



Important Rules That Govern Our Benefits Program



Your Guide to Online Enrollment

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.

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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 enclosed for more details.



Alternative formats available upon request. Contact Employee Benefits as soon as possible. It can take up to two weeks to fulfill your request.

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 may enroll them during any future annual enrollment period.
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 healthcare plans.
4. You must drop coverage for your enrolled spouse/domestic partner or dependent child when he/she loses eligibility (e.g., divorce, or your child attains age 23 or marries).

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. For more information about your benefit options, please review the information provided in the annual enrollment guide.

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 under age 23 and who have never been married
 - Any child, who is under age 23 and has never been married, for whom you have legal custody, have been required to cover under your medical plan as part of a qualified medical child support order or who resides with you (generally in the absence of the natural or adoptive parent) and who 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 a spouse, domestic partner or domestic partner's child to 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 27, 2006. **Please remember to keep a copy of all documentation for your records.**

Spouse

A copy of your certificate of marriage and your spouse's social security number 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.

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.

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 and/or dental 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
- Are in a domestic partnership as attested by both of you through a signed California Declaration of Domestic Partnership Agreement. You must also give a copy of this form to your Department Representative.

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

- Specified same-sex domestic partnership between persons who are both at least 18 years of age, and
- Specified opposite-sex domestic partnerships where one person is over the age of 62.

Children

The County permits you to enroll children (natural, adopted, or step children) 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 reside with the employee 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, an *Affidavit of Eligibility Form* must be completed and submitted at the time they are enrolled:

- You have been granted legal custody or joint legal custody of the child
- The child resides with you (generally in the absence of the natural or adoptive parent)
- The child who is the natural, adopted, stepchild or economically dependent child of your domestic partner

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.

Disabled Children (Age 23 or Over)

The employee 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 the 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 the annual enrollment period, most of your new 2007 coverage elections will be effective January 1, 2007. Your deductions for medical, dental and vision coverage will begin with the first pay warrant in December 2006. Deductions for the Flexible Spending Accounts (Health Care and Dependent Care) and supplemental life insurance (up to the guaranteed issue amount) will begin on your first pay warrant in January 2007. Any supplemental life insurance changes exceeding the guaranteed issue amount will be implemented upon carrier approval. 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 issue limits are effective when Human Resources receives carrier approval.

Premiums, including medical, dental and vision, are collected in advance of the month of coverage; Flexible Spending Accounts (Health and Dependent Care) and supplemental life insurance coverage are collected 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 a double-deduction amount being required for the first pay-period to begin the benefits you have requested. Employees are encouraged to 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 of 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 15th, your coverage will end on August 31st. In the event of your death, coverage for your enrolled dependents will end at the end of the month when you have a mid-year qualifying event, the termination of coverage is the end of the month in which the qualifying event occurs. In all events, coverage may terminate earlier if premiums are not received timely. 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 2007 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 therefore, are both 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 \$596.42. Your spouse/domestic partner reviews the Can You Waive County Coverage

information on page 6 of the Enrollment Guide and chooses to be covered by your County medical coverage (a group plan), electing Medical Waiver during the annual enrollment and providing information about your County plan online during the annual enrollment. To continue receiving Flexible Benefit Credits, your spouse/domestic partner enrolls in the Flexible Spending Account for Health Care at \$10.00 per pay period (\$20 per month). In this specific example, your family will have a combined Flexible Benefit Credit of \$399.44 after premiums are paid. (See Example 1 below.)

Example 1:	You	Your Spouse/DP	Net Family Credit
County's Flexible Benefit Credit Contribution	\$590.46	\$425.40	
Cost for Exclusive Care, 2-Party Coverage	(\$623.42)		
County Subsidy	\$25.00		
Net Premium	\$596.42		
Cost for FSA Health Care Enrollment		(20.00)	
Flexible Benefit Credits Remaining	(\$5.96)	\$405.40	\$399.44

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 will 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 \$570.40 remaining after premiums are paid. (See Example 2 below.)

Example 2:	You	Your Spouse/DP	Net Family Credit
County's Flexible Benefit Credit Contribution	\$590.46	\$590.46	
Exclusive Care, Single Coverage	(\$305.44)	(\$305.44)	
Flexible Benefit Credits Remaining	\$285.02	\$285.02	\$570.04

Net Family Savings (Monthly): \$170.60

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 family out-of-pocket benefit costs.

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

Important: You must notify Human Resources within 60 days of a change in status. Failure to notify Human Resources will result in the County's inability to correct benefit elections and/or refund premium deductions.

Use the previous examples above 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 of the Enrollment Guide for details about whether or not you and/or your spouse/ domestic partner are eligible to waive coverage as well as what is required to receive Flexible Benefit Credits.*

Making Mid-Year Changes

Your benefit elections stay in effect from January 1, 2007 through December 31, 2007 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 the close of annual enrollment you can make medical, dental, vision, and FSA changes ONLY if you have a qualified status change. Qualified status changes include:

- Marriage or registering a domestic partner
- Divorce or separation from domestic partner
- Birth or adoption of a child
- Death of a spouse/domestic partner or a child
- Change in 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, student status, 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 (IRC) 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, the premiums paid for these dependents may not be taken on a before-tax basis. Please read the following information carefully to determine if you are eligible for the pre-tax payment option and what your obligations to report that you are enrolling a non-tax qualified dependent into a County health plan.

"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 qualify as a "tax-qualified" dependent, including your domestic partner and his/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 on-line at Workforce Exchange. To access the form on-line, go to www.workforceexchange.net or, from a County computer without Web/internet access, <http://intranet.co.riverside.ca.us>. Select the "Benefits" tab at the top of the screen. This tab will take you to the Benefits Web site. 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	\$623.42	\$784.50	\$317.98	\$479.06
Blue Shield HMO	\$769.48	\$998.40	\$383.74	\$612.66
Blue Shield PPO	\$1,423.22	\$1,849.70	\$711.16	\$1,137.64
Kaiser HMO	\$830.00	\$1,079.00	\$414.00	\$663.00
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	\$110.90	\$163.40	\$50.04	\$102.54
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 \$784.50 per month, but you are taxed differently.

Total Monthly Premium	\$784.50
Imputed Amount Taxable	\$317.98
Additional Taxes (assuming 28% tax rate)	\$89.03

Coordinating Your County Plan with Other Coverage

Cost is an important factor when making a health plan choice. However, it shouldn't be the only factor you consider. If you have other health plan coverage, you should consider how your plans will coordinate your benefits before deciding on which County plan to select. Careful research before enrollment will ensure that you make the best decision for your specific situation.

How Coordination of Benefits Provisions Effect 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 or, 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.

Researching Coordination of Benefits

Each plan contains coordination of benefits (COB) provisions which determines how your plan will pay benefits and how it will apply COB with another plan. 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. Your secondary plan will pay benefits using COB.

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 member enrolled in both plans. Standard coordination rules are contained below.

Ask Each Plan Information

To determine how your plan's 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.

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 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.

Most Important Question

Verify if the plan considers benefits of the primary carrier to be covered, whether or not a claim was filed or deemed payable by the primary carrier. This type of COB provision will result in you having 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 the employee will pay first.
3. When two plans (one covering each parent) cover the same child as a dependent, the plan 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 covers the parent the longest pays first. The plan that covers the other parent for a shorter time pays second
 - However, other rules apply if a claim is made for a covered dependent child whose parents are separated or divorced. If the parent with the custody of the child has not remarried, the plans will pay in this order:
 - First – any plan in which the child is covered as a dependent of the custodial parent
 - Second – any plan in which the child is covered 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 – any plan in which the child is covered as dependent of the parent who has custody
 - Second – any plan in which the child is covered as the dependent of the stepparent
 - Third – any plan in which the child is covered 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 this SPD). Any plan in 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 of Riverside sponsored medical plans and prescription drug coverage available to people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

The County of Riverside has determined that your prescription drug coverage with the County sponsored medical plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay 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 extra if you later decide to enroll in Medicare coverage.

People with Medicare can enroll in a Medicare prescription drug plan between November 15th through December 31st each year.

The current coverage options for County-sponsored medical plans are described below.

Prescription Drugs	Exclusive Care EPO	Kaiser HMO	Blue Shield HMO	Blue Shield Preferred Care PPO	
	Network Only	Network Only	Network Only	In-Network	Out-of-Network
Network retail pharmacies (30- to 34-day supply)	Generic: \$5 copay Brand preferred: \$15 copay Brand (nonpreferred): \$25 copay	Generic: \$10 copay (up to 100-day supply) Brand formulary: \$25 copay (up to 100-day supply)	Generic: \$10 copay Brand preferred: \$25 copay Brand (nonpreferred): \$50 copay	Generic: \$5 copay Brand preferred: \$15 copay Brand (nonpreferred): \$30 copay	Generic: \$5 copay Brand preferred: \$15 copay Brand (nonpreferred): \$30 copay
Network mail order (90-day supply)	Generic: \$10 copay Brand preferred: \$30 copay Brand (nonpreferred): \$50 copay	Generic: \$10 copay (up to 100-day supply) Brand formulary: \$25 copay (up to 100-day supply)	Generic: \$20 copay Brand preferred: \$50 copay Brand (nonpreferred): \$100 copay	Generic: \$10 copay Brand preferred: \$30 copay Brand (nonpreferred): \$60 copay	Generic: \$10 copay Brand preferred: \$30 copay Brand (nonpreferred): \$60 copay

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

You should also know that if you drop or lose your coverage with a County of Riverside sponsored medical plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay

more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until November to enroll.

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

Contact our office at (951) 955-4981 for further information.

NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage 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 will be available in October 2006 in the "Medicare & You 2007" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	October 1, 2006
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, and 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.

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

County Privacy Office
 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 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
- Surgery 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, if any, (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.

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 a child losing 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 child losing 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 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 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 May 1st for a COBRA Qualifying Event, Continuation Coverage must begin on May 1st 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 six 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 Flexible Spending Account 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 timely paid.
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, excluding Exclusive Care, 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 Exclusive Care, 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) 955-5744

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