RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST RETIREE AND MEDICARE PLAN PARTICIPANTS

OPEN ENROLLMENT

Your 2012 Benefits Brochure

If you and/or your dependants become eligible for Medicare in the next 12 months please contact the Benefit Trust Office as your Premium Amounts will change

Inside Information

RIVERSIDE SHERIFFS' ASSOCIATION
BENEFIT TRUST RETIREE
OPEN ENROLLMENT 2012

IMPORTANT RETIREE 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.

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 plans that you have with the RSA Benefit Trust to determine if you wish to make any changes. 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).

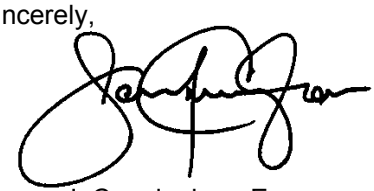
Be sure to stop by the RSA Health Fair at the Sheriff's Picnic on Saturday, October 15, 2011, from 10:00 a.m. – 5:00 p.m., at Diamond Valley Lake Community Park in Hemet. You can make your plan changes at the picnic if you wish!

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,



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

IMPORTANT HEALTH PLAN CHANGES EFFECTIVE JANUARY 1, 2012
PLEASE REVIEW

Plans Affected	*Changes*
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 an 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.

Riverside Sheriffs' Association Benefit Trust Retiree Open Enrollment 2012

Open Enrollment Dates

Open enrollment will be held from **October 1 – 31 from 8 a.m. – 5 p.m. Monday through Friday,** with the exception of October 10 in observance of Columbus Day. Open enrollment change 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 retiree monthly premium selection 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.

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 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 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

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 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
- 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.

Medicare Eligibility

Several months before you or your spouse turn 65, it is important to contact the Social Security office regarding Medicare enrollment. 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.

Please contact the Benefits Office at (951) 653-8014 to request an application for your appropriate medical plan at the same time you contact Social Security. All of our insurance carriers have Medicare options available. If you enrolled in Anthem, you will not have to change providers.

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. Insurance carriers will *increase* premiums for those members who are eligible for Medicare, but have not yet submitted paperwork. Medicare will not give reimbursement for those premiums. Participants will be required to pay the higher premiums until the insurance carriers receive the paperwork.

By enrolling in a supplemental Medicare plan, your medical premiums will be decreased through the RSA Benefit Trust. For rate information please contact the Benefits Office. Social Security will deduct your Medicare premium from your Social Security check.

If you have any questions about retiree coverage please contact the Benefits Office at (951) 653-8014, Brown Insurance Services at (714) 460-7744, or 1-800-Medicare.

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 B in some cases and through this plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

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

2012 Retiree Non-Medicare HMO Comparison
Rates Do Not Reflect County Contribution
And/or RAP Benefit, If Applicable

	KAISER	ANTHEM SELECT HMO CA CARE	ANTHEM HMO CA CARE	ANTHEM EPO PLAN (Blythe Only)
MONTHLY RATES				
RETIREE ONLY	**$582.00**	**$541.00**	**$634.00**	**$634.00**
RETIREE + SPOUSE	**$970.00**	**$813.00**	**$954.00**	**$954.00**
RETIREE + CHILD(REN)	**$939.00**	**$788.00**	**$925.00**	**$925.00**
RETIREE +FAMILY	**$1213.00**	**$1011.00**	**$1187.00**	**$1187.00**
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	No charge	No charge	No charge	No charge
Immunizations	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	$0 copay Pre-authorization Required	$0 copay - hospital, $10 co-pay - physician hospital visits Pre-authorization Required
SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY				
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 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	No charge Limit of 1 hearing aid per ear every three yrs.	No charge; Limit of 1 hearing aid per ear every three years	No charge; Limit of 1 hearing aid per ear every three years
HOME HEALTH CARE BENEFIT	No Charge	$20/visit - 100 visits per cal year	$10 copay: 100 visits per cal year	$0 copay; 100 visits per cal year
PROSTHETIC DEVICES	No charge	No Charge	No charge	$0 copay
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/Visits / (combined with physical therapy) Limited to a 60 day period of care after an illness or injury	No charge, 24 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.

2012 Retiree Non-Medicare POINT-OF-SERVICE
Rates Do Not Reflect County Contribution
And/or RAP Benefit, If Applicable

MONTHLY RATES			
RETIREE ONLY	**$717.00**		
RETIREE + SPOUSE	**$1393.00**		
RETIREE + CHILD(REN)	**$1371.00**		
RETIREE + FAMILY	**$1821.00**		
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	No charge Preauthorization required	No Charge Preauthorization required
SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY			
Outpatient	$10 per visit / Utilization review required after 12 visits	$20 per visit / Utilization required after 12 visits	40% / Utilization 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; Hearing aids limited to 1 hearing aid per ear every 3 years	20%; ; Hearing aids limited to 1 hearing aid per ear every 3 years	40%; ; Hearing aids limited to 1 hearing aid per ear every 3 years
ORTHOTIC & PROSTHETIC DEVICES	No charge	20%; $1,000 max benefit/yr	40%; $1,000 max benefit/yr
ANNUAL OUT OF POCKET MAXIMUM	$1500 Individual $3000 Family	$3000 Individual / $6000 Family PPO & Opt-Out Providers Combined	
LIFETIME MAXIMUM	N/A	Unlimited	
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		

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 Retiree Non-Medicare BLUE CARD (Out-of-State)
Rates Do Not Reflect County Contribution
And/or RAP Benefit, If Applicable

MONTHLY RATES		
RETIREE ONLY	**$797.00**	
RETIREE + SPOUSE	**$1669.00**	
RETIREE + CHILD(REN)	**$1645.00**	
RETIREE + FAMILY	**$2387.00**	
DEDUCTIBLE	**$250 / $500 / $750**	**$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 through age six	No charge	40%, limited to $20 per exam
Immunizations birth through age six	No charge	40%, limited to $12 per immunization
Physical Exam 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	40% deductible waived
Vision & Hearing Screening	Not covered	Not covered
Diagnostic lab & x-ray	20%	40%
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	$10 per visit Utilization review required after 12 visits	40% Utilization review required after 12 visits
Inpatient	10% Pre-authorization required	40% Pre-authorization required
SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY		
Outpatient	$10 per visit Utilization review required after 12 visits	40% Utilization review required after 12 visits
Inpatient; as medically necessary	10% Pre-authorization required	40% Pre-authorization required
EMERGENCY ROOM	20% after $100 ded, waived if admitted	20% after $100 ded, waived if admitted
AMBULANCE	20%	20%
DURABLE MEDICAL EQUIPMENT	20%, hearing aids limited to 1 hearing aid per ear every three years	40%, hearing aids limited to 1 hearing aid per ear every three years
PROSTHETIC DEVICES	20%	40%
ANNUAL OUT OF POCKET MAXIMUM	$2000 individual / $4000 family	$6000 individual / $12000 family
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
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.

2012 HMO Comparison Medicare Parts A & B
Insurance Carriers Prescription Coverage Part D
Rates Do Not Reflect County Contribution And/or RAP Benefit, If Applicable

	KAISER	ANTHEM SELECT HMO CALIFORNIACARE	ANTHEM HMO CALIFORNIACARE	ANTHEM EPO PLAN (Blythe Only)
MONTHLY RATES				
Retiree with Medicare	**252.00**	**278.00**	**284.00**	**284.00**
Retiree & Spouse with Medicare	**491.00**	**545.00**	**556.00**	**556.00**
Retiree with & Spouse w/out Medicare	**640.00**	**538.00**	**589.00**	**589.00**
Retiree w/out & Spouse with Medicare	**821.00**	**783.00**	**878.00**	**878.00**
Retiree with & Child w/out Medicare	**609.00**	**538.00**	**589.00**	**589.00**
Retiree with & Children w/out Medicare	**609.00**	**727.00**	**818.00**	**818.00**
Retiree & Spouse with & Child w/out Medicare	**734.00**	**805.00**	**861.00**	**861.00**
Retiree & Spouse with & Children w/out Medicare	**734.00**	**994.00**	**1090.00**	**1090.00**
Retiree with, Spouse & Child(ren) w/out Medicare	**883.00**	**727.00**	**818.00**	**818.00**
Retiree & Child(ren) w/out & Spouse with Medicare	**1064.00**	**1019.00**	**1155.00**	**1155.00**
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	$10 per visit	No charge	No charge	No charge
Immunizations	$10 per visit	No charge	No charge	No charge
Vision & Hearing Screening	$10 per visit	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	$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/individual $5/group	$20 per visit; Utilization review required after 12 visits	$10 per visit; Utilization review req. after 12 visits	$10 per visit; Utilization review required after 12 visits
Inpatient	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	$20 per visit; Utilization review required after 12 visits	$10 per visit; Utilization review req. after 12 visits	$10 per visit; Utilization review required after 12 visits
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	No charge/ Limit of 1 hearing aid per ear every three years	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	$20/visit - 100 visits per cal yr	$10/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	$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/Visits / (combined with physical therapy) Limited to a 60 day period of care after an illness or injury	No charge, 24 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

2012 Point-Of-Service Medicare Parts A & B
Insurance Carriers Prescription Coverage Part D
Rates Do Not Include County Contribution
And/or RAP Benefit, If Applicable

MONTHLY RATES			
Retiree with Medicare	**$417.00**		
Retiree & Spouse with Medicare	**$823.00**		
Retiree with & Spouse w/out Medicare	**$1093.00**		
Retiree w/out & Spouse with Medicare	**$1122.00**		
Retiree with & Child w/out Medicare	**$1093.00**		
Retiree with & Children w/out Medicare	**$1521.00**		
Retiree & Spouse with & Child w/out Medicare	**$1499.00**		
Retiree & Spouse with & Children w/out Medicare	**$1927.00**		
Retiree with, Spouse & Child(ren) w/out Medicare	**$1521.00**		
Retiree & Child(ren) w/out & Spouse with Medicare	**$1776.00**		
DEDUCTIBLE	**None**	**$250 / $750 aggregate max**	**$250 / $750 aggregate max**
PHYSICIAN SERVICES	**HMO**	**PPO**	**OPT OUT**
Office Visits	$10 per visit	$20 per visit, ded waived	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 in physician office	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, ded waived	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;Utilization review required after 12 visits	$20; Utilization review required after 12 visits	40%; Utilization review required after 12 visits
Inpatient	No charge Pre-authorization required	No charge Pre-authorization required	40% Pre-authorization required
SUBSTANCE ABUSE; ALCOHOL AND CHEMICAL DEPENDENCY			
Outpatient	$10;Utilization review required after 12 visits	$20; Utilization review required after 12 visits	40%; Utilization review required after 12 visits
Inpatient; as medically necessary	No charge Pre-authorization required	No charge Pre-authorization required	40% Pre-authorization 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; limit of 1 hearing aid per ear every three years	20%; limit of 1 hearing aid per ear every three years	40%; limit of 1 hearing aid per ear every three years
PROSTHETIC DEVICES	No charge	20%	40%
ANNUAL OUT OF POCKET MAXIMUM Individual/Family	$1500 / $3000 All Providers Combined	$3000 Individual / $6000 Family PPO & Opt-Out Providers Combined	
LIFETIME MAXIMUM	N/A	Unlimited	
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, Comb. with physical therapy	$5/visit 20 visits/year	40% Combined with physical therapy

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 Retiree Fee-For-Service (Out-of-State) Medicare Parts A & B
Insurance Carrier Prescription Coverage Part D
Rates Do Not Include 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	**$587.00**
Retiree & Spouse with Medicare	**$1162.00**
Retiree with & Spouse w/out Medicare	**$1458.00**
Retiree w/out & Spouse with Medicare	**$1372.00**
Retiree with & Child w/out Medicare	**$1458.00**
Retiree with & Children w/out Medicare	**$2177.00**
Retiree & Spouse with & Child w/out Medicare	**$2033.00**
Retiree & Spouse with & Children w/out Medicare	**$2752.00**
Retiree with, Spouse & Child(ren) w/out Medicare	**$2177.00**
Retiree & Child(ren) w/out & Spouse with Medicare	**$2220.00**
DEDUCTIBLE	**$250 / $750 aggregate maximum**
PHYSICIAN SERVICES	
Office Visits	$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%
MATERNITY CARE SERVICES	
Pre/Post-natal maternity visits	$10 per visit
Delivery/Newborn care	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% - $25 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%, limited to $25/visit & 24 visits calendar year; Additional visits may be authorized

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 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	**Anthem Select**	**Anthem**
Monthly Amount	Monthly Amount	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	**Prescription Drugs Mail Order**	**Prescription Drugs Mail Order**
100 Day supply	90 Day Supply	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 RETIREE DENTAL PLANS

	UHC DENTAL (DHMO D0103)	UHC DENTAL (Union D0266)	DELTA CARE / PMI HMO Plan CAA22	DELTA PREFERRED OPTION PPO Plan	
MONTHLY RATES					
Retiree Only	**$18.00**	**$26.00**	**$18.00**	**$48.00**	
Retiree + One Dependent	**$32.00**	**$42.60**	**$32.00**	**$83.50**	
Retiree + Two or More Dependents	**$49.00**	**$62.90**	**$46.00**	**$138.00**	
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	$1700	$1,600	50%, max $2,000	50%, max $2,000
Adult	$1,895	$1700	$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 RETIREE VISION PLANS

	Medical Eye Services PPO Vision Plan
	Full Service* (exam, frames & lenses)
MONTHLY RATES	
Retiree Only	**$8.50**
Retiree + 1 Dependent	**$15.50**
Retiree + 2 or more Dependents	**$22.00**
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.

Out of State Medical Plans

The RSA Benefit Trust has an **Out Of State Retiree Assistance Program Reimbursement Option**. An eligible retiree shall be eligible for a reimbursement of insurance premium up to the maximum accrued RAP rate, provided that certain requirements are met. All out of state retirees still have the continued option of enrolling in the Blue Card plan. For further information, call the Benefits Trust office at (951) 653-8014.

YOUR CONTACTS

Benefits Office		(951) 653-8014	www.rcdsa.org
	Fax:	(951) 653-9204	RSA Benefit Trust Page
James Cunningham *Trust Administrator*		(619) 297-6900	jjc@sdlaborlaw.com
Linda Gartley *Benefits Manager*		(951) 653-8014 Ext. 222	Linda@rcdsa.org
Connie Collins *Benefit Administrative Assistant*		(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	(800) 288-2539	
	(Out of State Medicare Enrollees)		
	Blue Card PPO	(800) 288-2539	
	(Out of State Plan)		
	Express Scripts	(866) 297-1013	
	Guest Membership	(800) 827-6422	
	Away from Home	(800) 810-BLUE (2583)	
	(Urgent Care when you're traveling in the U.S.)		
Kaiser Permanente		(800) 390-3510	www.kp.org
Dental Insurance Carriers			
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
Vision Insurance Carrier			
MES Vision		(800) 877-6372	www.mesvision.com
Supplemental Insurances			
Brown Insurance Services *(Retiree/AWOP Billings)*		(888) 346-6966	www.brownbis.com
Samantha Curtin *(Life insurance quotes/comparisons)*		(888) 346-6966	Samantha@brownbis.com
AFLAC – Nicki Turner *Cancer, Intensive Care, Hospital, & Accident*		(714) 328-0225	nicki_turner@us.aflac.com
Homeowners, Auto, Miscellaneous Insurances			
Brown Insurance Services		(888) 346-6966	www.brownbis.com
Liberty Mutual			www.libertymutual.com
Cynthia Kelley, w/Liberty Mutual		(760) 930-0841 Ext. 7158245	
Nationwide		(877) 677-3678	www.nationwide.com
Valic	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.
- **<u>If you do not want to keep your children on your plan until age 26,</u>** 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. <u>This applies to medical and pharmacy benefits only; not dental or vision</u>.

- **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 heath-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 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. **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 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;
- Prostheses; 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 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
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
Sheriff's Department 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, turn left onto Anglers Ave.

Representatives from Blue Cross, 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


RIVERSIDE SHERIFFS' ASSOCIATION
BENEFIT TRUST