

RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST

OPEN ENROLLMENT



YOUR 2012 BENEFITS BROCHURE

INSIDE INFORMATION

| | |
|--|----|
| INTRODUCTION LETTER | 1 |
| IMPORTANT MEDICAL CHANGES | 2 |
| OPEN ENROLLMENT | 3 |
| MEDICAL PLANS | 5 |
| PRESCRIPTION DRUG PROGRAM | 8 |
| DENTAL PLANS | 9 |
| VISION PLAN | 10 |
| YOUR CONTACTS | 11 |
| FEDERAL HEALTH CARE REFORM | 12 |
| EXPLANATION OF MEDICAL PLANS & HIPAA LAW | 13 |
| NOTICE OF PRIVACY PRACTICES | 14 |
| ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE | 15 |
| WOMEN'S HEALTH AND CANCER RIGHTS | 16 |
| CHIP PROGRAM | 17 |



RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST OPEN ENROLLMENT 2012

IMPORTANT OPEN ENROLLMENT INFORMATION Please Read Carefully

There will be **no rate increases** on **any** of our dental plans or on the vision plan this year, and no benefit changes. As to the major medical plans the RSA Benefit Trust, like many benefit groups across the Country, has seen increases in all of its plans. The good news is that we have been able to maintain the highest quality care and the lowest deductibles and co-pays in the County. While there is a cost to maintaining that level of benefits, when it is time for our members to utilize the medical care, they will get the best possible care with the lowest out of pocket expenses.

To help reduce costs for those who wish a low cost Plan without all of the extensive coverage's the regular Plans contain, the RSA Benefits Trust is offering a NEW Plan. Anthem Select HMO is a select network plan with higher co-pays for prescriptions, office visits and in-patient and out-patient hospitalization. Please see summary of benefits on the medical comparison page. (Page 5)

Inside the open enrollment packet you will see the effects of the new healthcare reform bill as well as the impact on rising health care costs and utilization. While the rates are higher than we would like, we believe that by aggressively addressing the reasons for the increases, on many levels, we will be in a better position next year to control these spiraling health care costs. We have provided a chart inside that explains exactly what the dollar amounts of the increase will be for your plan. (Page 10)

United HealthCare Vision, formerly PacifiCare Full Service Vision will terminate December 31, 2011. If you have this plan, your coverage **will automatically roll over into the MES Vision Plan**. If you do not wish to enroll in the MES Vision Plan, you must notify the Benefits Trust office and complete a cancellation form.

It is very important that you check all of your health insurance plans that you have with the RSA Benefit Trust to determine if you wish to make any changes. For active members, your plans are listed on your pay stub. If you would like to make changes to your plans, **you must contact the Benefits Office** at (951) 653-8014 to request applications and/or change forms during the Open Enrollment period. (See page 3 for more information).

Be sure to stop by the RSA Health Fair at the Sheriff's Picnic on Saturday, October 15, 2011, from 10:00 a.m. – 5:00 p.m., at Diamond Valley Lake Community Park in Hemet. You can now make your plan changes at the picnic!

IF YOU DO NOT NEED TO MAKE A CHANGE, YOU DO NOT NEED TO DO ANYTHING.

If you have young children, please take the opportunity during open enrollment to verify that they are covered under your dental & vision policies. You will be unable to add your dependents outside of open enrollment unless they have had a loss in coverage.

It is indeed our pleasure to continue to provide the RSA Membership with the best service and health plans available. We will be updating you throughout the year on ways to better utilize your medical insurances to maximize your health care needs.

Sincerely,

A handwritten signature in black ink, appearing to read "James J. Cunningham".

James J. Cunningham Esq.
Benefit Trust Administrator
RSA Benefit Trust

**IMPORTANT HEALTH PLAN CHANGES EFFECTIVE JANUARY 1, 2012
PLEASE REVIEW**

| <i>Plans Affected</i> | <i>Changes</i> |
|--|--|
| Anthem POS, Blue Card PPO (Out-of-State), Fee-for-Service (Out-of-State Medicare) | Ambulatory Surgical Centers: The benefit for non-PPO providers will be limited up to \$1000 per day. Benefits remain the same for participating in-network providers. |
| Anthem POS – Prudent Buyer Section, EPO, Blue Card PPO (Out-of-State), Fee-for-Service (Out-of-State Medicare) | The following have been added to the Utilization Review section requiring Pre-Service Review; Specific outpatient services, including diagnostic treatment and other services; specific outpatient surgeries performed in an outpatient facility or a doctor’s office; air ambulance in a non-emergency; and specific durable medical equipment. In addition, Echocardiography has been added to the list of specific diagnostic procedures that require Pre-service review. Please refer to the 2012 EOC for more detailed information. |
| Anthem HMO, EPO, POS, Blue Card PPO (Out-of-State) | Non-Covered Dental Services – A participating dentist who provides services that are not covered by the plan may charge his or her usual and customary rate for those services. |
| Anthem HMO, POS-HMO Side | OB/GYN – Providers specializing in obstetrical and gynecological services will be able to refer members to other providers for necessary related treatment on the same basis as a primary care doctor. |
| Anthem HMO | Smoking Cessation Program – The \$50 lifetime limit will be removed. |
| Anthem HMO, POS-HMO Side | Allergy Testing and Treatment – Formerly listed with preventative services, will now be listed under General Medical Care. |
| Anthem HMO, EPO, POS, Fee-for-Service (Out-of-State Medicare), Blue Card PPO (Out-of-State) | Durable Medical Equipment – The \$5,000 annual limited will be removed. |
| Anthem HMO, EPO, POS, Fee-for-Service (Out-of-State Medicare), Blue Card PPO (Out-of-State) | Hearing Aid Services – A frequency limit of one hearing aid per ear every 3 years will be added. (Fee-for-Service plan: the hearing aid provision will be separated from the Durable Medical Equipment provision). |
| Anthem HMO, EPO | Exclusion for Non-Licensed Providers will be added. |
| Anthem EPO, Blue Card PPO (Out-of- State) | For emergency services provided by non-participating providers , the copayment will match the copayment for participating providers. Reference to the first 48 hours of emergency services provided by a hospital will be removed. |
| Anthem POS | For emergency services provided by Prudent Buyer Plan and non-Prudent Buyer providers , the copayment will match the copayment for participating providers until the member can be safely moved from the facility. Reference to the first 48 hours of emergency services provided by a hospital will be removed. |
| Anthem POS | Under Medical Care that is covered, in the HMO and PLUS benefits section, the existing prostate cancer screening provision, “other cancer screening tests” provision, and HIV testing provision will all be revised to state that when provided under the plan’s HMO benefits, no copayment will apply, and when provided under the PLUS benefits, coverage is provided according to the terms and conditions apply to all other medical benefits. |
| Anthem Fee for Service (Out-of-State Medicare), Blue Card PPO (Out-of-State) | The \$5000 lifetime maximum for all inpatient and home hospice will be removed. The limit of four bereavement visits in 12 months at \$25 per payment will also be removed. |
| Anthem Blue Card PPO (Out-of-State) | Screenings for hearing and vision will be covered as part of routine exams under the Well Baby and Well Child and Physical Exam (Insured persons age 7 and over) benefits. |
| Kaiser Permanente HMO | Prescription Drug Copayments will now be: Plan Pharmacy Generic \$5 –(30 day supply) \$10 –(31-60 day supply) \$15 –(61-100 day supply) Plan Pharmacy Most Brand Name \$10 –(30 day supply) \$20 –(31-60 day supply) \$30 –(61-100 day supply) Mail Order Service Generic \$5 –(30 day supply) \$10 –(31-100 day supply) Mail Order Service Most Brand Name \$10 –(30 day supply) \$20 –(31-100 day supply) Plan Pharmacy Formerly: \$5 – Generic (100 day supply) \$10 – Brand Name (100 day supply) |
| Kaiser Permanente HMO | Emergency Room Copayment – will be increased to \$50 from \$35, copayment waived if admitted to the hospital. |

Open Enrollment Dates

Open enrollment will be held from **October 1 – 31, 8 a.m. – 5 p.m. Monday through Friday**, with the exception of October 10 in observance of Columbus Day. Open enrollment changes can also be made at RSA's Annual Health Fair held on Saturday, October 15th 2011. Please use this time to change insurance carriers or add dental, and/or vision. **Under most circumstances, you will be unable to change carriers mid-year.**

All changes made during open enrollment must be submitted with signed carrier change forms/applications, signed payroll deduction forms, marriage/birth certificates, divorce decree or legal separation documentation and social security numbers as discussed in the required Proof of Eligibility for Dependents section of this packet.

The IRS does not allow for mid-year changes except in the following instances:

- Marriage
- Divorce or Legal Separation (must be certified by the court)
- Birth or adoption of a child
- Legal Guardianship or court order
- Death of a spouse or child
- Change in spouse's employment resulting in loss or gain of coverage for spouse and/or dependents

All changes made mid-year must be submitted to the RSA Benefits Office with signed carrier change forms, signed payroll deduction forms, marriage/birth certificates, and proof of qualifying event and social security members. Changes must be submitted to the Benefits Office within 30 days of the qualifying event.

Pre-Taxed Medical Benefits

As an employee of the County of Riverside you are part of the IRS Section 125 plan, which

enables your medical, dental, and vision deductions to be taken before tax deductions.

When Coverage Begins

If you are enrolling for coverage or making changes to your current benefits elections during the annual enrollment period, your new coverage will be effective Jan. 1, 2012, and will continue through Dec. 31, 2012. Your deductions for coverage are taken beginning with the first paycheck in Dec. 2011 for the new coverage's for January 2012.



Required Proof of Eligibility for Dependents

Spouse

Copy of marriage certificate and spouse's social security number must be submitted with change forms and/or applications.

Children

Natural, step, adopted child(ren), legal dependent child of a domestic partner, or children for whom you and your spouse have been appointed legal guardians by a court of law shall be eligible for dependent medical coverage up to the age of 26. Grandchildren under age 26, for whom you or your spouse have legal guardianship, or the grandchild's parent is an enrolled dependent under your family plan is covered. Additional requirements are that grandchildren must permanently reside with you and receive all of their support and maintenance from you or your spouse.

Disabled Children

If a dependent is incapable of self-sustaining employment by reason of physical handicap or mental retardation, you must attach a letter from the child's physician explaining the diagnosis, extent of disability and prognosis along with the carrier change form and/or application. You must also include Medicare information and a copy of the Medicare identification card if applicable

Domestic Partnership

A Domestic Partner of an eligible employee shall satisfy the Trust's general eligibility so long as both the members of the partnership meet the following criteria:

- Provide a copy of a valid Declaration of Domestic Partnership filed with the Secretary of State pursuant to Section 297 of the Family Code.
- Submit a signed Affidavit of Partnership for Insurance Carriers (supplied by the Benefit Trust)
- Are at least 18 years of age
- Share a common residence
- Are unmarried and not a member of another domestic partnership
- Are not related by blood that would prevent you from being married in the state of California
- For opposite-sex domestic partnerships, one or both persons must be over the age of 62 and meet the criteria under Title II of the Social Security Act.

Life Insurance

Employer/RSA Sponsored Coverage: RSA Law Enforcement Unit members have the following coverage:

- \$55,000 California Law Enforcement Association Life, (no cost to member)
- \$5,000 Blue Cross Life, paid by the RSA
- \$5,000 Blue Cross Accidental Death & Dismemberment, paid for by RSA
- More than \$500,000 death benefit provided by the federal and state government if killed in the line of duty

Supplemental Life Insurance Available

The premium for supplemental plans is deducted from your paycheck with your RSA dues. These plans can be elected throughout the plan year.

If you would like to review your current life insurance policy, update beneficiaries, or would like to compare policies, you may contact the representatives below:

Group Life through Anthem Blue Cross

- Age-rated, premium increase every 5 years
- Can get up to \$50,000 employee coverage and \$25,000 spousal coverage
- Accidental death and dismemberment available
- Call the RSA Benefits Office for more details

First Colony Term Life Insurance

- Rate guaranteed for a specified term
- Call Denis at Brown Insurance Services for a quote (714) 460-7744

Personal Life Insurance Policies

- Level term, Universal and Variable life available
- Call Samantha Curtin at Brown Insurance Services for a quote (714) 460-7744

Cancer, Accident, Intensive Care Unit Insurance

- AFLAC – Nicki Turner at (714) 328-0225

Homeowners, Auto, and Miscellaneous Insurance

- Liberty Mutual at (866) 672-3543, ext 210

2012 HMO COMPARISON Bi-Weekly Flexible Benefit \$245.05

| | KAISER | ANTHEM SELECT HMO | ANTHEM HMO CAL CARE | ANTHEM EPO (Blythe) |
|---|---|---|---|--|
| BI-WEEKLY RATES | 1/1/12 | 1/1/12 | 1/1/12 | 1/1/12 |
| EMPLOYEE ONLY | \$291.00 | \$270.50 | \$317.00 | \$317.00 |
| EMPLOYEE + SPOUSE | \$485.00 | \$406.50 | \$477.00 | \$477.00 |
| EMPLOYEE + CHILD(REN) | \$469.50 | \$394.00 | \$462.50 | \$462.50 |
| EMPLOYEE +FAMILY | \$606.50 | \$505.50 | \$593.50 | \$593.50 |
| DEDUCTIBLE | None | None | None | None |
| PHYSICIAN SERVICES | | | | |
| Office Visits | \$10 per visit | \$20/visit – primary care dr. | \$10 per visit | \$10 per visit |
| Allergy testing | \$10 per procedure | \$20/visit - primary care dr. | \$10 per visit | \$10 per visit |
| Allergy injection visits | No charge | \$20/visit – primary care dr. | \$10 per visit | \$10 per visit |
| Well baby & child care birth through age six | No charge | No charge | No charge | No charge |
| Immunizations | No charge | No charge | No charge | No charge |
| Physical Exam persons age seven and older | No charge | No charge | No charge | No charge |
| Adult Preventive Services (FDA approved screenings for cervical cancer, mammography testing, breast cancer & prostate cancer) | No charge | No charge | No charge | No charge |
| Vision & Hearing Screening | No charge | No charge | No charge | No charge |
| Diagnostic lab & x-ray in physician office | No charge | No charge, advanced imaging not included | No charge | No charge |
| Specialist Consultation | \$10 per visit | \$40/visit | \$10 per visit | \$10 per visit |
| INPATIENT HOSPITAL SERVICES | | | | |
| Preauthorized semi-private room | No charge | \$250/admit | No charge | No charge |
| Intensive/coronary care unit | No charge | | No charge | No charge |
| Operating room and anesthesia | No charge | | No charge | No charge |
| X-ray, laboratory testing-diagnostic studies | No charge | | No charge | No charge |
| MATERNITY CARE SERVICES | | | | |
| Pre/Post-natal maternity visits | \$10 per visit | \$20 per visit | \$10 per visit | \$10 per visit |
| Delivery/Newborn care | No charge | \$250/admit | No charge | No charge |
| FAMILY PLANNING SERVICES | | | | |
| Vasectomy | \$10 per visit | \$50 | \$50 | \$100 |
| Tubal ligation | \$10 per visit | \$150 | \$150 | \$150 |
| Elective termination of pregnancy | \$10 per visit | \$150 | \$150 | \$150 |
| Infertility testing | 50% charge | 50% of costs | 50% of costs | Not covered |
| MENTAL HEALTH | | | | |
| Outpatient | \$10 per visit; \$5.00/group | \$20 per visit; Utilization review required after 12 visits | \$10 per visit; Utilization review required after 12 visits | \$10 per visit; Utilization review required after 12 visits |
| Inpatient | No charge Pre-authorization Required | \$250/admit Pre-authorization Required | No charge Pre-authorization Required | No Charge Pre-authorization Required |
| SUBSTANCE ABUSE; ALCOHOL & CHEMICAL | | | | |
| Outpatient | \$10/individual \$5.00/group | \$20 per visit; Utilization review required after 12 visits | \$10 per visit; Utilization review required after 12 visits | \$10 per visit; Utilization review required after 12 visits |
| Inpatient; as medically necessary | No charge | \$250/admit Pre-authorization Required | No charge Pre-authorization Required | No Charge Pre-authorization Required |
| EMERGENCY ROOM | \$50; waived if admitted | \$150; waived if admitted | \$50; waived if admitted | \$50; waived if admitted |
| AMBULANCE | No charge, as medically necessary | \$100/trip | No charge, as medically necessary | No charge, as medically necessary |
| DURABLE MEDICAL EQUIPMENT | No charge in accordance with formulary | No charge / Limit of 1 hearing aid per ear, every three yrs. | No charge / Limit of 1 hearing aid per ear, every three yrs. | No charge / Limit of 1 hearing aid per ear, every three yrs. |
| HOME HEALTH CARE BENEFIT | No Charge | \$20/visit -100 visits per ca year | 100 visits per cal year | No Charge, limited to 100 visits/yr |
| PROSTHETIC DEVICES | No Charge | No Charge | No Charge | No Charge |
| ANNUAL OUT OF POCKET MAXIMUM Individual/Family | \$1500/\$3000 | \$2000/\$4000 | \$1000/\$2000/\$3000 | Not applicable |
| PRESCRIPTION DRUGS | | | | |
| Generic/Brand Name/Non-formulary | \$5 / \$10 30 day supply \$10 / \$20 31-60 day supply \$15 / \$30 61-100 day supply | \$250/Cal yr deductible, waived for generic \$10 / \$35 / \$50 - 30 day | \$5 / \$10 / \$40 30 day supply | \$5 /\$10 / \$40 30 day supply |
| Mail Order Pharmacy | \$5 / \$10 30 day supply \$10 / \$20 31-100 day supply | \$250/Cal yr deductible, waived for generic \$10 / \$70 / \$100 - 90 day | \$10 / \$20 / \$80 90 day supply | \$10 / \$20 / \$80 90 day supply |
| CHIROPRACTIC | N/A See benefit listed below | \$20 / (combined with physical therapy) Limited to a 60-day period of care after an illness or injury | \$10 / (combined with physical therapy) Limited to a 60-day period of care after an illness or injury | No charge, 24 visits per cal year combined physical & occupational therapy |
| CHIROPRACTIC RIDER | \$5 / 20 visits per calendar year Must use ASH Providers | \$5 / 20 visits per calendar year Must use ASH Providers | \$5 / 20 visits per calendar year Must use ASH Providers | None |

The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

BLUE CROSS-AND KAISER-MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

Mental Health Parity and Addiction Act of 2008 requires group health plans that offer mental health or substance abuse benefits to provide those benefits on par with medical and surgical benefits. The Act prohibits plans from imposing financial requirements (e.g. co-pays) or treatment limits (e.g. outpatient visit limit) on mental health or substance abuse benefits that are more restrictive than the predominant financial requirements or treatment limits that apply to substantially all medical and surgical benefits, and it bars separate cost sharing and treatment limits for mental health and substance benefits. The Act also makes permanent the prohibition on lower annual and lifetime dollar limits on covered Mental Health benefits from the 1996 Mental Health Parity Act and expands this prohibition to include covered substance abuse benefits.

2012 POINT-OF-SERVICE Bi-Weekly Flexible Benefit \$245.05

| BI-WEEKLY RATES | 1/1/12 | | |
|--|---|--|--|
| EMPLOYEE ONLY | \$358.50 | | |
| EMPLOYEE + SPOUSE | \$696.50 | | |
| EMPLOYEE + CHILD(REN) | \$685.50 | | |
| EMPLOYEE + FAMILY | \$910.50 | | |
| NETWORK | HMO | PPO | Out-of-Network |
| DEDUCTIBLE | None | \$250/\$750 aggregate max | \$250/\$750 aggregate max |
| PHYSICIAN SERVICES | | | |
| Office Visits | \$10 per visit | \$20 per visit | 40% |
| Allergy testing & injections | \$10 per visit | 20% | 40% |
| Well baby & child care | No copay | Not covered | Not covered |
| Immunizations | No copay | Not covered | Not covered |
| Vision & Hearing Screening | No copay | Not covered | Not covered |
| Diagnostic lab & x-ray | No copay | 20% | 40% |
| Specialist Consultation | \$10 per visit | \$20 per visit | 40% |
| INPATIENT HOSPITAL SERVICES | | | |
| Preauthorized semi-private room | No charge | 20% | 40% |
| Intensive/coronary care unit | No charge | 20% | 40% |
| Operating room and anesthesia | No charge | 20% | 40% |
| X-ray, laboratory testing-diagnostic studies | No charge | 20% | 40% |
| MATERNITY CARE SERVICES | | | |
| Pre/Post-natal maternity visits | \$10 per visit | \$20 per visit | 40% |
| Delivery/Newborn care | No Charge | 20% | 40% |
| FAMILY PLANNING SERVICES | | | |
| Vasectomy | \$50 | 50% | 50% |
| Tubal ligation | \$150 | 50% | 50% |
| Elective termination of pregnancy | \$150 | 20% | 40% |
| Infertility testing | 50% | Not covered | Not covered |
| MENTAL HEALTH * | | | |
| Outpatient | \$10 per visit; Utilization review required after 12 visits | \$20 per visit; Utilization review required after 12 visits | 40%; Utilization review required after 12 visits |
| Inpatient | No charge Preauthorization required | 20% Preauthorization required | 40% Preauthorization required |
| SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY | | | |
| Outpatient | \$10 per visit; Utilization review required after 12 visits | \$20 per visit; Utilization review required after 12 visits | 40%; Utilization review required after 12 visits |
| Inpatient; as medically necessary | No charge Preauthorization required | No charge Preauthorization required | No charge Preauthorization required |
| EMERGENCY ROOM | \$25; waived if admitted | \$25; waived if admitted | \$25; waived if admitted |
| AMBULANCE | No charge | 20% | 20% |
| DURABLE MEDICAL EQUIPMENT | No charge | 20% | 40% |
| ORTHOTIC & PROSTHETIC DEVICES | No charge | 20% | 40% |
| ANNUAL OUT OF POCKET MAXIMUM | \$1500 Individual \$3000 Family | \$3000 Individual / \$6000 Family PPO & Opt-Out Providers Combined | |
| LIFETIME MAXIMUM | N/A | N/A | |
| PRESCRIPTION DRUGS | | | |
| Generic/Brand Name/ Non-formulary | \$5 / \$10 / \$40 / 30 day supply | \$5 / \$10 / \$40 / 30 day supply | \$5 / \$10 / \$40 / 30 day supply |
| Mail Order Pharmacy | \$10 / \$20 / \$80 / 90 day supply | \$10 / \$20 / \$80 / 90 day supply | \$10 / \$20 / \$80 / 90 day supply |
| CHIROPRACTIC | \$10/visit, 60 cons days per illness or injury (combined with physical therapy) | 20%; combined with physical therapy, 60 cons days per illness or injury (combined with physical therapy) | 40%; combined with physical therapy, 60 cons days per illness or injury (combined with physical therapy) |
| CHIROPRACTIC RIDER | \$5 per visit / 20 visits per calendar year/ Must use ASH providers | \$5 per visit / 20 visits per calendar year/ Must use ASH providers | \$5 per visit / 20 visits per calendar year/ Must use ASH providers |

The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

BLUE CROSS-AND KAISER-MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

Mental Health Parity and Addiction Act of 2008 requires group health plans that offer mental health or substance abuse benefits to provide those benefits on par with medical and surgical benefits. The Act prohibits plans from imposing financial requirements (e.g. co-pays) or treatment limits (e.g. outpatient visit limit) on mental health or substance abuse benefits that are more restrictive than the predominant financial requirements or treatment limits that apply to substantially all medical and surgical benefits, and it bars separate cost sharing and treatment limits for mental health and substance benefits. The Act also makes permanent the prohibition on lower annual and lifetime dollar limits on covered Mental Health benefits from the 1996 Mental Health Parity Act and expands this prohibition to include covered substance abuse benefits.

2012 BLUE CARD (Out-of-State) Bi-Weekly Flexible Benefit \$245.05

| BI-WEEKLY RATES | 1/1/12 | |
|---|--|--|
| EMPLOYEE ONLY | \$398.50 | |
| EMPLOYEE + SPOUSE | \$834.50 | |
| EMPLOYEE + CHILD(REN) | \$822.50 | |
| EMPLOYEE + FAMILY | \$1,193.50 | |
| DEDUCTIBLE | \$250 / \$500 / \$750 | |
| PHYSICIAN SERVICES | PPO Providers | Non PPO Providers |
| Office Visits | \$10/visit | 40% |
| Allergy testing & injections | 20% | 40% |
| Well baby & child care birth to age six | No charge | 40%, limited to \$20 per exam |
| Immunizations birth to age six | No charge | 40% limited to \$12 per immunization |
| Physical Exam persons age seven and older | No charge | Not covered |
| Adult Preventive Care (FDA approved screenings for cervical cancer, mammography testing, breast cancer & prostate cancer) | No charge | Not covered |
| Vision & Hearing Screening | No charge | Not covered |
| Diagnostic lab & x-ray | 20% | 20% |
| Specialist Consultation | \$10/visit | 40% |
| INPATIENT HOSPITAL SERVICES | | |
| Preauthorized semi-private room | 20% | 40% |
| Intensive/coronary care unit | 20% | 40% |
| Operating room and anesthesia | 20% | 40% |
| X-ray, lab testing-diagnostic studies | 20% | 40% |
| MATERNITY CARE SERVICES | | |
| Pre/Post-natal maternity visits | \$10/visit | 40% |
| Delivery/Newborn care | 20% | 40% |
| FAMILY PLANNING SERVICES | | |
| Vasectomy | 20% | 40% |
| Tubal ligation | 20% | 40% |
| Elective termination of pregnancy | 20% | 40% |
| Infertility testing | Not covered | Not covered |
| MENTAL HEALTH * | | |
| Outpatient | 20%, max to \$25 per visit | 40%, max to \$25 per visit |
| Inpatient | 20%, max to \$175 a day, pre-auth required waived for emergency | 40%, max to \$175 a day, pre-auth required waived for emergency |
| SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY | | |
| Outpatient | 20%, max to \$25 per visit 50 visit/cal yr | 40%, max to \$25 per visit 50 visit/cal yr |
| Inpatient; as medically necessary | 20%, max to \$175 a day (30 days/ cal yr) pre-auth required, waived for emergency | 40%, max to \$175 a day (30 days/ cal yr) pre-auth required, waived for emergency |
| EMERGENCY ROOM | 20% after \$100 ded, waived if admitted | 20% after \$100 ded, waived if admitted |
| AMBULANCE | 20% | 20% |
| DURABLE MEDICAL EQUIPMENT | 20%, combined with orthotic benefit | 20%, combined with orthotic benefit |
| ORTHOTIC | 20%, limited \$1000/cal year combined with DME benefit | 40%, limited \$1000/cal year combined with DME benefit |
| PROSTHETIC DEVICES | \$2,000 Annual Maximum | |
| ANNUAL OUT OF POCKET MAXIMUM | \$2000 per individual | \$6000 per individual |
| LIFETIME MAXIMUM | N/A | |
| PRESCRIPTION DRUGS | | |
| Generic / Brand Name / Non-formulary | \$5 / \$10 / \$40, 30 day supply | \$5 / \$10 / \$40, 30 day supply |
| Mail Order Pharmacy | \$10 / \$20 / \$80, 90 day supply | \$10 / \$20 / \$80, 90 day supply |
| CHIROPRACTIC | 20%, 24 visits/cal yr included with physical therapy benefit | 40%, max \$25/visit combined with physical therapy benefit |

The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

BLUE CROSS-AND KAISER-MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

Mental Health Parity and Addiction Act of 2008 requires group health plans that offer mental health or substance abuse benefits to provide those benefits on par with medical and surgical benefits. The Act prohibits plans from imposing financial requirements (e.g. co-pays) or treatment limits (e.g. outpatient visit limit) on mental health or substance abuse benefits that are more restrictive than the predominant financial requirements or treatment limits that apply to substantially all medical and surgical benefits, and it bars separate cost sharing and treatment limits for mental health and substance benefits. The Act also makes permanent the prohibition on lower annual and lifetime dollar limits on covered Mental Health benefits from the 1996 Mental Health Parity Act and expands this prohibition to include covered substance abuse benefits. The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

RSA Benefit Trust Prescription Drug Program

KAISER PERMANENTE PRESCRIPTION DRUG PROGRAM

Kaiser Permanente has a prescription mail service for your convenience through their Pharmacy. Kaiser will ship a 100-day supply of your prescribed medication, after orders are shipped they should arrive within 7 to 10 business days and are shipped "Postage Paid."

ANTHEM BLUE CROSS PRESCRIPTION DRUG PROGRAM

Express Scripts mail service Pharmacy through Anthem, will fill a 90 day supply of your prescribed medication. Orders are shipped within 14 days of receipt of your prescription. Their standard shipping is free, (expedited shipping is available for an additional charge).

PRESCRIPTION DRUG PLAN RETAIL VS. MAIL ORDER

| Kaiser Permanente Monthly Amount | Anthem Select Monthly Amount | Anthem Monthly Amount |
|--|---|---|
| \$5.00 co-pay per generic prescription | \$10.00 co-pay per generic prescription | \$5.00 co-pay per generic prescription |
| \$10.00 co-pay per brand name prescription | \$35.00 co-pay per brand name prescription | \$10.00 co-pay per brand name prescription |
| Non-Formulary Not Applicable | \$50.00 co-pay per non-formulary prescription | \$40.00 co-pay per non-formulary prescription |
| Prescription Drugs Mail Order 100 Day supply | Prescription Drugs Mail Order 90 Day Supply | Prescription Drugs Mail Order 90 Day Supply |
| \$10.00 co-pay per generic prescription | \$10.00 co-pay per generic prescription | \$10.00 co-pay per generic prescription |
| \$20.00 co-pay per brand name prescription | \$70.00 co-pay per brand name prescription | \$20.00 co-pay per brand name prescription |
| Non-Formulary Not Applicable | \$100.00 co-pay per non-formulary prescription | \$80.00 co-pay per non-formulary prescription |

Save Money with Generic

Save money on prescription medications by requesting generic drugs when filling a prescription. Generic drugs are comparable in strength, concentration, and dosage to their brand name counterparts.

2012 DENTAL PLANS

| | UHC DENTAL (DHMO D0103) | UHC DENTAL (UNION D0266) | DELTA CARE / PMI HMO Plan CAA22 | DELTA PREFERRED OPTION PPO Plan | |
|--|----------------------------|-----------------------------|------------------------------------|---|---|
| BI-WEEKLY RATES | 1/1/12 | 1/1/12 | 1/1/12 | 1/1/12 | |
| Employee Only | \$9.00 | \$13.00 | \$9.00 | \$24.00 | |
| Employee + One Dependent | \$16.00 | \$21.30 | \$16.00 | \$41.75 | |
| Employee + Two or More Dependents | \$24.50 | \$31.45 | \$23.00 | \$69.00 | |
| NETWORK | Choose Panel Dentist | In-Network Dentist | Choose Panel Dentist | In-Network | Out-of-Network |
| ANNUAL MAXIMUM | None | None | None | \$1,000 / Cal Yr \$2,000 Ortho Lifetime | \$1,000 / Cal Yr \$2,000 Ortho Lifetime |
| DEDUCTIBLE | None | None | None | None | \$50, waived for preventive services |
| PREVENTIVE SERVICES | | | | | |
| Office visit | No Charge | No Charge | No Charge | No Charge | No Charge |
| Oral Exams | No Charge | No Charge | No Charge | No Charge | No Charge |
| Complete x-rays | No Charge | No Charge | No Charge | No Charge | No Charge |
| Prophylaxis (cleaning) 1 per 6 month period - DHMO 2 per calendar year - DPO | No Charge | No Charge | No Charge | No Charge | No Charge |
| Bitewing - single film | No Charge | No Charge | No Charge | No Charge | No Charge |
| Topical fluoride treatments | No Charge | No Charge | No Charge | No Charge | No Charge |
| RESTORATIVE SERVICES | | | | | |
| Amalgam - 1 tooth surface | No Charge | No Charge | No Charge | 20% | 50% |
| Amalgam - 2 tooth surfaces | No Charge | No Charge | No Charge | 20% | 50% |
| Amalgam - 3 tooth surfaces | No Charge | No Charge | No Charge | 20% | 50% |
| CROWN, CAST AND PROSTHETICS* | | | | | |
| Crown 3/4 cast metal | \$110 | No Charge | \$90 | 40% | 50% |
| Resin Crown (Not for molars) | \$90 | No Charge | \$90 | 40% | 50% |
| Porcelain / Ceramic (Not for molars) | \$110 | No Charge | \$90 | 40% | 50% |
| Pontic cast noble metal | \$110 | No Charge | \$90 | 40% | 50% |
| Pontic porcelain fused to metal | \$110 | No Charge | \$90 | 40% | 50% |
| * Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast and cast cores, inlays and onlays. | | | | | |
| ENDODONTICS | | | | | |
| Root Canal – anterior | \$45 | No Charge | \$45 | 20% | 50% |
| Root Canal – bicuspid | \$85 | No Charge | \$90 | 20% | 50% |
| Root Canal – molar | \$130 | No Charge | \$135 | 20% | 50% |
| Pulp Capping | No Charge | No Charge | No Charge | 20% | 50% |
| DENTURES | | | | | |
| Repair broken complete base | \$10 | No Charge | \$20 | 40% | 50% |
| Complete upper or lower | \$110 | No Charge | \$110 | 40% | 50% |
| Partial upper or lower | \$90 | No Charge | \$125 | 40% | 50% |
| Adjust full upper or lower | \$0 | No Charge | \$10 | 40% | 50% |
| Add tooth or clasp | \$10 | No Charge | \$10 | 40% | 50% |
| Reline full upper or lower | \$50 | No Charge | \$45 | 40% | 50% |
| PERIODONTICS | | | | | |
| Gingivectomy per quadrant | \$40 | No Charge | \$125 | 20% | 50% |
| Gingivectomy per tooth | \$5 | No Charge | \$25 | 20% | 50% |
| ORAL SURGERY | | | | | |
| Simple extraction - single tooth | No Charge | No Charge | \$3 | 20% | 50% |
| Removal of impacted tooth (soft tissue) | \$25 | No Charge | \$40 | 20% | 50% |
| Removal of impacted tooth (completely bony) | \$50 | No Charge | \$80 | 20% | 50% |
| ORTHODONTICS | | | | | |
| Start-up Fee | \$250 | \$200 | \$350 | Not applicable | Not applicable |
| Adolescent | \$1,895 | \$1,700 | \$1,600 | 50%, max \$2,000 | 50%, max \$2,000 |
| Adult | \$1,895 | \$1,700 | \$1,800 | 50%, max \$2,000 | 50%, max \$2,000 |

The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

2012 VISION PLAN

| | Medical Eye Services PPO Vision Plan |
|---|---|
| | Full Service (exam, frames & lenses) |
| BI-WEEKLY RATES | |
| Employee Only | \$4.25 |
| Employee + 1 Dependent | \$7.75 |
| Employee + 2 or more Dependents | \$11.00 |
| DEDUCTIBLE | \$10 |
| COMPLETE EXAM (1 time every 12 months) | No Charge |
| LENSES (Medically Necessary) | |
| Single Vision | No Charge |
| Flat Top Bifocal | No Charge |
| Trifocal | No Charge |
| FRAMES | \$125.00 Allowance (every 24 months) |
| CONTACT LENSES | |
| Medically Necessary | No Charge |
| Cosmetic Purposes | \$125.00 Allowance |

*Benefit for MES Vision are for In-Network providers.

The above is a brief summary of benefits only and not an offer of insurance.
Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

NET COST OF MEDICAL BENEFITS

| Anthem HMO / EPO | New 2012 Rates | Total out of Pocket Cost |
|--------------------------|----------------|--------------------------|
| Single | \$634.00 | \$71.95 per pay period |
| Employee + Spouse | \$954.00 | \$231.95 per pay period |
| Employee + Children | \$925.00 | \$217.45 per pay period |
| Family | \$1,187.00 | \$348.45 per pay period |
| Anthem Select HMO | | |
| Single | \$541.00 | \$25.45 per pay period |
| Employee + Spouse | \$813.00 | \$161.45 per pay period |
| Employee + Children | \$788.00 | \$148.95 per pay period |
| Family | \$1,011.00 | \$260.45 per pay period |
| Anthem POS | | |
| Single | \$717.00 | \$113.45 per pay period |
| Employee + Spouse | \$1,393.00 | \$451.45 per pay period |
| Employee + Children | \$1,371.00 | \$440.45 per pay period |
| Family | \$1,821.00 | \$665.45 per pay period |
| Kaiser Permanente | | |
| Single | \$582.00 | \$45.95 per pay period |
| Employee + Spouse | \$970.00 | \$239.95 per pay period |
| Employee + Children | \$939.00 | \$224.45 per pay period |
| Family | \$1,213.00 | \$361.45 per pay period |

YOUR CONTACTS

Benefits Office

| | | | |
|---|------|----------------------------------|--|
| | Fax: | (951) 653-8014 (951) 653-9204 | www.rcdsa.org RSA Benefit Trust Page |
| James Cunningham <i>Trust Administrator</i> | | (619) 297-6900 | jjc@sdlaborlaw.com |
| Linda Gartley <i>Benefits Manager</i> | | (951) 653-8014 Ext. 222 | Linda@rcdsa.org |
| Connie Collins <i>Benefit Administrative Assistant</i> | | (951) 653-8014 Ext. 216 | Connie@rcdsa.org |
| Chaplain Harley Broviak | | (951) 232-3837 | |

Medical Insurance Carriers

| | | | |
|-------------------|--|-----------------------|--|
| Anthem Blue Cross | HMO | (800) 227-3771 | www.anthem.com/ca |
| | Select HMO | (800) 227-3771 | |
| | POS | (800) 288-6921 | |
| | EPO | (800) 288-2539 | |
| | Fee for Service <i>(Out of State Medicare Enrollees)</i> | (800) 288-2539 | |
| | Blue Card PPO <i>(Out of State Plan)</i> | (800) 288-2539 | |
| | Express Scripts | (866) 297-1013 | |
| | Guest Membership | (800) 827-6422 | |
| | Away from Home <i>(Urgent Care when you're traveling in the U.S.)</i> | (800) 810-BLUE (2583) | |

| | | | |
|---|--|----------------|--|
| Kaiser Permanente | | (800) 390-3510 | www.kp.org |
| <u>Dental Insurance Carriers</u> | | | |
| UnitedHealth Care Dental (PCD D0103) | | (800) 228-3384 | www.myuhcdental.com |
| UnitedHealth Care Dental (PUD D0266) | | (800) 999-3367 | www.myuhcdental.com |
| Delta Dental DPO | | (800) 765-6003 | www.deltadentalca.org |
| Delta Dental PMI (HMO) | | (800) 422-4234 | www.deltadentalca.org |
| <u>Vision Insurance Carrier</u> | | | |
| MES Vision | | (800) 877-6372 | www.mesvision.com |

Supplemental Insurances

| | | | |
|---|--|----------------|--|
| Brown Insurance Services <i>(Retiree/AWOP Billings)</i> | | (888) 346-6966 | www.brownbis.com |
| Samantha Curtin <i>(Life insurance quotes/comparisons)</i> | | (888) 346-6966 | Samantha@brownbis.com |
| AFLAC – Nicki Turner <i>Cancer, Intensive Care, Hospital, & Accident</i> | | (714) 328-0225 | nicki_turner@us.aflac.com |
| CLEA <i>Long Term Disability policy/Life Insurance</i> | | (800) 832-7333 | www.clea.org |

Homeowners, Auto, Miscellaneous Insurances

| | | | |
|---|-------------------|-----------------------------|--|
| <u>Brown Insurance Services</u> | | (888) 346-6966 | www.brownbis.com |
| <u>Liberty Mutual</u> | | | www.libertymutual.com |
| Cynthia Kelley, w/Liberty Mutual | | (760) 930-0841 Ext. 7158245 | |
| <u>County of Riverside</u> - Benefits Information Line | | (951) 955-4981 | www.workforceexchange.net |
| <u>CalPERS</u> | | (888) 225-7377 | www.calpers.ca.gov |
| <u>Nationwide</u> | | (877) 677-3678 | www.nationwide.com |
| <u>Valic</u> New accounts (800) 982-5558 | Existing accounts | (888) 568-2542 | www.valic.com |

Federal Health Care Reform Laws That May Affect You

Federal health care reform legislation was signed by President Obama in early 2010. Different provisions of this legislation will be phased in over several years but some of the provisions will take effect this year. It will take some time to fully understand this legislation and what it will mean to your benefits but there are important changes resulting from the federal health care reform law that will be effective for RSA plans effective January 1, 2011. In this notice, you will find important information about a special enrollment period for certain members under the new law.

CHILDREN CAN REMAIN ON THEIR PARENT'S HEALTH INSURANCE POLICY UNTIL THEY ARE 26 YEARS OLD

The health care reform law allows you to keep your children on your health plan until they turn 26 years old. That means that the maximum dependent age for our group has now been changed to age 26 according to federal law.

To be eligible for this coverage, children do not need to be financially dependent on you for support, claimed as dependents on your tax return, residents of your household, enrolled as students or unmarried to be eligible. Children-in-law (spouse of children) are not eligible and grandchildren still must meet the previous eligibility requirements of your plan. "Children" includes natural children, legally adopted children, stepchildren and children who are dependent on you during the waiting period before adoption.

- **If you want to add dependents to your health plan that are younger than 26 years of age**, you will need to add your dependent during the enrollment period which takes place beginning October 1, 2011 and ends October 31, 2011. This applies to adult children under 26 who were denied coverage in the past because they exceeded the maximum dependent age, or who were enrolled and lost coverage because they reached the maximum dependent age under the policy.
- **If you currently have single or employee/spouse coverage and you want to add children**, you need to change your enrollment status to family or employee/child(ren) coverage and will have additional costs.
- **If you are not currently enrolled, but wish to do so to take advantage of the dependent coverage right**, you and your adult child may both enroll during the enrollment period if you meet the eligibility requirements.
- **If you want your child(ren) to stay on your plan**, you do not need to do anything.
- **If you do not want to keep your children on your plan until age 26**, you will need to contact the RSA Benefits office to remove them as dependents under your policy.

NO MORE LIFETIME DOLLAR LIMITS ON BENEFITS AND RELATED SPECIAL ENROLLMENT RIGHT

The health care reform law requires health insurance companies to remove lifetime dollar limits on benefits from all plans. This applies to medical and pharmacy benefits only; not dental or vision.

- **If you are covered by the Riverside Sheriffs' Association health plan now**, you do not need to do anything.
- **If you are not covered by the Riverside Sheriffs' Association health plan now and are not eligible to enroll during the special enrollment period**, contact the RSA Benefits office for more information on when you can enroll.

NO DISCRIMINATION AGAINST CHILDREN WITH PRE-EXISTING CONDITIONS. RSA medical plans will continue to cover children with pre-existing conditions.

We will keep you informed of other health care reform provisions and changes as more details become available. Should you have any questions concerning health care reform, please contact the RSA Benefits office at (951) 653-8014 or Brown Insurance Services, the RSA insurance brokers, at (888) 346-6966.

Explanations of Medical Plan Options

Kaiser Permanente

Services must be provided, prescribed, authorized, or directed by a plan physician or facility within the covered service area. A list of covered zip codes is provided in the Kaiser enrollment packet. For members who reside in Coachella Valley and Western Ventura County, you must choose a primary care plan physician within the “affiliated provider” network. For more information, please contact the benefits office. You will have co-payments for approved services. Hospitalization is covered at 100% and there is a co-payment for emergency room visits.

Anthem California Care/Select HMO

Your primary care physician will belong to either a medical group or an IPA. In order to serve you best, your medical group or IPA should be located within 30 miles of your home or work. All care, except in a medical emergency, must be provided or authorized by assigned primary care physician, medical group, or IPA. You will have co-payments for approved services.

Medical Group - A team practice of physicians and health care providers. Most services, including special exams, X-ray and lab tests, are usually available at the medical group’s facility.

Independent Physician Association (IPA) - A medical partnership of physicians who practice in private offices. The IPA physician may refer you to other locations for special services, including special exams, X-ray and lab tests.

Anthem EPO (Blythe Residents Only)

Since there are no HMO providers in the Blythe Area, you may choose a provider from the Anthem Prudent Buyer network. Most benefits are only payable if you visit a Anthem PPO network health care provider. However, you may receive an exception if Anthem authorizes a referral when there is no Anthem PPO network health care provider within a 25-mile radius of your home who can perform the services you need. It is the member’s responsibility to verify that a provider is a Anthem PPO health care provider.

The Prudent Buyer provider might wait for the Explanation of Benefits (EOB) to determine how to bill you for their services. However, at the time of service, the provider may ask you for payment of your office visit co-payment, plus a percentage of charges that are not covered under your benefits. **When using Non-PPO and Other Health Care Providers for an authorized referral, an emergency, or urgent care, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage co-payment.**

Anthem POS (Point-of-Service)

The Point-of-Service is a plan that allows you to visit HMO, PPO and out-of-network health care providers. You will choose a primary care physician from the Anthem HMO Provider Directory. You will have co-payments for visits with your HMO provider. *Please keep in mind that certain services, well baby/child care, eye examinations, vision screenings, are only covered under the HMO side of the Point-of-Service plan. You will have co-payments for visits with your HMO provider. If you use the HMO tier, all care must be provided or authorized by your primary care physician, medical group, or IPA.*

You may choose to seek services from a PPO (Prudent Buyer) provider from the Anthem network. For these services, you will have a co-payment for your office visits and pay an annual deductible and percentage for other services (i.e. lab work, x-rays, hospitalization). PPO providers bill Anthem for services. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses. You do

not need a referral from your HMO provider to seek services from a PPO provider.

If you “Opt-Out” and choose a non-network provider, you will likely pay higher out-of-pocket expenses and need to file a claim with Anthem for reimbursement or processing of claims. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses. **When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage co-payment.** You do not need a referral from your HMO provider to seek services from a non-network provider.

Anthem Blue Card (Out-of-State) Plan

You have the option of choosing providers from the PPO (Prudent Buyer) network or Non-PPO providers. For services from a PPO provider you will have a co-payment for your office visits and pay an annual deductible and percentage for other services (i.e. lab work, x-rays, hospitalization). PPO providers bill Anthem for services. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses.

If you “Opt-Out” and choose a non-network provider, you will likely pay higher out-of-pocket expenses and need to file a claim with Anthem for reimbursement or processing of claims. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses. **When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage co-payment.**

Medicare Plan Options

All RSA sponsored medical plans have Medicare plan options available to you and/or your spouse. You will not have to change providers, however a new enrollment application and copy of Medicare card is required. Medicare supplemental plan applications should be submitted to the Benefits Office at least one month before your Medicare effective date. You are required to enroll in Medicare Parts A & B if eligible. **Do not enroll in Part D coverage through Medicare.**

The HIPAA Law and How It Affects You

The Federal Health Insurance Portability and Accountability Act (HIPAA), includes a Privacy Rule that establishes safeguards that health carriers, doctors, brokers, and benefits administrators must use to protect the privacy of health information.

The Benefit Trust has put procedures in place to ease your mind. If you have a claims issue, a question as to why a certain procedure or prescription was not covered fully; the Benefit Trust must have you sign an authorization form before the health carrier will release information to us. If you have not already done so and would like to designate a personal representative, please contact the Benefits Office to have a form mailed to you. The personal representative does not need to be enrolled in your insurance coverage, but must know your social security number. As always, in emergency situations we will do whatever it takes to get you the care you need.

Your medical, dental and vision plans have phone numbers and Web sites available to retrieve eligibility, benefit and claims information by using a personal pin. To find out more, see Your Contacts on page 10 or log onto www.rcdsa.org, and click on Benefit Trust. The carrier links will bring you to the applicable Web sites.

RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST NOTICE OF PRIVACY PRACTICES
Effective September 1, 2005

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. The Riverside Sheriffs' Association Benefit Trust is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
 - a. For Treatment:
 - The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; or
 - Consultation between health care providers relating to a patient; or
 - Referral of a patient for health care from one health care provider to another.
 - b. For Payment:
 - To obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or
 - To obtain or provide reimbursement for the provision of health care.
 - c. For Health Care Operations:
 - Conducting quality assessment and improvement activities;
 - Reviewing the competence or qualifications of health care and provider performance;
 - Underwriting, premium rating and other related activities;
 - Conducting or arranging for medical review;
 - Business planning and development;
 - Business management and general administrative activities, including:
 - Management activities relating to compliance with the HHS privacy regulation;
 - Customer Service;
 - Resolution of internal grievances;
 - The transfer to or merger with another plan;
 - Creating de-identified health information.
2. Riverside Sheriffs' Association Benefit Trust is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.
3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.
4. Riverside Sheriffs' Association Benefit Trust intends to engage in one or more of the following activities:
 - a. Riverside Sheriffs' Association Benefit Trust may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
 - b. Riverside Sheriffs' Association Benefit Trust may contact the individual/Patient to raise funds for Riverside Sheriffs' Association Benefit Trust; or
 - c. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The Individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. Riverside Sheriffs' Association Benefit Trust is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
6. Riverside Sheriffs' Association Benefit Trust is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
7. Riverside Sheriffs' Association Benefit Trust is required to abide by the terms of the Notice currently in effect.
8. Riverside Sheriffs' Association Benefit Trust reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Riverside Sheriffs' Association Benefit Trust will provide individuals or patients with a revised Notice by mail.
10. If you want to exercise your rights under this Notice or if you wish to communicate with us about Privacy issues or if you wish to file a complain with us, you can write to:

Riverside Sheriffs' Association
6215 River Crest Drive, Suite A
Riverside, CA 92507
(951) 653-8014

You will not be penalized for filing a complaint with us.
11. You have the right to file a complaint with the federal government. You may write to:

Office of the Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

You will not be penalized for filing a complaint with the federal government.

Important Notice from Riverside Sheriffs' Association (RSA) About Your Prescription Drug Coverage and Medicare

This is an annual notice. It is to ensure that active members, retirees and their dependents have this important information. If you are already enrolled in a Medicare D plan through RSA and do not want to make any changes - no action is needed, your coverage remains the same. If you or a dependent is becoming Medicare eligible in the near future, please remember to contact the RSA Benefits Office at (951) 653-8014 before making any decisions about your coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with RSA and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. RSA has determined that the prescription drug coverage offered by the Blue Cross of California and Kaiser Permanente is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your RSA prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with RSA and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

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

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

Contact our office for further information contact our insurance brokers, Brown Insurance Services at (714) 460-7744 or (888) 346-6966. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through RSA 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 prescription drug plans. For more information about Medicare prescription drug plans:

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

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

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

| | |
|---------------------------|--|
| Date: | September 28, 2011 |
| Name of Entity/Sender: | Brown Insurance Services for RSA |
| Contact--Position/Office: | Diana Leiter - Administrator |
| Address: | 962 Town & Country Road Orange, CA 92868 |
| Phone Number: | (714) 460-7744 or (888) 346-6966 |

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymph edemas. (The swelling of tissues caused by obstruction of the lymphatic drainage. It results from fluid accumulation and may arise from surgery, radiation or the presence of a tumor in the area of lymph nodes.)

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plans of the RSA Benefit Trust. For more information on WHCRA benefits, please contact the Benefits Office at (951) 653-8014.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can 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 and you live in a State listed below, you can contact your State 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 State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility –

| | |
|--|--|
| ALABAMA – Medicaid | CALIFORNIA – Medicaid |
| Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504 | Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443 |
| ALASKA – Medicaid | COLORADO – Medicaid and CHIP |
| Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 (In Anchorage): 907-269-6529 | Medicaid Website: http://www.colorado.gov/ Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243 |
| ARIZONA – CHIP | |
| Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437 | |
| ARKANSAS – CHIP | FLORIDA – Medicaid |
| Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275 | Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237 |
| GEORGIA – Medicaid | MONTANA – Medicaid |
| Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150 | Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084 |
| DAHO – Medicaid and CHIP | NEBRASKA – Medicaid |
| Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588 | Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092 |
| INDIANA – Medicaid | NEVADA – Medicaid and CHIP |
| Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479 | Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669 |
| IOWA – Medicaid | |
| Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562 | |
| KANSAS – Medicaid | NEW HAMPSHIRE – Medicaid |
| Website: https://www.khpa.ks.gov Phone: 800-766-9012 | Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254 |
| KENTUCKY – Medicaid | NEW JERSEY – Medicaid and CHIP |
| Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570 | Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 |
| LOUISIANA – Medicaid | |
| Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207 | |

| | |
|---|---|
| MAINE – Medicaid | NEW MEXICO – Medicaid and CHIP |
| Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557 | Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 |
| MASSACHUSETTS – Medicaid and CHIP | CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583 |
| Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120 | |
| MINNESOTA – Medicaid | NEW YORK – Medicaid |
| Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670 | Website: http://www.nyhealth.gov/health_care/ medicaid/ Phone: 1-800-541-2831 |
| MISSOURI – Medicaid | NORTH CAROLINA – Medicaid |
| Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944 | Website: http://www.nc.gov Phone: 919-855-4100 |
| NORTH DAKOTA – Medicaid | UTAH – Medicaid |
| Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604 | Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414 |
| OKLAHOMA – Medicaid | VERMONT – Medicaid |
| Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 | Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427 |
| OREGON – Medicaid and CHIP | VIRGINIA – Medicaid and CHIP |
| Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678 | Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647 |
| PENNSYLVANIA – Medicaid | WASHINGTON – Medicaid |
| Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730 | Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669 |
| RHODE ISLAND – Medicaid | WEST VIRGINIA – Medicaid |
| Website: www.dhs.ri.gov Phone: 401-462-5300 | Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604 |
| SOUTH CAROLINA – Medicaid | WISCONSIN – Medicaid |
| Website: http://www.scdhhs.gov Phone: 1-888-549-0820 | Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002 |
| TEXAS – Medicaid | WYOMING – Medicaid |
| Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493 | Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531 |

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
OMB Control Number 1210-0137 (expires 09/30/2013)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565



**Riverside Sheriffs' Association
Annual Health Fair
and
Open Enrollment**

Saturday, October 15th
from
10:00 a.m. – 5:00 p.m.

at the
Riverside County Sheriff's Annual Picnic

at

Diamond Valley Lake Community Park
(located right next to the Aquatic Center)
1801 Anglers Avenue
Hemet, CA 92544

Directions: From the 215 Freeway, exit Newport Road heading west, travel approx 10 miles west, turn left onto Domenigoni Parkway, turn right onto Searl Parkway, and turn left onto Anglers Avenue.

****** LOOK FOR THE RSA FLAG ******

Representatives from Anthem, Kaiser
Brown Insurance Services, and other vendors will be in attendance.
Free Flu Shots for the first 150 RSA Members
Cholesterol check, Massage Therapist,
and Blood Pressure check