County Circle Drive Atrium and Patio area
Riverside, Flood Control	10/09/2007	12:00 p.m. – 4:00 p.m.	Flood Control 1995 Market Street, Conference Room
Riverside, Spruce Street	10/02/2007	10:00 a.m. – 1:00 p.m.	Veterans Services 1151 Spruce Street Conference Rooms 1-3
Temecula	10/23/2007	11:00 a.m. – 3:00 p.m.	Workforce Development Center 41002 County Center Drive



If you require reasonable accommodations please contact the Benefits Information Line at (951) 955-4981 at least two weeks prior to the scheduled fair date.

**REMINDER: CHANGING  
PRIMARY CARE PROVIDER  
ON EXISTING COVERAGE**

If you are keeping your current coverage but you would like to change your primary care provider, please contact your carrier directly. The County's online enrollment system cannot update existing carrier records.

## Enrolling in Your Benefits

A few things to remember as you prepare to enroll for your benefits:

- Be sure to have current dependent information, including Social Security numbers, available so you can enter correct information online if necessary.
- If you are going to enroll in a plan that requires selecting a specific provider to access care, visit the insurance carrier's Web site for a list of doctors/dentists in your area. Web sites for the carriers are listed on the inside back cover. If you elect Kaiser coverage, you do not need to choose a provider. In the provider field, enter "Kaiser" to move on to the next screen.
- Directions for accessing the online enrollment process, including your login and password combination, are included in your Personalized Annual Enrollment Statement that was mailed with this enrollment guide.

## Flexible Benefit Credits – Helping You Pay for Coverage

To help you with the cost of benefits, the County of Riverside provides Flexible Benefit Credits. You may also qualify for a Premium Subsidy if you are in an eligible bargaining unit and you elect to enroll one or more dependents; please see the chart on page 6 for more information. The Flexible Credits you receive and your eligibility for a Premium Subsidy are determined by the applicable union Memorandum of Understanding or Management/Confidential Resolution that governs your bargaining unit. See the table below for the Flexible Benefit Credits you will receive beginning pay period 25 of 2007 for January 2008 premiums:

2008 FLEX CREDITS				
Bargaining Unit	Monthly Flex Credit	Semi-Monthly Flex Credit	Monthly Flex Credit	Semi-Monthly Flex Credit
	Enrolled in County Health Plan		Not Enrolled in County Health Plan (Waiver)	
Management	\$706.00	\$353.00	\$534.00	\$267.00
Confidential	\$706.00	\$353.00	\$534.00	\$267.00
Unrepresented	\$706.00	\$353.00	\$534.00	\$267.00
Unrepresented Mgt. Atty.	\$582.90	\$291.45	\$425.40	\$212.70
LIUNA	\$612.92	\$306.46	\$425.40	\$212.70
SEIU	\$612.92	\$306.46	\$465.00	\$232.50
DDAA	\$582.90	\$291.45	\$425.40	\$212.70
Elected Officials	\$706.00	\$353.00	\$534.00	\$267.00
LEMU	\$679.28	\$339.64	0.00	0.00
RSA - Public Safety	\$568.00	\$284.00	\$456.72	\$228.36
Physician Residents/ Physician Fellowships	\$312.50	\$156.25	\$312.50	\$156.25

Flexible Benefit Credits shown are for full-time employee status; partial credits are provided to part-time employees.

## Premium Subsidy

Employees in the SEIU and LIUNA bargaining units are eligible for a Premium Subsidy. The premium shown on your personalized enrollment statement has been reduced to reflect this additional employer-paid contribution. If you are in either of these two bargaining units, please see the table below for the Premium Subsidy contribution you receive as a reduction to the 2008 medical plan premiums shown on pages 23-25.

SEIU AND LIUNA 2008 PREMIUM SUBSIDIES			
Monthly Flex Premium Subsidy	Semi-Monthly Premium Subsidy	Monthly Flex Premium Subsidy	Semi-Monthly Premium Subsidy
Family Coverage		Two-Party Coverage	
\$100.00	\$50.00	\$25.00	\$12.50

## Pre-Tax Deductions

When you enroll in a County-sponsored medical, dental and/or vision plan, your premiums are automatically collected before taxes are calculated on your earnings. (Note: Coverage for your domestic partner and your non-tax-qualified dependents are collected on an after-tax basis.) For most employees, collecting premiums on a pre-tax basis is the most cost-effective way to pay for your premiums.

You may, however, choose to pay your medical, dental and vision premiums with after-tax dollars. This election will reduce your take-home pay, as you will pay taxes on your full earnings before your premium deductions are collected. To elect this option, please contact your Department Representative for the *Election to Pay Premiums with After-Tax Dollars Form*. You may elect this option during the Annual Enrollment period and within 60 days of a qualified status change.

### IF YOU LOSE YOUR OTHER COVERAGE AFTER YOU HAVE WAIVED...

...you may be able to enroll in a County plan, provided that you request enrollment within 60 days after your other coverage ends. Refer to "Making Mid-Year Changes" on page 31 for more information and rules about making mid-year elections.

## Can You Waive County Coverage?

If you are an employee in one of the approved groups listed on the next page, you may waive your participation in County plans and receive a portion of the County's contribution toward your benefits in the form of cash. The applicable union Memorandum of Understanding or Management/Confidential Resolution determines whether you are required to enroll in a medical plan as well as what is required to receive Flexible Benefit Credits. Use the information that applies to you in the following table for assistance in making informed benefit decisions.

WAIVER ELIGIBILITY FOR COUNTY MEDICAL COVERAGE	
Waiver Eligibility	Waiver Requirements
<p>You are eligible* to waive if you are:</p> <ul style="list-style-type: none"> <li>• Elected Official elected before 11/13/2003</li> <li>• Management hired before 11/13/2003</li> <li>• Confidential hired before 11/13/2003</li> <li>• Unrepresented hired before 11/13/2003</li> <li>• LIUNA hired before 11/13/2003</li> <li>• SEIU hired before 11/11/2004</li> <li>• RSA Public Safety hired before 02/02/2006</li> <li>• DDAA</li> <li>• Resident Physicians</li> </ul>	<p>You must have other group medical plan coverage (see table below) and ALL of the following:</p> <ol style="list-style-type: none"> <li>1. Enroll in at least one of the other County-sponsored dental, employee-paid vision or FSA (health or dependent care) options;</li> <li>2. Elect Medical Waiver Reduction as your medical plan option by either: (a) completing the eBenefits online enrollment system during annual enrollment; or (b) submitting a completed <i>Benefit Election Form</i> if you are a newly eligible employee or requesting a mid-year change; and</li> <li>3. Provide information about your other coverage by either: (a) completing the Proof of Insurance information during the online Annual Enrollment process; or (b) submitting proof of insurance to your Department Representative if you are a newly eligible employee or are making a mid-year change.</li> </ol>
<p>You are not eligible to waive if you are:</p> <ul style="list-style-type: none"> <li>• Elected Official elected on or after 11/13/2003</li> <li>• Management hired on or after 11/13/2003</li> <li>• Confidential hired on or after 11/13/2003</li> <li>• Unrepresented hired on or after 11/13/2003</li> <li>• LIUNA hired on or after 11/13/2003</li> <li>• SEIU hired on or after 11/11/2004</li> <li>• LEMU</li> <li>• RSA Public Safety hired on or after 02/02/2006</li> </ul>	<p>You are required to enroll in a County-sponsored medical plan within 60 days of eligibility (e.g., date of hire or transfer to eligible unit). If you do not submit your enrollment, the following will occur:</p> <ul style="list-style-type: none"> <li>• No Flexible Benefit Credits will be paid until your enrollment is implemented.</li> <li>• If no election paperwork is received within 60 days of eligibility, you will be automatically enrolled for single coverage in the lowest-cost PPO medical plan. This will be deemed your medical plan election, and you will not be able to change your enrollment until the next Annual Enrollment unless you have a qualifying mid-year status change.<sup>†</sup></li> <li>• Once coverage is implemented, you will be eligible for Flexible Benefit Credits.</li> </ul>

\* Date of hire for eligibility is based on your last hire date with the County.

† LEMU and RSA Public Safety are not subject to automatic enrollment; no Flexible Benefit Credits will be paid if you are not enrolled in any plan.

**What is “group coverage”?** A group health plan offers health care coverage through employers, student organizations, professional associations, religious organizations, the government, and other groups. Individual plans are health care plans sold directly to individuals; they do not qualify to meet waiver requirements.

EXAMPLES OF ELIGIBLE GROUP MEDICAL PLAN COVERAGE	
Approved Coverage	Ineligible Coverage
<p>Employer-sponsored medical plans Medicare TRICARE</p>	<p>Coverage purchased as an individual</p>

\* **Special Note Regarding Medicare and TRICARE:** TRICARE and Medicare are now on the list of approved coverage; both will qualify to satisfy the requirement that an employee have “other group coverage” when waiving County-sponsored medical coverage and receiving flexible benefit credits in cash, provided that an employee meets the waiver rules described in the Memorandum of Understanding or Management Resolution. If The Department of Defense or Centers of Medicare and Medicaid Services provide new clarification on rules in the future, the County will review waiver rules and make any changes necessary to ensure continued compliance with federal law.

# Medical – the Protection You Need

The County of Riverside cares about your health and well-being and is pleased to offer you a choice of medical plan options. To be eligible, you must be a regular County employee scheduled to work at least 20 hours per week. Your bargaining or representation unit determines which medical plans you may choose.

MEDICAL PLAN ELIGIBILITY	
Eligible for County Medical Plans	Eligible for CalPERS Medical Plan
Elected Officials	DDAA Represented Employees
SEIU Represented Employees	LEMU Represented Employees
LIUNA Represented Employees	RSA Public Safety Unit Employees
Management Employees	
Confidential Employees	
Unrepresented Employees	
Resident Physicians	

## EPO MEDICAL PLANS

### *Exclusive Provider Organization (EPO)*

Exclusive Care was created by the County of Riverside as a high-value health plan option whose members pay substantially less than other health plans in premiums and copayments. The savings in premiums alone will often enable employees to purchase two-party or family coverage versus only individual coverage. Employees who are eligible for either the County medical plans or CalPERS medical plans may enroll in this plan.

An EPO provides coverage for non-emergency care through contracted health care providers. Exclusive Care is the County’s self-administered EPO. Unlike other managed health care plans, Exclusive Care’s primary care providers are not paid a fixed amount each month. All providers are paid for each treatment no matter how frequently a patient is seen.

### *How an EPO Plan Works*

If you enroll in the EPO, you (and each enrolled family member) will choose a primary care physician (PCP) from the Exclusive Care network. Your chosen PCP will coordinate all of your health care. This PCP may be a family practitioner, internist, pediatrician or general practitioner. If you need specialty care, your PCP will refer you to a network specialist or hospital. Through your PCP, you will have access to full-service medical care within the network and in some circumstances outside of the network. Initial visits to OB/GYNs and chiropractors who participate in the network can be made without a referral from your PCP. You pay no annual deductible under this plan and will generally receive 100% coverage with a small copayment for certain services. In a life-threatening emergency, you are covered wherever

you seek services, even if outside of the network. A number of local urgent care centers are also included in the network.

For additional information or a Provider Directory, visit Exclusive Care at [www.exclusivecare.com](http://www.exclusivecare.com) or contact Exclusive Care Member Services at (800) 962-1133. You may also learn more about Exclusive Care by attending a Benefits Fair or contacting your Department Representative. If you have an eligible dependent who lives outside of the plan's service area, please contact Exclusive Care for information.

## HMO MEDICAL PLANS

### *Health Maintenance Organization (HMO)*

A health maintenance organization (HMO) provides comprehensive medical services with affiliated health care providers only.

The County offers the following HMO plans:

- Blue Shield Access+ HMO
- Kaiser Permanente HMO

### *How an HMO Plan Works*

**Blue Shield Access+ HMO:** If you enroll in the Blue Shield Access+ HMO plan, you (and each enrolled family member) will choose a personal care physician (PCP) who is part of the provider network. Your PCP will coordinate all of your health care. You pay only an affordable copayment each time you see a physician. You may also self-refer to certain specialists for a higher copayment through the Access+ *Specialists<sup>sm</sup>* option. If you need a Provider Directory, visit Blue Shield online at [www.blueshieldca.com](http://www.blueshieldca.com), contact Blue Shield Member Services at (800) 642-6155, attend a Benefits Fair or contact your Department Representative.

Blue Shield Access+ HMO includes coverage for out-of-area urgent and emergency care. That care can be conveniently provided through BlueCard. Simply call (800) 810-BLUE for help in locating a participating provider who participates in the local BlueCard network.

**Kaiser Permanente:** You have access to full-service medical care if you use Kaiser's doctors, hospitals and other health care facilities. You pay no annual deductible under this plan and will generally receive 100% coverage after a copayment for office visits. In a life-threatening emergency, you are covered wherever you seek services for a small copayment. If you need a listing of Kaiser Permanente facilities, visit [www.kaiserpermanente.org](http://www.kaiserpermanente.org), contact the plan's Member Services at (800) 464-4000, attend a Benefits Fair or contact your Department Representative. Also, if you have an eligible dependent who lives outside of the Kaiser service network, please contact the Benefits Information Line for information about enrolling your dependent.

## PPO MEDICAL PLANS

### *Preferred Provider Organization (PPO)*

A PPO gives you the freedom to receive medical services from any licensed provider you choose, with lower copayments when you use the network providers.

The County offers the Blue Shield Spectrum PPO plan.

### *How a PPO Plan Works*

A PPO is a medical plan that lets you choose between in-network providers who offer their services at discounted rates and out-of-network providers. You may seek services from a specialist without a referral from a primary care physician.

With a PPO plan, you are responsible for paying a certain amount of covered expenses (the deductible) before the plan pays benefits. The plan pays a higher level of benefits (you pay less) when you use in-network physicians and hospitals. If you receive non-emergency care from an out-of-network provider, the plan will pay benefits based on what Blue Shield has determined is an appropriate charge for a particular service in your area. Blue Shield calls this the “allowable amount.” If your doctor charges more than the allowable amount covered by the plan, you will have to pay the difference.

If you need a provider directory, visit Blue Shield online at [www.blueshieldca.com](http://www.blueshieldca.com), contact Blue Shield Member Services Department toll-free at (800) 642-6155, attend a Benefits Fair or contact your Department Representative.

The BlueCard Program connects you and your family to care when you’re outside of California and around the world. Simply call (800) 810-BLUE for help in locating a participating provider who participates in the local BlueCard network.

Your Blue Shield member ID card contains information that a BlueCard provider will need. Please note that you are not required to access care with a BlueCard provider, but you are protected from excess charges when you do so.

COUNTY MEDICAL PLANS COMPARISON CHART					
These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.					
	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network <sup>2</sup>
Choice of physician	Any Exclusive Care network physician	Any Kaiser physician and/or facility	Any BSC HMO network physician	Any BSC PPO network physician	Any licensed physician and/or facility
Deductible	None	None	None	Individual: \$500 combined; Individual +1: \$1,000; Family: \$1,000 combined in- and out-of-network	
Calendar year out-of-pocket maximum	\$3,000/person	\$1,500/person \$3,000/family	\$800/person \$1,600/2-party \$2,400/family	\$3,000/person \$6,000/family	
Lifetime maximum	\$1,000,000/person	None	None	\$6,000,000/person	
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered	Not covered for 6 months unless you provide proof of previous coverage	
Office Visit Benefits					
Diagnostic X-ray & lab	100%	100%	100%	80% after deductible	60% after deductible
Physician hospital visits	100% after \$5 copay at physician clinics	\$15 copay per admission	\$15 copay per admission	\$20 copay/visit	60% after deductible
Immunizations	100% after \$5 copay for office visit	100%	100% after \$15 copay	No charge	60% after deductible <sup>4</sup>
Maternity care	100% after \$5 copay	100% after \$15 copay	No charge	80% after deductible	60% after deductible <sup>4</sup>
Periodic health evaluations/physicals	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay for referred visits	\$20 copay/visit <sup>3</sup>	60% after deductible <sup>4</sup>
Physician office visits	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay; 100% after \$30 copay for self-referred visits	\$20 copay/visit <sup>3</sup>	60% after deductible <sup>4</sup>
Vision exams	Not covered	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit <sup>3</sup>	60% after deductible <sup>4</sup>
Well baby care	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit <sup>3</sup>	60% after deductible <sup>4</sup>
Well woman care	100% after \$5 copay	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit <sup>3</sup>	60% after deductible <sup>4</sup>

<sup>1, 2, 3, 4, 5, 6</sup> Refer to the box below for footnote references.



**PLEASE USE THE FOLLOWING REFERENCES WITH COUNTY MEDICAL PLANS COMPARISON CHART**

1. Severe mental health conditions are covered the same as any other illness. Benefits for physician visits or hospital care include the diagnosis and medically necessary treatment of the following conditions: anorexia nervosa, bipolar disorder, bulimia nervosa, major depressive disorder, obsessive-compulsive disorder, panic disorder, pervasive developmental disorder or autism, schizoaffective disorder, schizophrenia.
2. You will pay any amount charged by an out-of-network provider that is in excess of the Blue Shield's allowable amount.
3. Benefits are not subject to deductible.
4. Deductibles and copayments do not accrue to out-of-pocket maximum.
5. Outpatient mental health and substance abuse visits accrue to a combined 30-visit maximum per calendar year.
6. Outpatient treatment for severe and non-severe mental health conditions is limited to a combined in-network and out-of-network benefit maximum of 20 visits per calendar year.

**Please refer to the individual medical plan booklets for detailed lists of covered expenses, and exclusions and limitations. Medical plan booklets are available from your Department Representative, at a Benefits Fair or by contacting the Benefits Information Line at (951) 955-4981.**

COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)					
These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.					
	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network <sup>2</sup>
<b>Prescription Drugs</b>					
Network retail pharmacies (30- to 34-day supply)	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$25 copay	Generic: \$10 copay (up to 100-day supply) Brand formulary: \$25 copay (up to 100-day supply)	Generic: \$10 copay Preferred brand: \$25 copay Nonpreferred brand: \$50 copay	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$30 copay	Generic: \$5 copay Preferred brand: \$15 copay Nonpreferred brand: \$30 copay
Network mail order (90-day supply)	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$50 copay	Generic: \$10 copay (up to 100-day supply) Brand formulary: \$25 copay (up to 100-day supply)	Generic: \$20 copay Preferred brand: \$50 copay Nonpreferred brand: \$100 copay	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$60 copay	Generic: \$10 copay Preferred brand: \$30 copay Nonpreferred brand: \$60 copay
<b>Hospital and Emergency Room Benefits</b>					
Ambulance (medically necessary)	100%	100%	100%	80% after deductible	80% after deductible
Ambulatory surgical center	100%	100% after \$15 copay	100%	80% after deductible	60% after deductible <sup>4</sup>
Physician hospital visits	100% after \$5 copay	100% after \$100 copay per admit	100%	\$20 copay/visit	60% after deductible <sup>4</sup>
Inpatient hospital	100% at network facility; \$250 per day for emergency services at non-network facility	\$100 copay per admit	\$100 copay per admit	80% after deductible	60% after deductible <sup>4</sup>
Outpatient hospital	100%	100%; \$15 copay/procedure for outpatient surgery	100%	80% after deductible	60% after deductible up to \$600/day <sup>4</sup>
Hospital emergency room	100% after \$50 copay at network facility; 100% after \$250 copay at non-network facility (waived if admitted)	100% after \$50 copay; waived if admitted	100% after \$50 copay; waived if admitted	\$50 copay/visit <sup>3,4</sup>	
Urgent care	100% after \$20 copay at network facility; 100% after \$50 copay at non-network facility	100% after \$15 copay	100% after \$35 copay; waived if admitted	80% after deductible	60% after deductible <sup>4</sup>
<b>Severe Mental Health Treatment</b>					
Inpatient benefit	100%; unlimited admissions	\$100 per admit; unlimited visits	\$100 per admit; unlimited visits	80% after deductible	60% after deductible <sup>4</sup>
Outpatient benefit	\$10 copay/visit for visits 1-10; \$25 copay for visits 11-30	\$15 copay; private visit; \$5 copay/group visit (unlimited visits)	100% after \$15 copay <sup>5</sup>	\$20 copay/visit <sup>3,6</sup>	60% after deductible <sup>4,6</sup>
<b>Non-Severe Mental Health Treatment</b>					
Inpatient benefit	100%; unlimited admissions	\$100 copay per admit; up to 30 days/cal. year	Not covered	Not covered	Not covered
Outpatient private	\$10 copay/visit for visits 1-10; \$25 copay for visits 11-30	\$15 copay (unlimited visits)	100% after \$15 copay <sup>5</sup>	80% after deductible <sup>4,6</sup>	60% after deductible <sup>4,6</sup>
Outpatient group		\$7 copay (unlimited visits)	100% after \$15 copay (counts as 1/2 private visit toward the combined 30 visit max) <sup>5</sup>		

<sup>1,2,3,4,5,6</sup> Refer to the box on page 11 for footnote references.

COUNTY MEDICAL PLANS COMPARISON CHART (CONTINUED)					
These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.					
	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network <sup>2</sup>
<b>Substance Abuse</b>					
Inpatient program	100%; up to 90 days/lifetime max.	Residential program: \$100 copay; up to 30 days/cal. year; transitional residential recovery centers: \$100 copay; up to 60 days/cal. year or 120 in 5-year period	\$100 per admission; up to 30 days/cal. year	Not covered	Not covered
Inpatient detoxification	100% as medically necessary for 3-5 days; limit one episode/lifetime	\$100 copay per day, as medically necessary (detox. only)	\$100 copay	80% after deductible	60% after deductible <sup>4</sup>
Outpatient hospital services	\$5 copay for visits 1-10; \$15 copay for visits 11-30		100% after \$15 copay; 100% after \$30 copay for self-referred visits <sup>5</sup>	Not covered	Not covered
Outpatient office visit	\$5 copay for visits 1-10; \$15 copay for visits 11-30	\$15 copay/private; \$5 copay/group visit; unlimited visits	\$15 copay; up to 30 visits/cal. year <sup>5</sup>	80% after deductible; 24 visits per calendar year combined in- and out-of-network <sup>4</sup>	60% after deductible; 24 visits per calendar year combined in- and out-of-network <sup>4</sup>
<b>Other Benefits</b>					
Allergy testing & treatment	100% after \$5 copay	100% after \$15 copay; \$3/injection	100% after \$15 copay	\$20 copay/visit	60% after deductible
Chiropractic	100% after \$5 copay; up to 20 visits/cal. year	100% after \$15 copay/visit; up to 20 visits/cal. year	100% after \$15 copay/visit; up to 20 visits/cal. year	80% after deductible; 12 visits per calendar year combined in- and out-of-network	60% after deductible; 12 visits per calendar year combined in- and out-of-network
Durable medical equipment	100%	100%	100%	80% after deductible; up to combined max of \$3,000/cal. year	60% after deductible; up to combined max of \$3,000/cal. year
Family planning - Elective pregnancy termination	100% after \$50 copay for 1st trimester; \$100 for 2nd trimester; 3rd trimester not covered unless life threatening	100% after \$15 copay	\$100/elective abortion, tubal ligation; \$75/vasectomy	Elective abortion, tubal ligation, vasectomy = 80% after deductible	Not covered
- Infertility services	50% copay of \$10,000 lifetime max	50% of costs	Infertility – 50% of allowed charges	Infertility services not covered	
- Tubal ligation	100%	100% after \$15 copay			
- Vasectomy	100%	100% after \$15 copay			
Home health care	100%	100%	100% after \$15 copay	80% after deductible	60% after deductible
Hospice – routine home and inpatient respite care	100%	100%	100%	No charge	No charge with prior authorization
Hospice – 24 hour continuous home care and general inpatient care	100%	100%	100%	80% after deductible	80% after deductible with prior authorization
Physical therapy	100% up to 30 visits/disability (within 90 day period)	100% after \$15 copay	100% after \$15 copay	\$20 copay/visit <sup>3</sup>	60% after deductible
Skilled nursing facility	100%; up to 100 days/disability	100% up to 100 days per cal. year	\$100 copay; up to 100 days/cal. year	80% after deductible	60% after deductible <sup>4</sup>

1, 2, 3, 4, 5, 6 Refer to the box on page 11 for footnote references.

## Dental – It’s Important to Your Health

Dental coverage is an important part of your benefits package and a key to your overall health. The County is pleased to offer you a choice of plans, providers and coverage options. To be eligible, you must be a regular County employee scheduled to work at least 20 hours per week and in one of the bargaining units listed below.

### DENTAL PLAN ELIGIBILITY

- Confidential
- DDAA
- Elected Officials
- LEMU (Law Enforcement Management)
- LIUNA
- Management
- RSA Public Safety Unit Employees
- SEIU
- Unrepresented
- Resident Physicians

### PLEASE USE THE FOLLOWING REFERENCES WITH COUNTY DENTAL PLANS COMPARISON CHART

1. You will pay any amount charged by your provider that is in excess of what is considered usual, customary and reasonable (UCR).
2. Precious metal costs not included. United Concordia’s dentists can charge up to an additional \$125 for precious metals.
3. Applies to standard cases only. Other discounts apply for non-standard cases.

**Please refer to the individual dental plan booklets for detailed lists of covered expenses, exclusions and limitations. Dental plan booklets are available from your Department Representative, at a Benefits Fair or by contacting the Benefits Information Line at (951) 955-4981.**

COUNTY DENTAL PLANS COMPARISON CHART						
These benefit summaries only highlight your benefits. They are not Summary Plan Descriptions (SPDs). If any discrepancy exists between these benefit summaries and the official plan documents, the official plan documents will prevail.						
	United Concordia Dental HMO		Local Advantage EPO	United Concordia Preferred PPO		Freedom Dental Indemnity
	TCA-21	TCA-36	Plus	In-Network	Out-of-Network	
Annual deductible	None	None	None	None	\$50 individual \$150 family	None
Calendar year maximum benefit	None	None	\$1,500/person	\$1,200/person	\$1,000/person	\$1,500/person
<b>Diagnostic &amp; Preventive</b>						
Exams	No charge	No charge	No charge	No charge	No charge <sup>1</sup>	No charge <sup>1</sup>
Cleaning	No charge	No charge	No charge	No charge	No charge <sup>1</sup>	No charge <sup>1</sup>
Full mouth X-rays	No charge	No charge	No charge	No charge	No charge <sup>1</sup>	No charge <sup>1</sup>
Topical fluoride – child	No charge	No charge	No charge	No charge	No charge <sup>1</sup>	No charge <sup>1</sup>
Sealants (per tooth)	No charge	No charge	No charge (under age 14)	You pay 20% (under age 14)	You pay 50% after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
<b>Restorative</b>						
Fillings	No charge	No charge	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
<b>Endodontics</b>						
Single root canal	\$20 copay	\$55 copay	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
Bicuspid root canal	\$30 copay	\$70 copay	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
Molar root canal	\$40 copay	\$110 copay	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
<b>Periodontics</b>						
Periodontal scaling and root planing 4 or more teeth/quadrant	No charge	\$30 copay	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
<b>Crowns &amp; Bridges</b>						
Crowns	\$60 - \$75 copay	\$175 - \$200 copay <sup>2</sup>	You pay 35%	You pay 40% <sup>2</sup>	You pay 50% of UCR after deductible <sup>1,2</sup>	You pay 40% of UCR <sup>1</sup>
Bridges	\$50 - \$75 copay	\$175 - \$200 copay <sup>2</sup>	You pay 35%	You pay 40% <sup>2</sup>	You pay 50% of UCR after deductible <sup>1,2</sup>	You pay 40% of UCR <sup>1</sup>
<b>Prosthodontics</b>						
Complete upper denture	\$100 copay	\$175 copay	You pay 35%	You pay 40%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 40% of UCR <sup>1</sup>
Full lower denture	\$100 copay	\$175 copay	You pay 35%	You pay 40%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 40% of UCR <sup>1</sup>
<b>Oral Surgery</b>						
Simple extraction	No charge	\$10 copay	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
Impaction	No charge	\$25 - \$50 copay	You pay 10%	You pay 20%	You pay 50% of UCR after deductible <sup>1</sup>	You pay 20% of UCR <sup>1</sup>
<b>Cosmetic</b>						
Veneers, teeth whitening	No benefit	No benefit	You pay 50%	No benefit	No benefit	No benefit
<b>Orthodontics</b>						
Child	\$1,500 copay	\$1,500 copay	You pay \$120 down, \$120 per month for 24 months <sup>3</sup>	You pay 50%	You pay 50% after deductible <sup>1</sup>	You pay 50% of UCR <sup>1</sup>
Adult (19 & up)	\$2,000 copay	\$2,000 copay		You pay 50%	You pay 50% after deductible <sup>1</sup>	You pay 50% of UCR <sup>1</sup>
Lifetime maximum benefit	None	None	None	\$1,000/person	\$1,000/person	\$1,000/person

<sup>1,2,3</sup> Refer to the box on page 11 for footnote references.

## Vision – Take Good Care of Your Eyes

Good vision is an important component of your overall health. To be eligible for vision benefits, you must be a regular County employee scheduled to work at least 20 hours per week and in one of the bargaining units listed below. Your bargaining unit determines the plans for which you are eligible.

### VISION SERVICE PLAN (VSP) ELIGIBILITY

The County provides the Vision Service Plan for employees in the groups listed below and their eligible dependents at no cost. You do NOT need to enroll. The plan pays benefits and offers discounts for most vision care expenses you incur while covered by the plan, subject to the maximum amounts shown below.

- Elected Officials
- Management
- Confidential
- Unrepresented
- DDAA
- LEMU (Law Enforcement Management)
- Resident Physicians

### VISION SERVICE PLAN HIGHLIGHTS

Benefit Duration	In-Network	Out-of-Network
Exams (every 12 months)	\$20 copayment	\$20 copayment
Lenses (every 24 months)	\$20 copayment	\$20 copayment
Frames (every 24 months)	\$20 copayment	\$20 copayment
Contacts - Visually necessary (every 24 months) - Elective (every 24 months)	No copayment No copayment	No copayment No copayment
Benefit Maximum	In-Network	Out-of-Network
Eye examinations	100%	100% up to \$45
Eyeglass lenses and frames or contact lenses - Single vision lenses - Bifocal lenses - Trifocal lenses - Lenticular lenses	100% 100% 100% 100%	100% up to \$45 100% up to \$65 100% up to \$85 100% up to \$125
Frames	100% up to \$120	100% up to \$47
Contacts (in lieu of frames and lenses) - Visually necessary - Elective	100% 100% up to \$120	100% up to \$210 100% up to \$105

Note: If you receive a vision exam and purchase lenses and frames in a 12-month period, you pay only one \$20 copayment.

**MEDICAL EYE SERVICES (MES) PLAN ELIGIBILITY**

The County offers two vision options through MES for employees represented by the unions listed below.

- SEIU
- LIUNA
- RSA Public Safety Unit

For MES, you may choose between:

- Plan 1 – Eye Exam and Eyewear, or
- Plan 2 – Eyewear Only

Both plans have no deductible and include discounts for contact lenses. Both MES plans allow you to choose care from in-network or out-of-network providers. When you receive care from in-network providers, the plan pays the provider directly, and your out-of-pocket costs are lower. The plan pays benefits and offers discounts for most vision care expenses you incur while covered under the plan, subject to the maximum benefit amounts.

**MES PLAN HIGHLIGHTS**

<b>Benefit Duration</b>	<b>Plan 1 – Eye Exam and Eyewear</b>		<b>Plan 2 – Eyewear Only</b>	
Exams	12 months		Not covered	
Lenses	12 months		12 months	
Frames	12 months		12 months	
Contacts - Visually necessary - Elective	12 months 12 months		12 months 12 months	
PERCENTAGE PAYABLE Eye examinations	100%		Not covered	
Eyeglass lenses and frames or contact lenses	100%		100%	
<b>Benefit Maximum</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Eye examinations	100%	Up to \$60 for ophthalmologist; or up to \$50 for optometrist	Not covered	Not covered
Eyeglass lenses or contact lenses - Single vision lenses - Bifocal lenses - Trifocal lenses - Lenticular lenses	100% 100% 100% 100%	100% up to \$43 100% up to \$60 100% up to \$75 100% up to \$120 for monofocal; or 100% up to \$200 for multifocal	100% 100% 100% 100%	100% up to \$43 100% up to \$60 100% up to \$75 100% up to \$120 for monofocal; or 100% up to \$200 for multifocal
Frames	100% up to \$75	100% up to \$40	100% up to \$75	100% up to \$40
Contacts (in lieu of frames and lenses) - Visually necessary - Elective	100% \$100 allowance if chosen in lieu of all other services	100% up to \$250 \$100 allowance if chosen in lieu of all other services	100% \$100 allowance if chosen in lieu of all other services	100% up to \$250 \$100 allowance if chosen in lieu of all other services

# Flexible Spending Accounts – You Can Save on Your Taxes

Flexible Spending Accounts (FSAs) help you save money by setting aside pre-tax dollars to pay for certain health care and dependent care expenses. The County offers a Health Care FSA and a Dependent Care FSA. Each year you have the option of enrolling in one or both of these accounts. To participate, you must be a regular County employee scheduled to work at least 20 hours per week and in one of the bargaining units listed below.

**IMPORTANT!**  
Be sure to estimate your expenses carefully—you will forfeit any money remaining in your account after the plan year closes.

## FSA ELIGIBILITY

- Confidential
- DDAA
- Elected Officials
- LEMU (Law Enforcement Management)
- LIUNA
- Management
- RSA Public Safety Unit Employees
- SEIU
- Unrepresented
- Resident Physicians

## TAX SAVINGS

The money you put into an FSA is taken out of your paycheck before taxes are withheld, so you end up paying taxes on a smaller amount of income. This means more take-home pay for you!

## IMPORTANT FSA RULES

- Expenses will only be reimbursed if they were incurred during the 2008 plan year (January 1 through December 31) or the 2½-month grace period (January 1 through March 15, 2009). You have until April 15, 2009 to submit reimbursement requests.
- If your employment with the County ends, you can only be reimbursed for claims incurred up to your last day of employment, unless you elect COBRA for a Health Care FSA.
- You must spend all the money in your accounts, or you will lose it. IRS rules do not allow you to carry over an FSA balance from one year to the next, so be sure to estimate your contributions carefully.
- Your contributions will be in effect for the entire plan year. You cannot stop or change your FSA contributions during the plan year unless you have a qualified status change, such as marriage, divorce, or birth or adoption of a child. See page 31 for more information about making mid-year election changes.
- Money cannot be transferred between the health care FSA and the dependent care FSA for expense reimbursement.
- Each year during open enrollment, you must decide whether you want to participate in the FSAs—your enrollment election does not automatically carry over to the next year.

DETAILS ABOUT YOUR FLEXIBLE SPENDING ACCOUNTS		
	Health Care FSA	Dependent Care FSA
<p><b>Your contributions</b> Deducted in 24 equal amounts from your pay warrants.</p>	<p>You may contribute from \$240 to \$15,000 per year.</p>	<p>You may contribute from \$240 to \$5,000 per year, if your tax filing status is "married filing jointly" or "head of household." If you are married and file separate tax returns, you may contribute up to \$2,500 per year.</p>
<p><b>Eligible expenses</b> A complete list of eligible expenses is given in IRS Publications 502 and 503 available by calling 800-829-3676 or logging on to</p> <p><a href="http://www.irs.gov/publications/p502">www.irs.gov/publications/p502</a> <a href="http://www.irs.gov/publications/p503">www.irs.gov/publications/p503</a> <a href="http://benefits.rc-hr.com">http://benefits.rc-hr.com</a></p> <p>Information is also available from the FSA Claims Administrator at (951) 955-5873.</p>	<p>Expenses that could be deducted on your federal income tax return for you, your spouse and/or any dependent you list on your tax return, provided they have not been reimbursed by other coverages.</p> <p><b>Examples include:</b></p> <ul style="list-style-type: none"> <li>• Medical, dental or vision plan deductibles, copayments and coinsurance</li> <li>• Certain expenses not covered by a plan, including over-the-counter medications</li> </ul> <p>Examples of <b>ineligible</b> expenses are your payroll deductions for coverage and cosmetic procedures.</p>	<p>Expenses to care for eligible dependents that allow you (and your spouse, if married) to work or look for work.</p> <p>Eligible dependents include:</p> <ul style="list-style-type: none"> <li>• Children under age 13 who qualify as dependents on your federal income tax return</li> <li>• Your spouse (or other eligible dependent) who is physically or mentally incapable of self-care</li> </ul> <p>Examples of <b>ineligible</b> expenses include food, clothing, education or payments to a dependent relative, or care provided during nonworking hours.</p>
<p><b>Federal income tax</b></p>	<p>You cannot deduct expenses reimbursed by the FSA on your federal income tax return.</p>	<ul style="list-style-type: none"> <li>• You cannot use reimbursed expenses toward the Earned Income Credit or the Child Care Tax Credit.</li> <li>• You are required to list the Social Security number or tax identification number for any dependent care provider.</li> <li>• You and your spouse can not contribute more than \$5,000 combined.</li> </ul>

**HOW THE FLEXIBLE SPENDING ACCOUNTS WORK**

**This is a high-level summary. After you enroll, you will receive a complete FSA kit with detailed instructions.**

1. Make contributions – Your annual election is taken pre-tax in equal amounts over 24 pay periods.
2. Incur expenses – When you access services and pay any required copays, deductibles, coinsurance or dependent care expense.
3. Submit your expenses and reimburse yourself – You reimburse yourself by submitting a claim, along with your receipt or explanation of benefits (EOB), to the FSA plan coordinator. Your claim will be paid from the pre-tax money you accumulate in your Flexible Spending Accounts. Reimbursement checks are distributed once a week. Only eligible expenses incurred in the 2008 plan year (January 1, 2008 - December 31, 2008), or the grace period (January 1, 2009 - March 15, 2009), and submitted by April 15, 2009 will be reimbursed.

## Life Insurance – Protect Your Family’s Financial Future

Life insurance offers you and your family financial protection if you or a covered family member dies. The County provides basic life insurance coverage at no cost to you. Additionally, you may purchase supplemental life insurance through these same companies for yourself, your spouse/ domestic partner and your eligible dependents. Deductions for life insurance coverage are taken on an after-tax basis.

Online enrollment for supplemental life insurance is not available. Enrollment packets are available at <http://benefits.rc-hr.com>, from your Department Representative or by calling the Benefits Information Line at (951) 955-4981. If you are enrolling during Annual Enrollment, your application must be submitted by October 26, 2007.

BASIC LIFE INSURANCE		
	Lincoln Financial Group (formerly Jefferson Pilot)	Standard Life Insurance
<b>Eligible groups</b>	<ul style="list-style-type: none"> <li>• SEIU</li> <li>• LIUNA</li> </ul>	<ul style="list-style-type: none"> <li>• Elected Officials</li> <li>• Confidential</li> <li>• Management</li> <li>• Unrepresented</li> <li>• DDAA</li> <li>• LEMU</li> <li>• RSA Public Safety</li> </ul>
<b>Coverage amount</b>	Coverage is equal to 1x annual salary up to \$50,000	\$50,000 RSA Public Safety coverage is \$10,000
<b>Coverage reduction</b>	Coverage is reduced at certain ages as follows: <ul style="list-style-type: none"> <li>• Age 65 to 65% of original amount</li> <li>• Age 70 to 40% of original amount</li> <li>• Age 75 to 25% of original amount</li> </ul>	Coverage is reduced at certain ages as follows: <ul style="list-style-type: none"> <li>• Age 65 to 65% of original amount</li> <li>• Age 70 to 50% of original amount</li> </ul>

SUPPLEMENTAL LIFE INSURANCE		
	Lincoln Financial Group	Standard Life Insurance
<b>Eligible Groups</b>	<ul style="list-style-type: none"> <li>Elected Officials</li> <li>SEIU</li> <li>LIUNA</li> </ul> <p>Spouses/domestic partners and dependent children under age 23 who have never been married are also eligible. Coverage for children begins 14 days after birth and ends at age 23. The benefit amount is limited to \$250 until the child reaches 6 months of age.</p>	<ul style="list-style-type: none"> <li>Management</li> <li>Confidential</li> <li>Unrepresented</li> <li>DDAA</li> <li>LEMU</li> <li>RSA Public Safety</li> </ul> <p>Spouses/domestic partners and dependent children under age 23 who have never been married are also eligible. Coverage for children begins 14 days after birth and ends at age 23. The benefit amount is limited to \$250 until the child reaches 6 months of age.</p>
<b>Coverage Start Date</b>	<ul style="list-style-type: none"> <li>If you sign up for life insurance during Annual Enrollment, the full amount of your benefit up to the "guaranteed coverage amount" (see pages 22 &amp; 23) will go into effect on January 1, 2008. If you want to purchase more than the guaranteed coverage amount, you will have to give the insurance company satisfactory evidence of good health. The portion of your benefit above the guaranteed coverage amount will go into effect when Human Resources receives approval from the insurance company.</li> <li>If you sign up for life insurance at any time other than Annual Enrollment, the full amount of your benefit up to the "guaranteed coverage amount" (see pages 22 &amp; 23) will go into effect on the first of the month after Human Resources receives your completed enrollment form. If you want to purchase more than the guaranteed coverage amount, you will have to give the insurance company satisfactory evidence of good health. The portion of your benefit above the guaranteed coverage amount will go into effect when Human Resources receives approval from the insurance company.</li> </ul>	
<b>Beneficiaries</b>	A beneficiary is the person or persons you name to receive death benefits. You may choose or change beneficiaries at any time by completing the appropriate form available on Workforce Exchange, from your Department Representative, or by contacting the Benefits Information Line at (951) 955-4981.	
<b>Coverage Options –</b> <i>subject to Guaranteed Coverage Amounts (see pages 22 &amp; 23)</i>	<ul style="list-style-type: none"> <li>Employees (coverage max = 7x annual salary; coverage amounts over certain limits subject to proof of good health) <ul style="list-style-type: none"> <li>- \$10,000</li> <li>- \$50,000</li> <li>- \$100,000</li> <li>- \$150,000</li> <li>- \$200,000</li> <li>- \$250,000</li> </ul> </li> <li>Spouse/Domestic Partner (coverage max = 3.5x your annual salary) <ul style="list-style-type: none"> <li>- \$10,000</li> <li>- \$30,000</li> <li>- \$50,000</li> </ul> </li> <li>Dependent Children <ul style="list-style-type: none"> <li>- \$5,000</li> <li>- \$10,000</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Employees: Increments of \$10,000 up to \$500,000</li> <li>Spouse/Domestic Partner: Increments of \$5,000 up to \$100,000</li> <li>Dependents: \$5,000 or \$10,000</li> </ul>
<b>Coverage Reduction –</b> <i>occurs automatically; age determines cost per \$1,000 of reduced coverage</i>	Coverage is reduced at certain ages as follows: <ul style="list-style-type: none"> <li>Age 65 to 65% of original amount</li> <li>Age 70 to 40% of original amount</li> <li>Age 75 to 25% of original amount</li> </ul>	Coverage is reduced at certain ages as follows: <ul style="list-style-type: none"> <li>Age 65 to 65% of original amount</li> <li>Age 70 to 50% of original amount</li> </ul>
<b>Coverage Decrease and Termination</b>	<ul style="list-style-type: none"> <li>You may terminate or decrease supplemental life insurance coverage at any time during the year.</li> <li>Benefits automatically terminate when you retire or attain age 80; spouse's/domestic partner's coverage terminates when you attain age 70.</li> </ul>	<ul style="list-style-type: none"> <li>You may terminate or decrease supplemental life insurance coverage at any time during the year.</li> </ul>
<b>How to Enroll</b>	<b>How to Enroll for Supplemental Life Insurance</b> <ol style="list-style-type: none"> <li><b>Complete an enrollment form for Lincoln Financial Group or Standard Life.</b> If you are eligible for both plans, you may enroll for both or choose the plan that best meets your needs.</li> <li><b>Complete any required Evidence of Insurability (EOI) forms.</b> Review the EOI description carefully to determine if an EOI form is required. Forms submitted without required EOI will be returned to you and will delay the processing or may result in denial of your application.</li> <li><b>Return your completed forms to your Department Representative.</b></li> </ol>	

**Important Note:** You must elect coverage for yourself before you can elect coverage for your spouse, domestic partner or dependent children.

## Lincoln Financial Group's Coverage Options, Limits and Guaranteed Coverage Amounts

The charts below outline the maximum coverage you may elect and the coverage that does NOT require you to provide proof of good health (also known as "evidence of insurability," or EOI).

<b>Guaranteed Coverage Amount within 60 Days of Eligibility</b> (Within 60 days of date of hire or within 60 days from date entering an eligible bargaining unit)			
<b>Employee's Age*</b>	<b>Employee Coverage Limit</b>	<b>Spouse/Domestic Partner Coverage Limit</b>	<b>Dependent Coverage Limit</b>
Under 60	Elect up to \$250,000; no EOI required	Elect up to \$50,000; no EOI required	Elect up to \$10,000; no EOI required
Age 60-69	Elect up to \$100,000; no EOI required	Elect up to \$30,000; no EOI required	Elect up to \$10,000; no EOI required
Age 70 and Over	Elect up to \$50,000; no EOI required	No spouse coverage available after employee reaches age 70	Elect up to \$10,000; no EOI required
<b>Enrolling During Annual Enrollment</b> (You do not currently have coverage and you are beyond the initial eligibility period)			
<b>Employee's Age*</b>	<b>Employee Coverage Limit</b>	<b>Spouse/Domestic Partner Coverage Limit</b>	<b>Dependent Coverage Limit</b>
Under 60	Elect up to \$250,000; no EOI required up to \$100,000	Elect up to \$50,000; EOI required	Elect up to \$10,000; no EOI required
Age 60-69	Elect up to \$100,000; no EOI required up to \$10,000	Elect up to \$30,000; EOI required	Elect up to \$10,000; no EOI required
Age 70 and Over	Elect up to \$50,000; must provide EOI	No spouse coverage available after employee reaches age 70	Elect up to \$10,000; no EOI required
<b>Increasing Coverage During Annual Enrollment</b> (You currently have coverage and you are requesting additional coverage)			
<b>Employee's Age*</b>	<b>Employee Coverage Limit</b>	<b>Spouse/Domestic Partner Coverage Limit</b>	<b>Dependent Coverage Limit</b>
Under 60	Elect up to \$250,000; you may increase your coverage one level without EOI	Elect up to \$50,000; EOI required	Elect up to \$10,000; no EOI required
Age 60-69	Elect up to \$100,000; you may increase your coverage one level without EOI	Elect up to \$30,000; EOI required	Elect up to \$10,000; no EOI required
Age 70 and Over	Elect up to \$50,000; you may increase your coverage one level without EOI	No spouse coverage available after employee reaches age 70	Elect up to \$10,000; no EOI required

\*Employee's age determines spouse/domestic partner coverage limits and premiums.

<b>LINCOLN FINANCIAL GROUP SUPPLEMENTAL LIFE RATES</b>	
<b>Age of Employee</b>	<b>Monthly Rate Per \$1,000 of Coverage</b>
< 29	\$0.07
30-34	\$0.07
35-39	\$0.10
40-44	\$0.16
45-49	\$0.26
50-54	\$0.44
55-59	\$0.70
60-64	\$0.87
65-80	\$1.64
<b>Monthly Rates for Child Coverage</b>	
<b>Coverage Amount</b>	<b>Monthly Rate</b>
\$5,000	\$1.00
\$10,000	\$2.00

### Standard Life Coverage Options, Limits and Guaranteed Coverage Amounts

The charts below outline the maximum coverage you may elect and the coverage that does NOT require you to provide proof of good health (also known as “evidence of insurability,” or EOI).

Coverage Options (Subject to Guaranteed Coverage Amount Limits)		
<b>Employee</b> Increments of \$10,000 up to \$500,000	<b>Spouse/Domestic Partner</b> Increments of \$5,000 up to \$100,000	<b>Dependents</b> \$5,000 or \$10,000
<b>Guaranteed Coverage Amounts within 60 Days of Eligibility</b> (Within 60 days of date of hire or within 60 days from date entering an eligible bargaining unit)		
No EOI required up to \$250,000	No EOI required up to \$20,000	No EOI required
<b>Enrolling During Annual Enrollment</b> (You do not currently have coverage and you are beyond the initial eligibility period)		
No EOI required up to \$10,000	No EOI required up to \$5,000	No EOI required
<b>Increasing Coverage During Annual Enrollment</b> (You currently have coverage and you are requesting additional coverage)		
You may increase your coverage one level without EOI	You may increase your coverage one level without EOI	No EOI required

STANDARD SUPPLEMENTAL LIFE RATES	
Age of Employee	Monthly Rate Per \$1,000 of Coverage
< 29	\$0.06
30-34	\$0.08
35-39	\$0.09
40-44	\$0.13
45-49	\$0.21
50-54	\$0.35
55-59	\$0.58
60-64	\$0.70
65-80	\$1.32
Monthly Rates for Child Coverage	
Coverage Amount	Monthly Rate
\$5,000	\$0.35
\$10,000	\$0.70

## Rates – Know What You’ll Pay Before You Enroll

**SEIU and LIUNA**  
These rates do NOT reflect the subsidy contribution of \$25 for Two-Party coverage or \$100 for Family coverage. For more information on the subsidy contribution, please see page 6.

Rates are deducted semimonthly (twice a month). Deductions are taken 24 times a year. When you receive a third check in a month, it will not have a deduction for your health plans, unless you owe for uncollected premiums. When reviewing the costs below, remember that the County provides you with Flexible Benefit Credits (described on page 5) to help you with these costs.

PLAN COSTS FOR 2008		
	Monthly	Semimonthly
<b>County Medical Plans</b>		
<b>Exclusive Care EPO</b>		
Single	\$313.38	\$156.69
Two-Party	\$639.62	\$319.81
Family	\$804.90	\$402.45
<b>Blue Shield HMO</b>		
Single	\$414.60	\$207.30
Two-Party	\$827.18	\$413.59
Family	\$1,073.32	\$536.66
<b>Kaiser</b>		
Single	\$428.00	\$214.00
Two-Party	\$854.00	\$427.00
Family	\$1,109.00	\$554.50
<b>Blue Shield PPO</b>		
Single	\$743.58	\$371.79
Two-Party	\$1,486.32	\$743.16
Family	\$1,931.74	\$965.87

PLAN COSTS FOR 2008		
	Monthly	Semimonthly
<b>CalPERS Medical Plans – Other Southern California Counties Region (Riverside, Orange, San Diego and Imperial Counties)</b>		
<b>Blue Shield</b>		
Single	\$447.97	\$223.99
Two-Party	\$895.94	\$447.97
Family	\$1,164.72	\$582.36
<b>Blue Shield HPN</b>		
Single	\$401.98	\$200.99
Two-Party	\$803.96	\$401.98
Family	\$1,045.15	\$522.58
<b>Kaiser</b>		
Single	\$393.63	\$196.82
Two-Party	\$787.26	\$393.63
Family	\$1,023.44	\$511.72
<b>PERSCare</b>		
Single	\$712.71	\$356.36
Two-Party	\$1,425.42	\$712.71
Family	\$1,853.05	\$926.53
<b>PERS Choice</b>		
Single	\$458.59	\$229.30
Two-Party	\$917.18	\$458.59
Family	\$1,192.33	\$596.17
<b>PERS Select</b>		
Single	\$444.05	\$222.03
Two-Party	\$888.10	\$444.05
Family	\$1,154.53	\$577.27
<b>PORAC</b>		
Single	\$452.00	\$226.00
Two-Party	\$847.00	\$423.50
Family	\$1,076.00	\$538.00
<b>Exclusive Care EPO</b>		
Single	\$313.38	\$156.69
Two-Party	\$639.62	\$319.81
Family	\$804.90	\$402.45
<b>CalPERS Medical Plans – Los Angeles Area Region (Los Angeles, San Bernardino and Ventura Counties)</b>		
<b>Blue Shield</b>		
Single	\$392.01	\$196.01
Two-Party	\$784.02	\$392.01
Family	\$1,019.23	\$509.62
<b>Blue Shield HPN</b>		
Single	\$351.77	\$175.89
Two-Party	\$703.54	\$351.77
Family	\$914.60	\$457.30
<b>Kaiser</b>		
Single	\$359.30	\$179.65
Two-Party	\$718.60	\$359.30
Family	\$934.18	\$467.09
<b>PERSCare</b>		
Single	\$697.87	\$348.94
Two-Party	\$1,395.74	\$697.87
Family	\$1,814.46	\$907.23
<b>PERS Choice</b>		
Single	\$449.04	\$224.52
Two-Party	\$898.08	\$449.04
Family	\$1,167.50	\$583.75
<b>PERS Select</b>		
Single	\$434.80	\$217.40
Two-Party	\$869.60	\$434.80
Family	\$1,130.48	\$565.24
<b>PORAC</b>		
Single	\$452.00	\$226.00
Two-Party	\$847.00	\$423.50
Family	\$1,076.00	\$538.00
<b>Exclusive Care EPO</b>		
Single	\$313.38	\$156.69
Two-Party	\$639.62	\$319.81
Family	\$804.90	\$402.45

PLAN COSTS FOR 2008		
	Monthly	Semimonthly
<b>CalPERS Medical Plans – Out-of-State Region (Residents Outside California)</b>		
<b>Blue Shield</b>		
Single		
Two-Party	Not Available	
Family		
<b>Blue Shield HPN</b>		
Single		
Two-Party	Not Available	
Family		
<b>Kaiser</b>		
Single	\$625.52	\$312.76
Two-Party	\$1,251.04	\$625.52
Family	\$1,626.35	\$813.18
<b>PERSCare</b>		
Single	\$816.65	\$408.33
Two-Party	\$1,633.30	\$816.65
Family	\$2,123.29	\$1,061.65
<b>PERS Choice</b>		
Single	\$525.47	\$262.74
Two-Party	\$1,050.94	\$525.47
Family	\$1,366.22	\$683.11
<b>PERS Select</b>		
Single		
Two-Party	Not Available	
Family		
<b>PORAC</b>		
Single	\$452.00	\$226.00
Two-Party	\$847.00	\$423.50
Family	\$1,076.00	\$538.00
<b>Exclusive Care EPO</b>		
Single	\$313.38	\$156.69
Two-Party	\$639.62	\$319.81
Family	\$804.90	\$402.45
<b>County Plans – Dental</b>		
<b>Local Advantage - Plus</b>		
Single	\$42.08	\$21.04
Two-Party	\$83.74	\$41.87
Family	\$124.00	\$62.00
<b>Local Advantage - Blythe</b>		
Single	\$30.00	\$15.00
Two-Party	\$54.30	\$27.15
Family	\$83.20	\$41.60
<b>United Concordia DHMO – TCA21</b>		
Single	\$19.92	\$9.96
Two-Party	\$30.40	\$15.20
Family	\$47.80	\$23.90
<b>United Concordia DHMO – TCA36</b>		
Single	\$14.78	\$7.39
Two-Party	\$22.28	\$11.14
Family	\$34.68	\$17.34
<b>United Concordia PPO</b>		
Single	\$42.06	\$21.03
Two-Party	\$75.34	\$37.67
Family	\$109.78	\$54.89
<b>Freedom Dental Plan</b>		
Single	\$64.60	\$32.30
Two-Party	\$117.70	\$58.85
Family	\$173.42	\$86.71
<b>County Plans – Vision</b>		
<b>Medical Eye Services Plan 1</b>		
Single	\$9.46	\$4.73
Two-Party	\$14.28	\$7.14
Family	\$19.32	\$9.66
<b>Medical Eye Services Plan 2</b>		
Single	\$7.98	\$3.99
Two-Party	\$12.72	\$6.36
Family	\$17.54	\$8.77

## Rules Matter

Benefit programs are highly regulated by federal and state legislation. These regulations are designed to provide the County with specific operational guidelines and to protect participants' rights and access to information. Some of the information in this section is required. We have included other important information as part of the County's commitment to provide our plan participants with everything they need to take full advantage of our benefit programs.

## General Eligibility

### Employee Eligibility

You are eligible to participate in the benefits program if you are a regular County employee scheduled to work at least 20 hours per week. Your bargaining unit determines which plan options are available to you.

### Dependent Eligibility

You may enroll your eligible dependents in your medical, dental, and vision coverage. Eligible dependents include:

- Your legal spouse/registered domestic partner (see information below about domestic partner eligibility)
- Your and/or your spouse/domestic partner's dependent natural children, adopted children, foster children, and stepchildren who are under age 23 have never been married
  - Any child, who is under age 23 and has never been married, for whom you have legal custody, whom you are required to cover under your medical plan as part of a qualified medical child support order, or who lives with you (generally in the absence of the natural or adoptive parent) and is economically dependent upon you
  - An otherwise eligible child past age 23 if the child is incapable of self-support because of a mental or physical handicap and you continue to claim the child as a dependent on your federal income tax return

### Required Proof of Eligibility

You will need to provide proof of eligibility the first time you request that a spouse, domestic partner or domestic partner's child be added to your medical, dental or vision plan. Once you have completed your eBenefits online enrollment or *Benefit Election form*, submit all of the necessary documentation to your Department Representative. If you are doing so during Annual Enrollment, the deadline is October 26, 2007. **Please remember to keep a copy of all documentation for your records.**

### IMPORTANT NOTES ABOUT DEPENDENT ELIGIBILITY

1. It is against the law to enroll ineligible family members. If you do, you may have to pay for all costs incurred by the ineligible dependent from the date the coverage began.
2. If you do not add newly eligible family members to your health plan within the 60-day period of eligibility, you will have to wait until the next Annual Enrollment period before you can enroll them.
3. Your former spouse/ domestic partner, parents, parents-in-law, other relatives, and non-disabled children age 23 and over are not eligible for coverage under your health care plans.
4. You must drop coverage for your enrolled dependent when he or she loses eligibility (for example, if you and your spouse divorce or your child reaches age 23).

### *Spouse*

A copy of your certificate of marriage and your spouse's Social Security card must be submitted at the time your spouse is enrolled. If a marriage certificate is not available to meet the 60-day enrollment period or Annual Enrollment deadline, an *Affidavit of Marriage Form* must be completed and notarized.

### *Domestic Partner*

If you are in a domestic partnership and both of you meet all of the criteria listed below, you may enroll your domestic partner and his or her legal dependent children in your medical, dental and vision plans. A domestic partnership is defined as two people who both:

- Are at least 18 years of age, unmarried, and not a blood relative close enough to bar marriage in the State of California, and
- Live in a mutually exclusive relationship in which you are jointly responsible for each other's welfare and financial obligations, and
- Live in the same principal residence and intend to do so indefinitely, and
- Have registered with the State of California by completing a *Declaration of Domestic Partnership*, having both partners' signatures notarized and submitting the form (with the appropriate fee) to the Secretary of State. You must also give a copy of this form to your Department Representative.

**Important Note:**  
If you are enrolling a domestic partner for coverage, you will not be able to do so using the online enrollment Web site. You must complete a Benefit Election Form available from your Department Representative or at [www.workforceexchange.net](http://www.workforceexchange.net).

Based on state law (AB26 and AB25), the following partners are eligible to register with the state:

- Specified same-sex domestic partnerships between persons who are both at least 18 years of age, and
- Specified opposite-sex domestic partnerships in which one or both partners are age 62 or older.

### *Children*

The County permits you to enroll children (natural, adopted, or stepchildren) who are under the age of 23 and who have never been married in the medical, dental and vision plans. These children are not required to be enrolled in school and do not need to live with you to be eligible for the County's or CalPERS' plans. Additionally, no proof of eligibility is required for natural children, adopted children, or stepchildren.

You may enroll another person's child under the age of 23, who has never married, if the child is economically dependent on you. To verify eligibility, you must submit an *Affidavit of Eligibility Form* stating that:

- You have been granted legal custody or joint legal custody of the child;
- The child lives with you (generally in the absence of the natural or adoptive parent); or

**You may enroll a disabled child who is age 23 or over ONLY upon the initial enrollment or as a CONTINUATION of coverage beyond age 23. In other words, your child must be disabled before reaching age 23, unless you are a new employee enrolling for the first time.**

- The child is the natural, adopted or economically dependent child of your domestic partner

#### *Your Dependent Child's Newborn*

If your dependent child has a baby, the newborn is only eligible for coverage if the dependent child lives with you and is under age 18. The baby will be covered under your insurance for a maximum of one year, unless you have sole custody in the absence of the natural parent. To enroll your child's newborn, you must submit a **notarized** *Eligibility for Miscellaneous Children Form* to Human Resources within 30 days of the baby's birth.

#### *Disabled Children (Age 23 or Over)*

You must complete and submit a *Member Questionnaire for the Disabled Dependent Form* and a *Medical Report Form*. The *Medical Report Form* must be completed by the child's physician, and must be submitted to either the County or CalPERS directly. These forms must be received within 60 days of your initial enrollment or the child's 23rd birthday. The enrollment will be processed, but it will be contingent upon approval of the medical, dental or vision provider. If the dependent child is later deemed ineligible for benefits, the child's coverage will be deleted on a retroactive basis and you will be responsible for any medical services rendered.

## When Coverage Begins

If you are enrolling for coverage or making changes to your current benefits elections during Annual Enrollment, most of your new 2008 coverage elections will be effective January 1, 2008. Your deductions for medical, dental and vision coverage will begin with the first pay warrant in December 2007. Deductions for the Flexible Spending Accounts and supplemental life insurance (up to the guaranteed coverage amount) will begin on your first pay warrant in January 2008. Any supplemental life insurance changes exceeding the guaranteed coverage amount will go into effect when Human Resources receives approval from the insurance company. Keep in mind that both health and life insurance coverage effective dates will be delayed if you are not actively at work or if your enrolled dependent is admitted/confined to a hospital.

### **New Employee Coverage**

If you are a newly hired or newly eligible employee, you may elect to enroll in medical, dental, vision, Flexible Spending Accounts (Health Care and Dental Care) and supplemental life insurance within 60 days of your hire date into an eligible position. All coverage, except supplemental life insurance, will be effective the first day of the month following Human Resources' receipt of your elections. Supplemental life insurance elections

that exceed the guaranteed coverage limits are effective when Human Resources receives carrier approval.

Premiums for the medical, dental and vision plans are collected in advance of the month of coverage; FSA contributions and supplemental life insurance premiums are taken out of your pay during the month of coverage. Most mid-year changes result in a minimum of one month of premium being owed at the time coverage begins. This premium amount owed will be taken in full from the next possible pay warrant. Often, a late enrollment, a mid-year change or carrier notification of acceptance will result in double deductions for the first pay period to begin the benefits you have requested. Please keep this in mind and plan for these additional deductions.

## When Coverage Ends

Plan coverage ends for you and your enrolled dependents at the end of the month for which a full month's premiums have been collected. Typically, this will be the end of the next month following the month of termination. For example, if you terminate or lose eligibility on July 15, your coverage will end on August 31. In the event of your death, coverage for your enrolled dependents will end at the end of the month. If you have only paid half of the monthly premium when you terminate or lose eligibility, your coverage will end at the end of the month. For example, if your employment ends on July 2, your coverage will end on July 31, and any premium collected for August's coverage will be refunded.

In the case of a mid-year qualifying event, coverage will end at the end of the month in which the qualifying event occurs. In all events, coverage may terminate earlier if premiums are not received on time. See the section on COBRA for details about how you and/or your enrolled dependents may continue coverage when eligibility is lost due to a qualifying event.

## Married to Another County Employee?

### *Coordinate Your Coverage to Save Money*

The County of Riverside recognizes that increasing premiums are a burden for employees. By providing Flexible Benefit Credit increases only to employees enrolled in the County's medical plans, the County is able to provide more dollars to employees who are actually paying the County's medical premiums. It's important for you to understand how to make the most of your benefit options.

If you are married to a County employee, you will need to consider your medical plan options carefully during the Annual Enrollment period. When you and your spouse/domestic partner each choose to enroll in a County-sponsored medical plan, you will both receive the maximum Flexible Benefit Credit available. The result of these choices may mean more take-home pay for you and your family!

*Here's How You Might Save Money:*

Let's assume that you and your spouse/domestic partner are both County employees represented by LIUNA. You were both hired before November 13, 2003 and are therefore eligible to waive County-sponsored medical coverage.

**Example 1:** If you enroll yourself and your spouse/domestic partner in Exclusive Care, you will pay the monthly premium of \$639.62. Your spouse/domestic partner reviews the "Can You Waive County Coverage" information on page 6 and chooses to be covered by your County medical coverage (a group plan), electing Medical Waiver and providing information about your County plan online during Annual Enrollment. To continue receiving Flexible Benefit Credits, your spouse/domestic partner enrolls in the Flexible Spending Account for Health Care at \$10 per pay period (\$20 per month). In this specific example, your family will have a combined Flexible Benefit Credit of \$403.70 after premiums are paid (see below).

Example 1:	You	Your Spouse/DP	Net Family Credit
County's Flexible Benefit Credit Contribution	\$612.92	\$425.40	
Cost for Exclusive Care, 2-Party Coverage	(\$639.62)		
County Subsidy	\$25.00		
Net Premium	\$614.62		
Cost for FSA Health Care Enrollment		(20.00)	
<b>Flexible Benefit Credits Remaining</b>	<b>(\$1.70)</b>	<b>\$405.40</b>	<b>\$403.70</b>

**Example 2:** However, if you and your spouse/domestic partner each elect single coverage under Exclusive Care, you each will pay the premium rate for employee only and receive the maximum Flexible Benefit Credit. Your spouse/domestic partner is no longer required to enroll in another County-sponsored plan to receive Flexible Benefit Credits. Your family will have a combined Flexible Benefit Credit of \$599.08 remaining after premiums are paid (see below).

Example 2:	You	Your Spouse/DP	Net Family Credit
County's Flexible Benefit Credit Contribution	\$612.92	\$612.92	
Exclusive Care, Single Coverage	(\$313.38)	(\$313.38)	
<b>Flexible Benefit Credits Remaining</b>	<b>\$299.54</b>	<b>\$299.54</b>	<b>\$599.08</b>

**Net Family Savings (Monthly): \$195.38**

Comparing these two examples shows how changing the way you enroll in benefits may save your family money.

Your potential savings may differ from the above examples depending on your specific benefit elections. For example, your choice of plan(s), the number of family members you need to enroll in your plans, your Flexible Benefit Credits and your Waiver requirements for your bargaining unit will affect your specific out-of-pocket benefit costs.

Use the previous examples as a reference to help you explore your benefit options. You may find that you and your spouse/domestic partner can use your benefits together in a way that provides you more money to care for your family. Review the “Can You Waive County Coverage” section on page 6 for details about waiving coverage, as well as what is required to receive Flexible Benefit Credits.

#### **IMPORTANT:**

**You must notify Human Resources within 60 days of a change in status, or the County will not be able to change your benefit elections and/or refund your premium deductions.**

**Any mid-year benefit change must be consistent with the qualified status change and can be processed by submitting a new *Benefit Election Form* within 60 days of the event to your Department Representative.**

**Most changes are made prospectively from the date that Human Resources receives a properly completed and signed *Benefit Election Form*. Any exceptions for births or adoptions will be made to comply with the special enrollment rights defined under the Health Insurance Portability and Accountability Act.**

***Benefit Election Forms* are available on Workforce Exchange, from your Department Representative, or by contacting the Benefits Information Line at (951) 955-4981.**

## **Making Mid-Year Changes**

The benefit elections you make during Annual Enrollment will stay in effect from January 1, 2008 through December 31, 2008 if you remain eligible for benefits. Each year, during Annual Enrollment, you have the opportunity to change your coverage elections for the following plan year. However, after Annual Enrollment ends, you can make medical, dental, vision, and FSA changes **ONLY** if you have a qualified status change. Qualified status changes include:

- Marriage or registration of a domestic partner
- Divorce or separation from a domestic partner
- Birth or adoption of a child
- Death of a spouse/domestic partner or a child
- Change in your spouse/domestic partner’s employment
- Significant changes in your spouse/domestic partner’s employer’s medical coverage
- Child’s loss of eligibility due to age or marital status
- Full-time/part-time employment status change that results in an insurance eligibility change
- Commencement of or return from an unpaid leave of absence

## **Taxation of Benefits**

According to the IRS, the amount the County pays toward covering dependents who do not meet the definition of a “tax-qualified” dependent, as defined by Internal Revenue Code Section 152, must be reported as ordinary or “imputed” income to you. This means the value of your non-tax-

qualified dependent's coverage is subject to income taxes. Additionally, you may not pay the premiums for these dependents on a before-tax basis, nor may you use the funds in your Flexible Spending Accounts to pay for their health care or dependent care expenses. Please read the following information carefully to determine if you are eligible to make before-tax premium contributions for your dependents.

#### *"Tax-Qualified" Dependents*

To qualify as a "tax-qualified" dependent during a given tax year, your dependent must:

1. Share your principal residence for the full tax year, except for temporary absences such as vacation, military service or education; and
2. Receive more than half of their support from you.

Your spouse automatically qualifies as a tax-qualified dependent. Your non-spouse dependents, including your domestic partner and his or her dependent children, will be tax-qualified if the above criteria are met for a full tax year.

#### *Designating Dependents as "Tax-Qualified"*

Your dependents, *except* your domestic partner and his or her children, are designated by the County as tax-qualified by default. To change your dependent's default tax-qualified designation, you must submit a completed *Dependent Tax Certification Form* to your Department Representative.

#### *Designating Domestic Partner Dependents as "Tax-Qualified"*

Your domestic partner and his or her children are designated as non-tax-qualified by default. If your domestic partner or domestic partner's children meet the definition of tax-qualified, you may receive the tax benefit by completing and returning the *Dependent Tax Certification Form* to your Department Representative.

The *Dependent Tax Certification Form* is available from your Department Representative or online at the Benefits Web site. To access the form online, go to <http://benefits.rc-hr.com> or, from a County computer without Internet access, <http://intranet.co.riverside.ca.us>. Click on the "Forms" button on the right-hand side of the screen and look for the *Dependent Tax Certification Form*.

Whenever you have a change in tax-qualification for a dependent, it is your responsibility to submit this form within 30 days of the tax-status change. Submission of the *Non-Qualified Dependent Certification Form* will NOT remove your dependent from your medical, dental and/or vision plan.

The IRS does not permit partial-year tax-qualified designations. If your dependent is not tax-qualified for any portion of the year, then the County is required to consider that dependent as non-qualified for the full year. Upon receiving your *Non-Qualified Dependent Certification Form*, the County will recalculate your imputed taxes for the entire calendar year and make the appropriate adjustment in your pay warrant.

#### *Calculating and Reporting Imputed Income*

In general, your imputed income is the sum of (1) the amount the County contributes toward coverage of your non-tax-qualified dependent and (2) the amount you contribute toward coverage for your non-tax-qualified dependent for the medical, dental and/or vision plans. Review the table below for the imputed income amount.

### Monthly Rates Monthly Imputed Income

Plan	Monthly Rates		Monthly Imputed Income	
	Employee +1	Employee + Family	1 Non-Qualified Dependent	2 or More Non-Qualified Dependent
Exclusive Care	\$639.62	\$804.90	\$326.24	\$491.52
Blue Shield HMO	\$827.18	\$1,073.32	\$412.58	\$658.72
Blue Shield PPO	\$1,486.32	\$1,931.74	\$742.74	\$1,188.16
Kaiser HMO	\$854.00	\$1,109.00	\$412.58	\$658.72
Local Advantage Plus	\$83.74	\$124.00	\$41.66	\$81.92
Local Advantage Blythe	\$54.30	\$83.20	\$24.30	\$53.20
United Concordia DHMO (TCA21)	\$30.40	\$47.80	\$10.48	\$27.88
United Concordia DHMO (TCA36)	\$22.28	\$34.68	\$7.50	\$19.90
United Concordia PPO	\$75.34	\$109.78	\$33.28	\$67.72
Freedom Dental	\$117.70	\$173.42	\$53.10	\$108.82
Medical Eye Services Plan 1	\$14.28	\$19.32	\$4.82	\$9.86
Medical Eye Services Plan 2	\$12.72	\$17.54	\$4.74	\$9.56

*Taxation Example*

You and your three children are covered by Exclusive Care. You add your domestic partner to your coverage. Your premium for family coverage remains at \$804.90 per month, but you are taxed differently.

Total Monthly Premium	\$804.90
Imputed Amount Taxable	\$326.24
Additional Taxes (assuming 28% Federal tax rate)	\$91.35

Note: California income tax is not required on imputed income.

## Coordinating Your County Plan with Other Coverage

Cost is an important factor when choosing a health plan — but it shouldn't be the only thing you consider. If you have other health plan coverage, you should think about how your plans will coordinate your benefits before selecting a County plan. Careful research before enrollment will ensure that you make the best decision for your specific situation.

*How Coordination of Benefits Provisions Affect Your Coverage*

Most health plans include coordination of benefits (COB) provisions. These provisions are designed to prevent duplication of payments when you or your dependents are covered by more than one insurance plan. COB rules generally result in 100% health plan coverage; however, if the plan's COB provisions don't work well together, COB rules can result in YOU paying up to 100% of your health care expenses.

Your “primary plan” will pay your claim first. Your claim, along with the detail of what was paid by your primary plan, will then be submitted to your “secondary plan,” which will pay benefits according to the COB provisions.

You should review the provisions of your other coverage. If you need help, call the plan's member service department to get a thorough understanding of how your plan will coordinate before making a selection.

The following information is designed to help you ask questions so you can obtain the COB information you need to make an informed plan choice.

### *Determine Which Plan Pays First*

Generally, insurance plans follow standard coordination rules about which plan will pay first and which plan will pay second. Typically, for a County employee, the County's plan will be primary. However, your County plan may be either primary or secondary coverage for your spouse/domestic partner and/or your dependent children. It's important that you verify which plan will be primary and which plan will be secondary for each family member enrolled in both plans. Standard coordination rules are discussed on the following page.

### *Ask Each Plan Important Information*

To determine how both plans' specific provisions will work together, you need to request basic plan information, such as:

- Requirement to use a network to obtain benefits for routine, urgent and emergency care;
- Plan benefits; and
- Coordination of benefit provisions.

This information will be included in your plan's Summary Plan Description or Evidence of Coverage document.

### *Share Plan Information*

So each plan representative understands what benefits are being coordinated, you need to share the above information. The more information you are able to share, the more specific the coordination of benefit information you will receive.

### *Claims Payment Questions*

Ask each plan how benefits will be paid if you or your family members receive care both in-network and out-of-network for routine, urgent and emergency care. Be sure you understand how the plan will pay if it's secondary to your other plan.

### *Important Note*

If for some reason the primary plan does not pay the full benefit for a particular claim, the secondary plan will usually still pay only the amount it would normally cover. For example, suppose your primary plan denies payment for some or all of a claim; when you submit the claim to your secondary plan, that plan may pay benefits as if the primary plan had paid you the full benefit. This means you could end up with some out-of-pocket expenses if your primary plan denies your claim.

## Standard Rules for Coordination of Health Care Benefits

### *Which Plan Pays First?*

The following rules are a standard in the health care industry and will generally establish the order in which benefits will be determined:

1. Any plan that has no coordination of benefits provision will pay first.
2. When all plans have a coordination of benefits provision, the plan that covers the person as an employee will pay first.
3. When two plans (one covering each parent) cover the same child as a dependent, the plans will pay in this order:
  - The plan that covers the parent whose birthday falls earlier in the year pays first.
  - If both parents have the same birthday, the plan that has covered one of the parents the longest pays first.
  - However, other rules apply if a claim is made for a covered dependent child whose parents are separated or divorced. If the parent with custody of the child has not remarried, the plans will pay in this order:
    - First – the plan that covers the child as a dependent of the parent who has custody
    - Second – the plan that covers the child as a dependent of the parent who does not have custody
  - If the parent with custody of the child has remarried, the plans will pay in this order:
    - First – the plan that covers the child as dependent of the parent who has custody
    - Second – the plan that covers the child as the dependent of the stepparent
    - Third – the plan that covers the child as the dependent of the parent who does not have custody

These rules do not apply when a court order, such as a qualified medical child support order (QMCSO), establishes the responsibility for the health care costs of a child whose parents have separated or divorced. (QMCSOs are described in the “Plan Participation” section of the SPD.) Any plan under which the child is covered as the dependent of a parent with this legal responsibility will always pay first.

# Important Notice from the County of Riverside About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the County-sponsored medical plans and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

**DO NOT SIGN UP FOR A MEDICARE PRESCRIPTION DRUG PLAN IF YOU ARE ENROLLED IN ONE OF THE COUNTY'S MEDICAL PLANS.**

**Your County-sponsored plan already covers prescription drugs; if you sign up for a Medicare drug plan as well, you will lose your current health plan coverage.**

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The County of Riverside has determined that the prescription drug coverage offered by the County-sponsored health plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**You may need to give a copy of this Medicare notice when you join a new Medicare drug plan to show that you are not required to pay a higher premium amount.**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15 through December 31. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. *In addition, if you lose or decide to leave employer/union sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.* You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, your County of Riverside plan coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your health and prescription drug benefits.

If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the County-sponsored health plans during an open enrollment period under the County's benefit plans.

You should also know that if you drop or lose your coverage with a County-sponsored plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join a Medicare prescription drug plan.

#### **For more information about this notice or your current prescription drug coverage...**

Contact the County of Riverside at the telephone number listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the County-sponsored health plans changes. You also may request a copy.

#### **For more information about your options under Medicare prescription drug coverage...**

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

#### **For more information about Medicare prescription drug coverage:**

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. In California, call 1-800-510-2020.
- Call (800) MEDICARE (800-633-4227). TTY users should call (877) 486-2048.

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

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

Date: October 1, 2007  
 Name of Entity/Sender: The County of Riverside  
 Contact-Position/Office: Human Resources, Benefits Division  
 Address: 4080 Lemon Street, Riverside CA 92501  
 Phone Number: (951) 955-4981

# Health Insurance Portability and Accountability Act (HIPAA)

THIS NOTICE DESCRIBES HOW THE COUNTY OF RIVERSIDE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

## **Effective Date: April 14, 2003**

The County creates records of health care to provide quality care and comply with legal requirements. The County understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. The law requires the County to keep your health information private and to provide you this notice of our legal duties and privacy practices. The law also requires the County to follow the terms of this notice.

This notice outlines the limits on how the County will handle your health information. Under federal law, the County must provide a copy of this notice when you receive health care and related services from the County, or participate in certain health plans administered or operated by the County. The County reserves the right to change practices and make new provisions effective for all health information it maintains. You may request an updated copy of this notice at any time.

## **A. Use and Disclosure – General**

Generally, except as otherwise specified below, the County may use and disclose the following health information, as allowed by state and federal law:

- 1. For treatment.** The County uses and discloses health information to provide you health care and related services. For instance:
  - Nurses, doctors, or other County employees may record your health information, and they may share such information with other County employees.
  - The County may disclose health information to people outside the County involved in your care who provide treatment and related services.

- The County may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.
- In emergencies, the County may use or disclose health information to provide you treatment. The County will make its best effort to obtain your permission to use or disclose your health information as soon as reasonably practical.

**2. For payment.** The County may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.

**3. For health care operations.** The County may use information in your health record to assess the care and outcomes in your case to improve our services, in administrative processes such as purchasing medical devices, or for auditing financial data.

**4. For health plan administration.** As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, the County may disclose limited information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

### **B. Use and Disclosure Requiring Your Authorization**

On a limited basis, the County may use and disclose health information only with your permission, as required by state and federal law:

1. From mental health records.
2. From substance abuse treatment records.

### **C. Use and Disclosure Requiring an Opportunity for You to Agree or Object**

In certain cases, the County may use and disclose health information only if it informs you in advance and provides an opportunity to agree or object, as required by state and federal law:

1. The County may include your name, location in the facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.
2. To individuals assisting with your treatment or payment.
3. To assist with disaster relief to notify your family about you.

#### **D. Use and Disclosure NOT Requiring Permission or an Opportunity for You to Agree or Object**

In specific cases, the County may use and disclose the following health information without your permission and without providing you the opportunity to agree or object:

1. As required by law.
2. For public health activities, which may include the following:
  - Preventing or controlling disease, injury or disability;
  - Reporting births and deaths;
  - Reporting abuse or neglect of children, elders and dependent adults;
  - Reporting reactions to medications or problems with products;
  - Notifying people of recalls of products they may use; or,
  - Notifying a person exposed to or at risk to contract or spread a disease or condition.
  - For mandated reporting of abuse, neglect or domestic violence.
3. For health oversight activities necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.
4. To the minimum extent necessary to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.
5. To law enforcement:
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the hospital; or
  - In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.
6. To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.
7. For organ donation once you are deceased.
8. For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.
9. To avert serious threats to the health and safety of you or others.
10. Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.

**County Privacy Office**  
P.O. Box 1569  
Riverside, CA 92502  
(951) 955-1000

**Privacy Complaint Contracts**  
**Riverside County Regional**  
**Medical Center**  
**Privacy Officer**  
26520 Cactus Avenue  
Moreno Valley, CA 92555  
(951) 486-4659

**Office on Aging**  
6296 Rivercrest Drive,  
Suite K  
Riverside, CA 92507  
(800) 510-2020

**Community Health Agency**  
**Privacy Officer**  
4065 County Circle Drive  
Riverside, CA 92503  
(951) 358-5000

**Mental Health**  
**Privacy Officer**  
4095 County Circle Drive  
Riverside, CA 92503  
(951) 358-4500

**Public Social Services**  
**Privacy Officer**  
10281 Kidd Street  
Riverside, CA 92503  
(951) 358-3030

**Occupational Health**  
**& Wellness**  
P.O. Box 1569  
Riverside, CA 92502  
(951) 955-1000

**Veterans Services**  
1153A Spruce Street  
Riverside, CA 92507  
(951) 955-6050

**Employee Assistance**  
**Program**  
3600 Lime Street,  
Suite 111  
Riverside, CA 92501  
(951) 778-3970

**Exclusive Care Plan**  
P.O. Box 1508  
Riverside, CA 92502  
(800) 962-1133

**U.S Department of Health**  
**& Human Services Region**  
**IX Office of Civil Rights**  
50 United Nations Plaza,  
Room 322  
San Francisco, CA 94102  
TEL: (415) 437-8310  
TDD: (415) 437-8311  
FAX: (415) 437-8329

11. To determine your eligibility for or entitlement to veterans benefits.
12. To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.
13. To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.
14. To determine your eligibility for or enroll you in government health programs.
15. For Workers' Compensation or similar programs, to the minimum extent necessary.

The County will not disclose your health information for marketing, fundraising, or other reasons not listed above without your prior written permission, and you may withdraw that permission in writing at any time. If you do, the County will no longer use or disclose health information about you for the reasons you permitted. You understand the County is unable to retract disclosures already made with your permission, and must retain records of care already provided.

### **E. Rights and Responsibilities**

With regard to health information, the County recognizes and commits to safeguard your:

- 1. Right to request restrictions on certain use and disclosure.** You have the right to request restriction or limitation on the health information the County uses or discloses for treatment, payment or health care operations, though the law does not require the County to agree to your request. If the County agrees, it will comply except to provide emergency treatment. Requests must be in writing and state the following: the information you want to limit; whether to limit use, disclosure, or both; and, to whom limits apply. For instance, you may ask not to disclose to your spouse.
- 2. Right to confidential communications.** You have the right to ask the County to communicate with you in a certain way, or at a certain location.
- 3. Right to request to inspect and copy records.** You have the right to request to inspect and obtain copies of your health information. Requests may be required in writing, and the County may charge you a fee for the costs of fulfilling your request. The County may deny requests to inspect or copy psychotherapy notes, mental health records, or materials for legal proceedings. You may ask for review of a denial by another health care professional chosen by the County. The County will comply with the results of that review.

**4. Right to amend health records.** If information the County has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. The County may deny your request if it is not in writing, or does not include a reason supporting it. The County may deny requests if the information:

- Was not created by the County;
- Is not health information kept by or for the County;
- Is not information you are permitted to inspect and copy; or
- Is accurate and complete.

**5. Right to an accounting of certain disclosures.** You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. The County may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.

**6. Right to obtain a paper copy of the notice of privacy practices upon request.**

**7. Right to file complaints without fear of retaliation.** Under law, the County cannot penalize you for filing a complaint. If you believe the County violated your privacy rights, you may file a complaint with the department privacy officer, County privacy office, or with the U.S. Secretary of Health and Human Services.

## Women's Health And Cancer Rights

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgical reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services is subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

# Initial COBRA Notification of Rights and Obligations

Federal law requires the County of Riverside to offer all covered active employees and their covered spouses and dependents (“Qualified Beneficiaries”) the opportunity to elect a temporary extension of their health and welfare plan coverage (called “Continuation Coverage,” “COBRA Continuation Coverage,” or “COBRA Coverage”) in certain instances where coverage under a group plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health Flexible Spending Account (FSA) or other plan sponsored by the County that provides medical care. For simplicity, any such group health plan is referred to in this notice as the “Plan.” You will have to pay the entire premium for your COBRA Coverage.

## *Coverage*

“Qualified Beneficiaries” are generally the employee, the employee’s spouse or the employee’s dependent children who are covered by the Plan on the day before a “Qualifying Event.” This notice is to provide you, your covered spouse and covered dependents (all of whom may be Qualified Beneficiaries if Plan coverage is lost) with a brief summary of your rights and obligations under current COBRA law.

Please note that COBRA Coverage is not available to domestic partners and their children because they do not meet the legal definition of “Qualified Beneficiaries.”

***Both you and your spouse should read this notice carefully and keep it with your records.***

You must notify the Plan Administrator in writing with the current addresses of covered dependents who do not reside with you and with any change of address for yourself so that the Plan Administrator can send this and other notifications to you and your dependents.

## *Qualifying Events*

Qualifying Events are defined as certain events that cause an individual to lose health coverage. The type of Qualifying Event will determine the amount of time a Plan must offer their health benefits to Qualified Beneficiaries under COBRA.

#### *Qualifying Events for the Employee*

If you are a covered employee, you have the right to elect COBRA Coverage for yourself and/or your dependents if you lose Plan coverage because of any of the following Qualifying Events:

- Voluntary or involuntary termination of your employment (for reasons other than your gross misconduct).
- Reduction in the hours of your employment.

#### *Qualifying Events for Spouses*

If you are the covered spouse of an employee, you have the right to elect COBRA Coverage if you lose Plan coverage because of any of the following Qualifying Events:

- The death of your spouse.
- Voluntary or involuntary termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the County of Riverside.
- Divorce or legal separation from your spouse.
- Your spouse becomes entitled to Medicare benefits.

#### *Qualifying Events for Dependent Children*

If you are the covered dependent child of an employee, you have the right to elect COBRA Coverage if Plan coverage is lost because of any of the following Qualifying Events:

- Voluntary or involuntary termination of your employee parent's employment (for reasons other than gross misconduct) or reduction in your employee parent's hours of employment with the County of Riverside.
- The death of the employee parent.
- Parent's divorce or legal separation.
- The employee parent becomes entitled to Medicare benefits.
- You cease to be a "dependent child" under the terms of the Plan(s).

#### *Required Notifications from the Employee, Spouse and Dependent(s)*

If a spouse or dependent child loses coverage under the Plan(s) due to a divorce, legal separation, or the loss of a child's dependent status under the terms of the Plan(s) then under COBRA, you (the employee) or your spouse or dependent child have the responsibility to provide written notice to the Plan Administrator of the divorce, legal separation, or loss of a child's dependent status under the terms of the Plan(s). The employee or covered spouse or covered dependent must give this written notice within 60 days of the date of the event or the date coverage terminates under the terms of the Plan(s) because of the event, whichever is later.

***If you or your family member fails to notify the Plan Administrator during the 60-day period, the individual losing coverage will NOT be offered the option to elect COBRA Continuation Coverage.***

*Required Notification from the Employer*

Within 30 days of the date of the loss of coverage due to the employee's termination or reduction in hours, death or eligibility for Medicare, the employer is required to notify the Plan Administrator of the loss of coverage.

*Required Notification from the Plan Administrator*

Upon receiving notice of a divorce, legal separation, a child losing dependent status, the covered employee's termination of employment, reduction in hours, death of the employee, or the employee parent becoming entitled to Medicare, the Plan Administrator will notify the affected Qualified Beneficiary of the right to elect COBRA Continuation Coverage within 14 days (no action required by employee, spouse or dependent).

*Election of Continuation Coverage*

The Qualified Beneficiary (the employee or the spouse or dependent children) must elect COBRA Continuation Coverage within 60 days after the Plan coverage ends or within 60 days after the Plan Administrator provides you or your covered dependent(s) with notice of the right to elect COBRA Continuation Coverage, whichever is later.

***If you or your spouse and dependent children do not elect COBRA Continuation Coverage within this 60-day election period, you will lose your right to elect COBRA Continuation Coverage.***

Each Qualified Beneficiary who was covered by the Plan on the day before the Qualifying Event has independent election rights to COBRA Continuation Coverage. You (the employee) and/or your spouse may elect COBRA Continuation Coverage for all qualifying family members. The covered employee, spouse and dependent child(ren) each have an independent right to elect COBRA Continuation Coverage. Thus, a spouse or dependent child may elect COBRA Continuation Coverage even if the covered employee does not elect it.

A Qualified Beneficiary does not have to show that he/she is insurable to choose Continuation Coverage. However, Continuation Coverage is available to Qualified Beneficiaries subject to their continued eligibility. The Plan

Administrator reserves the right to verify eligibility status. If it is determined that an individual is not a Qualified Beneficiary, he/she is not entitled to COBRA Continuation Coverage.

#### *Type of Coverage*

If a Qualified Beneficiary chooses Continuation Coverage, the County of Riverside must provide to COBRA participants coverage that is identical to the coverage provided to similarly situated active employees or family members. If the coverage for similarly situated employees or family members is modified, then COBRA Coverage will be modified in the same way. When a Qualified Beneficiary is first eligible for COBRA Coverage, he/she only has the right to continue the Plan benefits (for example, hospital, medical, prescription drug, dental or vision benefits) he/she had on the day before the event causing the Qualified Beneficiary's loss of coverage. However, a Qualified Beneficiary does have the right to change Plan benefits during the employer's open enrollment period, assuming regular employees may change their Plan benefits during this time. At the same time, a Qualified Beneficiary may add any dependents he/she did not have enrolled at the time of the Qualifying Event (their coverage will depend upon the Qualified Beneficiary continuing coverage under COBRA; dependents added during open enrollment are not considered Qualified Beneficiaries).

Under the provisions of COBRA, each Qualified Beneficiary has a separate right to elect to continue coverage for each of the employer's separate health and welfare plans. For instance, a Qualified Beneficiary could elect to continue his/her group medical coverage and waive the continuation of his/her group dental coverage. The applicable premiums will vary depending on the coverage elected. If a Qualified Beneficiary is covered by a region specific Health Maintenance Organization (HMO), and he/she is moving outside of the HMO service area, additional rights may be available to the Qualified Beneficiary at the time of the event. Please call the Plan Administrator for additional information.

#### *No Coverage During Election Period*

A Qualified Beneficiary will not be covered under the Plan(s) during the 60-day election period and 45-day period allowed to pay for the initial premium payment for COBRA Coverage. However, if a COBRA coverage election is made in accordance with the current COBRA laws and all applicable premiums are paid as detailed in a later section, then coverage under the health and welfare plan(s) selected will be retroactive to the original loss of coverage date in accordance with federal law. Upon timely receipt of a Qualified Beneficiary's properly completed and signed election form,

coverage shall be in effect under the applicable Plan. If a medical provider calls for verification of eligibility or benefits during the election period and the Plan Administrator does not have a record of a timely and properly completed election form and payment of premium, the medical provider will be told that the Qualified Beneficiary does not have coverage but that he/she will be covered as of the COBRA effective date provided that a timely and properly completed election form and premium payment are received. Upon timely receipt of a properly completed election form and payment of all applicable premiums, COBRA Continuation Coverage shall be in effect.

#### *Effective Date of Continuation (COBRA) Coverage*

For all COBRA Qualifying Events, coverage is lost at the end of the payroll period in the month in which the event occurs. COBRA Continuation Coverage begins the first day of the payroll period following the date of the Qualifying Event. Thereafter, COBRA coverage begins on the first day of each successive month. For example, if coverage ends on April 13 due to a COBRA Qualifying Event, Continuation Coverage must begin on May 1 as breaks in coverage are not permitted.

#### *Premium Payments*

You (the employee) or a family member is responsible for all premium payments for your Continuation Coverage. As allowed by federal law, your premium payment will be equal to the cost of the coverage you select plus 2% for administration. Exception: If coverage is being continued during a disability extension, then the premiums will be equal to 150% of the cost of coverage during that 11-month disability extension period. The cost may be 213% of the premiums if COBRA Coverage is further continued under California law when the employee was at least age 60 at the time of termination with a minimum of five (5) years of service with the County.

Premium payments for the "initial premium months" are due by the 45th day after electing Continuation Coverage. The initial premium must cover the period that elapsed from the date of the loss of coverage due to the Qualifying Event to the date paid. If you do not make the payment on time, there is no right to Continuation Coverage. All other premiums are due on the 25th day of the month prior to the month for which coverage is desired subject to a 35-day grace period. If you do not make the payment within the grace period, COBRA Coverage will be canceled as of the first day of that month.

### *Maximum Coverage Periods*

- 1. 36 Months.** If a spouse or dependent child(ren) Qualified Beneficiary loses group health coverage because of the employee's death, divorce, legal separation, the employee becoming entitled to Medicare after COBRA has been elected or because a Qualified Beneficiary loses status as a dependent under the Plan, the maximum coverage period for the Qualified Beneficiary spouse or dependent child(ren) is three years (36 months) from the date of the initial Qualifying Event.
- 2. 18 Months.** If an employee, spouse or dependent child(ren) Qualified Beneficiary loses group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, the maximum Continuation Coverage period (for employee, spouse or dependent child(ren)) is 18 months from the date of termination or reduction in hours or date of loss of coverage if that is later.
- 3. 29-Month Disability Exception.** If an employee or family member is disabled at any time during the first 60 days of the 18-month COBRA Continuation Coverage period, then the maximum period will be increased to 29 months for all enrolled family members provided total disability is determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act; the total disability award occurs within the first 18-months of coverage; and the Plan Administrator is notified within 60 days of the date the final determination of total disability is made by the Social Security Administration.

If a determination is made that the individual is no longer disabled, the individual must provide notice of the determination to the Plan Administrator within 30 days of that finding.

- 4. Second Qualifying Event Exception.** For a spouse or dependent Qualified Beneficiary who has the right to 18 months of COBRA Coverage due to an employee's termination of employment (other than for gross misconduct) or reduction of hours, there is a right to extend coverage an additional 18 months up to a maximum of 36 months in the event of a second Qualifying Event during the 18-month COBRA period. For example, the employee and spouse have continuing coverage under COBRA for 6 months when they divorce; the divorce is a second Qualifying Event that allows the spouse to have continued coverage for an additional 30 months (36 months less the 6 months he/she had already used of COBRA Continuation Coverage).

## 5. Special Rules Involving Employee's Entitlement to Medicare

**Benefits.** These rules apply to the duration of COBRA Continuation Coverage for spouses and dependents of employees who become eligible for Medicare prior to the Qualifying Event (whether or not coverage is lost at that time): If a Qualified Beneficiary employee first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-135ggg) before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:

- a. 36 months after the date the covered employee became entitled to Medicare benefits; or
- b. 18 months (or 29 months if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

**6. Shorter Maximum for FSAs.** The right to COBRA Continuation Coverage for a health care Flexible Spending Account (FSA) is limited. An employee may continue coverage if he/she has a balance on account in the health care FSA. The Plan Administrator shall determine if the employee qualifies for COBRA Continuation Coverage. If so, the maximum COBRA period for a health care FSA maintained by the employer ends on the last day of the Plan Year in which the Qualifying Event occurred.

### *Termination before the End of Maximum Coverage Period*

Continuation Coverage of the employee, spouse or dependent child(ren) will automatically terminate (even before the end of the maximum coverage period) when any one of the following four events occurs:

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for the Continuation Coverage is not paid on time.
3. You (the employee, spouse or dependent child(ren)) become covered under another group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any pre-existing condition that you have other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the other plan has exclusions or limitations, your COBRA Coverage will terminate after the exclusion or limitation no longer applies (e.g., after a 6-month preexisting condition waiting period expires).

4. You (the employee, spouse or dependent child(ren)) became entitled to a 29-month maximum coverage period, but then a final determination is made under the Social Security Act that you are no longer disabled. However, COBRA Continuation Coverage will not end until the month that begins more than 30 days after the determination.

#### *COBRA Extension under California Law*

Effective September 1, 2003, terminated employees or employees who have lost medical plan coverage due to a reduction in hours on or after January 1, 2003, may extend their coverage for up to an additional 18 months (not to exceed a total of 36 months of continuation coverage from the qualifying event). The premium cost for this coverage will be 110% of the total cost. This extension is not available for the Health Care Flexible Spending Account, dental plans and/or vision plans.

#### *Open Enrollment Rights and HIPAA Special Enrollment Rights*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA Coverage cannot be canceled. However, if the other plan's pre-existing condition rules do not apply to you due to HIPAA's restriction on pre-existing condition clauses, then COBRA Coverage can be canceled. You and your covered dependents will receive a Certificate of Creditable Coverage when your coverage under the County of Riverside health plan ends. You will receive another Certificate of Creditable Coverage when your COBRA Coverage ends.

To waive the pre-existing condition clause, you must have prior creditable coverage under another group health plan within the 62 days immediately before the date you enrolled in the Plan. You must receive a Certificate of Creditable Coverage from your Plan Administrator or directly from your past medical plan(s) as proof of prior coverage.

If your dependents were eligible for coverage, but did not enroll in the County-sponsored medical plan because they had other medical coverage, and they lose that other medical coverage, they will be allowed to enroll in the current medical plan during special enrollment periods after their initial eligibility period if certain conditions are met. These special enrollment rules apply to eligible dependents that are not enrolled for coverage under the terms of the Plan. You may also enroll newly acquired dependents under the special enrollment rules.

A dependent is eligible to enroll during special mid-year enrollment periods if the following conditions are met:

- When you declined enrollment for your dependent(s), your dependent(s) had COBRA Continuation Coverage under another plan and that COBRA Continuation Coverage has since been exhausted (i.e., ceased for any reason); or
- If the other coverage that applied to your dependent(s) when enrollment was declined was not under a COBRA Continuation provision, either the other coverage has terminated as the result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

*Children Born to or Placed for Adoption with the Covered Employee during a COBRA Period*

A child born to, adopted by, or placed for adoption with a Qualified Beneficiary during a period of Continuation Coverage is considered a Qualified Beneficiary unless the employee was a Qualified Beneficiary who elected not to continue coverage for himself/herself. The covered employee or other guardian has the right to elect Continuation Coverage for the child if the child satisfies the other applicable Plan eligibility requirements. The covered employee or a family member must notify the Plan Administrator within 30 days of the date of birth, adoption or placement for adoption in order to enroll the child on COBRA, and COBRA Coverage will last as long as it lasts for the other family members of the employee.

***If the covered employee or family member fails to notify the Plan Administrator timely, then the covered employee will NOT be offered the option to elect COBRA Coverage for the child.***

Note: the newborn or adoptee may be eligible for coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) even if he or she is not a Qualified Beneficiary for purposes of COBRA.

*Conversion to an Individual Policy*

Upon termination of the maximum COBRA Continuation Coverage period, you and any covered dependents will have the right to convert your coverage to an individual policy if one is available through your Plan. You will be notified of this right within 180 days prior to the end of your COBRA Coverage maximum period.

*Notice of Address or Status Changes to Plan Administrator*

*You must notify the Plan Administrator about address changes, any new marital status and changes in the status of your dependents.*

The Plan Administrator sends COBRA notices to your last known address of record with the employer. The address for a covered employee's spouse or child(ren) shall be the employee's address unless you (employee, spouse or dependent[s]) notify the Plan Administrator in writing of a different address for the spouse or dependent(s). If you or your spouse's or dependent's address changes, you must promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan(s)'s terms, you or your spouse or dependent must promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA rights for your spouse and dependent child(ren)). Otherwise, the Plan Administrator shall use your last known address.

*Plan Administrator*

The County of Riverside is the Plan Administrator for all group medical care plans. All notices and other communication regarding the Plans, and/or regarding COBRA and HIPAA must be directed to:

County of Riverside  
Human Resources Department  
Employee Services Division, Attention COBRA  
4080 Lemon Street  
P.O. Box 1569  
Riverside, CA 92502-1569  
Telephone Number: (951) 955-1000

*For More Information*

If you (the employee), your spouse or dependent child(ren) have any questions about this notice of COBRA rights, please contact the Plan Administrator. Also, please contact the Plan Administrator if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions and limitations.

***This Initial Notice is not intended to give greater rights than allowed under COBRA. If there is a conflict or ambiguity between the information in this notice and any other COBRA notice you receive from an insurance carrier, this notice shall prevail.***



## **Make Wellness Part of Your Life**

The County of Riverside's benefits programs are a valuable element of the overall compensation package for our employees. We aim to ensure that our benefits program and plans are competitive and provide reasonable levels of coverage that serve the diverse needs of our employees. But our commitment to you goes beyond a competitive benefits package to include a focus on promoting healthy lifestyles.

## **What the Wellness Program Is All About**

With this focus in mind, the **Riverside County Human Resources Wellness Program** was established to provide all Riverside County employees with a workplace that encourages and promotes healthy lifestyle choices leading to optimal health and well-being. The Wellness Program engages and empowers employees to improve their health and fitness and to achieve a better quality of life, while reducing health care costs and resulting in a more productive workforce. Plus, the Healthy Lifestyle Rewards Program provides cash incentives to improve your health.

## **What the Wellness Program**

### **Has to Offer:**

- Health seminars
- Walking clubs
- Targeted departmental programs
- Lifestyle management groups
- One-on-one consultations for employees at high risk for contracting lifestyle-related conditions
- Healthy Lifestyle Rewards (\$\$)

Participation in the program is free! So call, e-mail or log on to [www.rc-hr.com/wellness](http://www.rc-hr.com/wellness) to get on the path to a healthier life today.

## **Who to Contact**

Wellness Coordinator

Dave Williams, MD, MPH

[davewill@rc-hr.com](mailto:davewill@rc-hr.com)

Phone: (951) 778-3977

Health Educator

Eileen Ferrer

[emferrer@rc-hr.com](mailto:emferrer@rc-hr.com)

Phone: (951) 778-3976

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[www.rc-hr.com/wellness](http://www.rc-hr.com/wellness)