LOS RIOS COMMUNITY COLLEGE DISTRICT
1919 SPANOS COURT
SACRAMENTO, CA 95825

DATE: April 24, 2018

TO: SEIU Employees (with an assignment of 0.50 FTE or greater)

FROM: Theresa Matista, Deputy Chancellor

SUBJECT: 2018-19 OPEN ENROLLMENT

Open Enrollment for Medical, Dental, Vision, & Life Insurance is April 30 – May 25, 2018

Attached, please find a comprehensive guide covering the Los Rios Community College District employee benefits available to you. Included in this guide is everything you'll need to know about Open Enrollment, including the following topics:

- Changes effective July 1, 2018:
  - New Kaiser HDHP HMO option
  - The District HSA Contribution to the Sutter Health Plus High Deductible Health Plan (SHP HDHP) is changing to $75 for single coverage and $75 for family coverage
  - Revised Sutter Health Plus HMO plan design
- How to enroll (or make changes) in the Los Rios plans and medical insurance plan information
- List of providers with group numbers, telephone numbers and websites

The District contribution for SEIU members will remain at $1,233.63 per month for 2018-19. Below are the monthly premiums effective July 1, 2018:

Plan	Monthly Premium	Monthly District Contribution	Employee Monthly Contribution	Employee Tenthly Contribution	*Change in Employee Contribution from 2017-18:*	
					Monthly	*Tenthly*
Kaiser HMO	$1,397.51	$1,233.63	$163.88	$196.66	*$0.00*	*$0.00*
Kaiser DHMO	$1,292.28	$1,233.63	$58.65	$70.38	*$25.34*	*$30.41*
Kaiser HDHP HMO	$980.16	$980.16	$0.00	$0.00	*N/A*	*N/A*
Sutter Health Plus HMO	$1,398.62	$1,233.63	$164.99	$197.99	*$35.61*	*$42.73*
Sutter Health Plus HDHP HMO	$1,150.62	$1,150.62	$0.00	$0.00	*$0.00*	*$0.00*
WHA HMO	$1,279.91	$1,233.63	$46.28	$55.54	*$9.06*	*$10.87*
WHA 1800 HDHP HMO	$939.23	$939.23	$0.00	$0.00	*$0.00*	*$0.00*

FROM:	TO:	July Change	August Change	Total Adjustment	Regular Tenthly Deduction	Total August 31st Deduction
KAISER HMO	**Kaiser HMO**	$0.00	$0.00	$0.00	$196.66	$196.66
	Kaiser DHMO	($105.23)	($105.23)	($210.46)	$70.38	($140.08)
	Kaiser HDHP	($163.88)	($163.88)	($327.76)	$0.00	($327.76)
	Sutter HMO	$1.11	$1.11	$2.22	$197.99	$200.21
	Sutter HDHP	($163.88)	($163.88)	($327.76)	$0.00	($327.76)
	WHA HMO	($117.60)	($117.60)	($235.20)	$55.54	($179.66)
	WHA 1800 HDHP	($163.88)	($163.88)	($327.76)	$0.00	($327.76)
KAISER DHMO	**Kaiser HMO**	$130.57	$130.57	$261.14	$196.66	$457.80
	Kaiser DHMO	$25.34	$25.34	$50.68	$70.38	$121.06
	Kaiser HDHP	($33.31)	($33.31)	($66.62)	$0.00	($66.62)
	Sutter HMO	$131.68	$131.68	$263.36	$197.99	$461.35
	Sutter HDHP	($33.31)	($33.31)	($66.62)	$0.00	($66.62)
	WHA HMO	$12.97	$12.97	$25.94	$55.54	$81.48
	WHA 1800 HDHP	($33.31)	($33.31)	($66.62)	$0.00	($66.62)
SHP HMO	**Kaiser HMO**	$34.50	$34.50	$69.00	$196.66	$265.66
	Kaiser DHMO	($70.73)	($70.73)	($141.46)	$70.38	($71.08)
	Kaiser HDHP	($129.38)	($129.38)	($258.76)	$0.00	($258.76)
	Sutter HMO	$35.61	$35.61	$71.22	$197.99	$269.21
	Sutter HDHP	($129.38)	($129.38)	($258.76)	$0.00	($258.76)
	WHA HMO	($83.10)	($83.10)	($166.20)	$55.54	($110.66)
	WHA 1800 HDHP	($129.38)	($129.38)	($258.76)	$0.00	($258.76)
Sutter HDHP	**Kaiser HMO**	$163.88	$163.88	$327.76	$196.66	$524.42
	Kaiser DHMO	$58.65	$58.65	$117.30	$70.38	$187.68
	Kaiser HDHP	$0.00	$0.00	$0.00	$0.00	$0.00
	Sutter HMO	$164.99	$164.99	$329.98	$197.99	$527.97
	Sutter HDHP	$0.00	$0.00	$0.00	$0.00	$0.00
	WHA HMO	$46.28	$46.28	$92.56	$55.54	$148.10
	WHA 1800 HDHP	$0.00	$0.00	$0.00	$0.00	$0.00
WHA HMO	**Kaiser HMO**	$126.66	$126.66	$253.32	$196.66	$449.98
	Kaiser DHMO	$21.43	$21.43	$42.86	$70.38	$113.24
	Kaiser HDHP	($37.22)	($37.22)	($74.44)	$0.00	($74.44)
	Sutter HMO	$127.77	$127.77	$255.54	$197.99	$453.53
	Sutter HDHP	($37.22)	($37.22)	($74.44)	$0.00	($74.44)
	WHA HMO	$9.06	$9.06	$18.12	$55.54	$73.66
	WHA 1800 HDHP	($37.22)	($37.22)	($74.44)	$0.00	($74.44)
WHA 1800 HDHP	**Kaiser HMO**	$163.88	$163.88	$327.76	$196.66	$524.42
	Kaiser DHMO	$58.65	$58.65	$117.30	$70.38	$187.68
	Kaiser HDHP	$0.00	$0.00	$0.00	$0.00	$0.00
	Sutter HMO	$164.99	$164.99	$329.98	$197.99	$527.97
	Sutter HDHP	$0.00	$0.00	$0.00	$0.00	$0.00
	WHA HMO	$46.28	$46.28	$92.56	$55.54	$148.10
	WHA 1800 HDHP	$0.00	$0.00	$0.00	$0.00	$0.00

Summer Adjustments

As you know, our medical plans renew on July 1st of each year and our monthly premiums change according to the new rates. For continuing 9 and 10-month employees, our first opportunity to make premium adjustments for the months of July and August will be on the August 31st pay warrant. Please see chart above for more detailed information.

If you wish to make a change, **original Open Enrollment forms MUST be received in the Employee Benefits Department by 5:00 p.m., Friday, May 25, 2018.**

Webinar and On-Site Open Enrollment Workshops

There will be an Open Enrollment Webinar on
Thursday, May 10, 2018 from 1:30 p.m. - 3:30 p.m.

Link to stream live on YouTube: https://www.youtube.com/watch?v=Wq5dQW2uPRY

If you have any questions during the live stream, you can use the following information to phone in:

- Dial your telephone conference line: 1-719-785-4469 or toll free: 888-450-4821
  Participant Passcode: 448853
  - Participant Conference Feature
    *6 - Mute/unmute your line

FOR ASSISTANCE

CCC Confer Tech Support - Monday - Friday between 8:00 am - 4:00 pm
Phone: 1-760-744-1150 ext. 1537 or 1554
Email: clientservices@cccconfer.org

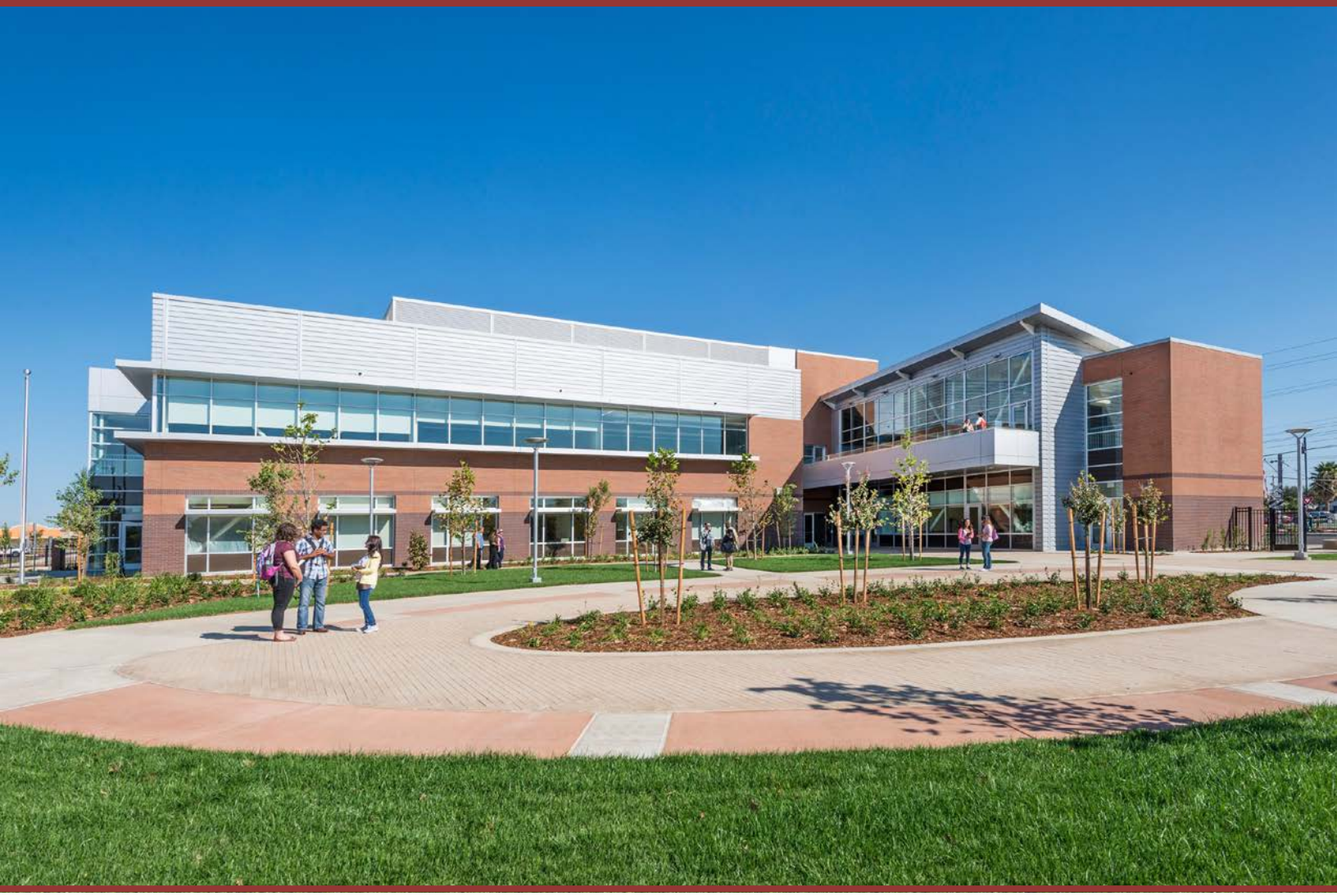
The Employee Benefits Department will also be hosting on-site Open Enrollment Workshops. The carriers will be available to answer your questions about their plans and networks.

District Office 1919 Spanos Court Sacramento, CA 95825	**Wednesday, May 9**	**8:30 – 10:30 a.m.**	Courtyard
American River College 4700 College Oak Dr. Sacramento, CA 95841	**Thursday, May 10**	**8:30 – 10:30 a.m.**	Community Rooms 3 & 4
Folsom Lake College 10 College Parkway Folsom, CA 95630	**Thursday, May 10**	**1:30 – 3:30 p.m.** ***Vendors: 1:30-3:30*** ***Presentation: 1:30***	FL1-20 (*Vendors*) FL1-109 (*Presentation*)

Please call Employee Benefits at (916) 568-3070 if you have any questions about this material or about Open Enrollment.

2018-19 Employee Benefits Guide

Regular Employees with a Permanent Assignment of 0.50 FTE or Higher
Effective July 1, 2018 - June 30, 2019



LOS RIOS
COMMUNITY
COLLEGE
DISTRICT

Please Read This Booklet & Retain for Your Records

Even if you are not making changes to your benefit elections, we encourage you to read through this booklet, especially the "Important Information" section on page 2, which highlights changes effective July 1, 2018, and the "Medical Plans" section beginning on page 10 which highlights the medical plans offered.

This booklet also contains summaries of other benefits available to you which are not limited to Open Enrollment such as supplemental life and long term care insurance.

In addition, the Contacts page at the back of the booklet offers a convenient one-page listing of plan numbers, phone numbers and web addresses of all of our benefit providers.

Table of Contents

Welcome to Your Employee Benefits Guide

Your benefits are a valuable addition to your overall compensation. Make sure you get the most from them by taking the time to understand your options and by selecting coverage that is a good fit for you and your family.

For information about the specific plans available to you, visit the "MyBenefits" site at https://bit.ly/KRnHQI or ask the Employee Benefits Department.

This Benefits Guide describes your benefit choices and your options to enroll. Please be sure to read the Important Notice below before you begin.

OPEN ENROLLMENT: April 30th – May 25th, 2018

Important Notice: Read Carefully

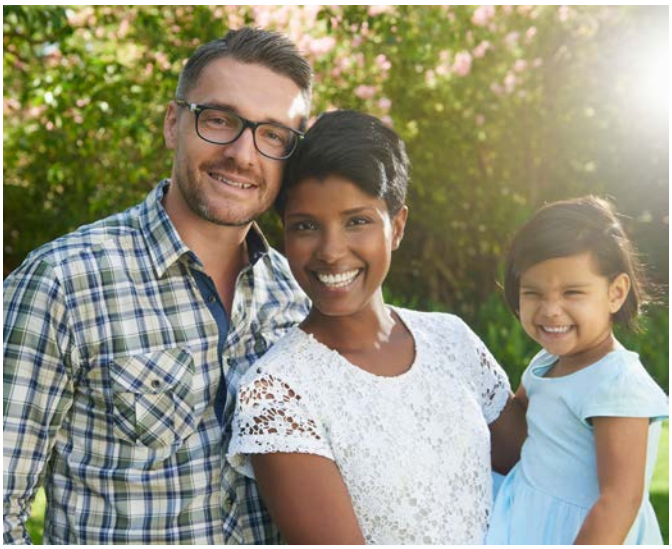
This Benefits Guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts and employment contracts or policies. This guide is not intended to be a complete description of the benefit plans and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern.

Important Information

Regular employees with a permanent assignment of 0.50 FTE or higher can participate in the benefits described in this guide.

Required Paperwork:

- **Medical Plan Waiver Form** -- This form is **required** for employees who do not enroll in Los Rios medical benefits.
- Additional forms are also required ***if you are making election changes*** during this Open Enrollment. (Refer to page 5 for a list of possible actions and the corresponding forms required.)



The Medical Plan Waiver Form can be accessed on the Employee Benefits website: http://www.losrios.edu/business/forms/Waiver_Form.pdf . **All completed form(s) must be received in the Employee Benefits Department by 5:00 pm, Friday, May 25, 2018.**

What's Changing from Last Year?

Medical

There is an added HSA compatible plan, the **Kaiser High Deductible Health Plan (HDHP) HMO**, which will have a monthly premium of $980.16. With the exception of the Kaiser HMO, the premiums for all medical plans are increasing. Please refer to your Open Enrollment memo for pricing and contribution information.

Due to an IRS mandate, the Calendar Year Deductible for Individuals within a Family who are on either the SHP HDHP HMO or the WHA 1800/0 HDHP HMO will increase from $2,600 to $2,700.

The Sutter Health Plus (SHP) ML32 HMO is being replaced by the **ML52 HMO**. Please make note of some of the changes listed below:

	2017-18 (ML32)	2018-19 (ML52)
Calendar Year Out-of-Pocket Limit	$750 / $1,500	$1,500 / $3,000
Physician/Specialist Office Visits	$10 copay	$15 copay
Outpatient Services	No Charge	$15 copay
Lab Tests	$10 copay	No charge
Diagnostic Imaging (MRI, CT, PET, etc.)	$50 copay	$15 copay
Emergency Room Services (waived if admitted)	$30 copay	$35 copay
Ambulance Services	$30 copay	No Charge
Prescription Drugs – Retail (30-day supply)	$5 Tier 1 / $20 Tier 2 / $40 Tier 3	$10 Tier 1 / $20 Tier 2 / $35 Tier 3

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

Additional medical plan coverage information can be found beginning on page 10.

Representatives from each employee unit serve on the Insurance Review Committee (IRC) and work in conjunction with District staff and our insurance brokers, Edgewood Partners Insurance Center (EPIC), to evaluate options to continue to provide quality coverage at a reasonable cost to you. Below is a brief outline of the medical, dental and vision insurance benefits offered this plan year. Details on each plan are found later in this benefit guide.

Medical

Medical Plan Options Available:

- Kaiser HMO
- Kaiser Deductible HMO
- Kaiser HDHP HMO (HSA Compatible) **New!!**
- Sutter Health Plus HMO
- Sutter Health Plus HDHP HMO (HSA Compatible)
- Western Health Advantage HMO
- Western Health Advantage 1800/0 HDHP HMO (HSA Compatible)

Our rates are composite, which means the rate you pay will not increase when you cover a spouse/domestic partner and/or eligible dependents. You can enroll yourself, your spouse/domestic partner, and/or eligible children, and your employee contribution will be the same regardless of self-only or family coverage.

The District and employee contributions for your unit can be found in your attached cover memo. Plan summaries can be viewed on pages 11-14. Plan documents and side-by-side comparison charts can be viewed on EPIC's "MyBenefits" website at https://bit.ly/KRnHQI.

Dental

Our dental rate is also composite, which means the rate you pay will not increase when you cover a spouse/domestic partner and/or eligible dependents. Currently, there is no monthly employee contribution for you to participate in our dental plan. The District contribution is $133/month for all units and covers the full premium. Keep in mind that the Los Rios dental plan is self-insured and costs are reviewed annually--the final rate for the 2018-19 plan year will be determined after the close of the current plan year of June 30, 2018, and you will be notified if the employee contribution changes. Plan details can be found on page 17.

Please note: If you enroll in the dental plan, you are making a two-year commitment and will not be permitted to cancel coverage until 24 months has passed, unless you have a qualified change-in-status event. Employees who cancel their dental coverage for any reason will have a required minimum 24-month waiting period before re-enrolling and the benefit level will restart at 70% due to the break in coverage under our incentive plan unless you remain continually covered by another group Delta Dental incentive plan.

Vision

The VSP Basic Plan and Buy-Up Plan premiums are decreasing. These plans are entirely employee-paid and have tiered rates, which means the employee contribution is higher if you choose to cover a spouse/domestic partner and/or dependents. Plan details can be found on page 18.

Please note: If you enroll in a voluntary vision plan, you are making a two-year commitment and will not be permitted to cancel coverage until 24 months has passed, unless you have a qualified change-in-status event. Employees who cancel their vision coverage for any reason will have a required minimum 24-month waiting period before re-enrolling.

Open Enrollment

Plan Years, Deductibles & Out-of-Pocket Expenses

Kaiser, WHA, SHP and Delta Dental have plan deductibles and/or annual maximums that are based on the calendar year (January 1 to December 31).

The voluntary vision plans are fiscal-year plans and annual maximums are based on the fiscal year (July 1 to June 30).

Open Enrollment Dates & Deadlines

Open Enrollment for the Los Rios health plans (medical, dental, vision, and life insurance) will be held from Monday, April 30, 2018 through Friday, May 25, 2018, with all changes effective July 1, 2018. **The first deduction for your new premium amounts will occur on your pay warrant dated June 29, 2018 for 11 and 12-month employees and August 31, 2018 for 9 and 10-month employees.**

Open Enrollment gives you the opportunity to elect coverage, change coverage for dependents (spouse/domestic partner and/or children), switch between plans or cancel coverage without a qualifying change-in-status event.

Paperwork is required to make elections or changes and **ORIGINAL forms must be received in the Employee Benefits Department by 5:00 pm, Friday, May 25, 2018.** *Please note that faxed and e-mailed copies **will not** be accepted*. After May 25, 2018, barring any qualifying change-in-status or Health Insurance Portability and Accountability Act of 1996 (HIPAA) qualifying event, the next opportunity to change medical, dental, vision, or life insurance coverage as an active employee will be during the next open enrollment in April/May 2019 with a July 1, 2019 effective date.

Webinar and On-Site Open Enrollment Fairs

There will be an Open Enrollment Webinar on Thursday, May 10, 2018 from 1:30PM-2:30PM. The link for employees to register and participate in the Webinar will be provided via communication separate from this Benefit Guide.

There will also be three On-Site Open Enrollment Fairs; dates, times, and locations will be provided via communication separate from this Benefit Guide. The carriers will be available to answer questions about their plans and networks.

We encourage you to either participate in the Webinar, or attend one of the On-Site Open Enrollment Fairs. It is a great opportunity to have your questions answered.

High Deductible Health Plan (HDHP) Information

The Western Health Advantage 1800/0 HDHP HMO, the Sutter Health Plus HDHP HMO, and the new Kaiser HDHP HMO plans are High Deductible Health Plans (HDHP) compatible with Health Savings Accounts (HSA). This type of plan design is different than a traditional HMO.

If you are considering enrolling in one of the High Deductible Health Plans, you are strongly encouraged to view the separate HDHP/HSA educational workshop recording conducted by BASIC pacific to learn more about plan details and IRS rules for HSAs before making your decision.

The video can be viewed from the "Recorded Presentations" section on the following web page: http://www.losrios.edu/business/recent_comm.php after May 10th.

Medical Plan Waiver Forms

We are requiring everyone who waives coverage to complete a waiver form and return it so it is received in the Employee Benefits Department by 5:00 pm, Friday, May 25, 2018. The form can be downloaded at http://www.losrios.edu/business/forms/Waiver_Form.pdf.

How to Enroll or Make Election Changes

You can enroll in benefits for yourself, your spouse/domestic partner, and your eligible dependents during the annual Open Enrollment. **Our medical and dental rates are composite, which means the rate you pay will not increase when you cover eligible family members.**

When you elect coverage, it will remain in effect for the entire plan year (July 1, 2018 – June 30, 2019) and into the subsequent plan year(s) until such time as you cancel coverage (due to a change-in-status or HIPAA qualifying event, during a future Open Enrollment, or due to separation from service). If you enroll in the dental or vision plan, you are making a two-year commitment and must remain enrolled for a full 24 months.

To enroll yourself and/or dependents and to make election changes, you must complete all necessary enrollment, change or cancelation forms. **ORIGINAL forms must be received in the Employee Benefits Department by 5:00 pm, Friday, May 25, 2018. Postmarks, placement in campus mail, emailed copies or faxes DO NOT meet the receipt deadline.** All forms are available online at www.losrios.edu/business/activeforms.php and at the Employee Benefits Department. Following is a list of the forms required for the noted changes.

ACTION	FORM / PAPERWORK REQUIRED
Enrolling in a new plan or adding a dependent	Enrollment / Change Form for each plan Payroll Deduction Form
Additional paperwork required for Spouse & Domestic Partner*	Copy of Marriage License or Certificate Affidavit of Domestic Partnership, or Copy of Domestic Partner Registration with State (whichever is applicable)
Dropping a Dependent	Enrollment / Change Form for each plan
Canceling Coverage	Cancelation Form (medical/dental) Enrollment / Change Form (vision) (Plus the Medical Plan Waiver Form if waiving medical or dental coverage; see below.)
Enroll or change UNUM Voluntary Life Insurance	UNUM Voluntary Life and AD&D Enrollment Form
Waiving Medical or Dental Coverage	Medical Plan Waiver Form

*Please visit the Los Rios website at www.losrios.edu/~business/downloads/Same_for_All/DP.pdf for a copy of the policies and procedures relating to domestic partner coverage and for the appropriate forms required to add a domestic partner and children of a domestic partner to your medical, dental or vision insurance.

Eligibility

Eligibility

Regular employees with a permanent assignment of 0.50 FTE or greater can participate in the benefits described in this guide.

Your Dependents

To maintain eligibility, you agree to notify the Employee Benefits Department **immediately** upon the failure of a dependent to satisfy any of the criteria listed below. You understand that you must remove ineligible dependents from coverage by submitting the necessary paperwork to the Employee Benefits Department within 31 days of ineligibility, and that it is a fraudulent act to obtain health coverage by misrepresenting any facts stated herein. Failure to do so could result in loss of benefits.

Listed below are the criteria for dependents (spouse/domestic partner and children) to be eligible for coverage:

Your eligible dependents include:

- Your spouse (as defined by applicable State law), which includes a same-sex spouse
- Your same-sex or opposite-sex domestic partner who meets certain criteria
- Your state-registered domestic partner
- Your dependent children under the age of 26 for medical, vision and life insurance, regardless of student or marital status
- Your unmarried dependent children under the age of 25 for dental insurance, regardless of student status
- Your grandchild(ren) (Kaiser only), only if your child (parent of the grandchild) is covered as an eligible dependent
- For long term care insurance: your spouse/domestic partner, parents and in-laws, grandparents and in-laws, siblings and their spouses/domestic partners, children and their spouses/domestic partners, and your spouse/domestic partner's siblings and spouses/domestic partners

Your children include:

- Your or your spouse/domestic partner's natural or adopted children
- Children placed in your home for adoption provided you have the legal right to direct all medical care
- Your or your spouse/domestic partner's dependent children over the age limit who are incapable of self-sustaining employment because of total disability (as defined by the carrier), which occurred prior to the limiting age and who are chiefly dependent upon you or your spouse/ domestic partner for support and maintenance
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

You may be required to provide proof of dependent status.

Domestic Partner Eligibility Criteria

If you are enrolling a domestic partner, you are required to have met all eligibility requirements listed below:

- You are each eighteen (18) years of age or older and are capable of consenting to a domestic partnership.
- You are financially interdependent and are jointly responsible for each others common welfare.
- You are each other's sole domestic partner and intend to stay in a committed relationship.
- Neither of you is married nor have you had another domestic partner within the last six (6) months (excluding any domestic partner or spouse who has died in the last 6 months).
- You are not closely related by blood that a legal marriage would otherwise be prohibited by law.

Note: *The value of health care coverage provided for a domestic partner or any enrolled dependent child(ren) of your domestic partner is treated as income to you for Federal tax purposes (and unless registered, State tax purposes). (Refer to "Imputed Income for Domestic Partners" on the next page for more detail.) Los Rios Community College District will report the value of the coverage as income to you on your Form W-2 and will withhold applicable taxes. It is recommended you consult with your tax advisor for more information on how this affects you.*

What's Next?

Effective Date of Coverage and First Deduction

Changes made during this Open Enrollment will take effect July 1, 2018. **The first deduction for your premium amounts will occur on your pay warrant dated June 29, 2018 for 11 and 12-month employees, and on August 31, 2018 for 9 and 10-month employees.**

Imputed Income for Domestic Partners

Please Note: Imputed income only applies to domestic partners regardless of gender. You are not subject to imputed income if you are in a same-sex marriage and you have submitted a copy of your marriage certificate to the Employee Benefits Department.

The Federal Government and IRS require that premiums paid for benefits of domestic partners or children of domestic partners be paid with post-tax dollars. Due to our composite rate structure and employer contribution for medical and dental insurance, the value of the medical and dental benefit results in imputed income to the employee. This means you will be taxed on the value of the coverage. For example, if you were covering a domestic partner on the Kaiser HMO and Delta Dental plans during the 2017-18 plan year, you were being taxed on $689.12 each month. Because vision coverage is entirely employee paid and has tiered rates, the premiums for domestic partners or children of domestic partners are taken with post-tax dollars and are thus not considered imputed income.

The State of California also considers the premiums imputed income unless you have filed a Declaration of Domestic Partnership with the California Secretary of State. Your domestic partnership does not need to be registered with the State for your dependents to be eligible for coverage. Registration simply allows the benefit to NOT be considered imputed income and subject to tax under the State tax laws. However, even if registered, the benefit will still be subject to tax under Federal tax law.

If you are adding or removing a domestic partner, or the children of a domestic partner, to or from your medical or dental coverage, please review your June 29th (or next affected) pay advice to ensure the imputed income amount in the 'Hours and Earnings' section of the advice was modified accordingly. If you do not see a change, contact the Employee Benefits Department as soon as possible.

Medical ID Cards

After you enroll in a medical plan or change plans, you will receive ID cards for the medical plan you select. When you receive your ID card, confirm that all information is accurate. If not, contact the carrier immediately.

You will not receive a card for dental or vision coverage; however, you can print generic dental and vision wallet cards from the Delta Dental and VSP websites.

See page 27 for carrier contact information.

Selecting a Primary Care Physician

If enrolling in one of the HMO plans for the first time, you will need to designate your choice of primary care physician (PCP). If you don't designate your preferred PCP, the HMO carrier will assign one for you. To choose a different PCP, call the insurance carrier and request that your PCP selection be changed to one of your choice in the network. Changes will be effective the first of the month (or the next month after, dependent upon carrier practices and when in the month the request is made) following your request.

It is recommended you make an appointment within the first 3 months with your new PCP to establish yourself as a patient and become familiar with your doctor.

Mid-Year Changes

What Happens if You Don't Enroll or Make Election Changes Now?

If you are an active employee and you don't enroll or make changes during Open Enrollment, you will continue to receive your current year's medical, dental, vision, and life insurance coverage elections for yourself and your covered dependents. (Remember that the Medical Plan Waiver Form may be required.)

Mid-Year Changes

After Open Enrollment, changes are permitted in limited circumstances and must be done within strict IRS timelines. If changes do not meet the criteria or are not made within the appropriate timeline, with the exception of *dropping ineligible dependents*, you will have to wait until the next Open Enrollment.

Acceptable change-in-status events are listed below. You have up to 31 days from the date of your qualifying event to make any benefit election changes, including adding new dependents due to marriage, birth or domestic partnership, or you must wait until the next Open Enrollment. To make election changes as a result of such an event, contact the Employee Benefits Department as the **original forms must be received** by the Employee Benefits Department within the 31-day time frame. **Exceptions will not be made—if you miss this deadline, you must wait until the next Open Enrollment.**

The plan's official documents govern how and when you can make enrollment changes during the plan year and may allow qualified change-in-status events in addition to those listed here. The change must be consistent with the qualifying event and proof of that event is required.

Qualified Change-in-Status Events
Marriage, Divorce, Legal Separation, Annulment
Establishing or Ending a Domestic Partnership
Birth, Adoption, Legal Guardianship of a Child, Death of a Dependent
Employment Status Change of the Employee, Spouse, Domestic Partner or Dependent
Change in other coverage (spouse, domestic partner or child gains or loses eligibility for coverage under another plan, such as through other employment)
Dependent Child no longer eligible due to age
A change in residence or work site of the Employee, Spouse, Domestic Partner or Dependent

Enrollment changes due to qualified change-in-status events generally are effective the first of the month following the event, provided that your original forms are received in the Employee Benefits Department by the 31-day deadline. Coverage for a new child due to birth, adoption or placement of adoption generally is effective on the date of the event. *Placement* for adoption without the legal right to direct all medical care for that child may not allow you to enroll that child in coverage until such time as the adoption is finalized or the authorization to direct all medical care is given by the court. Your Employee Benefits Department can provide complete details.

Mid-Year Changes

HIPAA Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline company-sponsored medical, dental or vision coverage for yourself or your dependents because you have other health insurance coverage (for example, through your spouse's employment), you may be able to enroll yourself and your dependents in our health care plan during the plan year if:

- You or your dependents lose eligibility for the other coverage
- The other employer stops contributing toward the other coverage
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP

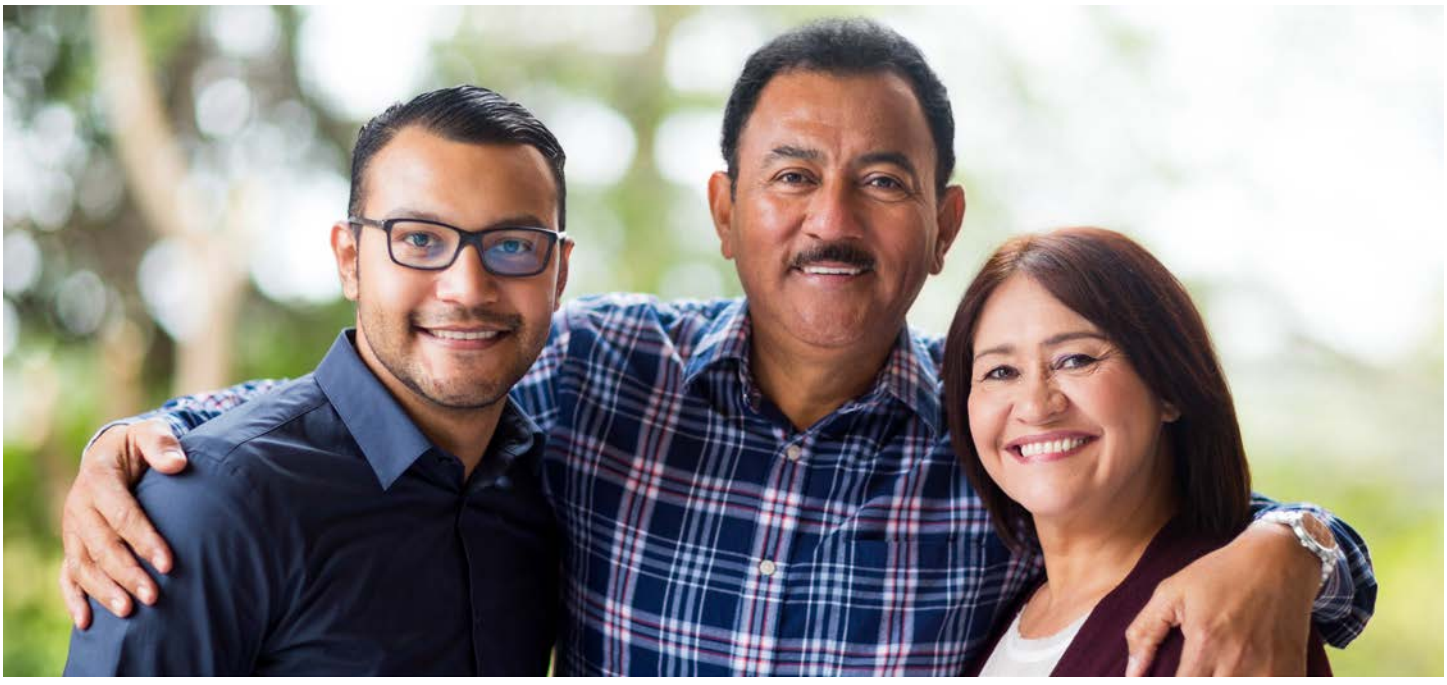
For any HIPAA special enrollment event, you must request enrollment within **31 days** after you or your dependent's other coverage ends (or after the other employer stops making a contribution toward the other coverage) or you acquire the new dependent. If the event is gaining or losing eligibility for coverage or premium assistance under Medicaid or CHIP, you have up to **60 days** to request a change.

For more information or to request special enrollment, contact the Employee Benefits Department.

Removing Ineligible Dependents (e.g. ex-spouse, over-age dependent, etc.)

If a dependent becomes ineligible during the plan year, you must remove the dependent from your coverage within 31 calendar days of the event. Even if you miss this deadline, it is your responsibility to contact Employee Benefits as soon as possible and request a retroactive termination of coverage based on when that dependent lost eligibility. Retroactive terminations are not always allowed and must be approved by the individual carriers. It is not the responsibility of the Employee Benefits Department to monitor this for you, and **you may be liable for claims paid during the period of ineligibility**.

When you experience any type of family change, you should also consider updating your life insurance beneficiaries at the same time. In addition, you may need to change your tax status by completing a new Form W-4 or update your address. For questions about tax forms or about updating your address, contact the Payroll Department or HR Department respectively.



Medical Plans

Your Medical Plans

You have the choice of the following medical plans. For specific plan options, please refer to pages 11-14. For District and employee contributions, refer to the attached cover memo.

- Kaiser HMO
- Kaiser Deductible HMO (DHMO)
- Kaiser HDHP HMO (HSA Compatible) **NEW!!**
- Sutter Health Plus HMO
- Sutter Health Plus HDHP HMO (HSA Compatible)
- Western Health Advantage HMO
- Western Health Advantage 1800/0 HDHP HMO (HSA Compatible)

You Must Enroll to Obtain Coverage

To obtain medical coverage, you must enroll as a new hire, when you experience a qualified change-in-status event or HIPAA special enrollment event, or during our annual Open Enrollment. If you do not elect a change during Open Enrollment, you will remain enrolled in your current plan. If you did not previously elect a medical plan, you will not have Los Rios medical coverage unless you enroll during this Open Enrollment.

Medical Plan Facilities/Networks

For a complete list of medical groups, please refer to the carrier websites.

KAISER

Roseville Medical Center
Sacramento Medical Center
South Sacramento Medical Center
With the following medical offices:
Davis, Elk Grove, Fair Oaks, Folsom, Lincoln, Point West, Promenade, Rancho Cordova, and Roseville

SUTTER HEALTH PLUS

Sutter Medical Group
Sutter Independent Physicians
Sutter Gould Medical Group
Sutter Medical Group of the Redwoods

WESTERN HEALTH ADVANTAGE

Hill Physicians Medical Group
Dignity Health/Mercy Medical Group
Dignity Health/Woodland Healthcare
Meritage Medical Network
NorthBay Healthcare

Medical Plans

KAISER HMO PLANS		
General Plan Provisions	**Kaiser HMO**	**Kaiser DHMO**
Calendar Year Deductible Individual / Family	None	$500 / $1,000
Calendar Year Out-of-Pocket Limit Individual / Family	$1,500 / $3,000	$3,000 / $6,000 (includes deductible)
Lifetime Maximum	None	None
Outpatient Services		
Doctor Office Visit Co-Pay	$15 copay	$10 copay (deductible waived)
Preventive Care	No Charge	No Charge
Well-Baby & Well-Child Care	No Charge	No Charge
Most Lab & X-ray	No Charge	$10 copay (after deductible)
Chiropractic	Not Covered	Not Covered
Acupuncture	$15 copay[1]	$10 copay[1]
Outpatient Surgery	$15 copay per procedure	10% coinsurance (after deductible)
Inpatient Services		
Hospitalization	No Charge	10% coinsurance (after deductible)
Emergency Services		
Emergency Room	$100 copay/ waived if admitted	10% coinsurance (after deductible)
Ambulance	No Charge	$150 per trip (after deductible)
Mental Health		
Inpatient	No Charge	10% coinsurance (after deductible)
Outpatient	$15 copay per individual visit $7 copay per group visit	$10 copay per individual visit $5 copay per group visit (deductible waived)
Durable Medical Equipment (DME)		
DME	No Charge	20% coinsurance (deductible waived)
Prescription Drugs	**Up to a 30-day supply**	**Up to a 30-day supply**
Generic	$10	$10
Brand – Formulary	$20	$30
Brand – Non-formulary	N/A	N/A
Specialty Medications	10% coinsurance not to exceed $100 (up to a 30-day supply)	10% coinsurance not to exceed $100 (up to a 30-day supply)
Mail Order	$20 Generic / $40 Brand Name (up to 100-day supply)	$20 Generic / $60 Brand Name (up to 100-day supply)

[1] Typically provided only for the treatment of nausea or for the treatment of chronic pain

Please note: This chart is a brief overview of benefits and coverage for the medical plans. To more thoroughly compare plans, please also review the detailed disclosure/summary documents for each plan available from your Employee Benefits Department or online at the "MyBenefits" site: https://bit.ly/KRnHQI. For questions about a specific procedure, service or provider, please contact the medical carrier directly.

Medical Plans

KAISER HDHP HMO	
General Plan Provisions	**Kaiser HDHP HMO (HSA Compatible)**
Calendar Year Deductible Individual / Family	Self only: $1,800 Individual w/Family coverage: $2,700 Family coverage: $3,600
Calendar Year Out-of-Pocket Limit Individual / Family	Self only: $3,600 Individual w/Family coverage: $3,600 Family coverage: $7,200 (includes deductible)
Lifetime Maximum	None
Outpatient Services	
Doctor Office Visit Co-Pay	No Charge (after deductible)
Preventive Care	No Charge (deductible waived)
Well-Baby & Well-Child Care	No Charge (deductible waived)
Most Lab & X-ray	No Charge (after deductible)
Chiropractic	Not Covered
Acupuncture	No Charge (after deductible; referral required)
Outpatient Surgery	No Charge (after deductible)
Inpatient Services	
Hospitalization	No Charge (after deductible)
Emergency Services	
Emergency Room	No Charge (after deductible)
Ambulance	No Charge (after deductible)
Mental Health	
Inpatient	No Charge (after deductible)
Outpatient	No Charge (after deductible)
Durable Medical Equipment (DME)	
DME	No Charge (after deductible)
Prescription Drugs	**Up to a 30-day supply**
Generic	$10 (after deductible)
Brand – Formulary	$30 (after deductible)
Brand – Non-formulary	N/A
Specialty Medications	$50 (after deductible, up to a 30-day supply)
Mail Order	$20 Generic / $60 Brand Name (after deductible, up to 100-day supply)

Please note: This chart is a brief overview of benefits and coverage for the medical plans. To more thoroughly compare plans, please also review the detailed disclosure/summary documents for each plan available from your Employee Benefits Department or online at the "MyBenefits" site: https://bit.ly/KRnHQI. For questions about a specific procedure, service or provider, please contact the medical carrier directly.

Medical Plans

SUTTER HEALTH PLUS (SHP) HMO Plans		
General Plan Provisions	**SHP ML52 HMO**	**SHP HDHP HMO (HSA Compatible)**
Calendar Year Deductible Individual / Family	None	Self only: $1,500 Individual w/Family coverage: $2,700 Family coverage: $3,000
Calendar Year Out-of-Pocket Limit Individual / Family	$1,500 / $3,000	Self only: $3,000 Individual w/Family coverage: $3,000 Family coverage: $6,000 (includes deductible)
Lifetime Maximum	None	None
Outpatient Services		
Doctor Office Visit Co-Pay	$15 copay	No Charge (after deductible)
Annual Adult Physical Exams	No Charge	No Charge (deductible waived)
Well-Baby & Well-Child Care	No Charge	No Charge (deductible waived)
Most Lab & X-ray	No Charge	Lab / X-ray: No Charge (after deductible)
Chiropractic	Not Covered	Not Covered
Acupuncture	$15 copay[1]	No Charge (after deductible)[1]
Outpatient Surgery	$15 copay	No Charge (after deductible)
Inpatient Services		
Hospitalization	No Charge	$50 copay per admittance (after deductible)
Emergency Services		
Emergency Room	$35 copay/ waived if admitted	No Charge (after deductible)
Ambulance	No Charge	No Charge (after deductible)
Mental Health		
Inpatient	No Charge	$50 per admittance (after deductible)
Outpatient	$15 copay	No Charge (after deductible)
Durable Medical Equipment (DME)		
DME	No Charge	No Charge (after deductible)
Prescription Drugs	**Up to 30-day supply**	
Tier 1	$10	No Charge (after deductible)
Tier 2	$20	No Charge (after deductible)
Tier 3	$35	No Charge (after deductible)
Specialty Medications	20% coinsurance not to exceed $100 (up to a 30-day supply)	No Charge (after deductible) (up to a 30-day supply)
Mail Order	$20 Tier 1/ $40 Tier 2 / $70 Tier 3 (up to 90-day supply)	No Charge (after deductible) (up to a 100-day supply)

[1] Typically provided only for the treatment of nausea or for the treatment of chronic pain

Please note: This chart is a brief overview of benefits and coverage for the medical plans. To more thoroughly compare plans, please also review the detailed disclosure/summary documents for each plan available from your Employee Benefits Department or online at the "MyBenefits" site: https://bit.ly/KRnHQI. For questions about a specific procedure, service or provider, please contact the medical carrier directly.

Medical Plans

WESTERN HEALTH ADVANTAGE (WHA) HMO PLANS		
General Plan Provisions	**WHA Premier 15 HMO**	**WHA 1800/0 HDHP HMO (HSA Compatible)**
Calendar Year Deductible Individual / Family	None	Self only: $1,800 Individual w/ Family coverage: $2,700 Family coverage: $3,600
Calendar Year Out-of-Pocket Limit Individual / Family	$1,500 / $2,500	Self only: $3,600 Individual w/ Family coverage: $3,600 Family coverage: $7,200 (includes deductible)
Lifetime Maximum	None	None
Outpatient Services		
Doctor Office Visit Co-Pay	$15 copay	No Charge (after deductible)
Annual Adult Physical Exams	No Charge	No Charge (deductible waived)
Well-Baby & Well-Child Care	No Charge	No Charge (deductible waived)
Most Lab & X-ray	No Charge	No Charge (after deductible)
Chiropractic	$15 copay (up to 20 visits/calendar year)	No Charge (after deductible) (up to 20 visits/calendar year)
Acupuncture	$15 copay (up to 20 visits/calendar year)	No Charge (after deductible) (up to 20 visits/calendar year)
Outpatient Surgery	Office Setting: $15 copay Outpatient Facility: $100 copay	No Charge (after deductible)
Inpatient Services		
Hospitalization	No Charge	No Charge (after deductible)
Emergency Services		
Emergency Room	$100 copay / waived if admitted	No Charge (after deductible)
Ambulance	No Charge	No Charge (after deductible)
Mental Health		
Inpatient	No Charge	No Charge (after deductible)
Outpatient	$15 copay	No Charge (after deductible)
Durable Medical Equipment (DME)		
DME	20% coinsurance	No Charge (after deductible)
Prescription Drugs	**Up to a 30-day supply**	**Up to a 30-day supply**
Tier 1	$10	No Charge (after deductible)
Tier 2	$30	$30 (after deductible)
Tier 3	$50	$50 (after deductible)
Self-injectables	20% coinsurance not to exceed $100 (up to a 30-day supply)	No Charge (after deductible) (up to a 30-day supply)
Mail Order	$25 Tier 1 / $75 Tier 2 / $125 Tier 3 (up to 90-day supply)	No Charge Tier 1/$75 Tier 2/$125 Tier 3 (after deductible) (up to 90-day supply)

Please note: This chart is a brief overview of benefits and coverage for the medical plans. To more thoroughly compare plans, please also review the detailed disclosure/summary documents for each plan available from your Employee Benefits Department or online at the "MyBenefits" site: https://bit.ly/KRnHQI. For questions about a specific procedure, service or provider, please contact the medical carrier directly.

Health Savings Account

Health Savings Account

If you elect the Kaiser HDHP HMO, the Western Health Advantage 1800/0 HDHP HMO or the Sutter Health Plus HDHP HMO, which are high deductible health plans (HDHP), you may be eligible to fund a health savings account (HSA). An HSA is a Federal tax- exempt trust or custodial account with a qualified HSA trustee and is used to pay or reimburse yourself for certain medical expenses. As a participant in an HDHP, you may be able to contribute to an HSA, so long as you meet all the criteria outlined by the IRS, which includes the following:

- You must be covered by a high deductible health plan (HDHP).
- You have no other non-HDHP medical coverage (such as a traditional HMO through WHA, Kaiser, etc.)
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.
- You do not participate in a Medical Flexible Spending Account (FSA).*

BASIC pacific is the administrator for the Los Rios HSA plan. If you would like to fund the HSA using payroll contributions and to receive the District contribution (see below), you must establish an account with BASIC pacific. If you wish to establish an HSA with a different vendor, you can do so and directly fund the HSA using post-tax contributions.

What are the Benefits of an HSA?

The District will contribute funds toward the HSA: up to $100/month for employees with HDHP HMO employee-only coverage and up to $150/month for family coverage for those enrolled in the WHA or Kaiser HDHP plans, so long as you are eligible to contribute to an HSA and the account is established with BASIC pacific. Please note that the District contribution amount varies by your bargaining unit. Please see your Open Enrollment memo for additional information about the SHP HDHP District contribution.

Here are some additional benefits of an HSA:

- An HSA rolls from year to year and is not subject to any "use it or lose it rule."
- An HSA is "portable." It stays with you if you change employers or leave the work force.
- Contributions can be made via pre-tax payroll deductions or you can claim a Federal tax deduction for contributions you, or someone other than your employer, make to your HSA, even if you don't itemize deductions.
- Contributions to your HSA made by your employer or funded by you through the cafeteria plan may be excluded from your gross income for Federal income tax purposes.
- The contributions remain in your account until you use them.
- The interest or other earnings on the assets in the account are tax free and distributions may be tax free if you pay qualified medical expenses (Federal income and payroll taxes only).

Contribution Limits

The amount you or any other person can contribute to your HSA depends on the type of HDHP coverage you have, your age, the date you become an eligible individual, and the date you cease to be an eligible individual. The 2018 contribution limit is $3,450 for self-only coverage and $6,850 for family coverage. The District contribution counts toward this maximum. If you are an eligible individual who is age 55 or older by December 31, 2018, your contribution limit is increased by $1,000. For example, if you have self-only coverage, you can contribute up to $4,450 (the contribution limit for self-only coverage of $3,450 plus additional catch-up contribution of $1,000). For more information, please visit www.treasury.gov and enter "HSA contribution limits" in the search box.

Recorded Information Session

A special HSA information session will be recorded and is available for viewing after May 10th. All employees interested in participating in the HDHP are strongly encouraged to watch that video.

**Special Rules for Medical FSA Participants: If you participate in the 2018 Los Rios Medical Flexible Spending Account (FSA) and you elect a HDHP effective July 1, 2018, you cannot fund the HSA until January 1, 2019, provided the balance in your FSA is zero as of December 31, 2018. If your FSA account balance is not zero, you must wait until the first of the month following the end of the grace period (April 1, 2019) to fund the HSA. You may be able to use your FSA dollars to reimburse yourself for your medical costs incurred with the HDHP. (Participation in the Limited Purpose FSA will not prohibit you from contributing to an HSA.)*

Prescription Drug Coverage

Prescription Drug Coverage

Your prescription drug coverage is included as part of the medical plan option you select. We recommend that you always use a participating pharmacy (one that is contracted by your medical plan) to get the best price. You can access a list of pharmacies through your plan's website or by calling Member Services.

The medical plans have "tiered" co-payments for prescription drugs, meaning you pay a different amount for different classes or groups of drugs such as "generic" and "non-formulary." A **formulary** is a list of drugs (both generic and brand name) that are preferred by the health plans. You can learn more about your plan's prescription drug coverage, including which drugs are on the formulary or in a particular tier, by visiting your plan's website (see page 27 for carrier contacts and websites). Please be aware that **formularies are updated regularly throughout the year**. Refer to your plan's website to see any updates. It's good to keep checking back to determine if your prescriptions are a part of the formulary.

Generic and Tier 1 drugs always have the lowest co-pays, and non-formulary brand name and Tiers 2 and 3 drugs always have the highest co-pays.

As an example of how the prescription coverage works, if you choose a generic drug on the Kaiser HMO plan, you will pay $10 as opposed to $20 for most brand name drugs. Mail order is available for twice the co-pay for up to a 100-day supply. For specialty medications, you will pay 10% of the cost up to $100 for up to a 30-day supply.

If you choose a Tier 1 drug on the Sutter Health Plus HMO plan, you will pay $10 as opposed to $20 if you choose a Tier 2 drug or $35 for a Tier 3 drug, for retail, up to a 30-day supply. Mail order is available for twice the retail co-pay for up to a 90-day supply. For specialty medications, you will pay 20% of the cost up to $100 for up to a 30-day supply.

If you choose a Tier 1 drug on the Western Health Advantage HMO, you will pay $10 as opposed to $30 if you choose a Tier 2 drug or $50 for a Tier 3 drug, for up to a 30-day supply. Mail order is available for two and a half the retail co-pay for up to a 90-day supply. For self-administered injectables, you will pay 20% of the cost up to $100 for up to a 30-day supply. Under the WHA 1800/0 HDHP HMO plan, whether a retail 30-day supply or mail order 90-day supply for any tier, you must pay 100% of the discounted contracted rate until the deductible is met. Once the deductible is met, there is no charge for your prescriptions if you choose either the retail Tier 1 30-day supply, or the mail order 90-day supply for any tier. If you choose the retail Tier 2 30-day supply, once the deducible is met, there will be a $30 charge for your prescription. Similarly, if you choose the retail Tier 3 30-day supply, once the deductible is met, there will be a $50 charge for your prescription.

Check directly with your plan's member services or the website for specific formulary, specialty medication and drug tier lists.

Dental Plan

Your Dental Plan

The Los Rios Delta Dental plan gives you the freedom to choose your own dentist and receive coverage from in-network Delta Dental of California dentists or out-of-network providers. This plan is a preferred provider organization (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage and benefit from discounted rates, or if you go to a dentist who is out-of-network, you receive a lower plan benefit and may pay more for services.

This plan is an incentive plan, which means the percentage of coverage for Diagnostic, Preventive Care, Basic Care, Crowns, Inlays, Onlays, and Cast Restorations increases by 10% each consecutive year you visit the dentist to a maximum coverage of 100%. If you do not use your dental plan, the percentage remains at the level you reached the previous year. It will drop back to 70% only if you drop coverage or lose eligibility and then become covered again. The percentage for prosthodontic services (such as prosthetics, tissue conditioning, etc.) does not change each year you visit your dentist.

Delta Dental PPO Plan		
General Plan Provisions	**In-Network**	**Out-of-Network**
Calendar Year Deductible Individual/Family	None	
Calendar Year Plan Maximum	$2,200	$2,000
Diagnostic & Preventive Care	Covered at 70-100%	
Basic Care	Covered at 70-100%	
Crowns, Inlays, Onlays & Cast Restoration Benefits	Covered at 70-100%	
Prosthodontic Benefits	Covered at 50%	
Dental Accident Benefits	Covered at 100% (Calendar year maximum of $1,000 per enrollee)	
Orthodontic Care	Not Covered	
Monthly Contributions	**Los Rios**	**Employee/Family***
12 Month	$133.00**	$0.00**
10 Month	$159.60**	$0.00**

**Our rates are composite which means the rate you pay will not increase when you cover eligible family members.*

***Final monthly premium to be determined after end of current plan year (June 30, 2018).*

Please note: *If you enroll in the dental plan, you are making a two-year commitment and will not be permitted to cancel coverage until 24 months has passed, unless you have a qualified change-in-status event. Employees who cancel their dental coverage for any reason will have a required minimum 24-month waiting period before re-enrolling and the benefit level will restart at 70% due to the break in coverage under this incentive plan unless the employee remained continuously enrolled under a non-Los Rios Delta Dental incentive plan.*

Vision Plans

Your Vision Plans

Los Rios offers two voluntary vision plans through VSP: the Basic Plan and the Buy-Up Plan with enhanced benefits. These are voluntary plans so there is not a District contribution toward the cost. VSP has the most extensive network of optometrists and vision care specialists in the country. Under these plans, you can use a VSP provider or another provider of your choice. However, when you obtain vision care through a non-VSP provider, you will receive a reduced level of benefits.

VSP (in-network benefits)		
General Plan Provisions	**Basic Plan**	**Buy-Up Plan**
Doctor Network	VSP Choice*	
WellVision Exam	$10	$25
Prescription Glasses	$20	$0 (included in WellVision Exam co-pay)
Lenses	Every plan year -Single vision, lined bifocal/trifocal lenses - Polycarbonate lenses for children -Average 20%-25% savings on other lens enhancements	Every plan year -Single vision, lined bifocal/trifocal and progressive lenses - Polycarbonate lenses for children -Average 20%-25% savings on other lens enhancements
Frame	Every other plan year - $120 allowance for wide selection of frames - $140 allowance for featured frame brands - $70 allowance at Costco Optical - 20% savings on the amount over allowance	Every plan year - $150 allowance for wide selection of frames - $170 allowance for featured frame brands - $80 allowance at Costco Optical - 20% savings on the amount over allowance
Contacts *instead of glasses*	Every plan year - Up to $60 copay for contact lens exam (fitting and evaluation) - $120 allowance for contacts	Every plan year - Up to $60 copay for contact lens exam (fitting and evaluation) - $150 allowance for contacts
Primary Eyecare	$20 - Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. (Limitations and coordination with medical coverage may apply.)	
Extra Savings	Glasses & Sunglasses - 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your WellVision Exam Laser Vision Correction - Average 15% off the regular price or 5% off the promotional price with contracted facilities	
12 Month Cost	**12 Month Employee Premium**	
Employee	$9.46	$15.85
Employee +One	$13.83	$23.08
Employee +Family	$24.79	$41.40
10 Month Cost	**10 Month Employee Premium**	
Employee	$11.34	$18.94
Employee +One	$16.58	$27.69
Employee +Family	$29.73	$49.67

**Coverage with a retail chain affiliate may be different than the benefit design described above. Visit vsp.com for details.*

***Please note:** If you enroll in a voluntary vision plan, you are making a two-year commitment and will not be permitted to cancel coverage until 24 months has passed, unless you have a qualified change-in-status event. Employees who cancel their vision coverage for any reason will have a required minimum 24-month waiting period before re-enrolling.*

Other Benefits

Other Benefits

The benefits described in the next section of this Employee Benefits Guide with the exception of the Supplemental life insurance, are available to eligible employees outside the spring Open Enrollment. Enrollment for some plans is automatic while, for others, you must apply for coverage.

Automatic Enrollment

- Basic Life Insurance
- Long Term Disability
- Employee Assistance Program
- Special Pay Plan

Apply Anytime

Supplemental Life Insurance (qualifying events or decrease in coverage only)

- Long Term Care Insurance
- 403(b) & 457 Retirement Savings Plans

Fall Open Enrollment

- Medical Flexible Spending Account
- Dependent Care Assistance Plan

Flexible Spending Accounts

Flexible Spending Accounts

Los Rios offers you flexible spending accounts through BASIC pacific. Flexible Spending Accounts (FSAs) help you save money on health care and dependent care expenses by paying for eligible expenses with tax-free dollars. **You must re-enroll in the plan every year.** FSAs always run on a calendar year basis and Open Enrollment is held in the fall with a January 1st effective date. FSAs are subject to mid-year change rules similar to the health plans. If you have a qualifying event, such as the birth of a child, and are interested in changing or electing an FSA, contact the Employee Benefits Department within 31 days of the qualifying event to see if you can make a change.

What are the Benefits of an FSA?

- Contributions to an FSA are deducted from your pay warrant pre-tax, i.e. before Federal, State, local, and Social Security taxes are withheld.
- Money used from your account(s) to pay for or reimburse you for eligible expenses isn't taxed.
- What you elect for a Medical or Limited Purpose FSA is pre-funded by Los Rios at the beginning of the plan year and both plans are funded in equal installments from your pay warrants throughout the plan year.

Medical FSA & Limited Purpose FSA

You can use the Medical Flexible Spending Account to pay for out-of-pocket health-related expenses. You can contribute up to $2,650 for the 2018 plan year to either a Medical FSA or a Limited Purpose FSA (see "Please Note" section below). Eligible expenses are "medically necessary" expenses not covered by your medical, dental or vision plans, including:

- Deductibles, co-pays and coinsurance
- Dental and orthodontia expenses
- Prescription glasses, contact lenses and lens cleaning solution
- Laser vision correction
- Prescription drugs and drug co-payments
- Medical supplies such as bandages, crutches, etc.

Eligible expenses do not include cosmetic procedures, treatments not supervised by a qualified health care professional, premiums for employer-provided health care plans, or other expenses that are not medically necessary.

Please Note: The Medical FSA is different than the Health Savings Account (HSA) associated with the high deductible HSA HMO plans. Participants cannot fund both a Medical FSA and an HSA at the same time, but they can fund a Limited Purpose FSA and an HSA. The Limited Purpose FSA follows the same guidelines above, except that only dental or vision expenses qualify. Those who enroll in an HDHP HMO, who also enroll in the full Medical FSA, must wait until they are no longer participating in a Medical FSA if they wish to contribute toward an HSA or receive the District contribution.

Dependent Care Assistance Program

You may use the Dependent Care Assistance Program (DCAP) to pay for the day care of your dependent children under the age of 13 and dependents of any age who are incapable of self-care, who live with you, and who are claimed as dependents on your income tax return.

You can contribute up to $5,000 each year. However, if your spouse has access to a DCAP, your total combined contribution may not exceed $5,000 and you may not contribute more than your spouse earns in wages. If you are married and file separate tax returns, each spouse may contribute $2,500. If your spouse is a full-time student or incapable of self-care, the maximum you may elect is $3,000 for one child in day care or $5,000 if you have two or more children in day care.

More Details

More details on the plans can be found on the Employee Benefits website (see Contacts).

Life Insurance

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance

Unum provides basic life and accidental death and dismemberment (AD&D) insurance to eligible Los Rios employees. Basic life insurance pays funds to your designated beneficiary(ies) after your death, while AD&D pays a separate amount up to your life insurance benefit in the event of an accidental death or for certain accidental injuries. Basic life and AD&D is provided at $50,000 automatically upon initial eligibility as a new hire.

Unum – Life Insurance	
Benefits	
Life Insurance	$50,000
AD&D Insurance	$50,000
Conversion	Included
Living Benefit	Included

Naming Your Beneficiary

You may name anyone you wish as the beneficiary who will receive your life and AD&D benefits in case of your death. However, if are married and choose to designate someone other than your spouse, your spouse must also sign the beneficiary form authorizing it. Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary designation form. You may change your beneficiary(ies) as often as you wish by submitting a new original form to the Employee Benefits Department.

Please be sure that you have an up-to-date beneficiary form on file with Los Rios. *It is important that you update the form as soon as possible if you experience any change in family status events, such as the birth of a child, adoption, marriage/domestic partnership, divorce, etc. Beneficiary forms can be found on the Los Rios Employee Benefits website (see Contacts).*

Age Reduction Schedule

Both the Basic and Supplemental Life Insurance are subject to the following age reduction schedule. For supplemental life, your premium will be based on the reduced value of the insurance.

Age Reduction Schedule		
	Basic Life Insurance	**Supplemental Life Insurance** (coverage is rounded to the next highest $500)
At Age 70	$32,500 (Original amount reduced by 35%)	Your original amount reduced by 35%
At Age 75	$25,000 (Original amount reduced by 50%)	Your original amount reduced by 50%
At Retirement	All coverage terminates (conversion available)	All coverage terminates (conversion available)

Supplemental Life Insurance

In addition to the basic life insurance plan, you may be eligible to purchase additional voluntary amounts of individual term life insurance for yourself, your spouse/domestic partner, and your child(ren) through Unum.

You may purchase amounts of voluntary life insurance coverage for yourself, in $10,000 increments, up to a maximum of the lesser of 5 times your annual earnings of $750,000. **If you previously enrolled in voluntary life insurance coverage for yourself,** you may increase your coverage by $10,000 (not to exceed the lesser or 5 times your annual earnings of $250,000) and medical underwriting will not be required. If you enroll in this coverage during your first 31 days of employment or initial eligibility, medical underwriting will be required only for amounts that exceed $250,000. Any amount requested after initial eligibility will be subject to medical underwriting and may or may not be approved. You may apply during Open Enrollment by submitting an application to the Employee Benefits Department. Open Enrollment will be held from Monday, April 30, 2018 through Friday, May 25, 2018, with all changes effective July 1, 2018. **The first deduction for changes to coverage not subject to medical underwriting will occur on your pay warrant dated June 29, 2018 for 11 and 12-month employees, and August 31, 2018 for 9 and 10-month employees**. For any coverage requests subject to medical underwriting, the first deduction will occur on the pay warrant following carrier approval of the request. Please note that medical underwriting involves answering a confidential questionnaire as to your current heath, which you will be asked to provide directly to Unum after you submit your application.

Spouse/Domestic Partner & Child Coverage*

If you have supplemental life insurance for yourself, you may request spouse/domestic partner life insurance, in $5,000 increments, up to $150,000, but no more than 100% of your election. If you enroll in this coverage during your first 31 days of employment or initial eligibility, medical underwriting will be required only for amounts that exceed $30,000. If you did not purchase coverage at that time, you may apply during Open Enrollment by submitting an application to the Employee Benefits Department. Open Enrollment will be held from Monday, April 30, 2018 through Friday, May 25, 2018, with all changes effective July 1, 2018. **The first deduction for changes to coverage not subject to medical underwriting will occur on your pay warrant dated June 29, 2018 for 11 and 12-month employees, and August 31, 2018 for 9 and 10-month employees**. For any coverage requests subject to medical underwriting, the first deduction will occur on the pay warrant following carrier approval of the request. Please note that any amount requested after initial eligibility will be subject to medical underwriting and may or may not be approved. In addition, a voluntary life insurance benefit of $10,000 may be purchased for your child(ren) ages 6 months up to age 26 (live birth to 6 months is $1,000) without a medical questionnaire.

Voluntary Life Insurance Rate per $1,000			Spouse or Domestic Partner Voluntary Life	Child(ren) Voluntary Life
	Monthly Rate	Tenthly Rates		
Under age 30	$0.042	$0.0504	Use employee's age bracket to calculate the spouse or domestic partner's rate per $1,000 (even if age is different)	Monthly Rate: $1.10/month regardless of the number of children covered Tenthly Rate: $1.32/month regardless of the number of children covered
30-34	$0.040	$0.0480		
35-39	$0.049	$0.0588		
40-44	$0.074	$0.0888		
45-49	$0.112	$0.1344		
50-54	$0.181	$0.2172		
55-59	$0.299	$0.3588		
60-64	$0.493	$0.5916		
65-69	$0.621	$0.7452		
70-74	$0.987	$1.1844		
75-79	$1.729	$2.0748		
80+	$3.074	$3.6888		
AD&D (added to rates above)	$0.020	$0.0240		

**You and your eligible family members may only be covered once under life and AD&D insurance. No one may be covered as both an employee and as a dependent. If you and your spouse or child work for Los Rios, be sure to coordinate your life insurance coverage so no one is covered more than once.*

Long Term Care Insurance

Long Term Care Insurance

Los Rios Community College District offers long term care insurance (LTC) through Unum. LTC helps pay for a variety of personal and medical services that are provided for people who can no longer care for themselves over a period of time. Services can be provided in a nursing home, residential care facility or at your own home.

This coverage is completely voluntary and employee paid. You may apply for this coverage at any time. New hires and newly eligible employees have 31 days to elect up to $6,000 in monthly benefit and for a duration of 5 years without having to go through medical underwriting (no medical questionnaire). This is called "guarantee issue." Anything over that amount or duration would be subject to medical underwriting; however, the guarantee issue, once given, would not be retracted even if the excess amounts were denied. The base benefit provides the following coverage:

Unum – Long Term Care	
Benefits	
Facility Monthly Benefit Amount	$3,000 - $9,000
Facility Benefit Duration	2 Years – Lifetime
Elimination Period	90 Days
Lifetime Maximum	Monthly Benefit Amount x Benefit Duration

You will be subject to medical underwriting only if you purchase more than the guarantee issue amount at the time of hire or apply after the initial eligibility period (within 31 days of hire or gaining eligibility) for any amount elected. The younger you are when you enroll, the lower the premiums will be. Rates will not increase due to your age after you are enrolled and coverage can continue with the same rate when you leave Los Rios or retire.

Family Coverage

Family members such as your spouse/domestic partner, child(ren), mother, father, sister, brother and even in-laws are all eligible to apply for this benefit *even if you do not elect it for yourself.* The cost of this benefit for yourself and/ or your spouse/domestic partner is deducted from your pay warrant, after tax. Coverage for family members is billed directly from Unum to the participant. All family members must be between the ages of 18 and 80 and go through medical underwriting, which means they may be denied coverage.

Caregiver Resources

Even if you haven't elected Long Term Care Insurance through Los Rios, the AGIS Network provides a wealth of resources and tools, such as caregiving hotlines, assistance finding local and long distance facilities and services, and online tools to help you organize family and friends around caregiving needs. Confronted with the need to provide or arrange for a loved one's care, many first-time caregivers feel overwhelmed by all the decisions and details. A little guidance can help you make sound decisions, even in urgent circumstances. You can find more details at www.LosRiosLTC.com.

Long Term Disability Insurance

Long Term Disability (LTD) Insurance

Long Term Disability (LTD) insurance coverage is provided by Los Rios at no cost to you, and is administered by Unum. LTD helps protect you by replacing up to 66.67% of your income (up to $12,000/month maximum) in the event you are unable to work, either fully or partially, due to a long-term illness or injury.

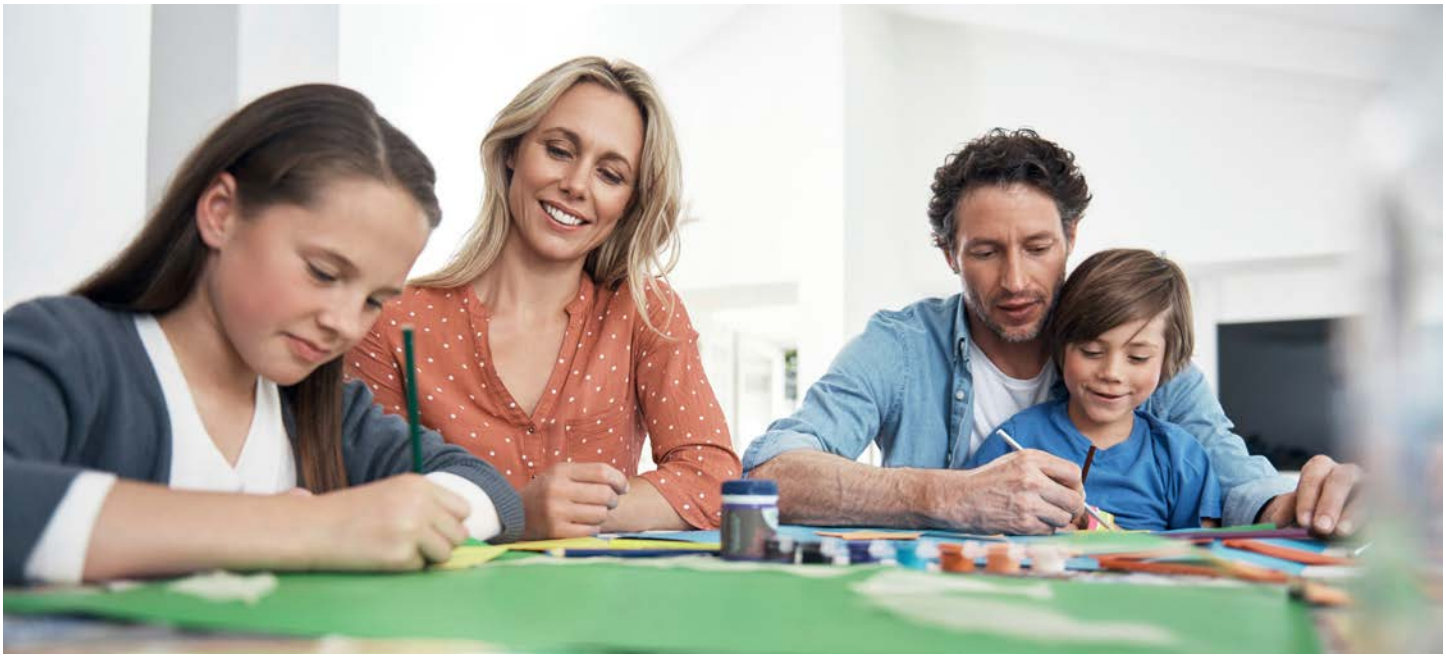
You are automatically enrolled in LTD coverage upon hire or when you are newly eligible.

Disability is defined by the Unum contract and typically means that you cannot perform one or more of the essential duties of your occupation due to injury, sickness, pregnancy or other medical condition covered by the insurance. You must be disabled for at least 90 days, or have exhausted all paid leave, and be in less than full-paid status before you can receive an LTD insurance benefit payment. Please note, this benefit is taxable at the time it is received.

Contact Employee Benefits if you think you need to be off work and they will assist you in applying for LTD when applicable.

Unum – Long Term Disability (LTD)	
Benefits	
Benefit Amount	66.67%
Maximum Benefit	$12,000 per Month
Elimination Period	The greater of 90 days or exhaustion of 100% paid leave
Maximum Duration	Between 2 years and to normal Social Security retirement age (Graded – Depending on class. Please see Employee Benefits.)
Definition of Disability	For the first 24 months of disability (depending on class--please see Employee Benefits) that you are not working and cannot perform your normal occupation due to injury or illness. After 24 months (depending on class--please see Employee Benefits) that you are not working and cannot perform any occupation you are reasonably qualified to perform based on background, training, or education.

Please note: This chart is just a brief overview of benefits and coverage for the LTD plan. Please review the detailed disclosure/summary documents for the plan, available from the Employee Benefits Department or online at the "MyBenefits" website: https://bit.ly/KRnHQI.



403(b) & 457

403(b) & 457 Retirement Savings Plans

As an employee of an educational institution, you have the option of participating in a tax-deferred retirement savings program as authorized by Sections 403(b) and 457 of the Internal Revenue Code. Through these programs, you can shelter a portion of your compensation currently subject to Federal and State income tax to purchase supplemental retirement benefits. Your 403(b) and 457 contributions, with accumulated interest and dividends, are not subject to Federal or State income taxes until the funds are withdrawn (usually at retirement). There are restrictions and you may have significant penalties on early withdrawals. There is also an element of risk associated with the 403(b) and 457 programs, as your funds are not insured and are subject to earnings (or losses) based on your investment choices and market performance.

Investment Options

Per the California Education Code, to offer the ability to invest with a 403(b) company, the vendor must be registered and listed on the 403(b) Compare website managed by CalSTRS (*www.403bcompare.com/).* For the 457 plan, specific companies have been designated as eligible for the District's program: CalPERS, CalSTRS, Schools Financial Credit Union and TIAA-CREF. CalPERS members may invest in the CalSTRS 457 program, and CalSTRS members may invest in the CalPERS 457 program. You may obtain a list of eligible companies by visiting the Envoy Plan Services website at *www.spokeskids.com/LosRiosCCD/* or by contacting the Employee Benefits Department.

How to Enroll

The first step in the enrollment process is to establish a 403(b) or 457 account with one of the companies on the approved vendor list. Once you have selected a company, call them and request literature on their 403(b) or 457 plan. Included in the information from the company will be their account application. Even if you already have a relationship with a company through a prior employer, you still must set up a 403(b) or 457 account under Los Rios.

During this process, download the appropriate Salary Reduction Agreement (SRA) form from the Envoy website under "FORMS." **Once the account is established**, fax or mail the SRA directly to Envoy. This form provides the necessary information for Employee Benefits to initiate your payroll deduction.

You may enroll or change your deduction anytime by submitting a new SRA to Envoy, but are subject to month-to- month cutoff dates to meet specific IRS and payroll deadlines. Please keep copies of all of your completed forms for your records.

Maximum Contribution

The 2018 maximum contribution for 403(b) and 457 plans is $18,500/calendar year for employees under age 50, and $24,500/calendar year for employees who are age 50 or over as of the last day of the year. These plans have separate limits, so an employee can contribute twice the amount listed if contributing to both types of plans.

Enhanced Employee Assistance Program (EAP)!

The Employee Assistance Program (EAP) paid for by Los Rios is offered through MHN, a wholly-owned subsidiary of Centene Corporation. Their enhanced benefit offerings include the following services:

Counseling and Clinical Support for personal concerns and life issues such as marriage, family and relationship issues, stress and anxiety, grief and loss, anger management, alcohol and drug dependency and other emotional health issues.

- Five (5) free in-person sessions, per each household member, per issue, per year.
- Telephonic and web-video consultations also available.
- More than 1,000 local professional providers in the MHN network with over 10,000 in California.

Work-Life Services

- **Legal Services** - Your EAP includes consultations with a licensed attorney and you receive one 30-minute office or telephone consultation per separate legal matter. If you retain an attorney, you receive 25% off the normal hourly rate.
  - You can receive assistance with legal issues such as divorce, name changes, bankruptcy, advice on planning and preparing estates, wills and trusts, adoption or guardianship issues, buying or selling property, lease and rental agreements, small claims court and more!
- **Financial counselors** can help you take control of your finances with guidance on such issues as buying a home for the first time, debt and budgeting assistance, credit counseling, planning for retirement, and more.
  - For each separate financial issue, you are eligible for as many consultations as you need, at no cost to you.
  - Financial counselors and educators are available without an appointment Monday-Friday, and prescheduled consultations are available on Saturdays.
- **Additional work-life services:** childcare and eldercare assistance and referrals, daily living services and identity theft recovery service.
- **Wellness coaching** and tools for a variety of topics such as smoking cessation, weight loss, nutrition, stress and more. Wellness coaches partner with you to support the changes you want to make for a healthier you!
  - Free, 24/7 access to the Wellness Center, the gateway to a suite of valuable interactive wellness tools.
  - Online health assessment which will provide a confidential, detailed report which highlights potential risks and includes suggestions for improvement.
  - Develop a meal plan and shopping list based on Mayo Clinic eating guidelines and a fitness program with suggested daily exercises.

Eligible employees are automatically enrolled at time of hire. You can contact the EAP 24 hours a day, 7 days a week, 365 days a year. Call 800-535-4985 or log onto members.mhn.com using company code "LRCCD."

Special Pay Plan (SPP)

If you accrue vacation while working for Los Rios, your unused, accrued vacation hours are payable to you when you retire or terminate employment. If you are under age 55 the year you retire or leave Los Rios, your vacation will be paid directly to you through the Payroll process and is subject to all applicable taxes. If you are age 55 or older anytime during that calendar year, your vacation hours will be paid into the Special Pay Plan, which is a retirement plan for special forms of compensation to be paid to employees in a tax-advantaged manner. You will permanently save payroll taxes, including 7.65% Social Security and Medicare taxes, on the money placed into the Special Pay Plan.

Envoy Plan Services and MidAmerica administer the Los Rios Special Pay Plan. MidAmerica will establish a Special Pay Plan account on your behalf, and you are 100% vested in the account balance at all times. Your account balance earns a guaranteed fixed interest rate of 1.30% in 2018 and is re-set each January. Assets can remain in the Special Pay Plan or you may withdraw the funds (at which point they will be subject to income tax), take multiple distributions, or rollover funds to an IRA or other retirement plan.

Contacts

If you have any questions, please call the Employee Benefits Department or you may contact the plan carrier directly.

EMPLOYEE BENEFITS DEPARTMENT		
Employee Benefits Department	(916) 568-3070	benefits@losrios.edu
Nicole Keller, Supervisor	(916) 568-3197	kellern@losrios.edu
Website & Forms	www.losrios.edu/business/benefits.php	www.losrios.edu/business/activeforms.php

PLAN	GROUP #	TELEPHONE #	WEBSITE
MEDICAL			
Kaiser Permanente HMO, DHMO & HDHP HMO	233	(800) 464-4000	www.kp.org
Sutter Health Plus HMO & HDHP HMO	030007	(855) 315-5800	www.sutterhealthplus.org
Western Health Advantage HMO & 1800/0 HDHP HMO	107423	(888) 563-2250	www.westernhealth.com
DENTAL			
Delta Dental PPO Plan	6632	(800) 765-6003	www.deltadentalins.com
VISION			
Vision Service Plan (VSP)	12221829	(800) 877-7195	www.vsp.com
FSA, DCAP & HSA			
BASIC pacific	Los Rios	(800) 574-5448	www.basicpacific.com
LIFE AND DISABILITY INSURANCE			
Unum	800795	(866) 679-3054	www.unum.com
403(b), 457 & SPECIAL PAY PLAN (SPP)			
Envoy Plan Services -- 403(b) & 457	Los Rios	(866) 873-4240 (800) 248-8858	www.spokeskids.com/LosRiosCCD
MidAmerica -- Special Pay Plan	Los Rios	(800) 430-7999	www.midamerica.biz
OTHER BENEFITS			
Employee Assistance Program -- MHN	LRCCD	(800) 535-4985	members.mhn.com
EPIC (broker) -- Claims Issues & Plan Questions	Los Rios	(877) 374-2151	csr@epicbrokers.com https://bit.ly/KRnHQI
Long Term Care Insurance & Caregiver Resources -- Unum	145431	(800) 227-4165	www.LosRiosLTC.com

Glossary & Annual Notice

Glossary of Terms

AD&D (Accidental Death & Dismemberment)	A plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of part of the body, or the loss of the use of part of the body).
Beneficiary	A person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit under the plan.
Coinsurance	A percentage of charges that you must pay when you receive a covered service, up to the plan's annual out-of-pocket limit.
Co-Payment or Co-pay	A set amount you pay out of pocket for a particular service. The plan pays the balance.
Deductible	The out-of-pocket amount you must pay each plan year before the plan pays for eligible benefits.
Dependent Care Assistance Plan (DCAP)	The Dependent Care Assistance Plan allows you to set aside tax-free dollars that will reimburse you for custodial or day care expenses for children who are your federal tax dependents under age 13, or for a disabled adult federal tax dependent who lives with you, so that you and your spouse (if applicable) can work, attend school or actively look for work.
Flexible Spending Account (FSA)	A Medical Flexible Spending Account allows you to set aside tax-free dollars that will reimburse you for qualified medical, dental and vision expenses incurred during the plan year. "Incurred" means the service must be performed during the plan year. "Qualified" expenses include most medically necessary (meaning not cosmetic) out-of-pocket medical, dental, and vision related expenses. A Limited Purpose FSA follows the same guidelines except that only dental or vision expenses would qualify.
Formulary	A list of prescription drugs covered by a health insurance plan.
Generic	Your prescription drug co-pay depends on the class or group of your prescribed medication. A generic drug generally has the lowest co-pay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand-name-only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand-name drugs; however, they are much less expensive.
Health Savings Account (HSA)	A Health Savings Account (HSA) allows individuals to pay for current health expenses and save for future qualified medical expenses on a pre-tax basis. An HSA is used in combination with a high deductible health insurance plan. The money in the account helps pay the deductible as well as any other eligible medical expenses. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax free, and that amount is available on a tax free basis to pay qualified medical costs.
High Deductible Health Plan (HDHP)	A health insurance plan which features higher deductibles than traditional insurance plans and does not cover the initial costs of medical expenses, except for preventive services. The deductible requires the insurance holder to pay the first portion of a medical expense before the insurance coverage kicks in. The minimum deductible for a plan to fall into the category of an HDHP may vary each year. A high deductible health plan may be combined with a Health Savings Account (HSA) to allow participants to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

Glossary & Annual Notice

HIPAA	Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules.
In-Network Provider	A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.
Negotiated Rates	The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are typically less than usual, customary and reasonable (UCR) charges.
Non-Formulary Drug	Your prescription drug co-pay depends on the class or group of your prescribed medication. A non-formulary drug generally has the highest co-pay level or is not covered by your plan because it is not on the plan's list of preferred drugs, called a "formulary" or "formulary list." You can find out how different drugs are classified by your plan by visiting the plan's website.
Out-of-Network Provider	A State-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits or no benefits when you use out-of-network providers. See your plan for coverage details.
Out-of-Pocket Expenses	Co-pays, deductibles, and other expenses that are not covered by the health plan.
Qualifying Change-in-Status Event	Certain events which may allow you to make changes to your benefits. Qualifying events include: marriage, divorce, domestic partner changes, death, birth, adoption or placement for adoption, and significant change in employment.

Annual Notice: Patient Protection Notice

Kaiser, Sutter Health Plus and Western Health Advantage generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, one will be assigned to you by Kaiser, Sutter Health Plus or Western Health Advantage. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser, Sutter Health Plus or Western Health Advantage member services at the number on your insurance card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser, Sutter Health Plus or Western Health Advantage or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser, Sutter Health Plus or Western Health Advantage member services at the number on your insurance card.

NOTES

Los Rios Community College District
Employee Benefits Department
1919 Spanos Court
Sacramento, CA 95825

916.568.3070 phone