YOUR BENEFITS

Choose Your 2022 County of Riverside Benefit Options

Who's Eligible for Benefits

More to Know Before You Enroll

RIVCO 1HR
putting people first

WHAT'S INSIDE

IMPORTANT NOTE

The CalPERS medical plans are not described in this guide. For CalPERS plans, visit ***www.calpers.ca.gov*** for more information. Resources available online include:

- Health Program Guide
- Health Benefit Summary
- Health Plan Search by ZIP Code, Evidence of Coverage, Provider Search

▶ **Choose Your Options** page 1
Check out what's available, who's eligible, and how you should use this guide.

▶ **Enrolling for the First Time** page 2
How to enroll for the first time.

▶ **Paying for Your Coverage** page 4
Find out how the County helps pay for your coverage.

▶ **Options to Meet Your Needs** page 9
Learn what benefits are available to you, how they work, and what to keep in mind as you consider which plans to choose.

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Get the support you need when you're unable to work due to an illness or injury—the County's got you covered.

▶ **The Rules and Requirements of Our Program** page 26
Understand the rules and requirements of our program before you enroll.

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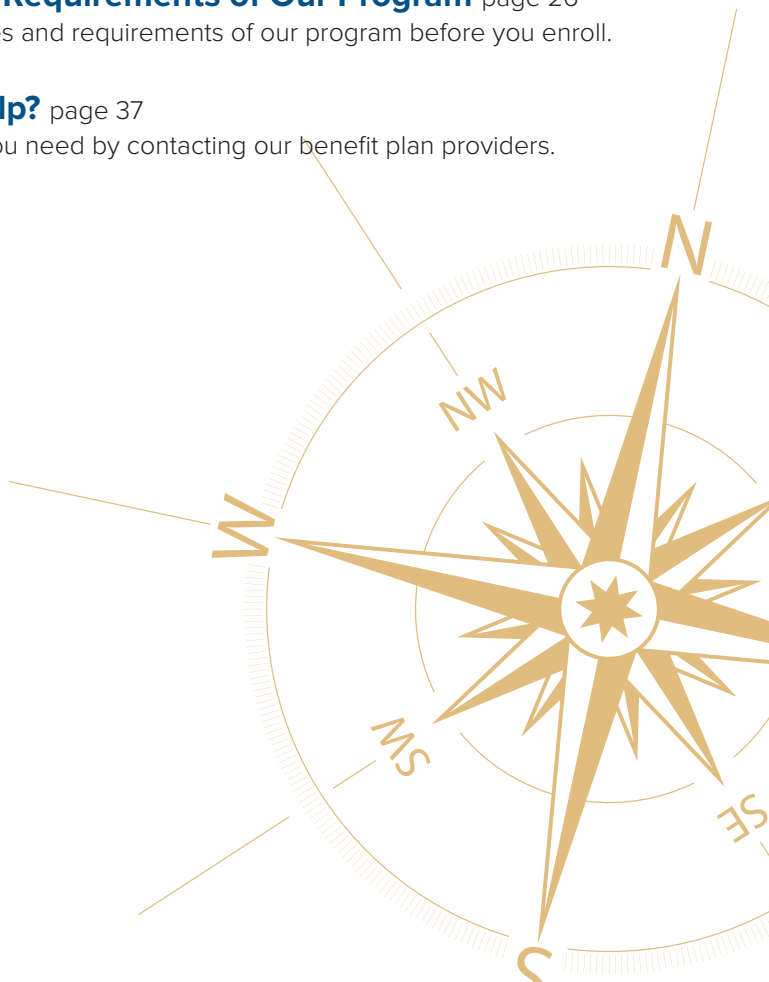
Find the answers you need by contacting our benefit plan providers.



CHOOSE 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.

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 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.
- **If you're new to the County,** see the checklist on page 2 to help you make the right choices.

It's important you understand the options available to you and how to make the most of 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 pages 26–28 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 or Per Diem Employees' Benefits Guide* available at ***http://benefits.rc-hr.com/*** for details about your medical coverage.

ENROLLING FOR THE FIRST TIME

YOUR BENEFIT OPTIONS

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

MEDICAL

- Exclusive Care EPO
- CalPERS medical plans (See the CalPERS 2022 Health Benefit Summary for a complete list of options available in your area)

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 Additional Life Insurance
- Dependent Additional Life Insurance
- Coverage during Leave of Absence
- Disability Coverage
- Retirement and Savings Plans

YOUR NEW HIRE CHECKLIST

Enroll or elect to decline coverage within 60 days from your date of hire. Refer to page 3 for instructions on how to enroll.

You may elect to decline coverage; however, you will not be eligible to receive flexible benefit credits unless you elect a medical plan or you are enrolled in other group medical coverage and eligible for a medical waiver program. See page 30 for details.

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 26–28 of this guide to determine if your dependents are eligible.

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're adding a dependent to coverage, be sure to have the appropriate documentation available (birth certificate, marriage certificate, domestic partner registration); you'll need to provide this information to Human Resources to complete your enrollment.

Read the information contained in this guide and the *CalPERS 2022 Health Benefit Summary*, 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 31 for a definition).

- Pages 4–5 — Flexible benefit credits and family subsidies so you'll know how much the County will contribute toward your premiums.
- Pages 6–8 — 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.
- Pages 11–13 — Comparison charts for our County dental and vision plans so you can quickly assess which options will meet your needs and fit your budget. You'll find information and comparison charts for the CalPERS medical plans in the *CalPERS 2022 Health Benefit Summary*.

Consider enrolling in additional 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 pages 20–21 for details.

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 16–17.

ENROLLING FOR THE FIRST TIME

COMPLETING YOUR NEW HIRE ELECTIONS

After you have reviewed your options and made your election choices, complete your election in PeopleSoft Self-service or download the *Benefit Election Form* available at ***http://benefits.rc-hr.com/***. Complete and sign the form, and submit it to your Department Representative. **Remember, you need to complete this step within 60 days of your date of hire.**

DEPENDENT DOCUMENTATION

If you're enrolling a spouse, a registered domestic partner or child(ren) for the first time, you are required to provide supporting documentation when you enroll them (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. Our enrollment for the dependent cannot be processed without the supporting documentation.

See the "Required Proof of Eligibility" section on page 27 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/***.

WHEN COVERAGE STARTS

Your coverage will begin on the first of the month following your date of hire. That means that the longer you wait to enroll, the more premiums you might owe, if you elect coverage that exceeds the employer contribution to your benefits. Employer contributions are discussed in detail on pages 4–5. You will typically owe an additional premium if you elect to enroll your dependents. A few medical plan options for employee only coverage will exceed the County flexible benefit contribution, but most are covered.

PREMIUM COLLECTION

The County of Riverside collects health care premiums a month in advance of coverage. That means you will be behind (in arrears) in premium collection by one month even if you enroll right away. If you select coverage that requires an employee contribution, you should be prepared for the initial payroll deduction. If you select coverage options that do not require an employee contribution, you won't have any out-of-pocket premium costs.

PAYING FOR YOUR COVERAGE

FLEXIBLE BENEFIT CREDITS

To help you with the cost of benefits, the County of Riverside provides flexible benefit credits. You may also qualify for a premium subsidy if you are in an eligible bargaining unit and elect to enroll one or more dependents. The flexible benefit credits you receive and your eligibility for a premium subsidy are determined by the applicable Memorandum of Understanding or Ordinance that governs your bargaining unit or employee group. To be eligible for flexible benefit credits, you must enroll in a County-sponsored medical plan or meet the requirements for the Medical Waiver Program that's described on page 30. See the tables that follow for the flexible benefit credits and premium subsidy you may receive.

2022 FLEXIBLE BENEFIT CREDITS				
Employee/Bargaining Unit	**Monthly Flex Credit**	**Semimonthly Flex Credit**	**Monthly Taxable Cash Payment**	**Semimonthly Taxable Cash Payment**
	Enrolled in County Health Plan		**Not Enrolled in County Health Plan (MEDWAV)***	
Employees Covered by the LIUNA MOU — Last date of hire before 11/13/2003	Up to $823.00	Up to $411.50	$425.40	$212.70
Employees Covered by the LIUNA MOU — Last date of hire on or after 11/13/2003	Up to $823.00	Up to $411.50	$200.00	$100.00
Employees in the Resident Physician & Surgeon, Pharmacy Resident and Physician Assistant Fellowship Classifications	Up to $823.00	Up to $411.50	$312.50	$156.25
Employees Covered by the Management Resolution — Last date of hire before 11/13/2003	Up to $823.00	Up to $411.50	$534.00	$267.00
Employees Covered by the Management Resolution — Last date of hire on or after 11/13/2003	Up to $823.00	Up to $411.50	$200.00	$100.00
DDAA	$823.00	$411.50	$575.40	$287.70
LEMU	Up to $959.28	Up to $479.64	$0.00	$0.00
RSA Public Safety	Up to $940.00	Up to $470.00	$0.00	$0.00
Employees Covered by the SEIU MOU — Last date of hire before 11/11/2004	Up to $823.00	Up to $411.50	$465.00	$232.50
Employees Covered by the SEIU MOU — Last date of hire on or after 11/11/2004	Up to $823.00	Up to $411.50	$200.00	$100.00

**If you are enrolling in the Medical Waiver program, you must complete a Decline Acknowledgment form and provide proof that you are enrolled in other group coverage, such as your spouse's employer plan. This information will be requested after enrollment closes.*

Health care rates for 2022 are deducted semimonthly (twice a month), which means deductions are taken from your paycheck during 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 shown in the table above from the premiums shown in the tables that follow. Rates are subject to change.

YOUR COUNTY OF RIVERSIDE BENEFITS

PREMIUM SUBSIDY

See the table below for the employer-paid subsidy contribution provided as a reduction to your medical premiums.

2022 PREMIUM SUBSIDY				
Employee/Bargaining Unit	**Monthly Premium Subsidy**	**Semimonthly Premium Subsidy**	**Monthly Premium Subsidy**	**Semimonthly Premium Subsidy**
	Family Coverage		**Two-Party Coverage**	
LIUNA	$200.00	$100.00	$50.00	$25.00
Employees Covered by the Management Resolution	$200.00	$100.00	$50.00	$25.00
LEMU	$200.00	$100.00	$50.00	$25.00
RSA Public Safety	$100.00	$50.00	$25.00	$12.50
Employees in the Resident Physician & Surgeon, Pharmacy Resident and Physician Assistant Fellowship Classifications	$100.00	$50.00	$25.00	$12.50
SEIU	$200.00	$100.00	$50.00	$25.00

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

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 (arrears). To see your net out-of-pocket cost for health care coverage, remember to subtract your flex credit (on page 4) from the premiums shown on the following pages. These rates DO NOT reflect the two-party or family premium subsidy that you may be eligible for as described above. Your bargaining unit or employee group determines which medical plans you may choose. Rates are subject to change.

REMINDER:
Premiums for medical, dental and vision plans are collected a month in advance of the coverage date.

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

HEALTH CARE PREMIUMS FOR 2022

To see your net out-of-pocket cost for health care coverage, remember to subtract your flex credit from the premiums shown below. These rates DO NOT reflect the premium subsidy. Rates are subject to change.

DENTAL AND VISION PLAN ELIGIBILITY
Eligible for County Dental Plans
All Regular County Employees
Eligible for County Vision Plans
Employees covered by the Management Resolution, Resident Physicians, Pharmacy Residents, DDAA and LEMU bargaining units are eligible for employer-paid VSP plan. Employees covered by the SEIU, LIUNA and RSA Public Safety bargaining units are eligible to purchase coverage through Medical Eye Services. See pages 12–13 for vision plan coverage.

COUNTY PLANS – DENTAL*	Monthly	Semimonthly
Local Advantage – Plus		
Employee	$32.26	$16.13
Two-Party	$61.50	$30.75
Family	$91.50	$45.75
Local Advantage – Blythe		
Employee	$20.98	$10.49
Two-Party	$32.02	$16.01
Family	$50.36	$25.18
DeltaCare USA DHMO – High Option Plan (10A)		
Employee	$20.98	$10.49
Two-Party	$32.02	$16.01
Family	$50.36	$25.18
Delta Dental PPO		
Employee	$45.00	$22.50
Two-Party	$78.00	$39.00
Family	$115.00	$57.50

COUNTY PLANS – VISION*	Monthly	Semimonthly
Medical Eye Services Plan 1		
Employee	$8.56	$4.28
Two-Party	$12.92	$6.46
Family	$17.48	$8.74
Medical Eye Services Plan 2		
Employee	$7.22	$3.61
Two-Party	$11.50	$5.75
Family	$15.88	$7.94

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

MEDICAL PLAN ELIGIBILITY
Eligible for CalPERS Medical Plans
Regular County employees scheduled to work at least 20 hours per week. (Temporary and Per Diem employees are only eligible for the Exclusive Care EPO.)

2022 MONTHLY DENTAL COSTS

Monthly dental costs will be temporarily reduced for the 2022 benefit plan year as a result of using dental premium reserves. Monthly costs will return to their actual levels for the 2023 benefit plan year.

PLAN COSTS FOR 2022*	Monthly	Semimonthly
Exclusive Care Medical Plan – Employees in ALL Regions		
Exclusive Care EPO		
Employee	$808.10	$404.05
Two-Party	$1,642.52	$821.26
Family	$2,063.90	$1,031.95

YOUR COUNTY OF RIVERSIDE BENEFITS

PLAN COSTS FOR 2022*	Monthly	Semimonthly
CalPERS Medical Plans – Region 2 (Orange and San Diego Counties; some plans may be limited geographically)		
Anthem Select HMO		
Employee	$712.44	$356.22
Two-Party	$1,424.86	$712.43
Family	$1,852.32	$926.16
Anthem Traditional HMO		
Employee	$1,007.14	$503.57
Two-Party	$2,014.26	$1,007.13
Family	$2,618.54	$1,309.27
Blue Shield Access+ HMO		
Employee	$900.22	$450.11
Two-Party	$1,800.44	$900.22
Family	$2,340.58	$1,170.29
Blue Shield Trio HMO		
Employee	$742.70	$371.35
Two-Party	$1,485.40	$742.70
Family	$1,931.02	$965.51
Health Net Salud y Mas HMO		
Employee	$548.26	$274.13
Two-Party	$1,096.52	$548.26
Family	$1,425.48	$712.74
Health Net SmartCare HMO		
Employee	$845.70	$422.85
Two-Party	$1,691.38	$845.69
Family	$2,198.80	$1,099.40
Kaiser Permanente HMO		
Employee	$706.02	$353.01
Two-Party	$1,412.04	$706.02
Family	$1,835.66	$917.83
PERS Platinum PPO		
Employee	$882.18	$441.09
Two-Party	$1,764.36	$882.18
Family	$2,293.68	$1,146.84
PERS Gold PPO		
Employee	$587.78	$293.89
Two-Party	$1,175.56	$587.78
Family	$1,528.24	$764.12
PORAC PPO**		
Employee	$775.00	$387.50
Two-Party	$1,550.00	$775.00
Family	$2,010.00	$1,005.00
Sharp HMO		
Employee	$699.22	$349.61
Two-Party	$1,398.42	$699.21
Family	$1,817.96	$908.98
UnitedHealthcare Alliance HMO		
Employee	$775.10	$387.55
Two-Party	$1,550.18	$775.09
Family	$2,015.24	$1,007.62
UnitedHealthcare Harmony HMO		
Employee	$782.74	$391.37
Two-Party	$1,565.48	$782.74
Family	$2,035.12	$1,017.56

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

***PORAC members only*

ABOUT CalPERS AND DUAL COVERAGE

CalPERS does not allow dual coverage between two CalPERS members or their dependents. Please review page 26 for more information.

YOUR COUNTY OF RIVERSIDE BENEFITS

PLAN COSTS FOR 2022*	Monthly	Semimonthly
CalPERS Medical Plans – Region 3 (Los Angeles, Riverside and San Bernardino Counties; some plans may be limited geographically)		
Anthem Select HMO		
Employee	$676.48	$338.24
Two-Party	$1,352.96	$676.48
Family	$1,758.86	$879.43
Anthem Traditional HMO		
Employee	$935.58	$467.79
Two-Party	$1,871.14	$935.57
Family	$2,432.48	$1,216.24
Blue Shield Access+ HMO		
Employee	$779.88	$389.94
Two-Party	$1,559.74	$779.87
Family	$2,027.66	$1,013.83
Blue Shield Trio HMO		
Employee	$668.14	$334.07
Two-Party	$1,336.26	$668.13
Family	$1,737.14	$868.57
Health Net Salud y Mas HMO		
Employee	$463.88	$231.94
Two-Party	$927.74	$463.87
Family	$1,206.06	$603.03
Health Net SmartCare HMO		
Employee	$764.96	$382.48
Two-Party	$1,529.92	$764.96
Family	$1,988.90	$994.45
Kaiser Permanente HMO		
Employee	$719.78	$359.89
Two-Party	$1,439.56	$719.78
Family	$1,871.44	$935.72
PERS Platinum PPO		
Employee	$863.38	$431.69
Two-Party	$1,726.74	$863.37
Family	$2,244.76	$1,122.38
PERS Gold PPO		
Employee	$575.56	$287.78
Two-Party	$1,151.12	$575.56
Family	$1,496.46	$748.23
PORAC PPO**		
Employee	$775.00	$387.50
Two-Party	$1,475.00	$737.50
Family	$1,894.00	$947.00
Sharp HMO	Not Available	
UnitedHealthcare Alliance HMO		
Employee	$771.86	$385.93
Two-Party	$1,543.70	$771.85
Family	$2,006.82	$1,003.41
UnitedHealthcare Harmony HMO		
Employee	$714.28	$357.14
Two-Party	$1,428.56	$714.28
Family	$1,857.14	$928.57

PLAN COSTS FOR 2022*	Monthly	Semimonthly
CalPERS Medical Plans – Out-of-State Region (Residents Outside of California)		
Blue Shield HMO	Not Available	
Blue Shield Trio HMO	Not Available	
Kaiser Permanente HMO		
Employee	$1,138.96	$569.48
Two-Party	$2,277.90	$1,138.95
Family	$2,961.28	$1,480.64
PERS Platinum PPO		
Employee	$847.72	$423.86
Two-Party	$1,695.42	$847.71
Family	$2,204.06	$1,102.03
PERS Gold PPO	Not Available	
PORAC PPO**		
Employee	$899.00	$449.50
Two-Party	$1,899.00	$949.50
Family	$2,223.00	$1,111.50
Sharp HMO	Not Available	
UnitedHealthcare Alliance HMO	Not Available	
UnitedHealthcare Harmony HMO	Not Available	

ABOUT CalPERS AND DUAL COVERAGE

CalPERS does not allow dual coverage between two CalPERS members or their dependents. Please review page 26 for more information.

OPTIONS TO MEET YOUR NEEDS

The County of Riverside contracts with the CalPERS health program to provide employees with access to three PPO plans and a variety of HMO medical plan options in addition to the County's own Exclusive Care plan. CalPERS health program options are described in the *Health Benefit Summary (HBD110)* and *Health Program Guide (HBD120)*, available at ***www.calpers.ca.gov***.

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]

[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**.

COMPARE YOUR OPTIONS

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

OPTIONS TO MEET YOUR NEEDS

HEALTH PLAN BENEFIT COMPARISON

CalPERS has standardized their copay structure for all their HMO plans. If you have detailed questions on what the plans cover, please review the Evidence of Coverage (EOC) booklet available at ***www.calpers.ca.gov*** or contact the individual health carrier. For Exclusive Care, go to ***http://benefits.rc-hr.com/*** or contact Exclusive Care directly.

2022 COPAY STRUCTURE		
	CalPERS HMO Plans	**Exclusive Care**
Office visit	$15	$15
Specialist	$15	$15
Urgent care	$15	$20
Emergency room	$50	$100
Generic prescription (retail – up to a 30-day supply)	$5	$10

CalPERS also offers two PPO plan options with comparable plan designs.

2022 COPAY STRUCTURE		
	PERS Gold* Only in California	**PERS Platinum Worldwide**
Network	Smaller network of doctors and hospitals	Large network of doctors and hospitals
Office visit copay	$35*	$20
Annual deductible*		
Individual	$1,000*	$500
Family	$2,000*	$1,000
Coinsurance (Percentage you pay after deductible is met)	You pay 20%, plan pays 80%	You pay 10%, plan pays 90%
Max coinsurance		
Individual	$3,000	$2,000
Family	$6,000	$4,000
Generic prescription – up to a 30-day supply	$5	$5

**PERS Gold offers incentives that can reduce the annual deductible and PCP office visit copay.*

IMPORTANT NOTE

If you want to see a specific doctor or use a specific medical group or hospital, select a plan that includes that specific provider. Contact the health plan(s) and/or provider directly to explore the availability of any specific provider before enrolling.

When you enroll in a health plan, services are provided through the health plan's delivery system, and the continued participation of any particular doctor, hospital or other provider cannot be guaranteed. The provider network may change during the plan year. If the network changes during the plan year, you will be permitted to select a new provider, but you will not be permitted to change plans.

OPTIONS TO MEET YOUR NEEDS

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	$2,000/person	$2,000/person	$1,500/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 10% 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 10% 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 10% of the PPO fee	You pay 50% of the PPO f ee after the deductible
Bicuspid root canal	$90	You pay 10%	You pay 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Molar root canal	$205	You pay 10%	You pay 10% 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 10% 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

OPTIONS TO MEET YOUR NEEDS

COUNTY DENTAL 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.				
	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**
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 10% of the PPO fee	You pay 50% of the PPO fee after the deductible
Impaction	$25–$90	You pay 10%	You pay 10% 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	Plan pays $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	$2,000/person	$1,500/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

OPTIONS TO MEET YOUR NEEDS

VSP HIGHLIGHTS (CONTINUED)		
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

All Regular County Employees

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 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 $2,000 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 37 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 dental expenses each year before the plan will pay benefits (your deductible). • After the deductible is paid, you will pay a percentage of your covered dental expenses (coinsurance). • Benefits under this plan are limited to $1,500 per individual annually. The annual maximum is increased to $2,000 when you use network contracted providers.	• The Delta Dental PPO plan covers 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.

OPTIONS TO MEET YOUR NEEDS

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
- Pharmacy Residents

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.

FSA ELIGIBILITY

All Regular County Employees

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, 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 31 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 $2,750 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 visiting: ***www.irs.gov/publications/p502*** and ***www.irs.gov/publications/p503***. 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 additional life insurance through Standard Insurance Company for yourself, your spouse/domestic partner and your eligible dependents. Deductions for additional life insurance coverage are taken on an after-tax basis.

NEW TO THE COUNTY?

As a new County employee, you can purchase up to $250,000 in group additional life insurance for yourself, up to $20,000 for your spouse or domestic partner and up to $20,000 for your eligible children, without providing Evidence of Insurability (EOI). Take advantage of this opportunity and enroll as soon as you become eligible. If you don't, you will be required to provide EOI when you enroll later.

To add or change your additional life insurance coverage or update your beneficiary information, use *Ready to Enroll* available on the County of Riverside benefit website at ***http://bit.ly/rivcoenroll***. The Group Number for Evidence of Insurability (EOI) is 641685. There you'll also find step-by-step instructions describing the enrollment process.

Note: Resident Physicians receive $50,000 in basic life insurance coverage through the American Medical Association.

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 • Pharmacy Resident
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 and premium reduction	Coverage (and premium) is reduced at certain ages as follows: • Age 65 to 65% of original amount • Age 70 to 50% of original amount	Coverage (and premium) 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.

LIFE INSURANCE

CONSIDER YOUR ADDITIONAL LIFE INSURANCE OPTIONS

While the County provides basic life insurance coverage at no cost, you may purchase group additional life insurance through Standard Insurance Company for yourself, your spouse/domestic partner and your eligible dependents. Deductions for additional life insurance coverage are taken on an after-tax basis.

During the additional life insurance open enrollment period, you can increase coverage up to the guaranteed amount without providing Evidence of Insurability (EOI), as governed by the open enrollment rules.

NEW *READY ENROLL* ONLINE APPLICATION

The County of Riverside is partnering with The Standard to provide a secure, web-based system, known as *Ready Enroll*, for enrolling in life insurance coverage and managing beneficiaries. This online application will provide a secure gateway and paperless process for enrolling and managing life insurance provided by The Standard, including:

- Access to benefit plan details and other tools to help you make informed decisions on life insurance coverage
- Enroll, cancel or change coverage
- Print a benefits confirmation or summary
- Update beneficiary information
- View your premium rate

This site is available 24/7 to assist you with your life insurance needs.

READY ENROLL

To add or change your additional life insurance coverage or update your beneficiary information, use *Ready Enroll* at ***http://bit.ly/rivcoenroll***. The Group Number for Evidence of Insurability (EOI) is 641685.

Logging in to *Ready Enroll* for the first time?

Know your...

1. Username is your six-digit employee ID (with no "E" at the beginning)
2. PIN is the last four digits of your Social Security number and the last two digits of your birth year

What you should do

1. Log in to *Ready Enroll* and review your basic life insurance benefits and additional life coverage elections, if applicable. This is a great time to apply for additional coverage for yourself and your eligible dependents. Coverage you elect during this Annual Enrollment period will be effective January 1, 2022 or upon underwriting approval.
2. *Ready Enroll* will maintain employee life insurance elections and all beneficiary designations. You are required to enter beneficiary designations if you have not already done so. You will have access to your information 24/7 to maintain your enrollment and beneficiary information. Beneficiary designations you make in *Ready Enroll* are effective immediately.

LIFE INSURANCE

ADDITIONAL LIFE INSURANCE

HOW TO ENROLL FOR ADDITIONAL LIFE INSURANCE

1. **Determine your eligibility.** See chart below.
2. **To add or change your additional life insurance coverage or update your beneficiary information,** use *Ready Enroll* at ***http://bit.ly/rivcoenroll***. The Group Number for Evidence of Insurability (EOI) is 641685. (Username is your six-digit employee number without the "E" at the beginning. Your PIN is the last four digits of your Social Security number and the last two digits of your birth year.)

ADDITIONAL 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 • Pharmacy Resident 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 21) 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 logging into Ready Enroll.	
Coverage Options—subject to guaranteed coverage amounts (see page 21)	• Employees: Increments of $10,000 up to $600,000 (SEIU/LIUNA classifications: Coverage max = 7x annual salary; coverage amounts over certain limits are subject to proof of good health) • Spouse/Domestic Partner: Increments of $5,000 up to $100,000 (the amount of Spouse/Domestic Partner Life Insurance may not exceed 50% of the amount of Employee Life Insurance) • Dependent Children*: $5,000 – $20,000 in $5,000 increments	
Coverage Reduction—occurs automatically; age determines cost per $1,000 of reduced coverage	Coverage and premium 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 additional life insurance coverage at any time during the year. • Your coverage automatically ends at the end of the month in which your employment terminates, 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 additional 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 additional 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 Additional Life	**Spouse/Domestic Partner Additional Life**	**Dependent Child Additional 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 Additional Life	**Spouse/Domestic Partner Additional Life**	**Dependent Child Additional Life**
EOI required	EOI required	No EOI required, once Employee Additional Life is approved
Increasing coverage during Annual Enrollment (you currently have coverage and you are requesting additional coverage)		
Employee Additional Life	**Spouse/Domestic Partner Additional Life**	**Dependent Child Additional 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
(Note for LIUNA and SEIU employees: The maximum coverage is 7x annual salary.)		

Note: Employees and/or their spouse/domestic partner who submit a Medical History Statement and are denied for additional life coverage will no longer be eligible for a guaranteed issue amount during all subsequent Open Enrollment periods. Guaranteed coverage amounts will only be reinstated after submitting a Medical History Statement and being approved for the requested additional life coverage.

COST OF COVERAGE

The rates you pay for additional life coverage are based on the group policy number listed for your bargaining unit or employee group. Premiums increase beginning in January of the year following the birthday when you reach a new age category.

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	**Semi-Monthly Rate**
Increments of $5,000 up to $20,000.	$0.72, per $5,000 elected

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	**Semi-Monthly Rate**
Increments of $5,000 up to $20,000.	$0.315, per $5,000 elected

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.

KEEPING 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 two million public employees, retirees and their families. The pension plan is designed to provide you with the security of a lifetime pension benefit, based on a retirement formula using your total service credit, your age at retirement, and your highest average annual compensation during any consecutive 12- or 36-month period throughout your CalPERS career. You become fully vested in the pension plan after five years of CalPERS-credited service.

All County employees may not be eligible to participate in the CalPERS pension plan. If you're employed in a classification that has been excluded from CalPERS participation, the County has an alternate retirement plan designed for you known as the County of Riverside Part-Time and Temporary Employees' Retirement Plan. Read further for details on this plan.

HOW YOUR RETIREMENT IS FUNDED

CalPERS is a defined benefit plan funded by employee contributions, employer contributions, and earnings made on CalPERS investments:

1. **Your contributions.** Member contribution amounts are set by law and vary by job classification, employer, and Social Security participation.
2. **Earnings.** The investment of assets in stocks, bonds, and other investment vehicles. The amount contributed from this source fluctuates from year to year.
3. **Employer contributions.** The amount your employer contributes is adjusted yearly based on specific economic and investment performance factors.

HOW YOUR RETIREMENT BENEFIT IS CALCULATED

Three factors are multiplied to calculate your retirement benefit:

- **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 final compensation for each year of service credit, based on your age at retirement.
- **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. Visit ***http://benefits.rc-hr.com/RetirementPlans/RetirementForms.aspx*** under CalPERS Forms & Publications for information about your retirement formula.

To learn more about the CalPERS pension plan, visit ***http://benefits.rc-hr.com/RetirementPlans/CalPERS.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.

mylCalPERS is a personalized secure website that allows you to view your account, create retirement estimates, register for educational workshops, and conduct your business with CalPERS. Access mylCalPERS at ***http://my.calpers.ca.gov***.

If you do not want to use the online Retirement Estimate Calculator, you can 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 training sources available to fit any calendar.

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 ***https://corlearning.sumtotal.host/*** 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. Individual appointments are available to employees who are ready for retirement and have attended a Retirement Planning Workshop.

1. **Enroll Now** – Enroll in a workshop online through the County of Riverside's Learning Center at ***https://corlearning.sumtotal.host/***.
2. **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@rivco.org***
3. To schedule an individual appointment with a County of Riverside Retirement Specialist, visit our **Online Appointment Scheduler** at ***https://rchr.checkappointments.com/***.

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 plan or the County of Riverside Part-Time and Temporary Employees' Retirement Plan.

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, RCDDAA, RSA, RSC, 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 defined benefit 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	
• RSA Public Safety	• Law Enforcement Executive Management • SEIU Supervisory • Deputy Coroner • Coroner Corporals • Correctional Counselors	• Supervising Correctional Counselors • Management • Confidential • Unrepresented • DDAA • Elected Officials • Pharmacy Resident

WHAT'S COVERED

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

If you are a Resident Physician, your disability coverage is provided through a contract with the American Medical Association as follows:

- A $2,500 monthly benefit once you complete the 90-day elimination period.
- Your benefit continues until you reach the Social Security Normal Retirement Age (SSNRA).
- Your monthly benefit doubles after 12 months of total disability.
- Call American Medical Association (AMA) at **(888) 627-6618** to file a disability claim.

EMPLOYEES COVERED BY SEIU AND LIUNA MEMORANDUMS OF UNDERSTANDING PARTICIPATE IN THE STATE DISABILITY INSURANCE (SDI) PROGRAM

Note: This information is limited to employees in the Service Employees International Union (SEIU) and Laborers' International Union (LIUNA) Memorandums of Understanding, and does not apply to employees covered by the Management Resolution, Ordinance 440 or other Memorandums of Understanding.

- Each pay period, a percentage of your taxable wages is reported to the SDI program. SDI taxes are paid on taxable income up to the limit set by the Employment Development Department (EDD) for the year.
- Employee SDI tax contributions go into a state fund used to pay Disability (SDI) and Paid Family Leave (PFL) benefits to eligible individuals.
- Eligible employees can receive up to 60–70% (depending on income) of wages earned 5–18 months before their claims start date.
- To qualify, you must have earned at least $300 in wages subject to SDI contributions during the base period determined by your disability start date.
- California law requires that wages you receive during a period of disability or family leave, plus DI or PFL benefits, cannot exceed 100% of your normal weekly salary (excluding overtime pay). You're responsible for providing information to your department payroll coordinator about any DI or PFL benefit you receive and ensuring that wages you receive during disability or family leave do not exceed 100% of your normal salary.
- The County of Riverside does not administer the SDI programs. They are administered by the California Employment Development Department (EDD). Eligible employees are responsible for properly filing a claim with the EDD. Claim concerns and issues should be addressed directly with the EDD.

To file a claim for state disability, visit: ***https://edd.ca.gov/Benefit_Programs_Online.htm***.

PROTECTION WHEN YOU'RE UNABLE TO WORK

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 at ***http://www.rc-hr.com*** and select the "HR Services" menu, and choose FMLA/CFRA/Leaves.

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 Services" menu, and choose FMLA/CFRA/Leaves 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

RULES AND REQUIREMENTS OF OUR PROGRAM

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 or per diem 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.

DUAL COVERAGE FOR CalPERS MEDICAL PLANS

CalPERS does not allow dual coverage between two CalPERS members or their dependents. Dual CalPERS coverage occurs when a person is enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. This duplication of coverage is not permitted by CalPERS.

When dual CalPERS coverage is discovered, CalPERS will retroactively cancel the enrollment that caused the dual coverage. You may be responsible for costs incurred from the date the dual coverage began.

Members may enroll in both a CalPERS health plan and a health plan provided through a non-CalPERS employer. For example, a spouse may be enrolled in a CalPERS plan as a dependent and also in a plan through his or her private employer. In this case, the two plans may coordinate benefits.

SPLIT ENROLLMENT FOR CalPERS MEDICAL PLANS

CalPERS does not permit split enrollment of dependents. When two CalPERS members are married to each other or in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan individually and include dependents, one person must cover all dependents on one health plan.

When a split CalPERS enrollment situation is discovered, CalPERS will retroactively cancel the enrollment that caused the split enrollment. You may be responsible for costs incurred from the date the split enrollment began.

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.** You and your registered domestic partner must be registered through the California Secretary of State's Office or an equivalent office from another state.
- **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.
  - For medical enrollment only, CalPERS allows employees to assume a "parent-child relationship" with a child in lieu of the child's adoptive, step or natural parent, up to age 26.

    A parent-child relationship occurs when the employee or annuitant assumes a parental role and is considered the primary care "parent." Evidence of this relationship may include assuming responsibilities such as providing shelter, clothing, food, child care or education for the child, as well as assuming parental duties, such as providing permission for school activities, health care services, extracurricular and recreational activities.

    A parent-child relationship must be certified at the time of enrollment for each child and annually thereafter up to age 26. Spouses of your recognized natural, adopted or stepchild are not eligible for enrollment.

    An *Affidavit of Parent-Child Relationship form* must be submitted with a copy of the employee's tax return from the previous tax year listing the child as a tax dependent.

RULES AND REQUIREMENTS OF OUR PROGRAM

- 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, even if your divorce decree requires you provide coverage
- Foster children
- Dependent children whose disability occurred after age 26
- Dependents for whom you initially continued coverage as disabled dependents beyond age 26 and who were later deleted from enrollment
- Dependent children over age 26 who are capable of self-support
- 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 or undergo a waiting 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 *Benefit Election Form*, submit all of the necessary documentation when you submit your form 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)

Dependents over age 26 who are incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician.

IMPORTANT NOTE:

If the rules described here differ from the CalPERS rules, the CalPERS rules will govern for the CalPERS medical plans.

RULES AND REQUIREMENTS OF OUR PROGRAM

Employees are required to complete and submit the Member Questionnaire for the *CalPERS Disabled Dependent Health Benefit (HBD-98) form* to CalPERS.

The treating physician must complete and submit a *Medical Report for the Disabled Dependent Benefit (HBD-34)* directly to CalPERS for approval. The initial certification of the disabled dependent must occur during one of the following eligibility periods:

- Within 90 days before and ending 60 days after the child's 26th birthday (employee and dependent currently enrolled); or
- Within 60 days of newly eligible employee's initial enrollment in the CalPERS health program.

Coverage of disabled dependents is contingent upon approval by CalPERS.

Upon certification of eligibility by CalPERS, the dependent's CalPERS health coverage must be continuous and without lapse. Upon expiration of the certification, you will be required to submit an updated questionnaire and medical report for re-certification. These documents must be received no earlier than 60 days prior to the expiration date, and no later than the 60-day expiration date.

The following disabled children are not eligible for coverage:

- Dependent children whose disability occurred after age 26
- Dependents who initially continued coverage as disabled dependents beyond age 26 under the Public Employees' Medical & Hospital Care Act (PEMHCA) program and who were later deleted from the enrollment
- Dependents who are capable of self-support
- Disabled dependents whose coverage (extension) was not requested in a timely manner

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 become 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 30 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 NEW EMPLOYEE COVERAGE BEGINS

You are eligible to commence coverage beginning the first of the month immediately following your date of hire.

IMPORTANT POINT TO KEEP IN MIND

The County of Riverside collects premiums one month ahead of the coverage effective date. Missed premiums (arrears) 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. Please be sure to prepare for this additional expense.

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 not be permitted to make an 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 31.

FOR CalPERS MEDICAL PLANS ONLY

If you do not have a qualified change of status defined by the Internal Revenue Code, CalPERS will allow you to enroll in a medical plan the first of the month following a 90-day waiting period.

For more information about this enrollment, please speak with a Benefits Specialist at **(951) 955-4981, option 1**.

YOUR COVERAGE

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 • Management • Confidential • Unrepresented • LIUNA • SEIU • DDAA hired before 11/04/2010 • Resident Physicians	You and all individuals for whom you expect to claim a personal exemption deduction for the plan year (Tax-Family) must have alternative minimum essential coverage (other than coverage in the individual market and other than individual coverage through Covered California) for the plan year. 1. Elect "Medical Waiver" (MEDWAV/MEDWAV2) as your medical plan option by submitting a completed *Benefit Election Form* if you are a newly eligible employee or requesting a mid-year change. Employees eligible for CalPERS medical plans must also complete an HBD-12 form to decline coverage and enter "MEDWAV/MEDWAV2" in box 14. 2. Provide information about your other group coverage by submitting proof of insurance to your Department Representative if you are a newly eligible employee or are making a mid-year change. You are required to provide such proof whenever requested by the Benefits Division for compliance audit. 3. Sign the *Decline Coverage Acknowledgment Form* every year. This form will be mailed to you after the Annual Enrollment period closes, as part of an audit for the upcoming plan year's enrollment.
You are ***not eligible*** to participate in the medical waiver program if you are: • LEMU • RSA Public Safety • 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. • 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.*

To participate in the medical waiver program, select the "Medical Waiver" (MEDWAV/MEDWAV2) option when you enroll online. See page 4 to determine how much you will receive in flexible benefit credits once you have met all the requirements above.

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, including plans purchased on the Exchange. Individual plans do not qualify for the Medical Waiver.

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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 next month following the month of termination for medical, dental and employee-paid vision coverage, and on your last day of work for additional 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 36 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
- **Registration or dissolution of Domestic Partnership**

YOUR COVERAGE

REQUESTING A MID-YEAR ELECTION CHANGE

Complete an election online using PeopleSoft Self-Service or complete a *Benefit Election Form*, which is available at ***http://benefits.rc-hr.com***. You'll need to provide documentation of the event, such as a marriage license, birth certificate, etc.

Return your completed *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 terminate dependent coverage if you get divorced or end your registered domestic partnership. Your ex-spouse/registered domestic partner will no longer be eligible for additional life insurance coverage or other coverage under the County plans. However, he or she can convert the additional 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 complete enrollment changes 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. *Benefit Election Forms* are available on the County's benefits website at ***http://benefits.rc-hr.com***, from your Department Representative or by calling the Benefits Information Line at **(951) 955-4981**.

OTHER IMPORTANT INFORMATION

PATIENT PROTECTION NOTICE

The HMO and 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 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 your health plan. Contact information is listed on your ID card.

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) 636-1980** or visit ***http://www.dhcs.ca.gov***.

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.

OTHER IMPORTANT INFORMATION

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

Note: CalPERS does not allow dual medical coverage between two CalPERS members or their dependents.

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.

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.

OTHER IMPORTANT INFORMATION

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.

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**.

OTHER IMPORTANT INFORMATION

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).

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**.

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		
Exclusive Care (EPO)	(800) 962-1133	www.exclusivecare.com
CalPERS Medical Plans		
Blue Shield	(800) 334-5847	www.blueshieldca.com/calpers
Kaiser Permanente (HMO)	(800) 464-4000	www.kp.org/calpers
PERS Platinum and PERS Gold (PPO)	(877) 737-7776	www.anthem.com/ca/calpers
PORAC	(855) 288-6928	http://ibtofporac.org/
Anthem Select HMO and Anthem Traditional HMO	(855) 839-4524	www.anthem.com/ca/calpers
Health Net Salud y Mas and Smart Care	(888) 926-4921	www.healthnet.com/calpers
Sharp	(855) 995-5004	www.sharphealthplan.com/calpers
UnitedHealthcare	(877) 359-3714	www.uhc.com/calpers
OptumRx	(855) 505-8110	www.optumrx.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 questions	(800) 628-8600	http://bit.ly/rivcoenroll
Other Benefits and County Resources		
Riverside County Human Resources Health and Welfare Unit Benefits Information Line	(951) 955-4981; option 1 TTY: 711 Fax: (951) 955-3490	http://benefits.rc-hr.com or http://intranet.co.riverside.ca.us Email: benefits@rivco.org
MedPlus Advantage (Resident Physicians and Pharmacy Residents)	(888) 627-6618	www.medplusadvantage.com
FSA Claims Administrator (ASIFlex)	(800) 659-3035	www.asiflex.com
CalPERS	(888) 225-7377	www.calpers.ca.gov
Enterprise Solutions Help Desk	(951) 955-9900	http://intranet.co.riverside.ca.us
Retirement		
Riverside County Human Resources Retirement Unit	(951) 955-4981; option 2 Fax: (951) 955-8538	Email: retirement@rivco.org
CalPERS	888 CalPERS or (888) 225-7377	https://calpers.ca.gov
Nationwide—Nationwide Retirement Solutions	(877) 677-3678	www.nationwide.com
AIG Retirement Services (VALIC)—Client Care Center	(800) 448-2542	www.valic.com
Disability		
Sedgwick (Short-Term Disability)	(800) 845-7739	www.claimlookup.com
The Standard (Long-Term Disability) • Open a claim	(800) 368-1135 (800) 378-2395	http://benefits.rc-hr.com
California State Disability Insurance (SDI) (SEIU and LIUNA only)	(800) 480-3287	https://edd.ca.gov/disability