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Human Resources Benefits Division, 4080 Lemon Street, P.O. Box 1569, Riverside, CA 92502, (951) 955-4981

RIVCO 1HR putting people first

County of Riverside, Human Resources Department

2019 Benefit Election Form

For Employees Eligible for County Medical Plans

Department Name:	Bargaining Unit:	Employee ID:	Hire Date:
Name:	Home Phone:	Work Phone:	Cell Phone:
Street Address:	City:	State: CA	Zip:
Email Address: *(Required, if available)*	Elected Coverage Begin Date *(must be first day of month)*:		
Status Change Eff.:	Reason for Change (Qualified Change of Status. e.g., marriage, birth, divorce, LOA, etc.):		

This form (5 pages) must be completed, signed, and returned to your Department Representative. You may submit this form during your first 60 days of employment, during the annual enrollment period, or if you have a qualifying mid-year status change. You have 60 days from the date of the qualifying event to submit this paperwork. Failure to submit this paperwork timely, may result in denial of coverage/changes.

Medical Plan Options and Monthly Rates

Select your medical plan coverage by checking the box next to the plan's coverage level. The following bargaining or representation units are eligible for the County medical plans: Elected Officials, SEIU represented employees, LIUNA represented employees, Management/Confidential/Unrepresented employees, and Resident Physicians.

Medical Plan	Coverage Level	Monthly Cost	
Exclusive Care EPO	☐ Single	$587.76	(331)
	☐ Two-Party	$1189.76	(332)
	☐ Family	$1493.76	(333)
United Healthcare HMO - Signature Value (Full Network)	☐ Single	$935.22	(US1)
	☐ Two-Party	$1902.54	(US2)
	☐ Family	$2468.72	(US3)
United Healthcare HMO - Alliance (Narrow Network)	☐ Single	$806.64	(UA1)
	☐ Two-Party	$1640.28	(UA2)
	☐ Family	$2128.20	(UA3)
Kaiser Permanente HMO	☐ Single	$668.84	(KP1)
	☐ Two-Party	$1329.54	(KP2)
	☐ Family	$1728.28	(KP3)
United Healthcare PPO	☐ Single	$1806.80	(UP1)
	☐ Two-Party	$3587.14	(UP2)
	☐ Family	$4655.84	(UP3)
Medical Waiver*	☐ Medical Waiver	$0	
No Coverage / No Flexible Benefit Credits	☐ Forfeit Credits	$0	

Medical Waiver:** To elect the Medical Waiver option, you must meet the requirements, which are located in the 2019 Benefits Annual Enrollment Guide. If you are eligible, you may waive coverage and receive a reduced amount of Flexible Benefit Credits. You MUST elect one of the other benefit options (dental, employee-paid vision, or Flexible Spending Account - HCA) to receive Flex Credits. Additionally, you must also provide proof of other eligible group medical coverage and submit a ***Decline Coverage Acknowledgement Form.

Medical Waiver/Proof of Other Medical Insurance

Complete this section if you are electing the Medical Waiver. You must provide proof of other eligible group medical coverage.

Name of Policy Holder	Policy Holder Social Security Number	Name of Insurer	Policy Group Number	Policy Holder Date of Birth

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Department Name:	Bargaining Unit:	Elected Coverage Begin Date:
Name:	Employee ID:	Status Change Date:

Dental Plan Options and Monthly Rates

Select your dental plan coverage by checking the box next to the plan's coverage level.

DeltaCare USA DHMO High Plan (10A)	☐ Single	$22.84	(DH1)
	☐ Two-Party	$33.80	(DH2)
	☐ Family	$52.00	(DH3)
Delta Dental PPO	☐ Single	$48.00	(DP1)
	☐ Two-Party	$82.00	(DP2)
	☐ Family	$120.00	(DP3)
Local Advantage Plus	☐ Single	$42.00	(151)
	☐ Two-Party	$80.00	(152)
	☐ Family	$117.00	(153)
Local Advantage Blythe	☐ Single	$30.00	(361)
	☐ Two-Party	$52.00	(362)
	☐ Family	$80.00	(363)
Waive Dental	☐ Waive	$0	

Vision Plan Options and Monthly Rates

Select your vision plan coverage by checking the box next to the plan's coverage level.

Medical Eye Services (MES) Plan 1 (Eye Exam and Eyewear) ***SEIU and LIUNA Only***	☐ Single	$9.24	(M11)
	☐ Two-Party	$13.96	(M12)
	☐ Family	$18.88	(M13)
Medical Eye Services (MES) Plan 2 (Eyewear Only) ***SEIU and LIUNA Only***	☐ Single	$7.80	(M21)
	☐ Two-Party	$12.42	(M22)
	☐ Family	$17.14	(M23)
Vision Service Plan (VSP) ***Elected Officials, Management, Confidential, Unrepresented, Resident Physicians Only, DDAA and LEMU***	☐ Single	Employer Paid Benefit	
	☐ Two-Party	Employer Paid Benefit	
	☐ Family	Employer Paid Benefit	
Waive Vision	☐ Waive	$0	

Flexible Spending Account (FSA)

*Please Note: You must re-enroll each year. Complete the election information below. If no election is entered below, your annual election will be $0.

Flexible Spending Account	Current Annual Election	New Annual Election
Health Care Account: Elect an annual amount between $240 and $2,650	$	$
Dependent Care Account (i.e., Child Care): Elect an annual amount between $240 and $5,000	$	$

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Name:	Employee ID:	Status Change Date:

Employee/Dependent Information

Enter below information for yourself and any eligible dependents you are enrolling into your medical, dental, and/or vision plan.

**A provider selection is required for Exclusive Care EPO, United Healthcare HMO and DeltaCare Dental (DHMO). Provider ID numbers are listed in the carrier's provider directories, the carrier's website, or can be obtained by calling the health or dental plan. If you do not indicate a provider, one will be automatically assigned to you by the carrier.

EMPLOYEE

Relationship	Employee Name:	Date of Birth:		Social Security #
SELF			☐ Male ☐ Female	

	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT # 1

Relationship:	Dependent Name:	Date of Birth:		Social Security #
			☐ Male ☐ Female	

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT # 2

Relationship:	Dependent Name:	Date of Birth:		Social Security #
			☐ Male ☐ Female	

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT # 3

Relationship:	Dependent Name:	Date of Birth:		Social Security #
			☐ Male ☐ Female	

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

DEPENDENT # 4

Relationship:	Dependent Name:	Date of Birth:		Social Security #
			☐ Male ☐ Female	

Tax Qualified Dep?	Enroll in Medical?	Enroll in Dental?	Enroll in Vision?	Medical Provider ID:	Dental Provider ID:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		

Release of Information: I authorize any physician, health care practitioner, hospital or other health care facility, clinic, health care service plan, or any other person or entity to release to any health care plan provider of the County of Riverside, a health care service plan, a self-insurer, or any insurance company, or its designee, all medical or personal information related to myself or any covered dependent, including mental health medical records from drug and alcohol abuse treatment or prevention, for the following purposes: Diagnosis or treatment; Payment of health services rendered; Billing, claims management, medical data processing, or other administrative function of the health plan in which I am enrolled through the County; Peer review, including reviewing the competence or qualifications of health care professionals; Utilization review and quality assurance, including reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges; Handling of member grievances or appeals, external independent review, or other health dispute resolution; Coordination of care with providers of health care or other health care service plans; Administering the health benefit plan; Chronic disease management programs, to monitor or administer care of a covered benefit; to verify my participation in other healthcare coverage if I elected to waive County sponsored benefit and other uses specifically authorized by law. This authorization is effective immediately and remains in effect for the duration of coverage under my health plan provider through the County of Riverside.

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Department Name:	Bargaining Unit:	Elected Coverage Begin Date:
Name:	Employee ID:	Status Change Date:

Binding Arbitration: I understand that the health plans that the County of Riverside offers use neutral binding arbitration to resolve disputes between Members, including but not limited to, claims of malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for claims subject to ERISA, between myself and the health plan. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceeding. The health plan and myself (and/or any enrolled family member), the parties to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. For additional information about each plan's arbitration provision, I may refer to the Disclosure and Evidence of Coverage, copies of which are available from each health plan.

Changes in Coverage: If you or your dependents experience a qualifying event resulting in a change in family status, you must contact Human Resources to request an enrollment change within 60 days from the date of the qualifying event. If you do not request enrollment within 60 days, you must wait until the next County Annual Enrollment period before you will be permitted to make a change.

Medical Waiver: I understand that if I waive medical coverage offered through the County of Riverside that I am subject to an annual audit whereby, I will have to provide proof of my other group (not individual) medical coverage when requested by the County. If at any time I do not have other group medical coverage, I understand I am not eligible for any Flexible contributions for any month that I do not have other group medical coverage and will have to repay the County for Flexible contributions that I was not eligible to receive.

Health Insurance Portability and Accountability – Special Enrollment Rights: If you are waiving enrollment for yourself and your dependents (including your spouse/domestic partner) because of other health insurance coverage; if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your dependents, provided that you request enrollment within 60 days after the qualifying event occurs.

Employee's Authorization, Release and Signature:

I understand that I must meet the eligibility requirements of my elections as indicated on this Benefit Enrollment form. Submission of this Benefit Election Form is not confirmation that eligibility requirements have been met or verified.

I have read, understand and agree to the terms and conditions set forth in this Benefit Election Form, including the Release of Information, Binding Arbitration, Changes in Coverage and Medical Waiver, if applicable.

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I certify that the information on this form is complete and correct and understand that, if it is not, I may be subject to disciplinary action by the County of Riverside. I understand that I must meet the eligibility requirements of each benefit plan that I have elected. I understand that submission of this enrollment form is not a confirmation that eligibility requirement have been met or verified. I also certify that the names of all dependents listed above for medical, dental, and vision coverage are my eligible dependents under the County of Riverside's Flexible Benefit Program. If I have enrolled a domestic partner and/or any dependent of a domestic partner that are not tax dependents as defined by the Internal Revenue Code Section 125, I understand that the Internal Revenue Service regulations require that the fair market value of domestic partner coverage will be included in my taxable income for FICA, Medicare, and Federal withholding purposes, and that the County of Riverside is obligated to withhold and report taxes on the fair market value of the domestic partner coverage.

Premium Collection - I authorize the County of Riverside to deduct from my County of Riverside pay warrant, all premiums required for the coverage elections I've selected on this enrollment form. I understand that the County of Riverside collects premiums for the medical, dental and vision plans a month in advance of the coverage effective date and the coverage begin date I select may require the collection of retroactive premiums. I further authorize the County of Riverside to deduct all premiums due up to and including my full pay warrant and from my final pay warrant at termination.

I certify that I have read, understand, and agree to the terms outlined on this Benefit Election Form.

_____ _____

Signature Date