RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST

2023

Retiree and Medicare Plan Participants'

BENEFIT GUIDE

2023 Open Enrollment

October 1, 2022 - October 31, 2022

Log in at **benefits.plansource.com** to make changes (see page 4 for instructions). If you are not making changes, nothing needs to be done but it may be a good time to update your contact information!

If you and/or your dependents become eligible for Medicare in the next 12 months, please contact the Benefit Trust Office as your premium amounts will change.

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RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST
Open Enrollment 2023

IMPORTANT OPEN ENROLLMENT INFORMATION
PLEASE READ CAREFULLY

Open Enrollment will run from **October 1st through October 31st.** You can log into Plansource to make your changes 24 hours a day, 7 days a week from your own computer or mobile device. Laptops will be available in the RSA benefits office **from 8:00 a.m. – 5 p.m. Monday through Thursday**, with the exception of Monday, October 10th in observance of Columbus Day. **All changes will take effect January 1, 2023.**

The Trustees of the RSA Benefit Trust work very hard alongside our consultants to ensure that the Benefit Trust offers best-in-class healthcare plans for retirees at the lowest possible costs.

We are continuing to see a significant increase in claim costs on the Anthem HMO plans. Because of this significant increase in claims, the non-Medicare Anthem HMO plans will receive a 12% increase in 2023. The Anthem HMO has averaged a 4.25% increase over the last four years which is well below the industry average of 6.30%. On the other hand, the Anthem PPO plans have seen significantly lower claim costs and the PPO rates will decrease by approximately 20% in 2023. The Blue Card (out-of-state) PPO rates will decrease by an average of 39%! This will provide a much more affordable out-of-state plan for retirees. The Kaiser medical premiums will be decreasing by approximately 1.75% in 2023. This will be the third consecutive year that the Kaiser plans have decreased in cost. Medical premiums can be found beginning on page 6.

We are pleased to announce that there will be no increase to any dental and vision plans in 2023! There will also be no plan design changes to any dental and vision plan in 2023 as well. All dental and vision premiums can be found on page 14-15.

The Trust will continue to provide meaningful financial incentives through the Virgin Pulse wellness program. Currently, retirees and enrolled spouses can EACH earn up to $145 per quarter ($580 per year) in incentives. We encourage everyone to take advantage of these financial incentives and to take an active role in managing your own health. By participating in the program, you are doing your part to help keep our premiums down so that the RSA Benefit Trust can continue to offer the same great plans at affordable costs.

Please log into the PlanSource System and verify all the insurance plans that you have are correct, as well as read any changes those plans may have for 2023 (included in this booklet on page 4). The RSA Benefit Trust staff will be available to assist you in verifying your current plans so you can determine if you wish to make any changes.

IF YOU DO NOT WISH TO MAKE A CHANGE TO YOUR CURRENT BENEFITS THEN NO ACTION IS REQUIRED DURING OPEN ENROLLMENT but please be sure to update any changes to your contact information or beneficiaries (via PlanSource).

For Your Board of Trustees,

Randall Wortman
Benefit Trust Chairman

RSA BENEFIT TRUST RETIREE ENROLLMENT INFORMATION

Open Enrollment Dates

Open enrollment will be held from **October 1st through October 31st.** Please use this time to change insurance carriers, change plans, add or drop dental and/or vision. **Under most circumstances, you will be unable to change carriers or plans mid-year.** Changes can be made online at Plansource.com. You are welcome to contact the RSA Benefits Office for guidance Monday – Thursday 8:00 – 5:00.

Certain changes made during open enrollment require separate documentation and/or social security numbers as discussed in the required Proof of Eligibility for Dependents section of this packet. Please provide them to the benefits office upon request in a timely manner to ensure your requested changes are processed in time for Open Enrollment.

Medical Benefits

Mid-year changes can be made 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 group coverage for spouse and/or dependents

All changes made mid-year must be submitted to the RSA Benefits Office with signed retiree monthly premium selection forms, marriage/birth certificates, proof of qualifying event and social security members.

Changes must be submitted to the Benefits Office within 30 days of the qualifying event.

Required Proof of Eligibility for Dependents

Spouse

- Social Security Number
- Marriage Certificate or filed State Declaration of Domestic Partnership

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 are eligible up to age 26.

- Social Security Number(s)
- Birth Certificate(s)
- Legal Documents and/or Marriage Certificates where appropriate (step children, etc.)

Disabled Children

Disabled Children (A dependent incapable of self-sustaining employment by reason of physical handicap or mental disability)

- Letter from the child's physician explaining the diagnosis, extent of disability, and prognosis
- Medicare information and a copy of the Medicare identification card if applicable

Domestic Partnership

A Domestic Partner of an eligible retiree 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.

MEDICARE ELIGIBILITY

Be sure to contact the Social Security office several months prior to you or your spouse turning 65; per the RSA Benefit Trust Plan Document and our insurance carriers, **all members and spouses who turn 65 must enroll in Medicare Parts A and/or B.**

Do not enroll in the Part D prescription option through Medicare or the Department of Social Security. The RSA Benefit Trust has implemented continued prescription coverage through the Anthem plans and Kaiser Permanente. There will be no charge in co-payments or benefits for prescriptions.

It is imperative that the Benefit Trust receives your supplemental Medicare plan application and a copy of your Medicare card at least one month prior to eligibility.

- Contact the Benefits Office (951-653-8014) to enroll in a Medicare compatible plan which will decrease the cost to you!

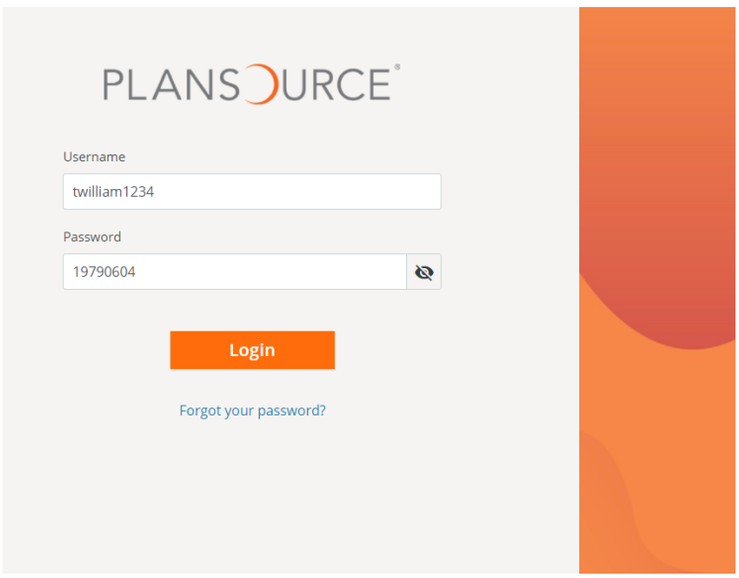
How does your enrollment in this plan affect coverage for the drug covered under Medicare Part A or Part B ?
Your enrollment in this plan doesn't affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, it can't be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part Bin some cases and through this plan (Medicare Part D) in other cases, but never both at the same time.

See your Medicare & You handbook for more information about drugs that are covered by Medicare Part A or Part B.

ENROLLMENT/ CHANGES INSTRUCTIONS

All Enrollment & Changes are made here:

benefits.plansource.com/login



Logging In :

Username: Your username is the first initial of your first name, up to the first six letters of your last name, and the last four digits of your SSN.

For example, if your name is Taylor Williams, and the last four digits of your SSN are 1234, your username would be twillia1234.

Password: Your initial password is your birthdate in the YYYYMMDD format.

So, if your birthdate is June 4, 1979, your password would be 19790604. The first time you log in, you will be prompted to change your password.

Open Enrollment:

On the Homepage, click “Get Started” to begin.

Benefit Changes:

On the Homepage, click “Update My Benefits” to begin.

If you need a password reset or have troubles logging in please contact our office at:
(951) 653 - 8014

Open Enrollment ends
Monday, October 31, 2022

PLAN CHANGES
Effective January 1, 2023

All Anthem Medical Plans	Hospital medical benefits for routine newborn care will be provided if the member is an enrolled *member*; formerly this benefit was limited to the primary subscriber or spouse/domestic partner, now **newborns of dependents will now have routine hospital coverage**.
All Anthem Medical Plans	**Hospice Care:** The 5-consecutive-day limit on respite care per admission has been removed. There is **no longer a limit** on inpatient respite care during hospice.
All Anthem Medical Plans	Benefit revised for **Ambulance** to distinguish services based on whether they are Emergency Services or Non-Emergency Services. Coverage is different depending if an ambulance is used as Emergency or non-Emergency.
All Anthem PPO Plans	Autism mandate will **expand the coverage of behavioral health treatment for** individuals with **ASD (Autism Spectrum Disorder)** and **PDD (Pervasive Development Disorder)**. Behavioral health treatment is defined as services and programs that develop or restore the functioning of an individual with ASD or PDD.
All Anthem PPO Plans	***Physical Therapy*** limit of 40 visits per benefit period has been removed. There is **no longer a limit** on Physical or Occupational Therapy.
All Anthem PPO Plans	***Speech Therapy*** limit of 20 visits per benefit period has been removed. There is **no longer a limit** on Speech Therapy.
All Anthem PPO Plans	***Cardiac Rehabilitation Therapy*** limit of 36 visits per benefit period has been removed. There is **no longer a limit** on Cardiac Rehabilitation Therapy.
All Anthem PPO Plans	Removed the requirement that **Accidental Dental** coverage only allows a 12-month claim file requirement from date of accident to be covered. There is **no claim file requirement**.
Kaiser	Certain **Mental Health and Substance Abuse** benefits will have $0 cost share (still subject to deductible). See the 2023 Evidence of Coverage for details.

2023 RETIREE NON-MEDICARE HMO COMPARISON

RATES DO NOT REFLECT COUNTY CONTRIBUTION AND/OR RAP BENEFIT, IF APPLICABLE

	KAISER PERMANENTE HMO	Anthem HMO (Cal Care)	Anthem SELECT HMO	Anthem EPO (Blythe Only)
	MONTHLY PREMIUM RATE:			
RETIREE ONLY	$768.00	$1,095.00	$906.00	$1,095.00
RETIREE + SPOUSE	$1,272.00	$1,646.00	$1,358.00	$1,646.00
RETIREE + CHILD(REN)	$1,235.00	$1,596.00	$1,317.00	$1,596.00
RETIREE + FAMILY	$1,592.00	$2,046.00	$1,690.00	$2,046.00
	PLAN DETAILS*:			
Network	Full Network	Full Network	Limited Network	PPO
Deductible	None	None	None	None
Primary Care Office Visit	$5 Copay	$5 Copay	$5 Copay	$5 Copay
Specialist Office Visit	$5 Copay	$5 Copay	$40/visit	$5 Copay
Virtual Doctor Visit	No Charge	$5 Copay	$5 Copay	$5 Copay
Allergy Testing	No Charge	$5 Copay	$5 Copay	No Charge
Preventive Care (All Ages)	No Charge	No Charge	No Charge	No Charge
Diagnostic Lab (Most*)	No Charge	No Charge	No Charge	No Charge
Vision / Hearing Screenings	No Charge	No Charge	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge	50% Coinsurance	No Charge
Urgent Care Visits	$5 Copay	$5 Copay	$5 Copay	$5 Copay
Hospital Services	No Charge	No Charge	$250/Admit	No Charge
Outpatient Surgery	$5 Per Procedure	No Charge	$125/Visit	No Charge
Emergency Room	$50; Waived if Admitted	$50; Waived if Admitted	$150; Waived if Admitted	$50; Waived if Admitted
Ambulance	No Charge if Medically Necessary	No Charge if Medically Necessary	$100 Copay per Trip	No Charge if Medically Necessary
ANNUAL OUT OF POCKET MAXIMUM	$1,500 Person / $3,000 Family	$1,000/Family Member (up to 3)	$2,000 Person / $4,000 Family	No Out of Pocket Limit
PRESCRPTION DRUGS Generic/Brand Name/Non-formulary	Copay: $0 / $10 (30 Day Supply) $0 / $20 (31-100 Day Supply)	Copay: $0 / $10 / $40 (30 Day Supply)	$250/$500 Cal Year Deductible; Waived for Generics $0 / $35 / $50 30 Day Supply	Copay: $0 /$10 / $40 30 Day Supply
Manipulation Therapy (Chiropractic, etc.)	N/A See Benefit Listed Below	$5/ (Combined with Physical Therapy) Limited to a 60-day Period of Care After an Illness or Injury	$20/ (Combined with Physical Therapy) Limited to a 60-day Period of Care After an Illness or Injury	No charge; Limit 30 Visits per Cal Year Combined Physical & Occupational Therapy
CHIROPRACTIC RIDER - ALL PLANS	$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	N/A

* 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.

2023 RETIREE NON-MEDICARE ANTHEM PPO

RATES DO NOT REFLECT COUNTY CONTRIBUTION AND/OR RAP BENEFIT, IF APPLICABLE

	Anthem PPO	
	MONTHLY PREMIUM RATE:	
RETIREE ONLY	$814.00	
RETIREE + SPOUSE	$1,544.00	
RETIREE + CHILD(REN)	$1,510.00	
RETIREE + FAMILY	$2,031.00	
	PLAN DETAILS*:	
NETWORK	PPO	Non-PPO (Out of Network)
DEDUCTIBLE	$250 Person /$750 Family	$250 Person /$750 Family
Primary Care Office Visit	$20 Copay	40% Coinsurance
Specialist Office Visit	$20 Copay	40% Coinsurance
Virtual Doctor Visit	$20 Copay	40% Coinsurance
Allergy Testing	20% Coinsurance	40% Coinsurance
Preventive Care (All Ages)	No Charge	40% Coinsurance
Diagnostic Lab (Most*)	20% Coinsurance	40% Coinsurance
Vision / Hearing Screenings	No Charge	Reimbursed up to $42
Durable Medical Equipment	20% Coinsurance	40% Coinsurance
Urgent Care Visits	$20 Copay	40% Coinsurance
Outpatient Surgery	20% Coinsurance	40% Coinsurance
Hospital Services	20% Coinsurance	$500 Copay and 40% Coinsurance
Emergency Room	$25 Copay; Waived if Admitted	
Ambulance	20% Coinsurance	
ANNUAL OUT OF POCKET MAXIMUM	$2,000 Person / $4,000 Family PPO and Out-of-Network Providers Combined	
PRESCRPTION DRUGS Generic/Brand Name/Non-formulary	Copay: $5 / $10 / $40 30 day supply	50% Coinsurance up to $250/Script
Manipulation Therapy (Chiropractic, etc.)	$5 Copay 20 Visits per Year	

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2023 RETIREE BLUE CARD (OUT-OF-STATE)

RATES DO NOT REFLECT COUNTY CONTRIBUTION AND/OR RAP BENEFIT, IF APPLICABLE

	Anthem Blue Card (Out-of-State) PPO	
MONTHLY PREMIUM RATE:		
RETIREE ONLY	$814.00	
RETIREE + SPOUSE	$1,544.00	
RETIREE + CHILD(REN)	$1,510.00	
RETIREE + FAMILY	$2,031.00	
PLAN DETAILS*:		
NETWORK	PPO	Out-of-Network
DEDUCTIBLE	$250 / Max of Three per Family	$250 / Max of Three per Family
Primary Care Office Visit	$10 Copay	40% Coinsurance
Specialist Office Visit	$10 Copay	40% Coinsurance
Virtual Doctor Visit	$10 Copay	40% Coinsurance
Allergy Testing	20% Coinsurance	40% Coinsurance
Preventive Care (All Ages)	No charge	40% Coinsurance
Diagnostic Lab (Most*)	20% Coinsurance	40% Coinsurance
Vision / Hearing Screenings	No Charge	Reimbursed up to $42
Durable Medical Equipment	20% Coinsurance	40% Coinsurance
Urgent Care Visits	$10 Copay	40% Coinsurance
Outpatient Surgery	20% Coinsurance	40% Coinsurance
Hospital Services	20% Coinsurance	$500 Copay and 40% Coinsurance
Emergency Room	$100 Copay and 20% Coinsurance; Copay Waived if Admitted	
Ambulance	20% Coinsurance	
ANNUAL OUT OF POCKET MAXIMUM	$2,000 Person / $4,000 Family	$6,000 Person / $12,000 Family
PRESCRPTION DRUGS Generic/Brand Name/Non-formulary	Copay: $5 / $10 / $40 30 day supply	50% Coinsurance up to $250/Script
Manipulation Therapy (Chiropractic, etc.)	$10 Copay; 30 Visits per Cal Year PPO/Non-PPO Combined	40% Coins.; 30 Visits per Cal Year PPO/Non-PPO Combined

* 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.

2023 HMO COMPARISON MEDICARE PARTS A AND B

INSURANCE CARRIERS PRESCRIPTION COVERAGE PART D
RATES DO NOT REFLECT COUNTY CONTRIBUTION
AND/OR RAP BENEFIT, IF APPLICABLE

	KAISER SENIOR ADVANTAGE	ANTHEM SELECT HMO CALIFORNIACARE	ANTHEM HMO CALIFORNIACARE	ANTHEM EPO PLAN (Blythe Only)
MONTHLY RATES				
Retiree with Medicare	**$212**	**$450**	**$458**	**$458**
Retiree & Spouse with Medicare	**$402**	**$879**	**$899**	**$899**
Retiree with & Spouse w/out Medicare	**$716**	**$885**	**$978**	**$978**
Retiree w/out & Spouse with Medicare	**$958**	**$1,336**	**$1,533**	**$1,533**
Retiree with & Child w/out Medicare	**$679**	**$885**	**$978**	**$978**
Retiree with & Children w/out Medicare	**$679**	**$1,202**	**$1,368**	**$1,368**
Retiree & Spouse with & Child w/out Medicare	**$722**	**$1,314**	**$1,419**	**$1,419**
Retiree & Spouse with & Children w/out Medicare	**$722**	**$1,631**	**$1,809**	**$1,809**
Retiree with, Spouse & Child(ren) w/out Medicare	**$1,036**	**$1,202**	**$1,368**	**$1,368**
Retiree & Child(ren) w/out & Spouse with Medicare	**$1,278**	**$1,747**	**$2,034**	**$2,034**
DEDUCTIBLE	**None**	**None**	**None**	**None**
PHYSICIAN SERVICES				
Office Visits	$10 per visit	$5/visit – primary care dr.	$5 per visit	$5 per visit
Online Office Visits (livehealthonline.com)	Not Covered	$5/visit	$5 per visit	$5 per visit
Allergy testing	$10 per procedure	$5/visit - primary care dr.	$5 per visit	$5 per visit
Allergy injection visits	No charge	$5/visit – primary care dr.	$5 per visit	$5 per visit
Well baby & child care	No charge	No charge	No charge	No charge
Immunizations	No charge	No charge	No charge	No charge
Vision & Hearing Screening	Screening No charge, $10 refraction, $10 hearing exam	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 per visit	$5 per visit	$5 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
MENTAL HEALTH				
Outpatient	$10/individual $5/group	$5 per visit	$5 per visit	$5 per visit
Inpatient; as medically necessary	No charge Pre-authorization Required	$250/admit Pre-authorization Required	$0 copay Pre-authorization Required	$0 copay Pre-authorization Required
SUBSTANCE ABUSE; ALCOHOL & CHEMICAL DEP.				
Outpatient	$10/individual $5.00/group	$5 per visit	$5 per visit	$5 per visit
Inpatient; as medically necessary	No charge Pre-authorization Required	$250/admit Pre-authorization Required	$0 copay Pre-authorization Required	$0 copay 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	50%- Hearing aids excluded	No charge/Limit of 1 hearing aid per ear every three yrs	No charge/Limit of 1 hearing aid per ear every three years
HOME HEALTH CARE BENEFIT	No charge 100 visits per cal yr	$5/visit - 100 visits per cal yr	$5/visit -100 visits per cal yr	No charge, limited to 100 visits/yr
PROSTHETIC DEVICES	No charge	No Charge	No charge	$0 copay,
ANNUAL OUT OF POCKET MAXIMUM IND/FAM	$1,500/$3,000	$2,000/$4,000	$1,000/$2,000/$3,000	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 supply	$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	$5 / (combined with physical therapy) Limited to a 60-day period of care after an illness or injury	$5/Visits / (combined with physical therapy) Limited to a 60-day period of care after an illness or injury	No charge, 30 visits per cal yr – comb. physical & occupational therapy
CHIROPRACTIC Rider	$5 / 20 visits per year Must use ASH providers	$5 / 20 visits per calendar year Must use ASH providers	$5 per visit / 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.

2023 PPO MEDICARE PARTS A AND B

INSURANCE CARRIERS PRESCRIPTION COVERAGE PART D
RATES DO NOT REFLECT COUNTY CONTRIBUTION
AND/OR RAP BENEFIT, IF APPLICABLE

MONTHLY RATES		
Retiree with Medicare	**$526**	
Retiree & Spouse with Medicare	**$1,016**	
Retiree with & Spouse w/out Medicare	**$1,258**	
Retiree w/out & Spouse with Medicare	**$1,317**	
Retiree with & Child w/out Medicare	**$1,258**	
Retiree with & Children w/out Medicare	**$1,743**	
Retiree & Spouse with & Child w/out Medicare	**$1,748**	
Retiree & Spouse with & Children w/out Medicare	**$2,233**	
Retiree with, Spouse & Child(ren) w/out Medicare	**$1,743**	
Retiree & Child(ren) w/out & Spouse with Medicare	**$2,013**	
DEDUCTIBLE	**$250/individual | $750/family aggregate max**	**$250/individual | $750/family aggregate max**
PHYSICIAN SERVICES	**PPO**	**OPT OUT**
Office Visits	$20 per visit, ded waived	40%
Online Office Visits (www.livehealthonline.com)	N/A	N/A
Allergy testing & injections	20%	40%
Well baby & child care	No Copay	Not covered
Immunizations	No Copay	Not covered
Vision & Hearing Screening	No Copay	Not covered
Diagnostic lab & x-ray in physician office	20%	40%
Specialist Consultation	$20 per 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, laboratory testing-diagnostic studies	20%	40%
MENTAL HEALTH		
Outpatient	$10/visit	40%/visit
Inpatient	No charge Pre-authorization required	40% Pre-authorization required
SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY		
Outpatient	$10/visit	40%/visit
Inpatient; as medically necessary	No charge Pre-authorization required	40% Pre-authorization required
EMERGENCY ROOM	$25; waived if admitted	$25; waived if admitted
AMBULANCE	20%	20%
DURABLE MEDICAL EQUIPMENT	20%; limit of 1 hearing aid per ear every three years	40%; limit of 1 hearing aid per ear every three years
PROSTHETIC DEVICES	20%	40%
ANNUAL OUT OF POCKET MAXIMUM Individual/Family	$2,000 Individual / $4,000 Family PPO & Opt-Out Providers Combined	
LIFETIME MAXIMUM	Unlimited	
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
CHIROPRATIC	$5 Per Visit 20 Visit Per Calendar Year	

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2023 RETIREE FEE-FOR-SERVICE (OUT OF STATE)

MEDICARE A AND B

INSURANCE CARRIERS PRESCRIPTION COVERAGE PART D
RATES DO NOT REFLECT COUNTY CONTRIBUTION
AND/OR RAP BENEFIT, IF APPLICABLE

	Insured persons are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage co-payment.
MONTHLY RATES	
Retiree with Medicare	**$713**
Retiree & Spouse with Medicare	**$1,397**
Retiree with & Spouse w/out Medicare	**$1,445**
Retiree w/out & Spouse with Medicare	**$1,478**
Retiree with & Child w/out Medicare	**$1,445**
Retiree with & Children w/out Medicare	**$1,930**
Retiree & Spouse with & Child w/out Medicare	**$2,129**
Retiree & Spouse with & Children w/out Medicare	**$2,614**
Retiree with, Spouse & Child(ren) w/out Medicare	**$1,930**
Retiree & Child(ren) w/out & Spouse with Medicare	**$2,174**
DEDUCTIBLE	**$250/individual | $750/family aggregate maximum**
PHYSICIAN SERVICES	
Office Visits	$10 per visit
Online Office Visits (www.livehealthonline.com)	$10 per visit
Well baby & child care (birth through age 6)	No copay
Immunizations (birth through age 6)	No copay
Preventive Care (persons age 7 and older)	No copay
Diagnostic lab & X-ray	20%
Specialist Consultation	$10 per visit
Radiation Therapy, Chemotherapy, and Hemodialysis treatment	20%
INPATIENT HOSPITAL SERVICES	
Physician visits	20%, includes skilled nursing facility visits
Surgeon & surgical assistant; anesthesiologist or anesthetist	20%
Preauthorized semi-private room	20%
Intensive/coronary care unit	20%
Operating room and anesthesia	20%
X-ray, laboratory testing-diagnostic studies	20%
MENTAL HEALTH	
Inpatient	20%, preauthorization required, waived for emergency admissions
Outpatient physician visits	$10 per visit
SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY	
Inpatient	20%, preauthorization required, waived for emergency admissions
Outpatient physician visits	$10 per visit
EMERGENCY ROOM	20%- $50 deductible per visit (waived if admitted)
AMBULANCE	20%
DURABLE MEDICAL EQUIPMENT	20% - **Hearing aid provision will now be separated from the Durable Medical Equipment Benefit, limited to 1 hearing aid per ear every three years**
PROSTHETIC DEVICES	20%
LIFETIME MAXIMUM	Unlimited
PRESCRIPTION DRUGS	
Generic / Brand Name / Non-formulary	$5 /$10 / $40, 30 day supply
Mail Order Pharmacy	$10 / $20 / $80, 90 day supply
PHYSICAL THERAPY, PHYSICAL MEDICINE, OCCUPATIONAL THERAPY & CHIROPRACTIC	20% Chiropractic – limited to 30 visits per year

RSA BENEFIT TRUST

MAIL ORDER PRESCRIPTION

DRUG PROGRAM

Get your monthly prescriptions mailed directly to your home –

GET THREE MONTHS FOR THE PRICE OF TWO!

SAVE MONEY, GO GENERIC!

KAISER PERMANENTE

Kaiser Permanente has a prescription mail service for your convenience through their Pharmacy. Kaiser will ship a 100-day supply of your prescribed medication. There is no charge for shipping and most orders arrive in as little as three days. Ordering available online or via phone.

	Kaiser HMO (Non-Medicare)		Kaiser Senior Advantage	
	Retail	Mail Order	Retail	Mail Order
Supply	30 Days	31-100 Days	30 Days	31-100 Days
Generic Copay	$0	$0	$5	$10
Brand Copay	$10	$20	$10	$20

ANTHEM BLUE CROSS

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

	Anthem HMO (Non-MEDICARE)		Anthem HMO Select (Non- MEDICARE)		Anthem PPO	
	Retail	Mail Order	Retail	Mail Order	Retail	Mail Order
Supply	30 Days	90 Days	30 Days	90 Days	30 Days	90 Days
Generic Copay	$0	$0	$0	$0	$5	$10
Brand Copay	$10	$20	$35	$70	$10	$20
Non-Formulary Copay	$40	$80	$50	$100	$40	$80
Deductable	None		$250 (waived for generic)		None	

RSA's **FREE** Wellness Program

You can earn **$580 a year** just by taking some small steps that lead to big changes.

Virgin Pulse

1. Sign up at join.virginpulse.com
2. Accept the Terms and Conditions
3. Connect a Fitness Tracker
4. Create Profile and Add Friends
5. Download the App

Download on the App Store | GET IT ON Google Play

All members and spouses enrolled in an RSA medical plan are eligible!

2023 DENTAL PLAN

UnitedHealthcare DELTA DENTAL

	DMO D125H	DMO D1065	HMO CA11A	PPO Plan	
Deductions per Pay Period:					
MEMBER ONLY	**$18.00**	**$29.40**	**$19.00**	**$49.00**	
MEMBER + ONE DEPENDENT	**$32.00**	**$48.18**	**$34.00**	**$85.26**	
MEMBER + 2 or MORE DEPENDENTS	**$49.00**	**$71.14**	**$49.00**	**$140.14**	
NETWORK	**CA Select DHMO**	**CA Select Direct Compensation**	**DeltaCare®**	**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
DIAGNOSTIC AND PREVENTIVE EXEMPT FROM MAXIMUM				Yes	Yes
DEDUCTIBLE	None	None	None	None	$50, waived for preventive services
PREVENTIVE SERVICES					
Office Visit / 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)	No Charge 1 per 6 month	No Charge 1 per 6 month	No Charge 1 per 6 month	No Charge 2 Per Calendar Year	
Topical fluoride treatments	No Charge	No Charge	No Charge	No Charge	No Charge
RESTORATIVE SERVICES					
Amalgam - 1, 2, or 3 tooth surface	No Charge	No Charge	No Charge	20%	50%
CROWN, CAST AND PROSTHETICS**					
Crown 3/4 cast metal	$125	No Charge	$210	40%	50%
Resin Crown (Not for molars)	$125	No Charge	$95-$195	40%	50%
Porcelain / Ceramic (Not for molars)	$215	No Charge	$240	40%	50%
Pontic cast noble metal	$125	No Charge	$150	40%	50%
Pontic porcelain fused to metal	$125	No Charge	$140-$240	40%	50%
ENDODONTICS					
Root Canal – anterior	$45	No Charge	$55	20%	50%
Root Canal – bicuspid	$75	No Charge	$120	20%	50%
Root Canal – molar	$115	No Charge	$250	20%	50%
DENTURES					
Complete upper or lower	$150	No Charge	$145	40%	50%
Partial upper or lower	$115	No Charge	$120-$160	40%	50%
Adjust full upper or lower	$0	No Charge	$10	40%	50%
Add tooth or clasp	$15	No Charge	$10	40%	50%
Reline full upper or lower	$40	No Charge	$60	40%	50%
PERIODONTICS					
Gingivectomy per quadrant	$50	No Charge	$80-$130	20%	50%
Gingivectomy per tooth	$35	No Charge	$80-$130	20%	50%
ORAL SURGERY					
Simple extraction - single tooth	No Charge	No Charge	No Charge	20%	50%
Removal of impacted tooth (soft tissue)	$25	No Charge	$50	20%	50%
ORTHODONTICS					
Start-up Fee	$250	$350	$200	Not Applicable	
Adolescent	$1,895	$750	$1,700	50%, max $2,000	
Adult	$1,895	$750	$1,900	50%, max $2,000	

*Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists

** 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.)

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.

2023 VISION PLAN

Note: MES ID cards are not distributed. Let your provider know you are a member of MES and they will look you up using your SSN.

mesvision®

	Member Deductions per Pay Period:	
Member Only	**$8.50**	
Member + 1 Dependent	**$15.50**	
Member + 2 or more Dependents	**$22.00**	
Copay:	$10.00	
Comprehensive Eye Exam:	No Charge (One Every 12 Months)	
Lenses:	One Pair Every 12 Months	
	In-Network Allowance	Out of Network Allowance
Single Vision Lenses	Covered	Up to $30
Bifocal Lenses	Covered	Up to $50
Trifocal Lenses	Covered	Up to $65
Standard Progressive Lenses	Covered	Up to $65
Frames:	One Frame Every 12 Months	
Standard (eyesize less than 61 milimeters)	Up to $150	Up to $75
Contact Lenses (in lieu of frames):	One Pair Every 12 Months	
Medical Necessary	Covered	Up to $250
Cosmetic or Convenience	Up to $150	Up to $150

A comprehensive eye exam is good for your health!

Many illnesses can be detected at an annual vision exam such as:

- diabetes
- high cholesterol
- cancer
- tumors

Make sure to get your eyes checked yearly!

Open Enrollment Checklist

- [ ] Review 2023 Open Enrollment Booklet
- [ ] Log into PlanSource and Make Changes:
  - Update Contact Information
  - Update Dependent(s)
    - If Adding or Removing
- [ ] Submit Documentation to Benefit Trust if making Dependent Changes
- [ ] Sign Up for Virgin Pulse
- [ ] Sign Up for Medicare 30 Days before Birthday

CONTACTS

RSA BENEFITS OFFICE:

Office Hours:

Monday:	8am - 5pm
Tuesday:	8am - 5pm
Wednesday:	8am - 5pm
Thursday:	8am - 5pm
Friday:	CLOSED
Saturday:	CLOSED
Sunday:	CLOSED

Main

- www.rcdsa.org/benefittrust/
  - (951) 653-8014
  - RSABenefits@rcdsa.org
- Connie Collins, Benefits Administrative Assistant
  - connie@rcdsa.org
- Lauren Driffill, Benefits Assistant
  - lauren@rcdsa.org
- Maryann Barbaro, Benefits Assistant
  - mikki@rcdsa.org
- Sandi Lowman, Benefits Assistant
  - sandi@rcdsa.org

Brown Insurance

- Third Party Administrators
  - (714) 460-7744
- Janelle Regan, Benefit Trust Administrative Officer
  - janelle@brownbis.com
  - (714) 425-8552
- Inquires: Julio Tirado
  - julio@brownbis.com
  - (888) 346-6966; Fax (714) 460-7755

MEDICAL INSURANCE:

- Anthem
  - HMO (Cal Care) (800) 227-3771
  - Select HMO (800) 227-3771
  - PPO (800) 288-6921
  - EPO (800) 288-2539
  - Fee for Service (Out of State Medicare Enrollees) (800) 288-2539
  - Blue Card PPO (Out of State Plan) (800) 288-2539
  - Ingenio Rx (833) 261-2460
  - Guest Membership (800) 827-6422
  - Away From Home (Urgent Care when traveling in the U.S.) (800) 810-2583 (800) 390-3510
- Kaiser Permanente

DENTAL INSURANCE :

- United Health Care
  - DMO D125H (800) 228-3384
  - DMO D1065 (800) 999-3367
- Delta Dental
  - Delta PPO (800) 765-6003
  - Delta Care HMO (800) 422-4234

VISION INSURANCE:

- MES Vision (800) 877-6372

SUPLEMENTAL BENEFITS:

- AFLAC – Cancer, Intensive Care, Hospital, & Accident
  - Nicki Albright
    - nicki_albright@us.aflac.com
  - Lisa Coots
    - lisa_coots@aflac.com
- Equitable Advisors (formerly AXA) – Life Insurance, Long Term Care, and Investments
  - Samantha Curtin
    - Sam.Curtin@equitable.com
    - (949) 833-5840
- CalPERS
  - (888) 225-7377
- CLEA - Long Term Disability policy/Life Insurance
  - (800) 832-7333
- County of Riverside Benefits Information Line
  - (951) 955-4981
- The Counseling Team International
  - (800) 222-9691
- Nationwide
  - (877) 677-3678
- Valic
  - (800) 982-5558
- VirginPulse
  - www.virginpulse.com

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 are 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, you must live or work within 15 miles or 30 minutes of your medical group. 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 copayment.**

Anthem PPO
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 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 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 17 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 Date of Notice: September 15, 2022

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

GENERAL PRIVACY RULES

The Board of Trustees, as the Plan Sponsor of the Riverside Sheriffs' Association Benefit Trust Health Plan (the "Plan") is required by law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information, and to notify you if there is a breach of your unsecured protected health information.

This notice describes the Plan's legal duties and privacy practices including:

- The Plan's uses and disclosures of protected health information;
- Your privacy rights with respect to such information;
- The Plan's duties with respect to such information;
- The person or office to contact for further information about the Plan's privacy practices.

Section 1.Notice of Uses and Disclosures

- (a) Required Uses and Disclosures. Upon your request, the Plan is required to give you access to certain protected health information, which includes all individually identifiable health information in order to inspect and copy it. Use and disclosure of your protected health information may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulation
- (b) Uses and disclosures to carry out treatment, payment and health care operations without your consent or authorization. The Plan and its business associates will use protected health information without your consent, authorization or opportunity to agree or object to carry out "treatment, payment and health care operations" as defined below.
  - (i) *Treatment* is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, your pharmacy may contact your treating physician to refill your prescription for medication.
  - (ii) *Payment* includes but is not limited to actions to make coverage determinations and to provide payment for the treatment you receive (including billing, claims management, Plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may use and disclose your protected health information to tell a doctor whether you are eligible for coverage or what percentage of a bill will be paid by the Plan.
  - (iii) *Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts and related business services. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs and audit the accuracy of its claims processing functions.
- (c) Other uses and disclosures for which consent, authorization or opportunity to object is not required. Use and disclosure of your protected health information is allowed without your consent, authorization or request under the following circumstances:
  - (i) When required by law. The Plan may use and disclose your protected health information when required by law, and when the use or disclosure complies with and is limited to the relevant requirement of such law.
  - (ii) When permitted for purposes of public health activities. For example, PHI may be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
  - (iii) Reports about victims of abuse, neglect or domestic violence to government entities. The Plan will disclose your protected health information in these reports only if the Plan is required or authorized to do so by law, or if you otherwise agree. In such case the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such disclosure has or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's protected health information.
  - (iv) To a public health oversight agencies. The Plan will provide protected health information as requested to government agencies that have the authority to audit our operations. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensures or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
  - (v) When required for judicial or administrative proceedings, provided certain conditions are met. Those conditions include that satisfactory assurances are given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
  - (vi) When required for law enforcement purposes. The Plan may release protected health information if asked to do so by a law enforcement official in the following circumstances: (1) to respond to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person, (3) to assist the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement, (4) to investigate a death the Plan believes may be due to criminal conduct, (5) to investigate criminal conduct, and (6) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).
  - (vii) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

- (viii) Organ procurement. The Plan may disclose protected health information to facilitate organ donation and transplantation.
- (ix) Medical research. The Plan may disclose protected health information for medical research projects, subject to strict legal restrictions. (x) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- (xi) Special government functions. The Plan may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.
- (xii) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

- (d) Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or disclosure. Disclosure of your protected health information to family members, other relatives and your close personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.
- (e) Uses and disclosures that require your written authorization or consent.
  - (i) In general, the Plan will obtain a written authorization before using or disclosing your protected health information whenever it is required to do so under the privacy rules. For example, we will not supply confidential information to another company for its marketing purposes (unless it is for Health Care Operations), for sale (unless under strict legal restrictions), or to a potential employer with whom you are seeking employment without your signed authorization. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. The Plan may use and disclose psychotherapy notes when needed by the Plan to defend against litigation filed by you. The Plan will not disclose to third parties the results of genetic testing in a manner which includes individually identifying characteristics without your written authorization, nor will it use or disclose your genetic information for underwriting purposes.
  - (ii) The Plan may require your consent to disclose protected health information, even to carry out treatment, payment or health care operations, to certain individuals or organizations. For example, if your union representative is helping you with a claim the Plan may require you to sign a consent form before it will disclose protected health information to that person.
  - (iii) Other uses and disclosures not described in this notices will be made only with your written authorization.
  - (iv) You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions the Plan has already taken.

Section 2. Rights of Individuals

- (a) Right to Request Restrictions on Protected Health Information Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. While the Plan will consider all requests for restrictions carefully, the Plan is not required to agree to your request. However, the Plan must comply with your request to restrict disclosure of your protected health information for payment or health care operations purposes if you paid for these services in full, out of pocket. Such requests should be made to the individual identified in Section 5.
- (b) Right to Receive Confidential Communications of PHI. The Plan will accommodate reasonable requests to receive communications of protected health information by alternative means or at alternative locations. The Plan must agree to your request if you state that disclosure of the information will put you in danger. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information. Such request should be made to the individual identified in Section 5.
- (c) Right to Inspect and Copy Protected Health Information. Except under certain circumstances limited by law, you have a right to inspect and obtain a copy of your protected health information "in a designated record set" for as long as the Plan maintains the protected health information.

"Protected health information" includes all individually identifiable health information transmitted or maintained by the Plan regardless of form.

"Designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual. If you request copies of your protected health information, the Plan may charge a reasonable fee to cover the cost.

You or your personal representative will be required to complete a form to request access to the protected health information. Requests for access to protected health information should be made to the individual identified in Section 5. If access is denied, you and your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise rights to review and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

- (d) Right to Amend Protected Health Information. You have the right to request that the individual identified in Section 5 amend your protected health information or a record about you in a designated record set for as long as the protected health information is maintained by the Plan. You or your personal representative will be required to complete a form to request amendment of the protected health information. The Plan may deny your request if you ask us to amend information that: (i) was not created by the Plan, unless the person who created the information is no longer available to make the amendment, (ii) is not part of the protected health information we keep about you, (iii) is not part of the protected health information that you would be allowed to see or copy, or, (iv) is determined by the Plan to be accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

- (e) The Right to Receive an Accounting of Protected Health Information Disclosures. You have the right to request a list of protected health information disclosures, which is also referred to as an accounting.

The list will not include disclosures the Plan has made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment, and health care operation purposes (except as noted in the last paragraph of this subsection (d)). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include disclosures the Plan has made for national security purposes or law enforcement personnel or disclosures made before April 14, 2003.

The list provided by the Plan will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period. The first list you request within a 12 month period will be free. You may be charged a reasonable fee for providing any additional lists within a 12- month period.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

You may also request and receive an accounting of disclosures made by the Plan for payment, treatment, or health care operations during the prior three years for disclosures made as of January 1, 2014 for electronic health records acquired before January 1, 2009, or January 1, 2011 for electronic health records acquired on or after January 1, 2009.

- (f) Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your protected health information or allowed to take any action for you. Proof of such authority may take one of the following forms: (1) A power of attorney for health care purposes, notarized by a notary public, (2) A court order of appointment of the person as the conservator or guardian of the individual, or (3) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

- (g) Right to Request a Paper Copy. If you agree to receive this Privacy Notice electronically, you have the right to obtain a paper copy of this Privacy Notice upon request from the individual identified in Section 5.

Section 3. The Plan's Duties

- (a) General Duty. The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any protected health information received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains protected health information. The revised notice will be mailed to all active and retired plan participants. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.
- (b) Minimum Necessary Standard. When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the Limited Data Set, or if necessary, the minimum necessary information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:
  - (i) Disclosures to or requests by a health care provider for treatment;
  - (ii) Uses or disclosures made to the participant or beneficiary;
  - (iii) Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
  - (iv) Uses or disclosures that are required by law; and
  - (v) Uses or disclosures that are required for the Plan's compliance with legal regulations.
- (c) De-Identified Information. This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

In addition, the Plan may use or disclose "summary health information" for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File A Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer named in Section 5 below, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, put your complaint in writing and address it to the Privacy Officer named in Section 5 below. The Plan will not retaliate against you for filing a complaint.

You may also contact the Privacy Officer if you have questions or comments about our privacy practices. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services online at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mailing your complaint to the appropriate the HHS Regional office. The list of regional offices can be found at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html. If you need help filing a complaint or have a question about the complaint or consent forms, please e-mail OCR at OCRComplaint@hhs.gov.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact:

Riverside Sheriffs' Association
21800 Cactus Ave
Riverside, CA 92518
Office: 951-653-5152

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 in 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. **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.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's 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 15, 2021
- Name of Entity/Sender: Brown Insurance Services for RSA
- Contact--Position/Office: Diana Leiter - Administrator
- Address: 316 S. Tustin Street, Orange, CA 92866
- Phone Number: (714) 460-7744 or (888) 346-6966

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

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998.

In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Each of the medical plan options available through the Fresno Unified School District Health Plan currently covers mastectomies and reconstructive surgery. Coverage is subject to each plan's deductibles, coinsurance and benefit provisions. These provisions are generally described in the Plan Booklet or Explanation of Coverage.

NEWBORN MOTHERS HEALTH PROTECTION ACT

Under the Newborn and Mothers Health Protection Act, the following language is now included in the Health Plan:

The Plan will provide for a hospital stay of no less than 48 hours for the eligible mother and newborn child following a normal delivery and no less than 96 hours for a cesarean birth, unless an attending physician in consultation with the mother approves an earlier discharge. The time periods outlined above begin at the birth of the child. The law also prohibits a plan from requiring health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

Riverside Sheriff's Association
21800 Cactus Avenue
Riverside, CA 92518

2023 Open Enrollment

October 1, 2022 - October 31, 2022

Mid Year Changes

Within 30 days of Life Events

benefits.plansource.com