YOUR BENEFITS

EXPLORE YOUR COUNTY OF RIVERSIDE BENEFIT OPTIONS

Options to Meet Your Needs

Learn about the County plans you're eligible for and the resources we offer to help you make the most of your benefits.

Who's Eligible for Benefits

Resources to Help You Choose the Right Coverage

More to Know Before You Enroll

COUNTY OF Riverside
HUMAN RESOURCES

WHAT'S INSIDE

EXPLORE YOUR OPTIONS

The County of Riverside is dedicated to offering you and your family a variety of benefits to help meet your needs and balance your career with your personal life. We also recognize that everyone's needs are unique, which is why we've designed our programs so they offer a variety of options to meet ***your*** needs—whether you're married or single, close to retirement or just beginning your career.

Keep reading for details about the County plans you're eligible for and tools and resources to help you make the most of your County benefits. Share this information with your family, and work together to make well-informed decisions about your health care coverage.

WHO IS ELIGIBLE

You're eligible to participate in the County's benefit program if you are a regular County employee scheduled to work at least 20 hours per week. Your bargaining unit or employee group determines which plan options are available to you and your eligible dependents.

You may enroll your eligible dependents in your medical, dental and vision coverage. Refer to page 31 to determine if your dependents are eligible.

Temporary and Per Diem Employees: If you're a temporary employee, you are eligible for the Exclusive Care medical plan only. Refer to the Temporary Employees' Benefits Guide available at ***http://benefits.rc-hr.com/*** for details about your medical coverage.

HOW TO USE THIS GUIDE

Before choosing your coverage, take the time to understand your options, how the plans work, what you'll pay for coverage, how to enroll and where to get help.

- **If you're new to the County,** see the checklist on the following page to help you make the right choices.
- **If you're an existing County employee,** use this guide as a reference all year long and during Annual Enrollment when it's time to decide if you need to make a change.

In either case, it's important you understand the options available to you and how to make the most of your health care coverage.

EXPLORE YOUR OPTIONS

CHECK OUT WHAT'S AVAILABLE

Here's a list of the options available to eligible employees:

MEDICAL

- Exclusive Care EPO
- Kaiser Permanente HMO
- UnitedHealthcare Signature Value HMO
- UnitedHealthcare Select Plus PPO

DENTAL

- DeltaCare USA DHMO
- Local Advantage EPO
- Delta Dental PPO

VISION

- Vision Service Plan (VSP)
- Medical Eye Services (MES)

OTHER BENEFITS

- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Employee Basic and Supplemental Life Insurance
- Dependent Supplemental Life Insurance
- Coverage during Leave of Absence
- Employee Assistance Services (EAS)
- Disability Coverage
- Advocacy Services
- Retirement and Savings Plans

YOUR NEW HIRE CHECKLIST

☑ **Confirm** you're eligible to participate in the benefits program and which benefits you can elect based on your bargaining or employee unit. Refer to pages 31-33 of this guide to determine if your dependents are eligible.

☑ **Read** the information contained in this guide, and share it with your family. Discuss your needs before you make a decision. Once you enroll, you can't make changes outside of Annual Enrollment unless you experience a qualified change of status (see "Making Mid-Year Election Changes" on page 36 for a definition).

☑ **Review this guide (and visit *http://benefits.rc-hr.com*)** for more information about our County-sponsored benefits, including:

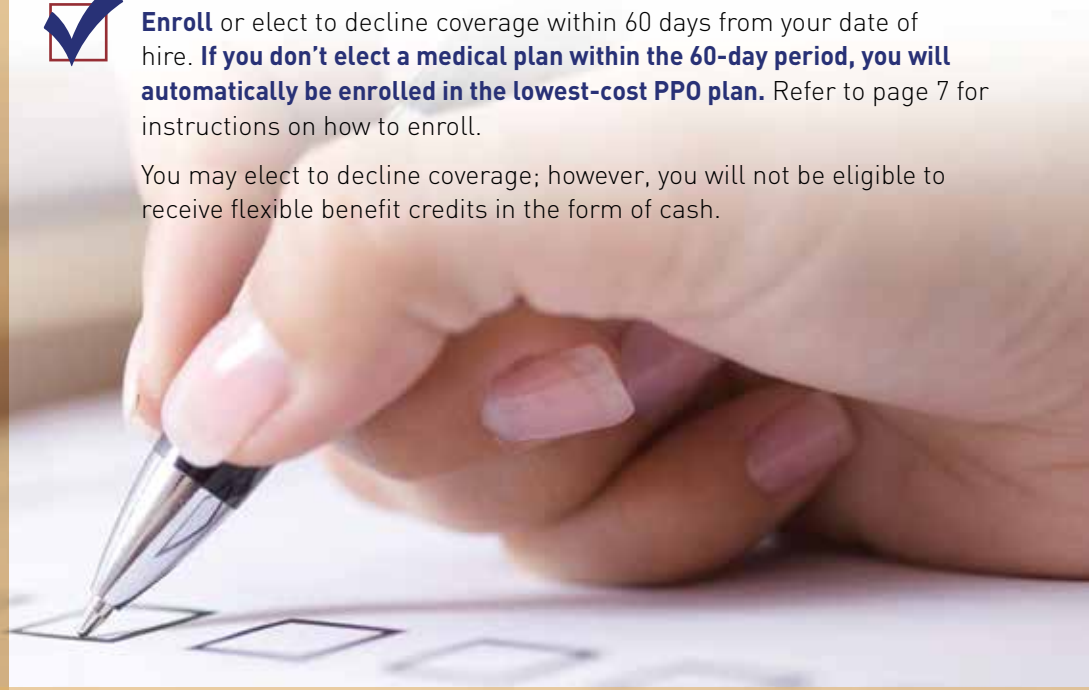
- Pages 16-20 - Comparison charts for our medical, dental and vision plans so you can quickly assess which options will meet your needs and fit your budget.
- Pages 11-13 - Plan premiums so you know how much you'll pay for your coverage. Once you enroll, your premiums will automatically be deducted from your paycheck before taxes.
- Page 9 - Flexible benefit credits so you'll know how much the County will contribute toward your premiums.

☑ **Important Note:** The CalPERS plans are not described in this guide. If you're eligible for CalPERS plans, visit ***www.calpers.ca.gov*** for more information.

☑ **Consider** enrolling in supplemental life insurance. Enrolling as a new hire means you won't be asked to provide evidence of insurability (EOI) as long as your election is within the guaranteed issue limits and you enroll during your initial eligibility period. Refer to page 26 for details.

☑ **Enroll** or elect to decline coverage within 60 days from your date of hire. **If you don't elect a medical plan within the 60-day period, you will automatically be enrolled in the lowest-cost PPO plan.** Refer to page 7 for instructions on how to enroll.

You may elect to decline coverage; however, you will not be eligible to receive flexible benefit credits in the form of cash.



RESOURCES TO GUIDE YOU

Your health benefits provide important protection for you and your family. Take the time to evaluate your needs and use the tools, resources and information available to make informed choices.

WHEN YOU NEED A HAND, ADVOCACY SERVICES CAN HELP

The County's Advocacy Services offers you and your family additional support to help you manage your health and make the most of your County benefits.

GET SMARTER	GET HEALTHIER	NAVIGATE BETTER
Advocates can help you:		
• Understand your benefits and how to use them • Find quality and pricing information for in-network services, allowing you to shop around for the best price • Understand additional coverage options such as Medicare	• Learn more about treatment options, specialists and prescription drugs • Understand a diagnosis and your doctor's prescribed course of treatment	• Resolve health care billing and insurance claim disputes • Locate doctors and hospitals • Receive second opinions, when needed

YOUR QUESTIONS ANSWERED

1. **Can an Advocate help me with all of my benefits?**
   Yes. Your Advocate is an expert on all your health benefit plans and can answer any questions you have regarding medical, dental and vision plans, flexible spending accounts, disability and life insurance, and more.
2. **How much does it cost me to use Advocacy Services?**
   The advice and assistance provided by Advocacy Services are free; however, some actions recommended by an Advocate may have costs (e.g., obtaining a second opinion from another doctor).
3. **If I can't get answers, how will my Advocate?**
   Your Advocate has an advantage. Only individuals with extensive benefits experience, advanced problem-solving skills and a demonstrated commitment to customer service are selected as Advocates. They are experts in the County's benefit plans, insurance billing procedures and claims resolution. Advocates also have designated contacts, whom you may not have access to, for escalated issues.
4. **How can I contact Advocacy Services?**
   It's easy. To reach Advocacy Services, simply call **(888) 622-1200** or **(951) 955-4981 (option 3)**, Monday through Friday, 5 a.m. – 4 p.m. Pacific Time to be connected to an Advocate.
5. **Can my dependents use Advocacy Services?**
   Yes. Advocacy Services are available for you and your family members, at no cost.

NEED HELP RESOLVING AN ISSUE?

Advocates have the experience needed to help you overcome the most challenging medical and benefit issues. They will work with your insurance carrier, doctors and whomever else it takes to resolve problems and concerns. To reach Advocacy Services, simply call **(888) 622-1200** or **(951) 955-4981 (option 3)**. Advocates are available Monday through Friday, 5 a.m. – 4 p.m. Pacific Time (PT). If you call after 4 p.m. PT, an Advocate will call you back within 24 hours.

RESOURCES TO GUIDE YOU

COMPARE YOUR OPTIONS

Your plan offers a series of health coverage options. For a quick overview of the options available to you, see the Plan Comparison chart on page 16. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBCs for the following plans are available online:

- Exclusive Care EPO
- Kaiser Permanente HMO
- UnitedHealthcare Signature Value HMO
- UnitedHealthcare Select Plus PPO

Visit ***http://benefits.rc-hr.com*** and click "Employee Benefits." Then select the benefits you are inquiring about to see a list of available "Summary of Benefits" for each plan.

You can obtain a printed paper copy of the SBC free of charge by calling **(951) 955-4981 (option 1)** or by email request. Please email **Benefits@rivco.org**.

LEARN ABOUT CalPERS MEDICAL PLANS (DDAA, LEMU AND RSA PUBLIC SAFETY ONLY)

Access the Web-based health workshop for CalPERS medical plans 24/7 simply by logging on to the CalPERS website. Go to ***www.calpers.ca.gov***. The website also offers convenient links to related health plan websites, such as the *Find a Provider* tool to locate in-network physicians and hospitals, and the *Find a Pharmacy* tool to locate in-network pharmacies and pharmaceutical formulary databases.

HOW TO ENROLL

When you're ready to enroll, download the Benefit Election Form available at ***http://benefits.rc-hr.com/***. Complete and sign the form, and submit it to your Department Representative within 60 days of your date of hire.

- **Dependent documentation.** If you are enrolling a spouse, a registered domestic partner, or child(ren) *for the first time*, you are required to provide supporting documentation along with your enrollment (or by the Annual Enrollment deadline if you're adding dependents for the first time during that period). Documentation typically includes documents such as marriage or birth certificates. Your enrollment for the dependent cannot be processed without the supporting documentation.

  See the "General Eligibility" section on page 31 for documentation requirements. **Note: You will be required to provide a Social Security number for any dependent when you enroll him or her in a County-sponsored health plan.** The County needs this information to comply with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173). This law requires group health plan insurers, third-party administrators and group health plan administrators to report information that the Department of Health and Human Services requires for purposes of coordination of benefits. Further information about the mandatory reporting requirements under this law is available at ***https://www.cms.gov/***.

DURING ANNUAL ENROLLMENT

Each year, you'll have an opportunity to make changes to your coverage during Annual Enrollment, which occurs in the fall. During Annual Enrollment, you'll use **Employee Self Service (ESS)** to enroll, change plans, add or delete dependents, waive coverage, and submit proof of insurance to support a medical waiver election. You can access the ESS enrollment system on any computer with Web/Internet access or through the County intranet from a County computer at ***http://intranet.co.riverside.ca.us***.

- **Your Employee Self Service ID** is ESS followed by your six-digit employee identification number (e.g., ESS123456). You will use the same ESS password you are currently using to access other ESS functions, such as viewing your online payroll information or making changes to your benefits coverage. If you don't remember your password, click on the "Forgot Password" link and follow the prompts; a temporary password will be emailed to you at the primary email address in the Human Resources database. If there is no email address listed in the database, you'll get an error message. Contact your Department Representative or the RCIT Help Desk at **(951) 955-9900** for assistance.
- **Enrolling registered domestic partners.** If you want to enroll, remove or make election changes for a registered domestic partner or a registered 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.

MAKING CHANGES DURING THE YEAR

Once you enroll, you can only change your coverage and/or add dependents during Annual Enrollment or when you experience a qualified change of status. See page 36 for information on what qualifies as a change of status and what's required.

HOW TO ENROLL

MORE TO KNOW BEFORE YOU ENROLL

- In addition to learning about your benefits, it's also important you're aware of the rules and requirements of our program. Refer to pages 31–37 for important information such as:
  - » Who's eligible for coverage and the documentation required when enrolling dependents for the first time
  - » When your coverage begins and ends
  - » What your coverage will cost (Pages 10-13)
  - » When you may make changes to your benefits during the year
  - » What to do if you want to participate in the County's medical waiver program
  - » What to expect when you become eligible for Medicare
- Be sure to have current dependent information, including Social Security numbers, available so you can enter correct information on your *Benefit Election Form* or online, if necessary.
- If you are going to enroll in a plan that requires selecting a primary care provider to access care, visit the insurance carrier's website for a list of doctors or dentists in your area. Websites for the carriers are listed on page 43 of this guide. **If you elect Kaiser Permanente coverage, you do not need to choose a provider.**
- Consider enrolling in a Flexible Spending Account (FSA) and setting aside pretax earnings to pay for eligible health care or dependent care expenses. Money is contributed tax-free and is reimbursed tax-free. For more information about FSAs, go to pages 23–24.

PAYING FOR YOUR COVERAGE

FLEXIBLE BENEFIT CREDITS

To help you pay for your coverage, the County of Riverside provides flexible benefit credits to eligible employees. You may also qualify for a premium subsidy if you are in an eligible employee group and elect to enroll one or more dependents. Please see your personalized annual enrollment statement or pages 11-13 for a complete listing of rates. The flexible benefit credits you receive and your eligibility for a premium subsidy are determined by the applicable union Memorandum of Understanding or Resolution.

2018 FLEXIBLE BENEFIT CREDITS

Employee/Bargaining Unit	Monthly Flex Credit	Semimonthly Flex Credit	Monthly Flex Credit	Semimonthly Flex Credit
	Enrolled in County Health Plan		Not Enrolled in County Health Plan (MEDWAV)	
Management	$823.00	$411.50	$534.00	$267.00
Confidential	$823.00	$411.50	$534.00	$267.00
Unrepresented	$823.00	$411.50	$534.00	$267.00
Management – Law Enforcement	$823.00	$411.50	$534.00	$267.00
LIUNA	$823.00	$411.50	$425.40	$212.70
SEIU	$823.00	$411.50	$465.00	$232.50
DDAA	$823.00	$411.50	$575.40	$287.70
LEMU	$959.28	$479.64	0.00	0.00
RSA Public Safety	$940.00	$470.00	$456.72	$228.36

PREMIUM SUBSIDY

Employees in the SEIU and LIUNA bargaining units who elect two-party or family coverage 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 monthly subsidy contribution you'll receive. Your premium will be reduced by the amount of your premium subsidy. For example, if your monthly premium for individual coverage is $225 per month, and your subsidy is $25, you'll pay $200 per month ($100 per pay period) before taxes (pretax).

2018 PREMIUM SUBSIDY FOR SEIU AND LIUNA

Monthly Premium Subsidy	Semimonthly Premium Subsidy	Monthly Premium Subsidy	Semimonthly Premium Subsidy
Family Coverage		Two-Party Coverage	
$100.00	$50.00	$25.00	$12.50

PRETAX 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. For most employees, pretax deductions are the most cost-effective way to pay for your premiums. (**Note:** Premiums for your registered domestic partner and your non-tax-qualified dependents are collected on an after-tax basis.)

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 only as a new hire or during the annual enrollment period.**

PAYING FOR COVERAGE

Health Care Rates for 2018. Rates are deducted semimonthly (twice a month), which means deductions are taken from your paycheck for 24 pay periods each calendar year. When you receive a third check in a month (the "free" pay period), it will not include a flexible benefit credit or a deduction for your health plans, unless you owe for uncollected premiums. To see your net out-of-pocket cost for health care coverage, remember to subtract your flex credit (on Page 9) from the premiums shown on the following pages. These rates DO NOT reflect the premium subsidy for SEIU and LIUNA members. Your bargaining unit or employee group determines which medical plans you may choose.

HELPING YOU PAY FOR YOUR COVERAGE

The County helps you pay for coverage by offering flexible benefit credits (and for some bargaining units, a premium subsidy) to reduce how much you pay in premiums. When you enroll in a County-sponsored medical, dental and/or vision plan, your premiums are automatically deducted before taxes are calculated on your earnings.

YOUR COUNTY OF RIVERSIDE BENEFITS

MEDICAL PLAN ELIGIBILITY	
Eligible for County Medical Plans	
Elected Officials	Confidential Employees
SEIU Represented Employees	Unrepresented Employees
LIUNA Represented Employees	Resident Physicians
Management Employees	

COUNTY PLANS – MEDICAL		
	Monthly	**Semimonthly**
County Medical Plans		
Exclusive Care EPO		
Single	$576.66	$288.33
Two-Party	$1,166.48	$583.24
Family	$1,464.80	$732.40
United Healthcare HMO		
Single	$823.00	$411.50
Two-Party	$1,673.66	$836.83
Family	$2,171.54	$1,085.77
Kaiser Permanente HMO		
Single	$667.66	$333.83
Two-Party	$1,327.16	$663.58
Family	$1,725.18	$862.59
United Healthcare PPO		
Single	$1,452.18	$726.09
Two-Party	$2,882.18	$1,441.09
Family	$3,740.56	$1,870.28

COUNTY PLANS – DENTAL		
	Monthly	**Semimonthly**
Local Advantage – Plus		
Single	$40.14	$20.07
Two-Party	$77.92	$38.96
Family	$114.42	$57.21
Local Advantage – Blythe		
Single	$29.22	$14.61
Two-Party	$51.26	$25.63
Family	$77.46	$38.73
DeltaCare USA DHMO – High Option Plan (10A)		
Single	$22.84	$11.42
Two-Party	$33.80	$16.90
Family	$52.00	$26.00
Delta Dental PPO		
Single	$43.58	$21.79
Two-Party	$78.02	$39.01
Family	$113.68	$56.84

COUNTY PLANS – VISION		
	Monthly	**Semimonthly**
Medical Eye Services Plan 1		
Single	$9.24	$4.62
Two-Party	$13.96	$6.98
Family	$18.88	$9.44
Medical Eye Services Plan 2		
Single	$7.80	$3.90
Two-Party	$12.42	$6.21
Family	$17.14	$8.57

MEDICAL PLAN ELIGIBILITY

Eligible for CalPERS Medical Plans
DDAA, LEMU and RSA Public Safety

PLAN COSTS FOR 2018*

	Monthly	Semimonthly
CalPERS Medical Plans – Other Southern California Counties Region (Riverside, Orange, San Diego and Imperial Counties)		
Anthem Select HMO		
Single	$659.70	$329.85
Two-Party	$1,319.38	$659.69
Family	$1,715.20	$857.60
Anthem Traditional HMO		
Single	$735.08	$367.54
Two-Party	$1,470.16	$735.08
Family	$1,911.22	$955.61
Blue Shield Access+ HMO		
Single	$695.98	$347.99
Two-Party	$1,391.94	$695.97
Family	$1,809.52	$904.76
Health Net Salud y Mas		
Single	$461.56	$230.78
Two-Party	$923.12	$461.56
Family	$1,200.06	$600.03
Health Net SmartCare		
Single	$607.68	$303.84
Two-Party	$1,215.36	$607.68
Family	$1,579.98	$789.99
Kaiser Permanente		
Single	$666.80	$333.40
Two-Party	$1,333.60	$666.80
Family	$1,733.68	$866.84
PERSCare		
Single	$733.50	$366.75
Two-Party	$1,467.00	$733.50
Family	$1,907.10	$953.55
PERS Choice		
Single	$698.96	$349.48
Two-Party	$1,397.92	$698.96
Family	$1,817.30	$908.65

PLAN COSTS FOR 2018*

	Monthly	Semimonthly
CalPERS Medical Plans – Los Angeles Area Region (Los Angeles, San Bernardino and Ventura Counties)		
Anthem Select HMO		
Single	$660.18	$330.09
Two-Party	$1,320.34	$660.17
Family	$1,716.44	$858.22
Anthem Traditional HMO		
Single	$784.72	$392.36
Two-Party	$1,569.44	$784.72
Family	$2,040.28	$1,020.14
Blue Shield Access+ HMO		
Single	$613.30	$306.65
Two-Party	$1,226.58	$613.29
Family	$1,594.56	$797.28
Health Net Salud y Mas		
Single	$404.32	$202.16
Two-Party	$808.64	$404.32
Family	$1,051.24	$525.62
Health Net SmartCare		
Single	$577.16	$288.58
Two-Party	$1,154.30	$577.15
Family	$1,500.60	$750.30
Kaiser Permanente		
Single	$642.70	$321.35
Two-Party	$1,285.40	$642.70
Family	$1,671.02	$835.51
PERSCare		
Single	$673.74	$336.87
Two-Party	$1,347.46	$673.73
Family	$1,751.70	$875.85
PERS Choice		
Single	$620.40	$310.20
Two-Party	$1,240.78	$620.39
Family	$1,613.02	$806.51

YOUR COUNTY OF RIVERSIDE BENEFITS

PLAN COSTS FOR 2018*	Monthly	Semimonthly
CalPERS Medical Plans – Other Southern California Counties Region (Riverside, Orange, San Diego and Imperial Counties)		
PERS Select		
Single	$654.74	$327.37
Two-Party	$1,309.48	$654.74
Family	$1,702.32	$851.16
PORAC		
Single	$734.00	$367.00
Two-Party	$1,540.00	$770.00
Family	$1,970.00	$985.00
Sharp		
Single	$618.14	$309.07
Two-Party	$1,236.28	$618.14
Family	$1,607.16	$803.58
UnitedHealthcare		
Single	$616.66	$308.33
Two-Party	$1,233.32	$616.66
Family	$1,603.32	$801.66

PLAN COSTS FOR 2018*	Monthly	Semimonthly
CalPERS Medical Plans – Out-of-State Region (Residents Outside California)		
Blue Shield Access+ HMO Not Available **PERS Select** Not Available		
Kaiser Permanente		
Single	$957.06	$478.53
Two-Party	$1,914.10	$957.05
Family	$2,488.34	$1,244.17
PERSCare		
Single	$718.98	$359.49
Two-Party	$1,437.96	$718.98
Family	$1,869.36	$934.68
PERS Choice		
Single	$661.46	$330.73
Two-Party	$1,322.90	$661.45
Family	$1,719.78	$859.89
PORAC		
Single	$734.00	$367.00
Two-Party	$1,540.00	$770.00
Family	$1,970.00	$985.00

PLAN COSTS FOR 2018*	Monthly	Semimonthly
Exclusive Care Medical Plans – CalPERS Employees in ALL Regions		
Exclusive Care EPO		
Single	$576.66	$288.33
Two-Party	$1,166.48	$583.24
Family	$1,464.80	$732.40

PLAN COSTS FOR 2018*	Monthly	Semimonthly
CalPERS Medical Plans – Los Angeles Area Region (Los Angeles, San Bernardino and Ventura Counties)		
PERS Select		
Single	$573.22	$286.61
Two-Party	$1,146.42	$573.21
Family	$1,490.36	$745.18
PORAC		
Single	$734.00	$367.00
Two-Party	$1,540.00	$770.00
Family	$1,970.00	$985.00
UnitedHealthcare		
Single	$602.78	$301.39
Two-Party	$1,205.56	$602.78
Family	$1,567.24	$783.62

** Some rates were rounded to the next even number for even semimonthly premium deductions.*

REMEMBER, ALL ENROLLMENT FORMS—INCLUDING YOUR *CALPERS HEALTH BENEFIT PLAN ENROLLMENT FORM (PERS-HBD-12)*— MUST BE COMPLETED AND RETURNED TO YOUR DEPARTMENT REPRESENTATIVE NO LATER THAN SEPTEMBER 29, 2017.

OPTIONS TO MEET YOUR NEEDS

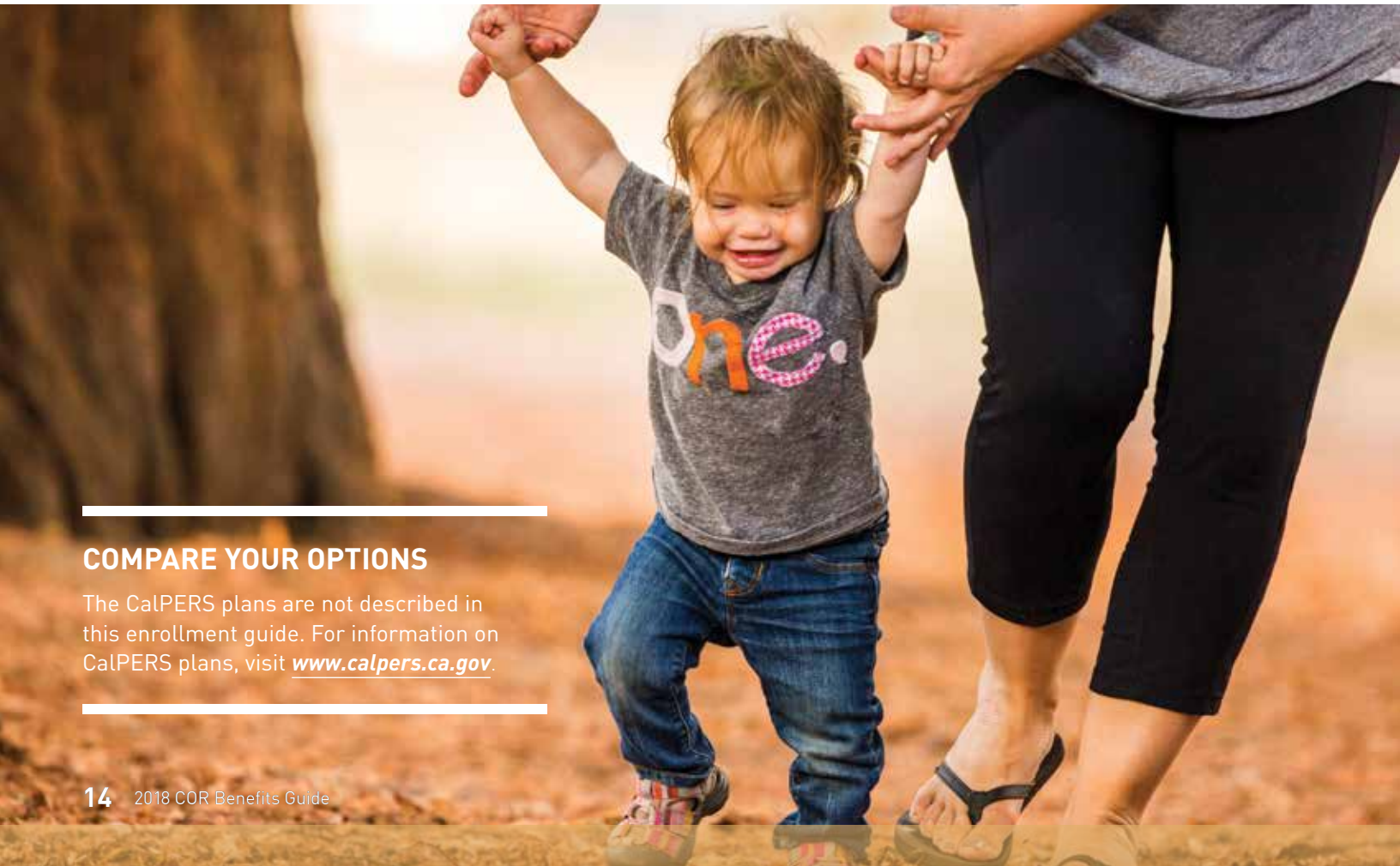
MEDICAL

The County of Riverside cares about your health and well-being and is pleased to offer you a choice of medical plan options. Your bargaining or employee unit determines which medical plans you may elect.

Refer to the County of Riverside Plan Comparisons on pages 15-20 (also available at ***http://benefits.rc-hr.com***) to compare what's covered under the County medical plan options. The CalPERS plans are not described in this enrollment guide. For information on CalPERS plans visit ***www.calpers.ca.gov***.

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

Temporary and Per Diem Employees: If you're a temporary employee, you are eligible for the Exclusive Care medical plan only. Refer to the temporary employee benefits available at ***http://benefits.rc-hr.com/*** for details about your medical coverage option.



COMPARE YOUR OPTIONS

The CalPERS plans are not described in this enrollment guide. For information on CalPERS plans, visit ***www.calpers.ca.gov***.

COUNTY MEDICAL PLANS

PLAN OPTION	HOW IT WORKS	WHAT TO KEEP IN MIND
Exclusive Care EPO For additional information or a provider directory, visit Exclusive Care at ***www.exclusivecare.com*** or contact Exclusive Care Member Services at **(800) 962-1133**.	• You (and each enrolled family member) will choose a **primary care physician** (PCP) who's part of the Exclusive Care network. • Your PCP will coordinate all of your health care needs. 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). • You pay no annual deductible under this plan and will generally receive 100% coverage with a small copayment for certain services.	• Employees who are eligible for either the County medical plan or the CalPERS medical plans may enroll in this EPO plan. • This unique plan design makes it important that you live or work within the service area, because you and enrolled dependents who live with you **must** receive all medical treatment from Riverside County providers, except in an emergency. • This plan provides an alternative option for your eligible dependents who do not reside with you, such as a dependent going to college outside of Riverside County or a dependent who lives with another custodial parent outside of Riverside County.[1]
Kaiser Permanente HMO For additional information or a list of Kaiser Permanente facilities, visit ***www.my.kp.org/countyofriverside*** or contact Member Services at **(800) 464-4000**.	• If you enroll in the Kaiser HMO plan, you must go to Kaiser doctors, hospitals and other health care facilities whenever you need medical care. • 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 will be covered wherever you seek services (you will pay a small copayment).	• Eligible dependents who live outside of the Kaiser Permanente service network are covered only if they reside in Northern California. Dependents residing in any other area are covered for emergency services only.
UnitedHealthcare (UHC) Signature Value HMO For more information about the UHC Signature Value HMO, visit ***www.myuhc.com*** or contact Member Services toll-free at **(800) 624-8822**.	• If you enroll in the Signature Value HMO plan, you (and each enrolled member of your family) will choose a **primary care physician** (PCP) from the UnitedHealthcare (UHC) provider network. Your PCP will coordinate all of your health care needs. • If you need specialty care, your PCP will refer you to a network specialist or hospital within the same participating group. You may change your PCP at any time. • You pay no annual deductible under this plan and will generally receive 100% coverage with a small copayment for certain services.	• When you enroll in the Signature Value HMO plan, you'll be asked to designate a PCP and provide his or her 10-digit PCP ID. • Visit ***www.uhcwest.com*** to locate a primary care physician in your area, and make note of the provider's ID number before going online to complete your enrollment election. • If you do not designate a PCP when you enroll, a PCP will be auto-assigned, and you'll need to complete the process for changing providers and receiving new ID cards. • This plan provides an alternative option for your eligible dependents who do not live within the plan's HMO service area, such as a dependent going to college outside of the area or a dependent who lives with another custodial parent.
UnitedHealthcare Select Plus PPO For more information about the United-Healthcare PPO, visit ***www.myuhc.com*** or contact Member Services toll-free at **(800) 624-8822**.	• A PPO plan gives you the freedom to receive medical services from any licensed provider you choose, with lower copayments when you use the in-network providers. • You must pay a portion of most covered medical expenses each year before the plan will pay benefits. This amount is called your "deductible." • After the deductible is paid, you will pay a percentage of your covered medical expenses; this percentage is called your "coinsurance." • If your share of the medical expenses reaches the "out-of-pocket maximum," you will not have to pay any more coinsurance for the rest of the calendar year (as long as you continue to use in-network providers).	• When you go to a network PPO provider, your coinsurance will be lower—and you can take advantage of the PPO provider's discounted rates. Also, there are no claim forms to complete when you go to an in-network provider. • If you go to a doctor or health care facility that does not belong to the UnitedHealthcare PPO Select Plus network, your out-of-pocket costs will be higher. Also, the plan will pay benefits only up to the "allowed amount," which is based on a limited fee schedule. You will have to pay any charges above the allowed amount (in addition to your regular coinsurance).

[1] *This alternative option is not available for your spouse or dependents who reside with you. Contact the plan if you have questions about this option or to enroll your dependents in the out-of-area plan option.*

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

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 Permanente HMO	UHC Signature Value HMO
	Network Only	Network Only	Network Only
Choice of physician	Any Exclusive Care network physician	Any Kaiser Permanente physician and/or facility	All care must be coordinated by your PCP
Deductible	None	None	None
Calendar year out-of-pocket maximum	$1,500/person $3,000/family	$1,500/person $3,000/family	$1,500/person $3,000/family
Lifetime maximum benefit	Unlimited	Unlimited	Unlimited
Pre-existing condition limitation	Fully covered	Fully covered	Fully covered
Office Visit Benefits			
Diagnostic X-ray and lab	100%	100%	100%
Immunizations	100%	100%	100%
Maternity care	100%	100%	100%
Periodic health evaluations/ physicals	100%	100%	100%
Physician office visits	100% after $15 copayment	100% after $15 copayment	100% after $15 copayment
Vision exams	100% for screening and refraction	100% after $15 copayment	100% for screening; $15 copayment for refraction
Well-baby care	100%	100%	100%
Well-woman care	100%	100%	100%
Prescription Drugs			
Network retail pharmacies (30- to 34-day supply)	Generic: $10 copayment Preferred brand: $25 copayment Nonpreferred brand: $50 copayment	Generic: $10 copayment (up to 30-day supply) Brand formulary: $25 copayment (up to 30-day supply)	Generic: $10 copayment Preferred brand: $25 copayment Nonpreferred brand: $50 copayment
Network mail order (90-day supply)	Generic: $20 copayment Preferred brand: $50 copayment Nonpreferred brand: $100 copayment **Mail order is MANDATORY for maintenance medications after a 30-day trial.**	Generic: $20 copayment (up to 100-day supply) Brand formulary: $50 copayment (up to 100-day supply)	Generic: $20 copayment Preferred brand: $50 copayment Nonpreferred brand: $100 copayment
Hospital and Emergency Room Benefits			
Ambulance (medically necessary)	100%	100%	100%
Ambulatory surgical center	100%	100% after $15 copayment	100%
Physician hospital visits	100% after $15 copayment	100% after $100 copayment per admission	100%
Inpatient hospital	$100 copayment per admission	$100 copayment per admission	$100 copayment per admission
Outpatient hospital	100%	100%; $15 copayment / procedure for outpatient surgery	100%
Emergency room services	100% after $100 copayment at a network facility	100% after $100 copayment; waived if admitted	100% after $100 copayment; waived if admitted
Urgent care	100% after $20 copayment at network facility; 100% after $50 copayment at non-network facility	100% after $15 copayment	100% after $35 copayment; waived if admitted

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 Permanente HMO	UHC Signature Value HMO
	Network Only	Network Only	Network Only
Mental Health Treatment			
Inpatient Benefit	$100 copayment per admission	100%; unlimited admissions	$100 copayment per admission (unlimited admissions)
Outpatient Benefit	$15 copayment/visit (unlimited visits)	$15 copayment/private visit; $7 copayment/group visit (unlimited visits)	$15 copayment/visit (unlimited visits)
Substance Abuse Treatment			
Inpatient Detoxification	$100 copayment per admission	$100 copayment per day, as medically necessary (detox only)	$100 copayment per admission (unlimited admissions)
Outpatient Detoxification	$15 copayment/visit (unlimited visits)	$15 copayment/private visit; $5 copayment/group visit (unlimited visits)	$15 copayment/private visit; (unlimited visits)
Other Benefits			
Allergy testing and treatment	100% after $15 copayment	100% after $15 copayment; $3/injection	100% after $15 copayment
Chiropractic	100% after $15 copayment; up to 12 visits/calendar year	100% after $15 copayment/visit; up to 20 visits/calendar year	100% after $15 copayment for chiropractic and acupuncture; up to 20 visits combined annual maximum
Durable medical equipment	50%	100%	100%
Family planning			
- Elective pregnancy termination	100% after $50 copayment for 1st trimester; $100 for 2nd trimester; 3rd trimester not covered unless life-threatening	100% after $15 copayment	100% after $125 copayment for 1st trimester; $200 for 2nd trimester; 3rd trimester (after 20 wks) not covered unless life threatening
- Infertility services	50% of costs, up to a lifetime maximum benefit of $10,000	50% of costs	50% of cost copayment
- Tubal ligation	100%	100%	100%
- Vasectomy	100%	100% after $15 copayment	$50 copayment
Home health care	100%	100%, up to 100 visits/calendar year	100% after $15 copayment; up to 100 visits/calendar year
Hospice – routine home and inpatient respite care	100%	100%	100%
Hospice – 24-hour continuous home care and general inpatient care	100%	100%	100% (prognosis of life expectancy of one year or less)
Physical therapy	$15 copayment/visit; up to 30 visits/disability (within 90-day period)	100% after $15 copayment	100% after $15 copayment
Skilled nursing facility	100%; up to 100 days/disability	100% up to 100 days/calendar year	$100 copayment; up to 100 days/benefit period

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.

	UHC Select Plus PPO	
	PPO Network	**Out-of-Network**
Choice of physician	Any network provider	Any licensed provider
Annual Deductible	$500/person $1,000/family	
Calendar year out-of-pocket maximum	$3,000/person $6,000/family	
Lifetime maximum benefit	Unlimited	
Office Visit Benefits		
Physician office visits	100% after $20 copayment	40% after deductible has been met
Diagnostic X-ray and lab	100%; deductible does not apply	40% after deductible has been met
Adult preventive care (includes mammography, Pap smear, sigmoidoscopy, and prostate exam)	100%	100%; copayments and deductibles do not apply
Well-baby care	100%	40% after deductible
Well-woman care	100%	40% after deductible
Vision exams	100% after $20 copayment	40% after deductible
Prescription Drugs		
Network retail pharmacies (up to a 31-day supply)	Generic: $5 copayment Preferred brand: $15 copayment Nonpreferred brand: $45 copayment	Generic: $5 copayment Preferred brand: $15 copayment Nonpreferred brand: $45 copayment
Network mail order (up to a 90-day supply)	Generic: $10 copayment Preferred brand: $30 copayment Nonpreferred brand: $90 copayment	Not covered
Hospital and Emergency Room Services		
Inpatient hospital services	20% after deductible	40% after deductible
Physician hospital visits	20% after deductible	40% after deductible
Ambulatory surgical center	20% after deductible	40% after deductible
Ambulance (medically necessary)	20% after deductible	20% after deductible
Hospital emergency room	$50 copayment waived if admitted	$50 copayment waived if admitted
Urgent care facility	100% after $20 copayment/visit	40% after deductible
Mental Health Treatment		
Inpatient services	20% after deductible	40% after deductible
Outpatient services	100% after $20 copayment	40% after deductible
Substance Abuse Treatment		
Inpatient program	20% after deductible	40% after deductible
Outpatient office visits	100% after $20 copayment	40% after deductible
Other Benefits		
Chiropractic	100% after $20 copayment/visit; benefits limited to 24 visits per calendar year	40% after deductible
Durable medical equipment	20% after deductible	40% after deductible
Family planning	20% after deductible	40% after deductible
Home health care	20% after deductible	40% after deductible
	Benefits limited to 100 visits per year	
Hospice services	20% after deductible	40% after deductible
Infertility services	20% after deductible	40% after deductible
	Benefits subject to a separate $500 lifetime deductible and a lifetime maximum benefit of $2,000; GIFT, ZIFT, in vitro fertilization, intrafallopian transfers, and artificial insemination not covered	
Rehabilitation therapy (includes outpatient physical, speech, occupational, respiratory, and cardiac therapy)	100% after you pay $20 copayment per visit	40% after deductible
Skilled nursing facility	20% after deductible	40% after deductible
	Benefits limited to 60 days per year	

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.

	DeltaCare USA DHMO	Local Advantage EPO Plus	Delta Dental PPO	
	High-Option Plan (10A)	In-Network	Delta Dental PPO Dentists	Premier Dentists Out-of-Network Dentists
Annual deductible	None	None	None	$50 individual | $150 family
Calendar year maximum benefit	None	$1,500/person	$1,500/person	$1,200/person
Diagnostic and Preventive				
Exams	No charge	No charge	No charge	No charge
Cleaning	No charge	No charge	No charge	No charge
Full mouth X-rays	No charge	No charge	No charge	No charge
Topical fluoride – child	No charge	No charge	No charge	No charge
Sealants (per tooth)	$5	No charge (under age 14)	No charge	No charge
Restorative				
Fillings – amalgam (silver)	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Fillings – composite resin (tooth-colored) for anterior (front) teeth	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Fillings – composite resin (tooth-colored) for posterior (back) teeth	$45–$75	When decay is present, you pay the cost difference between amalgam and resin For cosmetic purposes to replace an alloy/amalgam filling, you pay 50%	Not covered[4]	Not covered
Endodontics				
Single root canal	$45	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Bicuspid root canal	$90	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Molar root canal	$205	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Periodontics				
Periodontal scaling and root planing 4 or more teeth/ quadrant	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Crowns, Bridges and Implants				
Crowns	$35–$195	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Bridges	$55–$195	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Implants	Not covered	Not covered	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Prosthodontics				
Complete upper denture	$100	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Complete lower denture	$100	You pay 35%	You pay 40% of the PPO fee	You pay 50% of the PPO fee after the deductible
Oral Surgery				
Simple extraction	No charge	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Impaction	$25–$90	You pay 10%	You pay 20% of the PPO fee	You pay 50% of the PPO fee after the deductible
Cosmetic				
Veneers	No benefit	You pay 50%	Not covered	Not covered
Teeth whitening	$125	You pay 50%	Not covered	Not covered
Replacement of existing amalgam filling with composite	Not covered	You pay 50%	Not covered	Not covered
Orthodontics				
Child	$1,700	You pay $120 down, $120 per month for 24 months[2]	You pay 50% of the PPO fee	You pay 50% of the PPO fee after the deductible
Adult (19 and up)	$1,900		You pay 50% of the PPO fee	You pay 50% of the PPO fee after the deductible
Lifetime maximum benefit	None	None	$1,500/person	$1,200/person

VSP HIGHLIGHTS

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

MES PLAN HIGHLIGHTS

Benefit Duration	Plan 1 – Eye Exam and Eyewear		Plan 2 – Eyewear Only	
Exams	12 months		Not covered	
Lenses	12 months		12 months	
Frames	12 months		12 months	
Contacts				
- Visually necessary	12 months		12 months	
- Elective	12 months		12 months	
Percentage Payable	**Plan 1 – Eye Exam and Eyewear**		**Plan 2 – Eyewear Only**	
Eye examinations	100%		Not covered	
Eyeglass lenses and frames or contact lenses	100%		100%	
Benefit Maximum	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
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	100%	100% up to $43	100%	100% up to $43
- Bifocal lenses	100%	100% up to $60	100%	100% up to $60
- Trifocal lenses	100%	100% up to $75	100%	100% up to $75
- Lenticular lenses	100%	100% up to $120 for monofocal; or 100% up to $200 for multifocal	100%	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)				
- Medically necessary	100%	100% up to $250	100%	100% up to $250
- Elective	$100 allowance if chosen in lieu of all other services	$100 allowance if chosen in lieu of all other services	$100 allowance if chosen in lieu of all other services	$100 allowance if chosen in lieu of all other services

OPTIONS TO MEET YOUR NEEDS

DENTAL

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 or employee units listed below.

Please refer to the individual plan booklets for details of covered expenses, exclusions and limitations. Dental plan booklets are available online at ***http://benefits.rc-hr.com*** from your Department Representative, or by contacting the Benefits Information Line at **(951) 955-4981**.

DENTAL PLAN ELIGIBILITY

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

COUNTY DENTAL PLANS

PLAN OPTION	HOW IT WORKS	WHAT TO KEEP IN MIND
DeltaCare USA DHMO For additional information, visit DeltaCare USA at ***www.deltadentalins.com*** or contact Member Services at **(800) 422-4234**.	• As with a medical HMO, you (and each enrolled family member) will choose a primary care dentist from the DeltaCare USA network. • You pay no annual deductible under this plan and will generally receive 100% coverage with a small copayment for certain services.	• 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**.
Local Advantage EPO For a plan booklet, contact your Department Representative or call the Benefits Information Line at **(951) 955-4981**.	• If you enroll in the Local Advantage EPO, you (and each enrolled family member) may seek services only from a provider in the Local Advantage Plus network. • You pay no annual deductible under this plan. You will pay a percentage of your covered dental expenses (coinsurance). • Benefits under this plan are limited to $1,500 annually.	• Always request a pre-treatment estimate of predetermination of benefits before having major dental work done. Don't be afraid to ask questions! Do not agree to any treatment unless you fully understand what condition is being treated, why it is being treated, and the costs of that treatment. When in doubt, contact your dental plan; you'll find the phone number for each plan on page 43 of this guide.
Delta Dental PPO For additional information, visit Delta Dental at ***www.deltadentalins.com*** or contact Member Services at **(800) 765-6003**.	• Like a medical PPO, the Delta Dental PPO gives you the freedom to receive dental services from any licensed dental provider you choose, with lower copayments when you use the network providers. • You must pay a portion of most covered medical expenses each year before the plan will pay benefits (your deductible). • After the deductible is paid, you will pay a percentage of your covered medical expenses (coinsurance). • Benefits under this plan are limited to $1,200 per individual annually. The annual maximum is increased to $1,500 when you use network contracted providers.	• This plan will now cover implants. You will pay 40% in-network and 50% after the deductible out-of-network. • The cost of routine checkups, cleanings and x-rays will not count toward your calendar year maximum, leaving more benefits for major services.

VISION

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 covered by one of the eligible bargaining or employee units listed below. Your bargaining or employee unit determines the vision plans for which you are eligible.

VSP ELIGIBILITY

The County provides VSP coverage at no cost for employees in the groups listed and their eligible dependents. You do NOT need to enroll yourself, but you do need to elect coverage for your eligible dependents. The plan pays benefits and offers discounts for most vision care expenses you incur while covered by the plan.

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

MEDICAL EYE SERVICES (MES) PLAN ELIGIBILITY

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

- SEIU
- LIUNA
- RSA Public Safety

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 an in-network provider, 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.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) help you save money by setting aside pretax dollars to pay for certain health care and dependent care expenses. The County offers a Health Care FSA and a Dependent Care (Day 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 covered by one of the bargaining or employee units listed below.

FSA ELIGIBILITY

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

IMPORTANT REMINDER

The Dependent Care (Day Care) FSA is for child care expenses while you work. It is NOT for health care expenses for your dependents. Use the Health Care FSA for all your family's health care expenses.

HOW THE FLEXIBLE SPENDING ACCOUNTS WORK

This is a high-level summary. For details about the FSA and how it works, visit *http://benefits.rc-hr.com* and click on "Other Benefits" then "Flexible Spending Accounts" to view the Plan Documents.

1. Make contributions. Your annual election is taken pretax in equal amounts over the plan year.
2. Incur expenses. When you access services and pay any required copayments, deductibles, coinsurance or dependent care expenses.
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 administrator. Your claim will be paid from the pretax money you accumulate in your Flexible Spending Account. Eligible expenses incurred in the plan year (January 1 – December 31) or the grace period (January 1 – March 15) and submitted by April 15 will be reimbursed.

TAX SAVINGS

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

IMPORTANT FSA RULES

- Eligible expenses will be reimbursed only if they were incurred in the plan year (January 1 – December 31) or the 2½-month grace period (January 1 – March 15). You have until April 15 to submit reimbursement requests.
- If your employment with the County ends, you can be reimbursed only for claims incurred up to your last day of employment, unless you elect COBRA for a Health Care FSA.

NOTE ABOUT DEPENDENT CARE (DAY CARE) CONTRIBUTIONS

Dependent Care (Day Care) Flexible Spending Accounts are subject to non-discrimination testing each year to ensure the plan does not provide an unfair advantage to highly compensated employees. The testing compares the dependent care contributions of highly compensated employees with the dependent care contributions of all other employees. Depending on the results of this testing, contributions of certain employees may be limited, reduced or returned. You will be notified if this affects you.

FLEXIBLE SPENDING ACCOUNTS

- You must spend all the money in your accounts, or you will forfeit any remaining funds. The Plan 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 change of status, such as a marriage, divorce, or birth or adoption of a child. See page 36 for more information about making mid-year election changes.
- Money cannot be transferred between the Health Care FSA and the Dependent Care (Day Care) FSA for expense reimbursement.
- Each year during Annual 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 (Day Care) FSA
Your contributions Deducted in 24 equal amounts from your pay warrants.	You may contribute from $240 to $2,600 per year.	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.
Eligible expenses A complete list of eligible expenses is listed in IRS Publications 502 and 503, which are available by calling **(800) 829-3676** or logging on to: ***www.irs.gov/publications/p502***, ***www.irs.gov/publications/p503***, or ***http://benefits.rc-hr.com***. Please note that some tax-deductible expenses, such as long-term care and medical plan premiums, cannot be paid with the money in your FSA. Also, an expense is eligible for reimbursement based on the date on which it was incurred, regardless of when you actually paid the expense. Information is also available from ASIFlex, the County's FSA vendor at ***www.asiflex.com***.	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. Examples of **eligible** expenses include medical, dental and vision plan deductibles, copayments and coinsurance. Examples of **ineligible** expenses include cosmetic surgery and products that you use for general health (such as vitamins and toothpaste). **You cannot use the FSA to pay for over-the-counter drugs unless you have a "letter of medical necessity" from your health care provider.**	Expenses to care for eligible dependents that allow you (and your spouse, if married) to work or look for work. Eligible dependents include: • Children under age 13 who qualify as dependents on your federal income tax return • Your spouse (or other eligible dependent) who is physically or mentally incapable of self-care Examples of **ineligible** expenses include food, clothing, education, and payments to a dependent relative, or care provided during non-working hours.
Federal income tax	You cannot claim a federal tax return deduction for expenses reimbursed by your FSA.	• You cannot use reimbursed expenses toward the Earned Income Credit or the Child Care Tax Credit. • You are required to list the Social Security number or tax identification number for any dependent care provider. • You and your spouse cannot contribute more than $5,000 combined.

LIFE INSURANCE

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 group supplemental life insurance through Standard Insurance Company for yourself, your spouse/domestic partner and your eligible dependents. Deductions for supplemental life insurance coverage are taken on an after-tax basis.

To add or change your supplemental coverage or update your beneficiary information, you will use the *Enrollment/Change Insurance Form* available on the County of Riverside benefit website at ***http://benefits.rc-hr.com*** under "Other Benefits." There you'll also find step-by-step instructions describing the enrollment process.

BASIC LIFE INSURANCE		
	Standard Life Insurance (Group Policy #641685-F)	**Standard Life Insurance (Group Policy #641685-E)**
Eligible groups	• SEIU • LIUNA	• Elected Officials • Confidential • Management • Unrepresented • DDAA • LEMU • RSA Public Safety
Coverage amount	Coverage is equal to 1x annual salary up to $50,000	$50,000; $1,500 for dependents RSA Public Safety coverage is $10,000
Coverage reduction	Coverage is reduced at certain ages as follows: • Age 65 to 65% of original amount • Age 70 to 50% of original amount	Coverage is reduced at certain ages as follows: • Age 65 to 65% of original amount • Age 70 to 50% of original amount

DUAL COVERAGE

Note: You may elect double coverage if you and your spouse/domestic partner are both County employees.

THREE COMMON MYTHS ABOUT LIFE INSURANCE:

1. **If I'm single and don't have children, I don't need life insurance.** Not true! You may not need as much as someone who's married, has children or other major financial obligations, but you should have some coverage for funeral expenses and any debt repayment.
2. **My coverage at work is sufficient.** That may or may not be the case. Take time to assess your situation and make the right choice based on your needs.
3. **I'm better off investing my money than buying life insurance.** Unless you have enough assets to cover all of your debt, you're taking a risk if you rely solely on your investments.

SUPPLEMENTAL LIFE INSURANCE

HOW TO ENROLL FOR SUPPLEMENTAL LIFE INSURANCE

1. **Determine your eligibility.** See chart below.
2. **Enroll by completing the *Enrollment/Change Insurance Form*** available on our benefit website at ***http://benefits.rc-hr.com*** under "Other Benefits." You can also link to The Standard's website to complete any required Evidence of Insurability (EOI). Review the EOI description carefully to determine if an EOI form is required. Enrolling without required EOI will delay the processing or may result in denial of your application.

SUPPLEMENTAL LIFE INSURANCE		
	Standard Insurance (Group Policy #641685-F)	**Standard Insurance (Group Policy #641685-E)**
Eligible Groups	• SEIU • LIUNA Spouses/domestic partners and dependent children under age 26 are also eligible. Coverage for children begins at live birth and ends at age 26.	• Elected Officials • Management • Confidential • Unrepresented • DDAA • LEMU • RSA Public Safety Spouses/domestic partners and dependent children under age 26 are also eligible. Coverage for children begins at live birth and ends at age 26.
Coverage Start Date	• If you sign up for life insurance as a new hire or newly eligible employee or during Annual Enrollment, the full amount of your benefit that is not subject to EOI (see page 27) will go into effect on the first of the month following your enrollment or January 1st of the year following your Annual Enrollment election. If you want to purchase more than the guaranteed coverage amount, you will have to provide the insurance company with satisfactory evidence of good health. The portion of your benefit subject to EOI will go into effect on either January 1st or the first of the month following the date The Standard approves your EOI. • If you sign up for life insurance at any time other than your initial eligibility period or during Annual Enrollment, you will have to provide the insurance company satisfactory evidence of good health. If you want to purchase more than the guaranteed coverage amount, you will have to provide the insurance company satisfactory evidence of good health. Coverage will go into effect the first of the month following the date The Standard approves your EOI.	
Beneficiaries	A beneficiary is the person or persons you name to receive death benefits. You may choose or change beneficiaries at any time by completing an enrollment/change form available at ***http://benefits.rc-hr.com***.	
Coverage Options—subject to guaranteed coverage amounts (see page 27)	• Employees (coverage max = 7x annual salary; coverage amounts over certain limits are subject to proof of good health) • Employees: Increments of $10,000 up to $600,000 • Spouse/Domestic Partner: Increments of $5,000 up to $100,000 • Dependent Children*: $5,000 or $10,000	
Coverage Reduction—occurs automatically; age determines cost per $1,000 of reduced coverage	Coverage is reduced at certain ages as follows: • Age 65 to 65% of original amount • Age 70 to 50% of original amount	
Coverage Decrease and Termination	• You may terminate or decrease supplemental life insurance coverage at any time during the year. • Your coverage automatically ends when your employment ends, or when you are no longer eligible for benefits.	

**Disabled dependents—When a disabled child nears age 26, The Standard must receive an application for disabled child coverage within 31 days following the child's 26th birthday. If The Standard approves the request, the child can remain on the policy as an overage disabled dependent, as long as the child continues to meet the eligibility criteria of a disabled child.*

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

This is not the Group Insurance certificate. This is only a benefit summary to highlight supplemental life insurance coverage options. If any discrepancy exists between the summary and the official policy, the official policy will prevail. A detailed description of life insurance coverage is available at ***http://benefits.rc-hr.com***.

LIFE INSURANCE

WHEN IS EVIDENCE OF INSURABILITY REQUIRED?

The chart below shows the coverage amounts you may elect without providing proof of good health or EOI.

Guaranteed coverage amount within 60 days of eligibility (within 60 days of date of hire or within 60 days from date entering an eligible bargaining or employee unit)		
Employee Supplemental Life	**Spouse/Domestic Partner Supplemental Life**	**Dependent Child Supplemental Life**
No EOI required up to $250,000 ($290,000 for RSA Public Safety)	No EOI required up to $20,000	No EOI required
Enrolling during Annual Enrollment (you do not currently have coverage and you are beyond the initial eligibility period)		
Employee Supplemental Life	**Spouse/Domestic Partner Supplemental Life**	**Dependent Child Supplemental Life**
EOI required	EOI required	No EOI required
Increasing coverage during Annual Enrollment (you currently have coverage and you are requesting additional coverage)		
Employee Supplemental Life	**Spouse/Domestic Partner Supplemental Life**	**Dependent Child Supplemental Life**
You may increase your coverage by one $10,000 increment without EOI if currently enrolled for less than $600,000	You may increase your spouse's/domestic partner's coverage by one $5,000 increment without EOI if currently enrolled for less than $100,000	No EOI required

COST OF COVERAGE

The rates you pay for supplemental life coverage are based on the group policy number listed for your bargaining unit or employee group.

GROUP POLICY #641685-F	
SEIU • LIUNA	
Age of Employee	**Monthly Rate per $1,000 of Coverage**
< 35	$0.050
35-39	$0.072
40-44	$0.115
45-49	$0.187
50-54	$0.317
55-59	$0.504
60-64	$0.626
65+	$1.181
Monthly Rates for Covering Children	
Coverage Amount	**Monthly Rate**
$5,000	$1.44
$10,000	$2.88

GROUP POLICY #641685-E	
Elected Officials • Management • Confidential • Unrepresented DDAA • LEMU • RSA Public Safety	
Age of Employee	**Monthly Rate per $1,000 of Coverage**
< 29	$0.032
30-34	$0.043
35-39	$0.054
40-44	$0.086
45-49	$0.130
50-54	$0.205
55-59	$0.389
60-64	$0.486
65+	$1.156
Monthly Rates for Covering Children	
Coverage Amount	**Monthly Rate**
$5,000	$0.63
$10,000	$1.26

The County wants you to be financially secure and retire on your terms. Keep reading to learn more about the retirement plans available to help you keep your future in focus.

CalPERS PENSION PLAN

The County of Riverside offers a retirement pension plan through CalPERS—one of the largest pension funds in the nation—offering benefits to 1.7 million public employees, retirees and their families. The pension plan is designed to provide you with the security of a lifetime pension benefit, which will vary, based on your age, years of service and final compensation at time of retirement. You become fully vested in the pension plan after five years of qualifying service.

All County employees may not be eligible to participate in the CalPERS pension plan. Some classifications that are Seasonal and Per Diem are excluded from participating in CalPERS. If you're employed in a classification that has been excluded from CalPERS participation, the County has an alternate plan known as the 401(a) Part-Time and Temporary Employees' Retirement Plan designed for you. Read further for details on this plan.

HOW YOUR RETIREMENT IS FUNDED

Three sources fund a defined benefit retirement plan such as CalPERS:

1. Your contributions. The percentage of your contribution is fixed by statute or applicable Memorandum of Understanding (MOU) and is generally intended to be an amount that usually covers half of the normal cost of the benefit earned per year. Normal cost will vary by benefit type, because higher benefit formulas have higher normal costs.
2. Earnings. The investment of assets in stocks, bonds, real estate and other investment vehicles. The amount contributed from this source fluctuates from year to year.
3. Employer contributions. Employer contributions are required to be made to help fund the plan and may fluctuate depending on investment returns.

HOW YOUR RETIREMENT BENEFIT IS CALCULATED

Three factors are multiplied to calculate your service retirement:

- **Service credit** – As an eligible County employee, you earn service credit for each year or partial year you work for the County. Service credit accumulates on a fiscal year basis, July 1 through June 30. One year of service credit is equal to 1,720 hours worked in a fiscal year.
- **Benefit factor** – Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula based on your employee group.

Visit ***http://benefits.rc-hr.com/RetirementPlans/RetirementForms.aspx*** under CalPERS Forms & Publications to determine your retirement formula.

- **Final compensation** – Your final compensation is the highest average pay rate and special compensation during any consecutive one-year or three-year period. The compensation period used depends on your contracted benefit.

To learn more about the CalPERS pension plan, visit ***http://benefits.rc-hr.com/RetirementPlans.aspx*** or ***www.calpers.ca.gov***.

RESOURCES TO GUIDE YOU

CalPERS offers a Retirement Estimate Calculator which allows you to use a variety of retirement dates to see how much each would impact your benefit.

You can register for MY|CalPERS to view your account, create retirement estimates, register for educational opportunities, etc. by completing the registration process at ***www.calpers.ca.gov***.

If you do not want to use the online Retirement Estimate Calculator, youcan request that CalPERS calculate an estimate for you. To do this, complete a Retirement Allowance Estimate Request Form, which is available through the Human Resources Retirement Division or online at www.calpers.ca.gov.

INCREASE YOUR RETIREMENT BENEFIT

CalPERS offers various types of service credits you may be eligible to purchase. The purchase of service credits can help increase your service credit balance, which in turn increases your retirement pension. For information regarding the different types of service credit purchase options, visit the CalPERS website at ***www.calpers.ca.gov***.

CalPERS EDUCATIONAL TRAININGS

Whether you're a CalPERS member at the beginning, middle or end of your career, attend one of the CalPERS Benefits Education Events. The earlier you learn about your retirement benefits, the better prepared you'll be when making decisions in the future. There are different sources available for trainings to fit any calendar.

KEEPING YOUR FUTURE IN FOCUS

1. **Live Sessions:** Enroll in County of Riverside (COR) sponsored training through the COR Learning Center. For questions, please contact the COR Learning Center at ***HR-TheCenter@rc-hr.com*** or **(951) 955-3255**.
2. **CalPERS Benefits Education Events:** Register online or at a CalPERS Regional Office. To register, contact CalPERS at ***www.calpers.ca.gov*** or at **(888) 225-7377**.
3. **Online Webinars:** Watch live web events requiring prior registration or prerecorded videos available at any time. Visit CalPERS at ***www.calpers.ca.gov***.

READY FOR RETIREMENT

The County of Riverside offers Retirement Planning Workshops to all employees who meet the retirement eligibility guidelines and who plan to retire within one year. Retirement Specialists meet with small groups of specific employees in the same bargaining unit or employee group to provide retirement benefit information and services. Individual appointments are available to employees who are ready for retirement and have attended a Retirement Planning Workshop.

1. **Post-Employment Program (PEP) Workshop Schedule** – Enroll in a workshop specific to your bargaining or employee unit. For a list of workshops available in your area, visit the Retirement website at ***http://benefits.rc-hr.com***.
2. **Enroll Now** – Enroll in a workshop online through the County of Riverside's Learning Center at ***HR-TheCenter@rc-hr.com***.
3. **Contact Us** – Retirement Specialists are available to speak to you regarding all retirement benefits and services.
   - » **Online:** Visit our website at ***http://benefits.rc-hr.com/RetirementPlans.aspx*** for information on all retirement benefits and services
   - » **By phone:** Call **(951) 955-4981, Option 2**, Monday through Friday from 8:00 a.m. to 5:00 p.m.
   - » **By email:** ***Retirement@rc-hr.com***
4. To schedule an individual appointment with a County of Riverside Retirement Specialist, visit our **Online Appointment Scheduler** at ***https://checkappointments.net/book/rchr***.

THE 457 AND ROTH DEFERRED COMPENSATION CONTRIBUTION PLANS

In addition to the CalPERS pension plan, we offer a voluntary 457 Deferred Compensation Plan to assist you with meeting your financial goals in retirement. You may choose to contribute to the Deferred Compensation Plans through Nationwide Retirement Solutions and/or VALIC. There are two types of Deferred Compensation Plans:

- **Traditional** – Contributions are deposited into your account on a tax-deferred basis.
- **Roth** – Contributions are deducted on an after-tax basis.

While your funds are held in your accounts, you do not pay taxes on any tax-deferred contributions or gains. When you end your employment with the County, you're eligible to withdraw your funds or roll them over into another qualified plan, after 30 days of separation. Participation in the 457 Deferred Compensation Plan is separate from participation in the CalPERS or 401(a) Part-time and Temporary Employees' retirement plans.

401(a) MONEY PURCHASE PLAN

The Money Purchase Plan was developed by the County to supplement employees' retirement plans. This program is funded by the County at no cost to eligible employees, but to participate, employees must enroll and select investment elections. These are qualified funds which can be rolled into another qualified plan upon the employee's retirement or departure from the County. Eligible employees who may participate in this plan are represented by LEMU and RCDDAA bargaining units or covered by the Management, Confidential and Unrepresented employee groups.

401(a) PART-TIME AND TEMPORARY EMPLOYEES' RETIREMENT PLAN

The Part-time and Temporary Employees' Retirement Plan is a pension plan. This plan was designed to provide eligible employees not paying into Social Security with a benefit equivalent to Social Security. **You are required to participate** in the plan if you are designated as a temporary or part-time employee who is not covered under any other retirement system, and for whom the County is not paying Social Security taxes. The plan is funded by your contributions and those made by the County.

For more information about the 457 and 401(a) plans, visit ***http://benefits.rc-hr.com/RetirementPlans.aspx*** or call the Benefits Information Line at **(951) 955-4981, Option 2**.

PROTECTION WHEN YOU'RE UNABLE TO WORK

DISABILITY INSURANCE

Disability benefits are an important part of your benefits package, and you don't pay for the cost of your coverage—the County takes care of that for you.

Disability plans provide replacement income benefits when you are unable to work due to illness or injury. Learn more about your disability benefits so you'll be prepared when you need them.

Your employee unit determines which disability plan you have. Refer to the table below to determine which plan you are eligible for:

SHORT-TERM DISABILITY	LONG-TERM DISABILITY
• SEIU Represented Employees (Excluding Supervisory) • LIUNA Represented Employees • RSA Public Safety	• Law Enforcement Executive Management • SEIU Supervisory • Deputy Coroner • Coroner Corporals • Correctional Counselors • Supervising Correctional Counselors • Management • Confidential • Unrepresented • DDA • Elected Officials

WHAT'S COVERED

Your coverage depends on your employee group or bargaining unit. Visit ***http://benefits.rc-hr.com/OtherBenefits/DisabilityInsurance*** and click on your group or unit to see a schedule of benefits for your plan.

LEAVES OF ABSENCE

County of Riverside employees may be entitled to time off from work for specific reasons in accordance with a variety of different family and medical leave laws. These laws are designed to provide you with an opportunity to balance your work and family life by taking reasonable leave time without the fear of having to choose between your job and your family.

- **Family Medical Leave Act (FMLA):** FMLA is a federal law that allows you to balance your work and personal lives by taking unpaid, job-protected leave of up to 12 weeks (or 480 hours) in a 12-month period for certain family and medical reasons.
- **California Family Rights Act (CFRA):** CFRA is a California state law that provides California workers with unpaid, job-protected leave time to bond with a newborn, adopted or foster child; to care for certain family members with a serious health condition; or to care for the employee's own serious health condition.
- **Pregnancy Disability Leave (PDL):** PDL provides California workers with unpaid time off and job protection for prenatal care as well as pregnancy-related and childbirth-related disabling conditions for up to four months for each pregnancy.
- **Military Leave:** The County offers Military Leave. For details, refer to the policy available in the HR Toolbox by selecting the *Military Leave Law Procedures and Guidelines.*

Whether you're thinking about taking a leave now or in the future, it's important to understand the types of leave available, determine whether you are eligible, and the process for requesting a leave. This will ensure that your leave is approved and you have a plan for returning to work. To learn more, visit ***http://www.rc-hr.com***, select the "HR Toolbox" link, and choose *Leave forms and information* from the drop-down menu, or contact your Department Representative.

WHAT IS A "LEAVE OF ABSENCE"?

A leave of absence is an approved absence from work for a specific period due to things like:

- A serious health condition or injury you or a family member experiences
- A personal emergency leave (including providing care to a family member)
- Military leave

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 or employee group determines which plan options are available to you and your dependents.

Temporary and Per Diem Employees: If you're a temporary employee, you are eligible for the Exclusive Care medical plan only. Refer to the temporary employee benefits available at ***http://benefits.rc-hr.com/*** for details about your medical coverage.

DEPENDENT ELIGIBILITY

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

- **Legal spouse** to whom you are legally married, in accordance with applicable state law.
- **Registered domestic partner**, if you and your domestic partner meet all of the criteria listed below. A domestic partnership is defined as two people who both:
  - Are at least 18 years of age, unmarried, and not related by blood close enough to bar marriage in the State of California;
  - Live in a mutually exclusive relationship in which they are jointly responsible for each other's welfare and financial obligations;
  - 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, both partners' signatures having been notarized and filed with the Secretary of State.
- 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.
  - Specified opposite-sex domestic partnerships in which one or both partners are age 62 or older.
- **Children.** Your child must be less than age 26 unless they are disabled. Eligible children include your or your spouse's/registered domestic partner's:
  - Natural child
  - Stepchild
  - Child who is adopted by you or placed in your physical custody for adoption prior to age 18. "Placed for adoption" means that you have assumed a legal obligation for total or partial support of the child in anticipation of adopting the child. The child must be available for adoption, and the legal process must have begun.
  - Child for whom you have legal custody or guardianship
  - Child for whom you are required to provide coverage due to a **qualified medical child support order** (QMCSO). A QMCSO includes a judgment, decree or other order issued by a court of competent jurisdiction or through an administrative process established under state law. Coverage cannot be discontinued for any child who is enrolled to comply with a QMCSO unless you submit written evidence that the order is no longer in effect.
  - Disabled child over age 26 (who, except for age, meets the above eligibility requirements), if he or she is incapable of self-support because of a mental or physical disability that existed before age 26 (and continuously on a County-sponsored plan since age 26). The child must be dependent on you or your spouse/registered domestic partner for support and claimed as your dependent for federal income tax purposes. Coverage for a disabled child may be established only when you are first eligible for benefits or as a continuation of coverage beyond age 26.

The following are examples of individuals who **are not** considered eligible dependents:

- Your spouse following final decree of dissolution, divorce or legal separation
- Someone else's child (such as your grandchild, niece or nephew), unless you have been awarded legal custody or guardianship
- Parents or grandparents, regardless of their IRS dependent status

IMPORTANT NEWS ABOUT DEPENDENT ELIGIBILITY

If you're enrolling a dependent for the first time, you will be required to provide proof of dependent eligibility before the deadline to complete your enrollment.

Please keep the following rules in mind:

1. It is against the law to enroll ineligible people. If you do, you may have to pay for all costs incurred by the ineligible person 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/registered domestic partner, parents, parents-in-law, other relatives, and non-disabled children age 26 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 gets a job where benefits are offered).

REQUIRED PROOF OF ELIGIBILITY

You will need to provide proof of eligibility and your dependent's Social Security number the first time you request that a dependent be added to your medical, dental or vision plan, and periodically during routine audits. Once you have completed your eBenefits online enrollment or *Benefit Election Form*, submit all of the necessary documentation to your Department Representative. **Please remember to keep a copy of all documentation for your records.**

Legal Spouse

A certified copy of your marriage certificate must be submitted at the time your spouse is enrolled. If a certified copy of your marriage certificate is not available to meet the 60-day enrollment period or Annual Enrollment deadline, you are required to provide a copy of the marriage certificate (certified with state seal) as soon as it is available (but no later than 30 days from the date your request was received by Human Resources and when requested during a routine audit).

Registered Domestic Partner

You must provide a copy of the *Declaration of Domestic Partnership* registered with the Secretary of State and your partner's Social Security number.

Children

For a natural child, provide a copy of the child's birth certificate. For a stepchild, provide a copy of the child's birth certificate and a certified copy of your marriage certificate. For an adopted child or a child for whom you have legal custody or guardianship, you must provide a copy of the child's birth certificate ***and*** a copy of the judgment, decree or order issued by a court. You must also provide the child's Social Security number.

Disabled Children (Age 26 or Over)

You must submit a *Member Questionnaire for the Disabled Dependent Form* and a *Medical Report Form*. These forms must be received within 60 days of your initial enrollment or the child's 26th birthday. The forms must be approved by the insurance carrier upon enrollment and updated upon request. You must also submit a copy of your most recent federal income tax return indicating that the child is a qualified dependent and provide the dependent's Social Security number.

You may enroll a disabled child who is age 26 or over ONLY upon your initial eligibility or as a CONTINUATION of coverage on a County-sponsored plan beyond age 26. In other words, your child must have been disabled ***before*** reaching age 26,

unless you are a new employee enrolling for the first time. Also, you must claim the child as a deduction on your federal income tax return.

For Life Insurance Coverage

You must complete and submit The Standard's forms to document that your child is disabled. These forms must be submitted within 31 days after:

- The date on which coverage would otherwise end because of your child's age; or
- The effective date of your initial coverage, if your child is disabled on that date

At reasonable intervals thereafter, The Standard may require proof of your child's continued disability and may have your child examined at The Standard's expense.

WHAT TO EXPECT WHEN YOU BECOME ELIGIBLE FOR MEDICARE

Medicare is a federal health insurance program for people age 65 or older. Medicare also covers some people under age 65 with certain disabilities and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has several parts:

- **Medicare Part A** is hospital insurance that helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay), some home health care and hospice care. You usually don't pay a monthly premium for Part A coverage if you or your spouse paid Medicare taxes while working.
- **Medicare Part B** is medical insurance that helps pay for doctors' services, outpatient hospital care, and many other medical services and supplies that are not covered by Part A. You are responsible for paying the monthly Medicare Part B premium to Social Security.
- **Medicare Part D** provides prescription drug coverage. You pay a premium for Part D coverage when you elect it.

If you or your spouse becomes eligible for Medicare while you are still working—and covered under one of the County's medical plans for active employees—***you do not need to sign up for Medicare Part B or Part D until you retire***. You will have an opportunity after your employment ends to sign up for Part B and Part D coverage without paying late-enrollment penalties.

If you are eligible for the County's medical waiver program, you may elect to have Medicare as your only medical plan and waive County coverage (see page 35 for details). In this case, you would need to sign up for Parts A, B and D. Please review the Medicare benefit limitations carefully; they can be substantial.

For more information about Medicare enrollment dates and benefits, contact:

Centers for Medicare & Medicaid Services (CMS)
(800) 633-4227
TTY: **(877) 486-2048**
www.medicare.gov – see the publication *Medicare & You*

Social Security Administration
(800) 772-1213
TTY: **(800) 325-0778**
www.ssa.gov

WHEN COVERAGE BEGINS

If you are enrolling for coverage or making changes to your current benefit elections during Annual Enrollment, most of your new coverage elections will be effective January 1 of the following year. Your deductions for medical, dental and vision coverage will begin with the first pay warrant in December of the current year. Deductions for the Flexible Spending Accounts (FSAs) and supplemental life insurance will begin on your first pay warrant in January. Keep in mind that health coverage effective dates will be delayed if you are not actively at work or if your enrolled dependent is admitted/confined to a hospital on the effective date coverage was to begin.

NEW EMPLOYEE COVERAGE

You are eligible to commence coverage beginning the first of the month immediately following your date of hire, or you may elect within your initial eligibility period to delay commencement of coverage to a later date, but no later than the first of the month immediately following the end of your 60-day initial eligibility period. Unless you designate a future date that falls within your 60-day initial eligibility period, your coverage will begin on the first of the month following receipt of your completed *Benefit Election Form*. Premiums for the medical, dental and vision plans are collected in advance of the month of coverage.

IMPORTANT POINT TO KEEP IN MIND

If you haven't received a paycheck by the time your premium payments are due, any missed premiums and the current required premium will be deducted in full from your first available pay warrant(s). This could result in a significant deduction from your pay check.

To avoid this significant deduction, consider delaying the commencement of your coverage.

You will also receive flexible benefit credits for the elected coverage period to offset the cost of premiums. The effective date and coverage choices you make could result in a significant premium deduction from your pay warrant(s), up to and including your full pay. Please keep this in mind when electing coverage, and plan accordingly for additional deductions.

If you do not elect a medical plan within your initial 60-day eligibility period, you will automatically be defaulted into the lowest-cost PPO plan offered, and you will be deemed to have elected participation in the plan. You will not be permitted to modify the election during the plan year, except when the change is requested as a result of and is consistent with a qualified change of status as defined by the Internal Revenue Code, section 125.

MID-YEAR ELECTION CHANGES

Most changes are made prospectively from the date that Human Resources receives a properly completed and signed *Benefit Election Form.* Exceptions are made for birth or adoption to comply with special enrollment rights defined under the Health Insurance Portability and Accountability Act (HIPAA).

For additional information on changes during the plan year, see page 36.

WAIVING COVERAGE

ELIGIBILITY FOR THE COUNTY'S MEDICAL WAIVER PROGRAM

Waiver Eligibility	Waiver Requirements
You are ***eligible**** to participate in the medical waiver program if you are: • Elected Official elected before 11/13/2003 • Management hired before 11/13/2003 • Confidential hired before 11/13/2003 • Unrepresented hired before 11/13/2003 • LIUNA hired before 11/13/2003 • SEIU hired before 11/11/2004 • RSA Public Safety hired before 02/02/2006 • DDAA hired before 11/04/2010 • Resident Physicians	You must have other **group** medical plan coverage (as defined below) and do ALL of the following: 1. Enroll in at least one of the other County-sponsored health care plans (such as dental, employee-paid vision or the Health Care FSA). If you are using the FSA to qualify for a waiver, keep in mind that you must elect FSA coverage during each Annual Enrollment. 2. Elect "Medical Waiver" (MEDWAV) as your medical plan option by either: (a) completing the eBenefits online enrollment system during Annual Enrollment, or (b) submitting a completed *Benefit Election Form* if you are a newly eligible employee or requesting a mid-year change. 3. Provide information about your other group 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. 4. Sign the Decline Coverage Acknowledgment form.
You are ***not eligible*** to participate in the medical waiver program if you are: • Elected Official elected on or after 11/13/2003 • Management hired on or after 11/13/2003 • Confidential hired on or after 11/13/2003 • Unrepresented hired on or after 11/13/2003 • LIUNA hired on or after 11/13/2003 • SEIU hired on or after 11/11/2004 • LEMU • RSA Public Safety hired on or after 02/02/2006 • DDAA hired on or after 11/04/2010	You are required to enroll in a County-sponsored medical plan within 60 days of eligibility (e.g., date of hire or transfer to an eligible unit). If you do not submit your enrollment within the eligibility period, the following will occur: • No flexible benefit credits will be paid until your enrollment is implemented. • 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 mid-year qualified change of status.† • Once coverage is implemented, you will be eligible for flexible benefit credits.

**Your date of hire for eligibility purposes 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.*

To participate in the medical waiver program, select the "Medical Waiver" (MEDWAV) option when you complete a *Benefit Election Form* or enroll online.

If you do not meet the medical waiver program eligibility requirements above, and you do not want County medical coverage, you can decline coverage by selecting the "Waive (W)" option when you enroll. You will not be required to elect a medical plan—but you also will not be eligible to receive flexible benefit credits.

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.

Note: Coverage you buy through the California Exchange is individual coverage and does not meet the "other group coverage" requirement under the medical waiver program.

EXAMPLES OF ELIGIBLE GROUP MEDICAL PLAN COVERAGE	
Approved Coverage	**Ineligible Coverage**
• Employer-sponsored medical plans • Medicare • TRICARE	• Coverage purchased as an individual • Coverage purchased through Covered California

WHEN COVERAGE ENDS

If your employment ends, 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 medical, dental and employee-paid vision coverage, and on your last day of work for supplemental life insurance coverage and the Flexible Spending Accounts.

In the case of a mid-year qualified change of status, 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 on page 43 for details about how you and/or your enrolled dependents may continue coverage when eligibility is lost due to a qualified change of status.

MAKING MID-YEAR ELECTION CHANGES

The benefit elections you make as a new hire or during Annual Enrollment will stay in effect for the entire plan year, if you remain eligible for benefits. Each year during the annual enrollment period, you have an opportunity to change your coverage elections for the following year. However, after Annual Enrollment ends, you can make changes to your health care and FSA coverage ONLY if they are as a result of and consistent with a **qualified change in status** as defined by the Internal Revenue Service (IRS). Qualified changes of status include:

- **Change in legal marital status,** including marriage, divorce, legal separation, annulment or death of a spouse
- **Change in number of dependents,** including birth, adoption, placement for adoption or death of a dependent child
- **Change in employment status,** including the start or termination of employment by you, your spouse or your dependent child
- **Change in work schedule,** including an increase or decrease in hours of employment by you, your spouse or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status,** either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite,** including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in your or your spouse's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child

REQUESTING A MID-YEAR ELECTION CHANGE

- Complete a *Benefit Election Form* available at ***http://benefits.rc-hr.com***.
- Include documentation of the event, such as a marriage license, birth certificate, etc.
- Return the *Benefit Election Form* and supporting documentation to your Department Representative within **60 days** of the qualifying event.

IF YOU GET DIVORCED OR DISSOLVE A DOMESTIC PARTNERSHIP

Be sure to notify Human Resources if you get divorced or end your registered domestic partnership. Your ex-spouse/registered domestic partner will no longer be eligible for supplemental life insurance coverage or other coverage under the County plans. However, he or she can convert the supplemental life insurance coverage to an individual policy or continue it on a portable basis.

Also, you may want to change your beneficiary designation if your marriage or registered domestic partnership ends. See your Department Representative for details and forms.

IMPORTANT:
You must notify Human Resources within 60 days of a qualified change of 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 change of status and can be requested 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 special enrollment rights defined under the Health Insurance Portability and Accountability Act (HIPAA). *Benefit Election Forms* are available on the County's benefits website at ***http://benefits.rc-hr.com***, from your Department Representative, or by contacting the Benefits Information Line at **(951) 955-4981**.

OTHER IMPORTANT INFORMATION

PATIENT PROTECTION NOTICE

The UnitedHealthcare HMO plan and Exclusive Care EPO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from United Healthcare or Exclusive Care, or from any other person (including a primary care provider), in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or following procedures for making referrals.

For information about how to select a primary care provider, and for a list of the participating primary care providers—including a list of participating health care professionals who specialize in obstetrics or gynecology—contact United Healthcare or Exclusive Care. Contact information is listed on the back cover of this guide.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE (CHIP) PROGRAM

If you are eligible for health coverage from your employer but are unable to afford the premiums, you can inquire about the premium assistance programs that some states have to help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your Medicaid or CHIP office, or you can contact **(877) KIDS NOW** or visit ***www.insurekidsnow.gov*** to find out how to apply.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

For more information, contact Medicaid at **(916) 445-4171** or visit ***http://www.dhcs.ca.gov/Pages/default.aspx***.

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 cannot pay the premiums for these dependents on a pretax basis, nor can 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 pretax 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 more than one-half of such taxable year, except for temporary absences, such as vacation, military service, or education; and
2. Receive more than half of his or her support from you.

Your spouse automatically qualifies as a tax-qualified dependent. Your non-spouse dependents, including your registered 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 registered 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 PARTNERS AND THEIR DEPENDENTS AS TAX-QUALIFIED

Your registered domestic partner and his or her children are designated as non-tax-qualified by default. If your registered domestic partner and his or her children meet the definition of tax-qualified, you can 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 website. 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 *Home*, then select *Benefit Form* and look for the *Affidavit/Declaration* section and select the *Declaration of Dependent Status* 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 on 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. Refer to the *Plan Rates* available at ***http://benefits.rc-hr.com*** for the most current imputed income amounts.

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 plans' 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 details 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.

OTHER IMPORTANT INFORMATION

You should review the provisions of your other coverage. Before making a selection, call the plan's Member Services to get a thorough understanding of how your plan will coordinate.

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 parent the longest pays first.

IMPORTANT NOTICE 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.

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 or more than 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 can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to join a Part D plan. *In addition, if you lose or decide to leave employer- or 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 drugs. 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.

OTHER IMPORTANT INFORMATION

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 October 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 **(951) 955-4981** 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***.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for the telephone number) for personalized help. In California, call **(800) 510-2020**.
- Call **(800) MEDICARE**, or **(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 assistance, visit Social Security on the Web at ***www.socialsecurity.gov***, or call **(800) 772-1213**. TTY users should call **(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, 2017
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)

Keeping your personal health information private is your right. That's why the U.S. government passed the "Privacy Rule"—part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule protects your health information and makes it illegal for health care providers to reveal information about your health without your permission, unless needed to treat your condition. It also prevents the improper use of health information by health care benefit insurers and administrators. Doctors' offices and health care facilities are required by law to obtain your written permission to appropriately reveal information about your health.

If you would like to get a copy of the notice describing how the County of Riverside may use and disclose your personal health information, contact the Human Resources Benefits Information Line at **(951) 955-4981**. If you have a privacy concern or complaint, you may reach out to any of the contacts listed on the following page under "Privacy Complaint Contacts."

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.

COVERAGE

"Qualified Beneficiaries" are generally the employee, the employee's spouse/domestic partner or the employee's dependent children, and/or the domestic partner'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.

Both you and your spouse/domestic partner 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.

NEED MORE HELP?

CONTACT INFORMATION		
Plan	**Telephone**	**Website**
Medical		
UnitedHealthcare Signature Value (HMO)	(800) 624-8822	www.myuhc.com
UnitedHealthcare Select Plus (PPO)	(866) 633-2446	www.myuhc.com
Exclusive Care (EPO)	(800) 962-1133	www.exclusivecare.com
Kaiser Permanente (HMO)	(800) 464-4000	https://my.kp.org/countyofriverside/
PERSChoice, PERSCare and PERS Select (PPO)	(877) 737-7776	www.calpers.ca.gov
PORAC	(800) 655-6397	www.porac.org
Wellness Program		
Culture of Health Program	(951) 955-9086	http://cultureofhealth.rc-hr.com/
Dental		
DeltaCare USA (HMO)	(800) 422-4234	www.deltadentalins.com
Delta Dental (PPO)	(800) 765-6003	www.deltadentalins.com
Local Advantage (EPO)	(800) 331-5301	http://benefits.rc-hr.com
Vision		
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
Medical Eye Services (MES)	(800) 877-6372	www.mesvision.com
Life Insurance		
The Standard • Technical questions • Continued benefits (conversion/portability)	(800) 628-8600 (866) 623-0622 (800) 378-4668	http://benefits.rc-hr.com
Employee Assistance Services (EAS)		
Employee Assistance Services	(951) 778-3970 or (760) 328-6863	www.rc-hr.com/eas/
Other Benefits and County Resources		
eBenefits Online Enrollment System Entry	Call the Benefits Information Line for assistance at (951) 955-4981	http://benefits.rc-hr.com
Riverside County Human Resources Benefits Information Line	(951) 955-4981 TTY: (951) 955-8688 Fax: (951) 955-8538	http://benefits.rc-hr.com or http://intranet.co.riverside.ca.us Email: benefits@rivco.org
FSA Claims Administrator (ASIFlex)	(800) 659-3035	www.asiflex.com
CalPERS	(888) 225-7377	www.calpers.ca.gov
Enterprise Solutions Help Desk (formerly Oasis Help Desk)	(951) 955-9900	http://intranet.co.riverside.ca.us
Advocacy Services	(888) 622-1200 or (951) 955-4981, option 3	www.aonhewittadvocacy.com
Retirement		
CalPERS	888 CalPERS or (888) 225-7377	https://my.calpers.ca.gov
Nationwide • Nationwide Retirement Solutions	(877) 677-3678	www.nationwide.com
VALIC • VALIC Client Care Center	(888) 568-2542	www.valic.com
Disability		
Sedgwick (Short-Term Disability)	(800) 845-7739	www.claimlookup.com
The Standard (Long-Term Disability) • Insurance Claims	(800) 368-1135 (800) 378-2395	http://benefits.rc-hr.com/OtherBenefits/DisabilityInsurance